Utilising Clinical Redesign To Improve Service Delivery
- Our Medical Journey So Far

Presentation Sydney
16 September 2015

Clinical Redesign Program – South
Rethinking healthcare service delivery
Presenters

Dr. Nicole Hancock
Head of Department of General Medicine and the Assessment and Planning Unit of the Royal Hobart Hospital.

Clinical Lead Health Services Innovation Tasmania-ED Access & Whole of Hospital Flow Medical Patient Journey

Sue Hughes
Program Officer-Medical Patient Journey
RN, Midwife
Todays Presentation

Setting the scene:
• Background- our hospital & what’s going on
• Royal Hobart Hospital- why do service redesign?

Our story-journeying along the yellow brick road
• How did we start our journey?
• Maintaining the journey
• Outcomes from our journey so far
Clinical Redesign Program – South

Rethinking healthcare service delivery
Clinical Redesign Program – South
Rethinking healthcare service delivery
Clinical Redesign Program – South
Rethinking healthcare service delivery
Royal Hobart Hospital

• Australia’s second oldest hospital.
• Tasmania’s largest hospital and its major referral centre at tertiary level.
• Provides acute, sub acute, mental health, women's & children’s, aged care inpatient and ambulatory services
• 550 beds: 460 acute overnight and 90 day beds
Our Medical Journey
Our Emergency Department

Discharged patient group 59.8%

Admitted patient group are 34.1% of presentations

Did not wait 4.2%

ADMITTED TO:
26% EMU = ED short stay unit
22% General Medicine
9% General Surgery
6% Paediatrics
6% Psychiatry
General Medicine at the RHH

- Largest inpatient service in the hospital
- In 2013/2014 - 4,438 separations and 22,323 bed days
- Divided into 4 teams

**ADMISSIONS**

- Mainly from the Emergency Department
- A very small number from Emergency Short Stay Ward (EMU), Outpatients Department or “direct”.
General Medicine at the RHH

APU – Assessment & Planning Unit

The service has 2 areas where inpatient beds are located:

- Assessment and Planning Unit (APU) 18 beds
- Ward 1BN Up to 27 beds
  (shared with respiratory and infectious diseases units)

Clinical Areas

1BN – General Medical Unit, RHH

35 beds
How did we get started?

What is the ‘burning platform’ that captures the hearts and minds of staff to actively participate in the journey?

Once on the journey, how do you maintain staff engagement?
Gather Proof - what is going on?

Patient Flow/ED Access

• **WTBE**- WAS THE BED EMPTY? (Ref :Healthcare Reform Consulting)

*High level data review desktop exercise*

Inpatients 17,100 patient journeys from 2013/2014 were reviewed relating to overnight admissions only. Looking at hospital activity

• **WAISH Study**- WHY AM I STILL HERE? (Ref :Healthcare Reform Consulting)

A study undertaken over a 7 day period visiting every inpatient ward/unit morning and afternoon......

• **WOTTL Study**- Who Owns the Time Line (Ref :Healthcare Reform Consulting)

419 patients tracked through the ED between 0755 on 17 August to 0643 on 20 August 2014. (just under 72 hours)
Gather Proof - what is going on?

**WAISH Study** - WHY AM I STILL HERE?  (Ref: Healthcare Reform Consulting)

4143 beds reviewed over this 7 day period

37 separate criteria in a number of categories:
- EMPTY BED
- MEDICAL REASONS
- NON-MEDICAL REASONS
- Discharge requirements
- Discharge planning
- Discharge destination
- Transfer of care
- other
WAISH Study

<table>
<thead>
<tr>
<th>Bed Groups</th>
<th>Number</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical reason</td>
<td>2536</td>
<td>61.2%</td>
</tr>
<tr>
<td>Non-clinical Reason</td>
<td>1065</td>
<td>25.7%</td>
</tr>
<tr>
<td>Empty Bed</td>
<td>542</td>
<td>13.1%</td>
</tr>
</tbody>
</table>

If we combine the empty bed numbers and beds occupied for non-medical requirements the total is: **38.8%**

(noted by the study coordinators to be slightly past the 11-36% range observed from this study in other hospitals)
Clinical Redesign Program – South
Rethinking healthcare service delivery

WAISH

Waiting for review - Consultant or Allied Health

Awaiting discharge decision from doctor

Destination not ready - Rehab
WAISH

Evidence of latent bed capacity
Situation - Whole of Medicine

Ward admissions profile by day of week and hour of day

Ward discharge profile by day of week and hour of day
The Case for Change - Sources of variation in LOS, and possible bed savings

<table>
<thead>
<tr>
<th>Source of variation in LOS</th>
<th>Potential savings (bed days per year)*</th>
<th>Number of potential free beds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients on outlier wards</td>
<td>2410</td>
<td>6.6</td>
</tr>
<tr>
<td>Admitting team/consultant</td>
<td>1789</td>
<td>4.9</td>
</tr>
<tr>
<td>Mode of separation</td>
<td>1753</td>
<td>4.8</td>
</tr>
<tr>
<td>Time of day of admission</td>
<td>2020</td>
<td>4.5</td>
</tr>
<tr>
<td>Day of week of admission</td>
<td>1226</td>
<td>3.4</td>
</tr>
<tr>
<td>Access block (patients spending more than 8 hours in ED after admission)</td>
<td>767</td>
<td>2.1</td>
</tr>
<tr>
<td>Post-take discharges by day of week</td>
<td>215</td>
<td>0.6</td>
</tr>
</tbody>
</table>

*These potential savings are not additive, because removing one source of variation is likely to affect others.
Clinical Redesign Program – South
Rethinking healthcare service delivery

Situation - General Medicine

Beds required to accommodate patients admitted under general medicine

- 95% of the time
- 90% of the time
- 80% of the time
Case for Change

Our diagnostics have identified significant issues with having patients outlying from a home ward- most remarkably, these patients (38% in our data set) acquire a **LOS of 48% greater*** than patients in the “home wards” of APU, 1BN and DCCM.

*Adjusted for DRG, age, comorbidities, sex.
General Medicine at the RHH

• Inpatient bed need for the service is significantly greater than bed capacity
• A significant proportion of inpatients are outliers
• General Medicine inpatients occupy 3.5 ED cubicles every hour of every day
Clinical Redesign Program – South
Rethinking healthcare service delivery
The Case for Change - Sources of variation in LOS, and possible bed savings

<table>
<thead>
<tr>
<th>Source of variation in LOS</th>
<th>Potential savings (bed days per year)*</th>
<th>Number of potential free beds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients on outlier wards</td>
<td>2410</td>
<td>6.6</td>
</tr>
<tr>
<td>Admitting team/consultant</td>
<td>1789</td>
<td>4.9</td>
</tr>
<tr>
<td>Mode of separation</td>
<td>1753</td>
<td>4.8</td>
</tr>
<tr>
<td>Time of day of admission</td>
<td>2020</td>
<td>4.5</td>
</tr>
<tr>
<td>Day of week of admission</td>
<td>1226</td>
<td>3.4</td>
</tr>
<tr>
<td>Access block (patients spending more than 8 hours in ED after admission)</td>
<td>767</td>
<td>2.1</td>
</tr>
<tr>
<td>Post-take discharges by day of week</td>
<td>215</td>
<td>0.6</td>
</tr>
</tbody>
</table>

*These potential savings are not additive, because removing one source of variation is likely to affect others.
Variation in readmission rate and length of stay between consultants.
We Created The Burning Platform

Armed with data which showed our current situation the next step was to publicise this to the hospital staff

Communication and Engagement Strategy

• Showcase sessions
• CEO Forums
• Grand Rounds
• Presentations to multiple stakeholder groups including the Governing Council & Unions
• Standing item on meeting agendas
Clinical Redesign

“We have done this all before”

“I remember sitting in a series of meetings in 1998 working on projects like this”

“I have been working at this hospital since 2002 and we have done this 4-5 times in the past”

“Why do we think it will make a difference this time?”
Consistent Key Messages

Seize this opportunity

The collaboration UTAS & HSI creates a significantly different environment from previous DHHS-led initiatives:

TIMELINES

STRINGENT REPORTING REQUIREMENTS

RESEARCH/PUBLICATIONS

STAFF- experts in their fields

GENEROUS FUNDING- not run off “the smell of an oily rag”
Acknowledge our successes

Embrace Innovation

Aspire
How did we identify people in our Organisation & get buy in?

Stakeholder analysis
Communication and Engagement Strategy
Identify people who show interest and ask them to how they would like to participate
Invite ourselves to speak at meetings
Listen to what staff said
Momentum Slowed- Christmas

Although communication was underway and we had generated the burning platform we were being pressured to begin getting results before the implementing and further investigating the high level diagnostics.
Getting the Momentum Going Again

Diagnostics - Early 2015.

- Observations
  - CRO members
  - External consultants
  - Brisbane site visits
  - Attendance at conferences/workshops to build our capacity and knowledge

- Participation levels
  - Attendance to workshops - staff
  - Embrace staff enthusiasm & passion
  - Variance b/w professional groups

- Literature
  - What is it telling us
Yes- we have a *Project Timeline*

I have brought you to here

NOW OVER TO SUE........

**Plan**
15 Jan-20

**Diagnostics**
23 Feb-17 April 2015

**Implementation**
29 June-18 Sept 2015

**Sustain**
-23 Sept 2016
Approach to the Diagnostic Phase-Observations

• ‘Big Picture Mapping’ sessions
   Exploring The Medical Patient Journey – ‘decision to admit through to discharge or transfer of care’. One hundred and sixteen (116) issues were identified in this session.

• Delays in Discharge Audit

• Table top exercise - ACAT referral processes

• Graffiti Exercise
   “In the Medical Patient Journey, what drives you crazy?” 274 responses were gathered

• Waste Tools 312 sources of waste were identified.

• A Day in the Life of exercises – Multi-D meetings

• Quantitative data analysis - from various sources

• Interviews with key clinical and managerial staff - 30 + staff

• Patient Interviews/surveys - 10 interviews/64 Surveys
Overarching Cross-Organisational Themes

5 Themes

- Communication and Information Flow
- Culture and Mindset
- Ownership of the Patient Journey
- Teamwork
- Variability and Unclear Processes
High level observations and issues

Inflow
- Admission
- Transfers

Inpatient Management

Discharge Processes

APU
1BN
AOPU
P3
Outliers

APU
1BN
AOPU
P3
Outliers

APU
1BN
AOPU
P3
Outliers
Inflow: Admissions & Transfers
Key Observations and Issues

The issues are...

- **Variation and a lack of process definition** across the medical admission process causes delay and inefficiency
- There is variable and limited pull from ED and transferring of patients between wards
- There is limited synergy and flexibility in using resources across EMU and APU
- Lack of standardisation in forms and processes for admission and transfers
- There is limited access to **alternatives to admission** for medical patients
Inpatient Management

Key Observations and Issues

The issues are...

- Multidisciplinary team processes do not consistently lead to focused decision-making – there is a perception that the plans for patients are too often unclear with a ‘wait and see’ approach commonplace.

- Medical round has no defined, clear and consistent structure and process is variable depending on the team.

- Weekend discharge rates are low.

- Allied health disciplines do not have arrangements in place to facilitate a unified process to triage, screening, prioritisation and initial assessment where clinically appropriate.

- As a result of the absence of effective processes for information flow considerable time and effort is spent in attempting to communicate and liaise across teams and disciplines.
Discharge Process
Key Observations and Issues

The issues are...

- Discharge is managed on a **single-discipline basis**
- There is **significant batching** of actions arising from the weekend round
- The **transit lounge** is not used
- Discharge medications
- The use of **rural facilities** is patchy and variable
- Limited processes to address the needs and issues faced by patients with **very extended LOS** ("stranded patients")
- **Delays in moving patients to RACF**
- Delays in family decisions on placement into residential care
The Survey

Background:

- 72 Surveys undertaken over a period of 3 weeks
- Only 64 were completed and included in the report

Areas:

- 1BN = 33, APU = 15, P3 = 5, AOPU = 4,
- Medical Patient Outliers on wards 1BS = 4, 2AONC = 2, 2D = 2.

Average score out of 10 for satisfaction 8.4 (61 answers)
Do we give our patient adequate information about their discharge date?

Was enough notice given to the patient about discharge?

20% thought not.
30% thought ‘to some extent’

Frequently the patients had enough time to get ready, but those who were to pick them up did not and were unable to arrive at the hospital without warning.

Was the patient involved in discharge decisions?

15% thought they were not
7% did not want to be
50% discharges were delayed
Do we give enough information to our patients?

Given adequate printed information?
50% said no. (rest said yes, or I did not need it)

- 5% did not receive adequate information about their medicines
- 7% were given written information about their condition,
- All but 1 understood it.

Warning signs:
30% were not warned (the rest either said yes, or did not need the information)
30% were not told who to contact if necessary after discharge.
What are the patients telling us?

Solutions Workshop

Key messages:
• Listen to the needs of patient/carer
• Don’t make assumptions
• Check plan of care with patient and carer
• Check if patient/carer understands
Whole of Hospital Staff Engagement

Solutions

• Use the expertise of others
  o Advice
  o Invite credible people to sell our message
Whole of Hospital Staff Engagement

Solutions

- Go back to the plan — strengthen the effort
- Believe in our ability to carry it through

“The TRUE Courage is in Facing Danger when you are Afraid”
Identifying major themes and issues from the diagnostic phase and prioritising areas for action (dot voting)

Main themes identified to work on:

- Medical Rounding
- Multi-D meetings
- Communication and flow of information
- Community Engagement including the transition of the older person into residential care and the community
Whole of Hospital Staff Engagement

I have a feeling we’re not in Kansas anymore.
What have we done with all this information?
Allied Health

Working party to develop a concept to improve referral and assessment processes across AH for the medical patient journey.

Plan of Action  Developed

MD AH teams assigned to clinical areas/units/wards/community areas
Day to day resources / workload management (priority / triage)

Evaluation

Real time and retrospective data analysis gathering for:
  • Referral rates / flow
  • Referral seen / not seen
  • Time from referral to being seen
Multi-Disciplinary Working Group

Multi-D Meeting Working Group

Work Undertaken

• Meeting regularly
• Literature Reviews
• Visiting Speaker from Adelaide-Physio
• What are others doing?
• Decision made on type of MDM
• Rules written/communicated
• Staff notified of changes and agreement made
• Practice runs 2 weeks prior to trial
• Went live 24 August 2015

Multi-Disciplinary Meeting

RULES

✿ Meetings start promptly at 10:30am with or without all members – accountable to ward NUMs
✿ Standing room only – to improve pace
✿ Begin with ‘home ward’ patients starting at bed 1. Focus on new information
✿ Patient flow and referral focussed. Relevant information about a patient only. (Please see MDM Meeting Procedure)
✿ Each patient should have a discharge destination and EDD discussed and set. Patient referrals to be clearly articulated and updated
✿ Paperwork and updating EDD/Referrals are shared equally among the team members
✿ Communication is essential between teams
✿ No pagers or mobile phones to be used (except emergency pagers)
✿ Outliers discussed Tuesday/Thursday ONLY unless pressing issues
✿ MDM meeting length to be a maximum of 20 minutes
Multi-Disciplinary Working Group

Patient and Staff Engagement Working Group

- Meeting Regularly
- Literature searches/what do other hospitals do?
- Decision made to design patient posters/pamphlet
- Consumer and staff input by having a promotional stall in the foyer of the hospital-16 September 2015
- Staff education package being developed to be presented to-ALL health professional groups.

<table>
<thead>
<tr>
<th>Patients</th>
<th>WHAT HAPPENS WHEN YOU STOP MOVING?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Muscle wasting</td>
<td>Clots</td>
</tr>
<tr>
<td>Longer hospital stay</td>
<td>Lose your strength</td>
</tr>
</tbody>
</table>

Let’s move move move

Talk to your ward staff about how to increase your level of activity

Clinical Redesign Program – South
Rethinking healthcare service delivery
Current Ward Rounds

General Medical Ward

• Little predictability of when patients are going to be seen.
• Lots of teams there too.
• Poor communication
• No ward based medical staff

WHAT ABOUT THE POOR OUTLIERS?
Trial Medical Round Changes

Why did we think it was ok to see our outlier patients after 12 midday?

**AIM**

Every medical patient is to be seen before 10:30am
Results so Far
What the staff have said to us about the changes so far?

**MDM Feedback**
‘you pick up on things that are missed and not previously addressed. For example barriers to discharge.’
- Medical Staff Interview, 10/9/15

**MDM Feedback**
‘Good for communication. Good to be able to have a face to the name. get to know each other’.
- Allied Health Staff Interview, 10/9/15

**MDM Feedback**
‘It’s a benefit to have everyone in the same room at the same time so you can discuss patients together’.
- Allied Health Staff Interview, 10/9/15

**Medical Rounding Feedback**
‘See patients for discharge earlier and plan and know they have been seen before going back to home ward.’
- Medical Staff Interview, 10/9/15

**MDM Feedback**
‘Getting to know the team.’
- NUM of Gen Med Unit, 10/9/15

**MDM Feedback**
‘We know what’s happening to the patient so we can start getting things ready for their discharge earlier.’
- Nursing staff Member, 3/9/15

**MDM Feedback**
‘Clearer discharge planning. You know who is following up with what.’
- NUM of Gen Med Unit, 10/9/15

**Medical Rounding Feedback**
‘Good to see the Drs here early so we can get on with Patients care or discharge.’
- Nurse Outlier Ward, 28/8/15
What our data is telling us so far?

Multi-D Meetings - Rapid Round

• 95% starting on time @ 1030am
• All mandatory staff are present plus extras (Usually 20-25 staff)
• Time taken 15-20mins (30mins max)
• EDD updated 100% on Patient Flow Manager
• Stickers with outcome of meeting completed 90%
• EDD in patient notes 85%

Medical Rounding

• All patients in outliers wards are seen before 1030am
• All patients in home ward seen before 1030am-98%

Too early for clear measurable outcomes but we can see there are positive changes occurring
How will we know that we are making a difference?

- Patient & Staff surveys
- Start time of MDMs maintained
- The mandatory members attend
- EDD & Referrals are made
- Audit patient notes for EDD/Time of Drs rounds (outliers & home ward)
- Data gathering LOS/time of day discharges occur
- Use of Transit Lounge
- Compare and measure 28 day readmission rates

We continue on our journey
Other Benefits

Encouraging and Developing Leadership

- Role of Medical Lead for the General Medical Unit
- Team leaders for each of the multi-Disciplinary working groups
Program Timeline

Planning
15 Jan - 20 Feb 2015

Solution design
27 April - 31 July 2015

Evaluation
9 November 2015 – 31 March 2016

Diagnostics
23 Feb - 17 April 2015

Implementation
10 August – 31 Oct 2015

We are here

Sustain
31 March 2016 onwards

NB: Timeline for the Solution Phase was extended by 2 weeks
Thank You For Listening
Clinical Redesign Program – South
Rethinking healthcare service delivery