Clinical Redesign Case Study

Allied Health Assistants - (AHAs) opportunities to improve the care for medical inpatients project

Jolene May & Trish Filby
Allied Health Professional Services
### Phases

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<th>Phase</th>
<th>Purpose</th>
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</table>
| Scoping     | To define problem statement and determine scope, cover project management basics, establish governance and reporting, complete stakeholder mapping and determine communication plan | Governance established  
Stakeholders determined  
Communication plan |
| Diagnostics | To learn about change management, waste and big picture mapping  
To collect and assess critical data about processes, patients and staff. | Diagnostic plan  
Diagnostic report |
| Solutions   | To confirm problem statement, learn about tools and techniques for solutions, and determine issues prioritisation |                         |
| Implementation | To implement solutions and confirm the benefits are being delivered  
To revisit change management and communications | Implementation plan |
| Sustain     | To identify ways to improve the process, share lessons and drive sustainability and continuous improvement | Shared project learnings report |
Identifying the problem

Problem identified by the larger Medical Patient Journey project

Issue reported by:

- allied health professionals – can’t do all the work and can’t AHA aren’t available to help
- allied health assistants – don’t have work consistently, avoid the medical rotations if possible

A3 Initial problem statement

A perceived underutilisation of Allied Health Assistants (AHAs) within the RHH Medical Services contributing to:

- inability to provide appropriate and timely Occupational Therapy (OT) and Physiotherapy
- lack of job satisfaction for AHAs and therapy staff
Scoping the problem

- **Authorisation**
  - Director
  - Discipline leads

- **Sphere of Influence**
  - Project leaders manage OT and physio medical teams and influence unit level change

- **Why are we looking at the problem?**
  - AI can't meet demand
  - Utilisation of Aides ineffective

- **Structure & Resources**
  - Manage within Allied Health
  - Current staffing, managerial support and access to some training resources

- **Problem start & end**
  - Admission and discharge
  - Gen med
  - OPU
  - Med Specs

- **Volume**
  - 4% of clinical work

- **Stakeholders**
  - Director AH
  - Discipline Leads
  - AHP and AHA staff in med units
  - Other AHP service staff

- **Alignment with strategic goals**
  - Assist with: decreasing length of stay, preventing readmissions, improving patient outcomes
Planning the Project

Exactly what is it that needs fixing... and why?

What is the sequence of events that needs to happen for us to be successful?

Who are we going to report to?
Who will authorise stuff?

Who else should be part of the journey?

How do we let everyone know how we are doing?

What could possibly stop us from being successful?

Governance

Communication
Better utilisation of AHA to support and assist therapists to improve the quality and quantity of clinical care to medical patients
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A3 AHAs within Acute Medical Services
Diagnostic phase – What we did?

- Big Picture mapping
- Literature review
- Focus Groups
- Tracking
- File audit
- Task survey and volume
- Big picture data
Diagnostic Phase – Literature review

Utilised occupational therapy students

Valuable as it confirmed our findings were congruent with common issues relating to AHA

Didn’t discover any solutions

Results

- Potential scope of AHA in acute is unclear
- Up to 17% of tasks completed by AHP could be complete by AHA
- Opportunities for AHA work in screening and gaps in service delivery post discharge
- Skills and perception of AHP regarding delegation an issue
- Effective use requires communication with the MDT
- Barriers/ risks to underutilisation include:
  - Relationship between AHP and AHA
  - Perceived competency of AHA
  - Time to train and supervise AHA initially
Diagnostic Phase – Big Picture Mapping

Benefits
Gold mine of information
Excellent for engaging stakeholders
Great for facilitating stakeholders to communicate with each other
Understanding of the constraints (people, facilities, systems, processes)

Risks
All the right people aren’t in the room
Significance and frequency of issues are not always easy to determine – can send your diagnostics in the wrong direction
Need to be skilled in engaging and managing the group
Need to be skilled in communicating the ‘why’ to engage the group

Nine main themes
1. What an AHA can do is unclear
2. The value of AHA’s is underestimated
3. Trust
4. Delegation and AHA work processes unclear
5. Communication is difficult
6. Delegation is too time consuming
7. Not all AHPs have skills to delegate
8. Care and discharge planning is unclear
9. AHPS want to complete the task themselves
Diagnostic Phase – Focus Groups

Enabled more in depth understanding of the problem

Helped determine the core issues

Checked for between group differences

Consolidated constraints

4 core issues
1. Structures and process for delegation
2. Visibility of capacity/availability and capability of AHA
3. Relationships
4. Developing capacity
Diagnostic Phase – Tracking

DILO

Utilised students – time intensive
Identified waste

Understood flow

AHA activity

- Patient Care (Direct) 33%
- Motion 29%
- Care preparation/planning 16%
- Communication 3%
- Delegation 4%
- Searching 5%
- Documentaion 9%
- Waiting 1%
Diagnostic Phase – File Audit

Utilised students – time intensive

Understood the variation and the flow of work in the context of the patient journey

- OTA
  - Varied timing of delegation
  - Delegation timing related to tasks being delegated rather than length of stay
  - Documentation of delegation

- PTA
  - All PTA delegation were on the day of PT initial assessment
  - No documented evidence of PTA presence in the session or delegation
## Diagnostic Phase – Big picture data

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<th>OT (Jan-June 2015)</th>
<th>PT (Jan – Aug 2015)</th>
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<tr>
<td><strong>Total number of patients seen by discipline</strong></td>
<td>726</td>
<td>1648</td>
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<tr>
<td><strong>Number of patients seen by AHA</strong></td>
<td>171 (24% of total)</td>
<td>546 (33%)</td>
</tr>
<tr>
<td><strong>Occasions of service</strong></td>
<td>318</td>
<td>1649</td>
</tr>
<tr>
<td><strong>Hours/FTE allocated for AHA time period</strong></td>
<td>736 hours</td>
<td>874.5 (approx.)</td>
</tr>
<tr>
<td><strong>Hours of IPA AHP</strong></td>
<td>2241 hours</td>
<td>3558.82</td>
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<tr>
<td><strong>Hours of IPA AHA</strong></td>
<td>242.99 (33% of hours available, 10% total clinical)</td>
<td>519.75 (59.43% of hours available, 12.74% of total)</td>
</tr>
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### Graph 5: Frequency OTs and PTs work together with individual patients in medical units

*ABC Data: 2nd Jan 2015–31 Aug 2015*

**Percentage of Patients and the quality of intervention (Sept 2015)**

- Quality 4
- Quality 3

**Graph 4: Time OT’s and PTs spend in medical units**

*ABC Data: 2nd Jan 2015–31 Aug 2015*
Big picture data

1. Overwhelming – what do you need?

2. Trust
   - not always perfect fit to context
   - can change before you use it (creates distrust from stakeholders in the process)

3. Useful in creating context to help with implementing solutions

4. May not add to understanding of the problem
Current tasks all agreed by more than 80% of respondents except:

- Implementation of screening tools (78%)
- Patient education (72%)
- Walking aid issue and identification (60%)
A3 AHAs within Acute Medical Services

What *really* is my problem?

Now that diagnostics are complete how would we now describe my problem?

AHA are ineffectively utilised due to four root causes:

- Reduced opportunity to develop relationships between AHA and AHP
- Unknown capacity (capability, availability)
- Lack of structure and processes for delegation (including communication)
- Insufficient involvement of AHA in care and discharge planning process
A3 AHAs within Acute Medical Services
What is the goal?

What is my future state vision for this process? Short term and long term?
- Increased time in direct clinical care of AHA
- Decreased AHP sessions completing work suitable for AHA
- Increased availability and visibility of AHA
- AHAs included and valued as part of the AH team

How would we measure improvements?
- ABC statistics
- Staff survey
- Unmet need data

What would our target be?
- 70% IPA clinical care ratio for AHA
- <5% total sessions completed by AHP
- Staff report satisfaction within AHA utilisation, availability and participation within the team
- Improvement in number of patients seen by AH
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A3 AHAs within Acute Medical Services Solutions Workshop

- 22 people attended workshop
- Brainstormed solution ideas for each of the 4 root causes
- Pulled together common ideas
- Prioritised key areas to work on
- Working groups developed for each key area

Risks
- Loudest voice – not necessarily the best solution
- Wrong people in the room to make meaningful change decisions
- Set up expectations that may be difficult to fulfill
- Difficult for project leaders not to guide the group to the solutions they want
The case for change

Process redesign problems are adaptive, so..

- Need to learn new ways, not just deploy existing knowledge
- Good ideas can come from anywhere

Need to be allowed to experiment and be given permission to fail

Requires leadership
A3 AHAs within Acute Medical Services
What is the new process to achieve the goal?

<table>
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<th>Areas for change</th>
<th>LEAN tools</th>
</tr>
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<tr>
<td>AHA ward based staffing and team participation</td>
<td>Continuous flow of work AHA ‘pull’ work</td>
</tr>
<tr>
<td>AHA scope &amp; competencies</td>
<td>Standardise AHA work AHA ‘pull’ work</td>
</tr>
<tr>
<td>Professional development and feedback systems</td>
<td>Quality and skills</td>
</tr>
<tr>
<td>Delegation</td>
<td>Governance - safety and quality</td>
</tr>
<tr>
<td>Education</td>
<td></td>
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</tbody>
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4 core issues
1. Structures and process for delegation
2. Visibility of capacity/availability and capability of AHA
3. Relationships
4. Developing capacity

? Value
### A3 AHAs within Acute Medical Services
How and when will I achieve the goal?

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<td>March 2016</td>
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<td>Facilitate greater inclusion in discipline based social activities</td>
<td>December 2015</td>
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<td>Develop competency framework for AHAs</td>
<td>By March 2016</td>
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<td>By Jan 2016</td>
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What have we learned?

- Having a common goal and working together helps build relationships.
- Difficulty identifying quick wins in a complex system.
- Solutions process can be long to keep everybody engaged.
- Clinical redesign is time intensive.
Solution Development Plan - 16 November 2015 (next meeting TBC after 7/12/15).

Solution Theme: AHA ward based staffing & team participation

Clinical redesign technique/tool/concept: facilitate continuous flow of AHA work

Working Group:

Step 1: Do you have any other ideas to facilitate a solution? Add them to the list below

<table>
<thead>
<tr>
<th>Solution ideas</th>
<th>Priority</th>
</tr>
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<tr>
<td>Ward Based Staffing</td>
<td>2, as part of a ward based AHA trial</td>
</tr>
<tr>
<td>PT/OT delegation to PT/OTA</td>
<td>2</td>
</tr>
<tr>
<td>Increase ratio of AHA:Arp</td>
<td>2</td>
</tr>
<tr>
<td>Consistency of staffing (AHPs and AHA working together)</td>
<td>2</td>
</tr>
<tr>
<td>More consistent clinical load</td>
<td>2</td>
</tr>
<tr>
<td>Consider work times - hours of day AHA and AHP available</td>
<td>2</td>
</tr>
<tr>
<td>Daily meeting to discuss tasks and prioritise AHA work</td>
<td>2</td>
</tr>
<tr>
<td>AHA attendance at MDM</td>
<td>2</td>
</tr>
<tr>
<td>Team meetings</td>
<td>2</td>
</tr>
<tr>
<td>Rotation planning/orientation</td>
<td>2</td>
</tr>
<tr>
<td>Find easy location to base AHA to minimise travel and stress</td>
<td>2</td>
</tr>
<tr>
<td>Daily email to identify availability of AHA and how to contact</td>
<td>2</td>
</tr>
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Team Participation (consider activities that maybe continued outside the ward based staffing model)

- Routine daily meeting (AHA & AHP) to identify capacity and manage workload
- Reward input (Positive feedback/constructive criticism)
- Social events - pub, movie night
- Physio/OT culture change - team is both AHA and AHP

2. Use the matrix to prioritise the potential solutions

<table>
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<th>Impact</th>
<th>Level of Control</th>
</tr>
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<tr>
<td>High</td>
<td>Priority 1</td>
</tr>
<tr>
<td>These will really change things but might need more resources such as time, effort, special skills</td>
<td></td>
</tr>
<tr>
<td>Priority 2</td>
<td></td>
</tr>
<tr>
<td>These as they are feasible and will really change things</td>
<td></td>
</tr>
<tr>
<td>Low</td>
<td>Priority 3</td>
</tr>
<tr>
<td>These might be quick 'win' that will help but not change the world</td>
<td></td>
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3. What activities will be the focus of the working group in the next 4 months? What will be the intended outcome (measurable)? Who will do it?

<table>
<thead>
<tr>
<th>Activity</th>
<th>Outcome</th>
<th>Who</th>
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<tr>
<td>3-4 month trial of basing an AHA (OTA or PTA) on APU/ED and OPU (exclusive of increased medical beds) to receive delegation from PT and OT.</td>
<td>Increased time in direct clinical care of AHA</td>
<td>List of tasks for AHA could complete in APU/ED and OPU coordinated by Mary-Anne by 30/12/15.</td>
</tr>
<tr>
<td>Role description to include task list, skills, meeting attendance and work times required to meet team needs, FTE, governance and supervision plan.</td>
<td>Decreased AHP sessions completing work suitable for AHA</td>
<td>OT and physio managers, March 2016</td>
</tr>
<tr>
<td>Recruitment to trial - expression of interest plan to manage reduced AHA resources in recruitment, to achieve shortlist and interview to ensure fit for purpose</td>
<td>3 AHA recruited – 2 to complete work and 1 to cover for 3-4 months.</td>
<td>Jclene &amp; Trish by January 2016</td>
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<tr>
<td>Prioritisation</td>
<td>Process for OT and PT to enable prioritisation of AHA tasks relevant to clinical area and consistent with current guidelines</td>
<td>Carrie, Mitch by March 2016</td>
</tr>
<tr>
<td>Orientation to clinical areas of trial - team, environment, prioritisation principles. (NB skills orientation by competency working group)</td>
<td>Orientation process for selected areas</td>
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Open up social events to wider AHA group and increase social opportunities for medical services OTs, PTs, CTAs, PTAs.

- Include physio in T4 social committee
- AHR mail list for social activities
- Change AHA morning tea times to arrange lunchy/social activities for medical services areas.

4. Are there educational requirements to facilitate planned activities that need to be reported to the education working group?

Nil at this time

5. Are there things to communicate with the other working groups?

a. Delegation to enable verbal delegation
b. Supervision process is essential to this working

6. Messages from other working groups

a. Please consider a plan for attendance at team meetings/MDM for AHA outside of the trial
b. Please consider team meetings to include a brief reminder to reflect on work completed and client outcomes.

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Tasmanian Health Service

University of Tasmania | Health Services Innovation Tasmania

Tasmanian Government
Allied Health Assistants
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Skills & resources (time, skills to develop solutions, scope and influence of working group members, experts)

Engagement (not everyone involved in working group so lost touch with purpose of project, having the right people involved)

Communication
- large group with competing priorities
- information overload
- don’t rely on email
- must always articulate ‘why’
Preliminary results from the trial areas

Staff satisfaction → significantly increase

Unexpected client outcomes – mobility, engagement in activities of daily living

Data to be reviewed

Trust & relationships continue to be the main issue
Next steps……

1. Solid communication plan (formal, informal, roles & responsibilities, use existing meetings)
2. Re-engage staff outside of the trial area
3. Continue developing solutions – project at risk of insufficient resources to complete all required solutions to enable success
4. Evaluation
5. Sustainability

➢ Governance of project outcomes
What do we think of clinical redesign?

It is very time consuming to do well – clear your diary & ‘to do’ list

Don’t forget the consumer – easy to do when focused on processes

Get the right people in the room when making decisions

Start planning how sustainability will be governed

Remain vigilant – fixing up after dropping the ball is very hard

If resources are limited you need to manage scope and solution expectations
What do we think of clinical redesign?

Communication and relationships are king
Communication and relationships are king

“The quality of our relationships defines the quality of our results”