Redesigning sub-acute care at Alfred Health

Associate Professor Peter Hunter
Clinical Program Director
Rehabilitation, Aged and Community Care,
Alfred Health

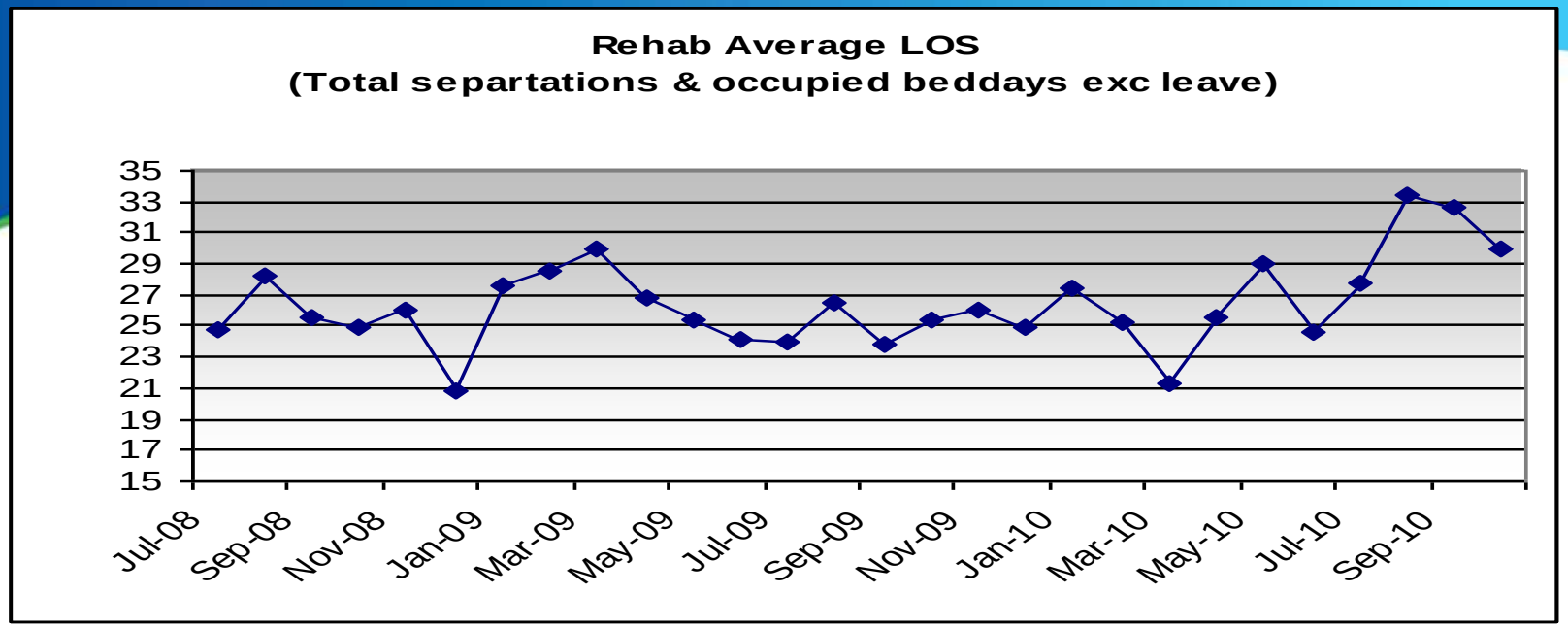
Rehabilitation LOS project

- Aim
  - Improve patient flow with standardisation of practice, reduced process inefficiencies and delays for inpatient rehabilitation services at Alfred Health
  - Focus on stroke rehabilitation; high volume and poor performance

- Objectives
  - Reduce LOS across inpatient rehabilitation units, starting with neuro-rehabilitation
  - Improve performance against benchmark
  - Improve patient experience

Key principles used in our redesign from the outset

- Explore anecdotes and assumptions with data
- Diagnostics
  - Measurable outcomes (you can't improve it if you can't measure it)
  - The patient journey
- Solutions considered based on data
- Clinician driven solutions with clinical relevant outcomes
- Discussion helps
- Improvement guided by results



Caulfield HOSPITAL

- 2010; trend towards increasing LOS across the rehab wards with increased wait times for transfer
- Anecdotal feedback from clinic team suggested reasons for higher LOS:
  - 'Out of area' patients
  - Access to discharge services
  - Outliers
  - Caulfield rehabilitation patients are more complex and admitted earlier
  - The system is already on "full stretch."
  - The current model of care was driving the best patient outcomes

Diagnostic Phase

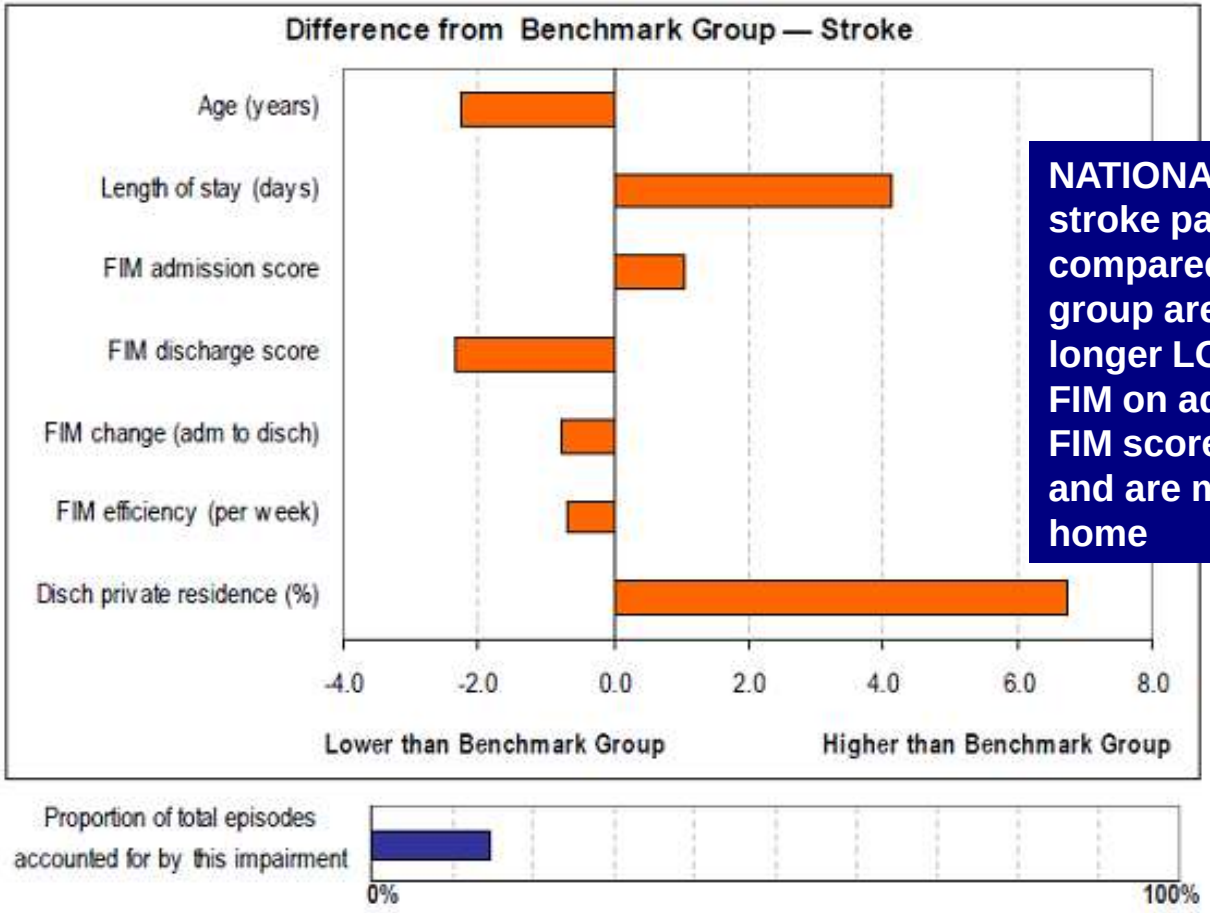
- Baseline performance diagnostics
  - LOS against current performance and benchmarked standard (and volumes of work)

- Other current state diagnostics
  - The patient journey; understanding admission/discharge processes
  - Impact of patients admitted outside ‘parent ward’
  - Variation in LOS by weekday of admission
  - Impact of out of area patients

What we found

- Robust data set with AROC allows good benchmarking
  - Small number of outliers (9%) with same LOS
  - Patients had some complexity as other services
- Patients not admitted any earlier than other services
- Half the patient were “out of area” suggesting our concept was in area was flawed

Outcome measures — Stroke



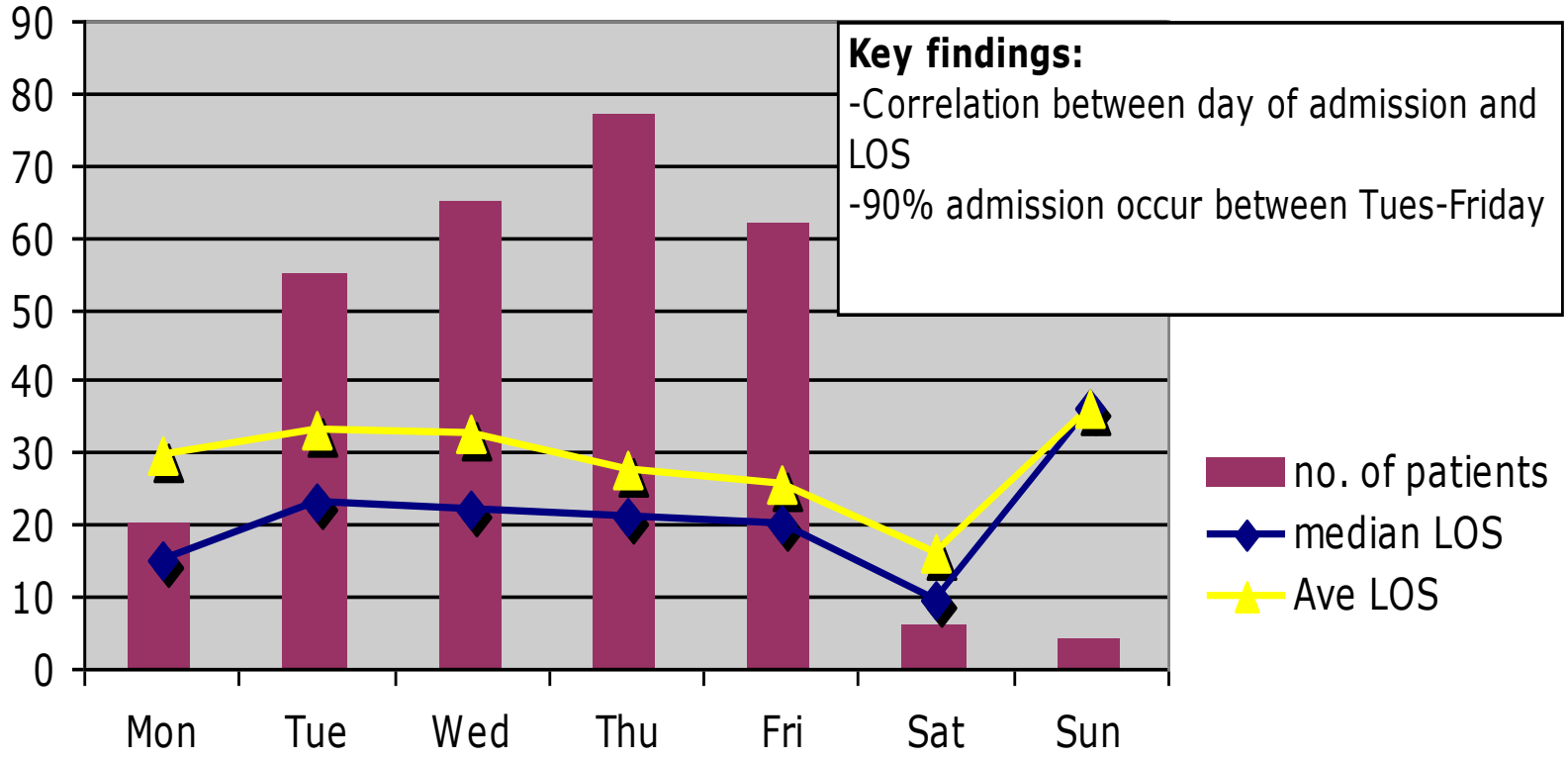
NATIONAL DATA Suggests stroke patients, when compared to benchmark group are: Younger, have a longer LOS, Slightly higher FIM on admission, lower FIM score on discharge, and are more likely to go home

Redefining Inpatient Rehabilitation Project- Current State Map
February 2010

Caulfield HOSPITAL

Variation in day of admission and LOS

Nov 2009-Oct 2010



Caulfield HOSPITAL

1. Correlation between day of admission and LOS- potential impact of weekly team meeting

2. Prediction planning for LOS in neuro-rehab was subjective

3.In some neuro rehab ANSNAP data we were not equalling or bettering benchmarking performances against other facilities-and ourselves

Clinician driven exploration of key issues

- Objective predicting of initial discharge date needed
- Delays in time of arrival to time of discussion at first team meeting
- Delay in communication to patient/family/carers.
- Design services so things happen daily, not in weekly blocks
  - the mantra became “make every day in rehab count”
- A lot of wasted effort from a patient perspective; duplication and waiting

Actions

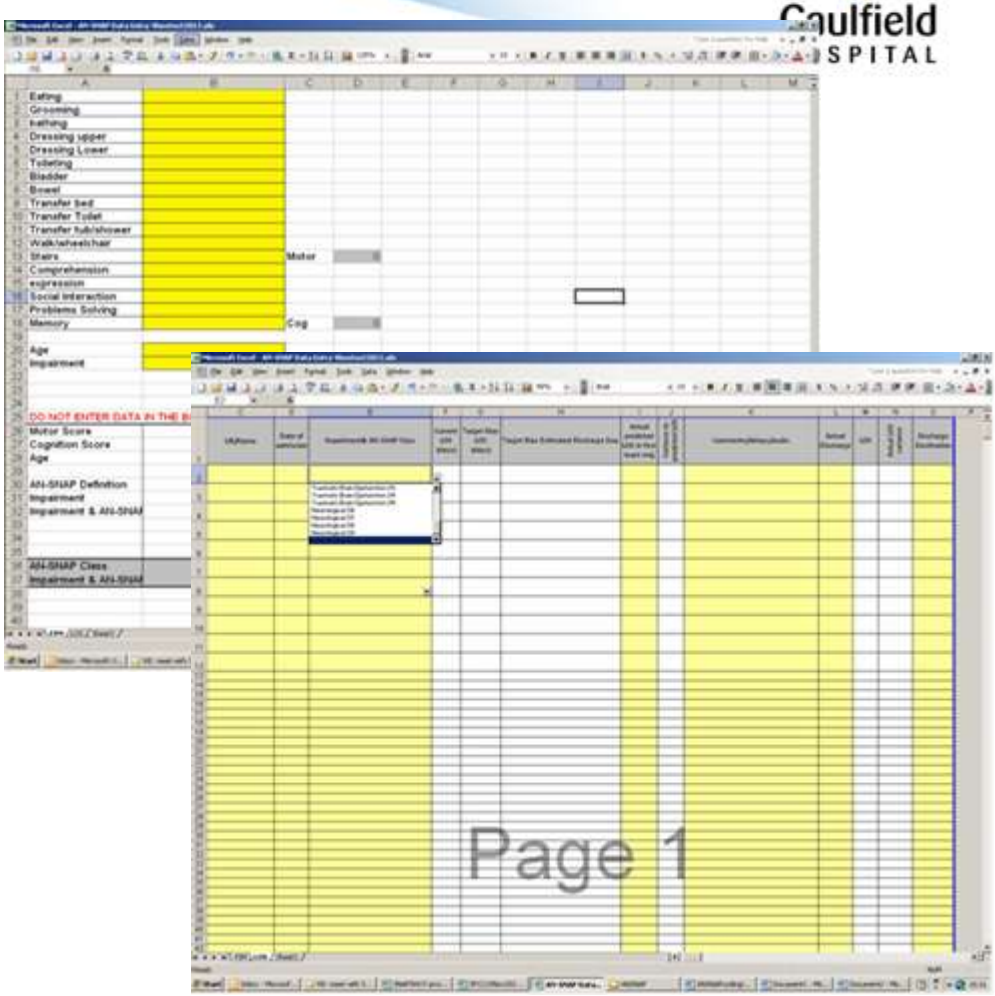
- Ward working group to develop and test solutions
- ‘Real time’ data collection and mechanism for reporting
- More frequent planning meetings and ward rounds from senior staff
- Barrier to discharge tool to flag high risk of prolonged admission
- Early involvement of home based rehabilitation team to facilitate transfer home
- AN SNAP clinical pathway tool

- Roll out methodology to other units

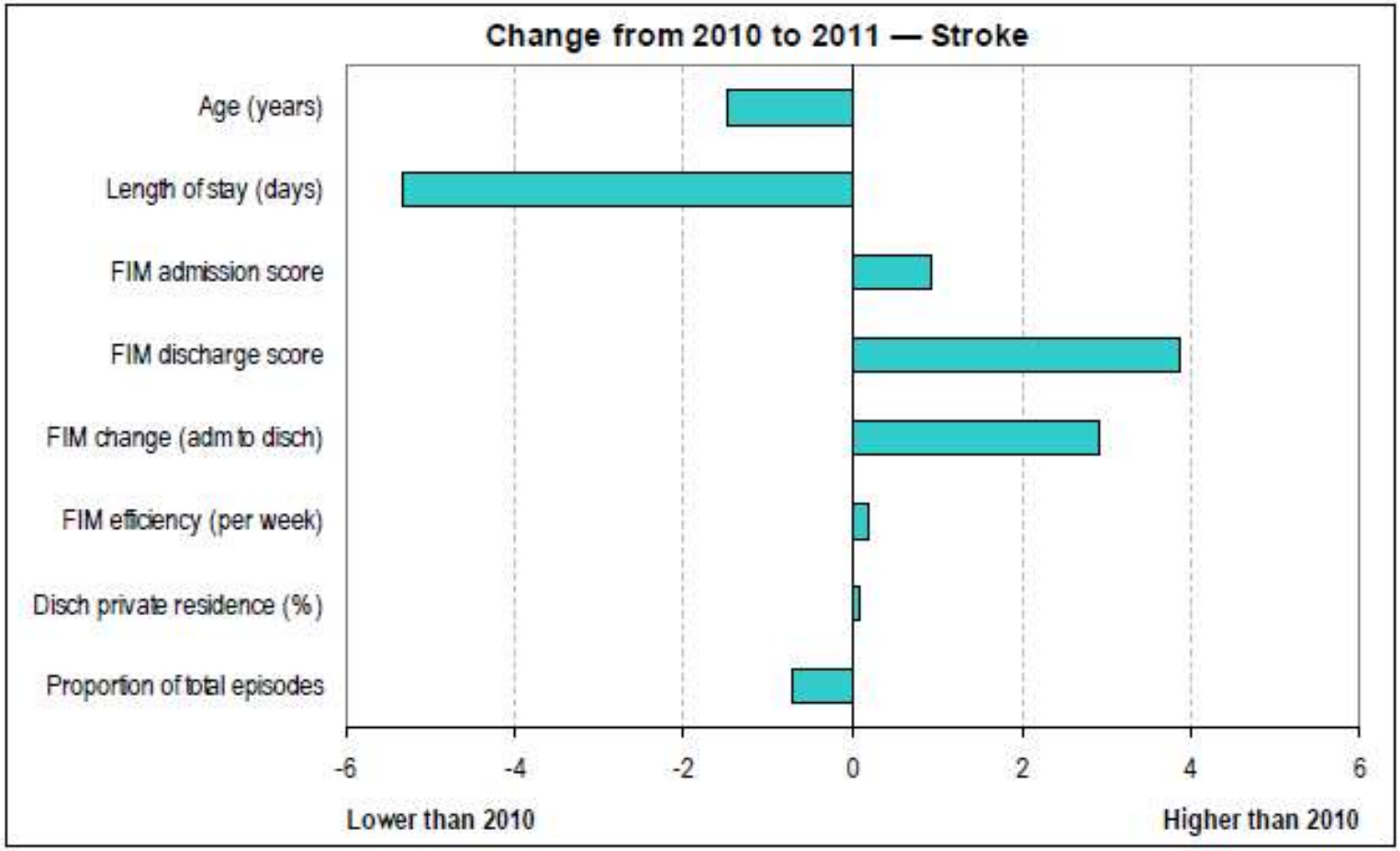
AN SNAP LOS predictor

Intervention:

- Mechanism to set EDD using clinically relevant LOS targets (AROC AN SNAP classification benchmark targets) across all rehabilitation units/teams



Change in outcome measures, 2010 to 2011



What are we learning?

- The easy problems have been solved; complex problems don’t respond to easy answers
- Time is needed for robust discussion and healthy debate
- Data is key;
  - You can’t improve something if you can’t measure it
  - Move from anecdote to fact
- Clinical outcomes and patient experience are compelling to clinicians; access and throughput are not
- While executive support is important, clinical champions are critical
- There is always more to do to improve the care for patients and to improve their experience

Evolving improvement

- Phase 1; Rehabilitation LOS project
- Phase 2; Timely Quality Care
- Phase 3; Ward Leadership and Governance

What is Timely Quality Care (TQC)?

- TQC transforms the way we treat our patients to ensure they all receive timely, quality care consistent with their clinical needs
- TQC is a whole of health service change that involves everyone (clinicians, managers and support staff)
- TQC changes how we assess and treat our patients from the moment they arrive to the time they are discharged

Caulfield HOSPITAL

THE 6 PRINCIPLES OF TIMELY QUALITY CARE

PRINCIPLE 1

On arrival to Emergency and Trauma Centre (E&TC), all patients will be seen within 10 minutes by a Consultant led interdisciplinary team who will initiate assessment, investigations & treatment.

PRINCIPLE 2

Patients will be discharged from the E&TC or admitted to the hospital as decided by the E&TC consultant staff.

PRINCIPLE 3

Patients will be reviewed by an inpatient unit within two hours of their arrival on a ward.

PRINCIPLE 4

Patients will be admitted to a bed in the most appropriate clinical place, the first time.

PRINCIPLE 5

Patients will have their investigations, consultations and interventions completed as soon as possible, in order of request and in no longer than 24hrs.

PRINCIPLE 6

Patients will be actively managed to ensure they are only in hospital for as long as is clinically necessary.

Guiding concepts for Alfred Timely Quality Care

- The patient should be seen by the most appropriate senior decision maker, as soon as possible along all points in their journey.
- Trust the referrer
- Accountability & responsibility begins on referral
- Right place, right time, 1st time
- Treat in turn
- Active management of patient's throughout their journey
- No tolerance for 'waiting'

RACC Timely Quality Care

Key Principles *The Way Forward*	Process *The Way We Work*	People & Culture *The Way We Align*
No delays or duplication	Patients will access sub-acute services without unnecessary duplication and delay with direct admission where possible	Trust the referrer
Smooth Transitions	Patients will be safe and comfortable, with appropriate and clearly defined processes for clinical handover at all transition points and plan clarified	Clear and consistent communication
Daily senior decision making & interdisciplinary care	Patients will be admitted to the most appropriate place the first time and reviewed daily by senior clinical decision makers	Effective team decision making
Make every day count	Rehabilitation is a continuum, patients and their interdisciplinary team will be actively working towards therapeutic and discharge goals 7 days a week	Interdisciplinary teams are aligned to patient care delivery
Contextual Therapy	Rehabilitation will be evidence based and contextual. Patients will receive ongoing therapy and care in the least restrictive environment to promote independence.	Trust the receiver
Truly patient centred in design and delivery	Patients have confidence in their discharge plan, through early discharge information and involvement	Committed to continuous improvement

Access

TIMELY ADMISSION

- Assessed as ready, to admission to RACC inpatient bed (Time, bed days waiting for Rehab, Aged Care)
- Acute referral to admission to RACC inpatient bed (Bed days, Rehab, Aged Care)
- Inpatient d/c (Alfred Health) date to date of initial Ax, (Community Rehab)

DIRECT ADMISSIONS

- Alfred to Inpatient RACC direct admission (count, % total transfers, time between referral and admission)
- Alfred to Community Rehab (count, %total referrals)

Effectiveness

Quality

PATIENT EXPERIENCE

- Patient experience (RACC inpatient and community rehab)

ASSESSMENT/CARE PLAN

- % IDAT A complete within 24 hrs
- % IDAT B complete within 48 hrs
- Time initial Assessment to first team mtg (Inpatient RACC, Community Rehab)
- % patient with EDD and Destination
- Time Initial Ax to first team meeting (Community Rehab)

FUNCTIONAL OUTCOMES

- FIM Change (Unit, AN SNAP)
- % Discharge destination to accommodation that allows for same or greater independence

RIGHT BED FIRST TIME

- %Unplanned readmits with 24 hours (all RACC admissions, direct admissions)
- % internal transfers within 72 hours (all RACC admissions, direct admissions)
- Count discharge home ≤ 7 days from time of admission

Safety

ADVERSE EVENTS

- Code Blue calls, inpatient
- Patient falls with serious injury, inpatient

HANDOVER/DISCHARGE PLANNING

- Handover (% internal transfer handover completed, % discharge summaries completed)

SEAMLESS TRANSFERS

- Internal ward transfer within 72 hours
- % Readmission to Alfred(Acute) within 72 hours
- % Unplanned readmission to Alfred Health within 28days

Efficiency

Activity

EFFICIENCY

- LOS (inpatient RACC by unit, ANSNAP, combined)
- FIM Efficiency (Rehab, Aged Care, ANSNAP)
- Average client contacts per month (Community Rehab)
- Completed Initial Ax (Community Rehab)

CAPACITY

- Bed Occupancy

Financial

- Project Expenditure
- Cost benefit of new model

Organisational Learnings

HOSPITAL

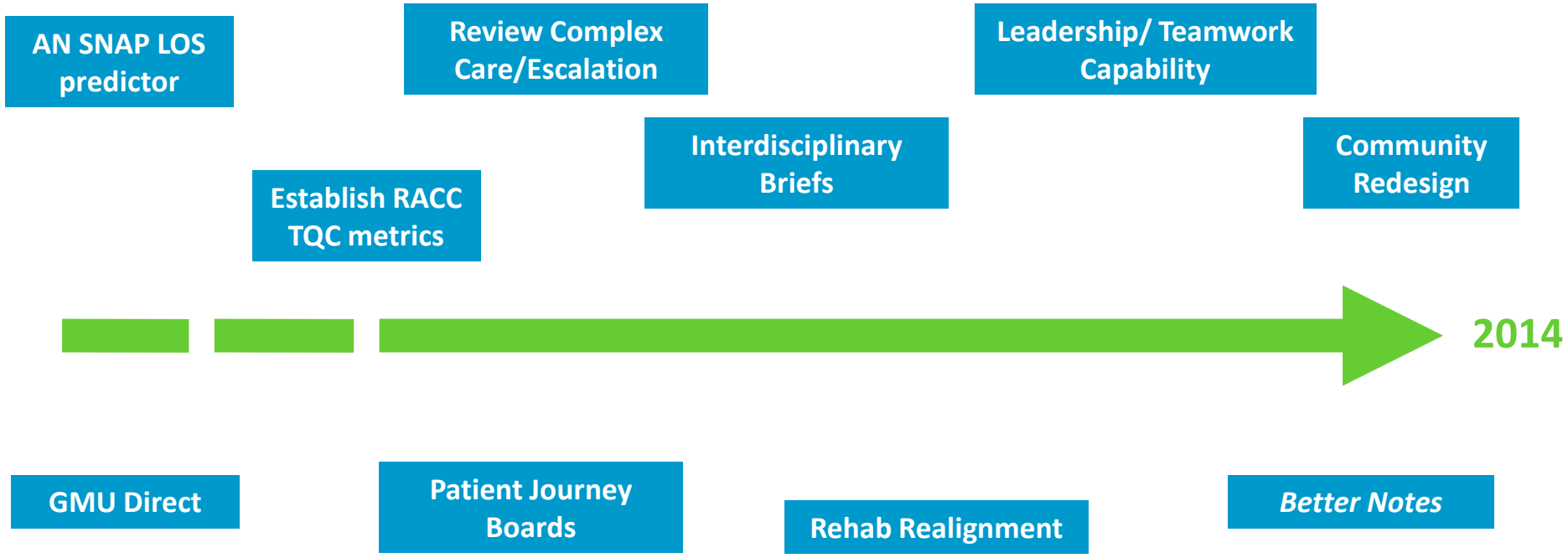
TEAM PERFORMANCE

- Team performance

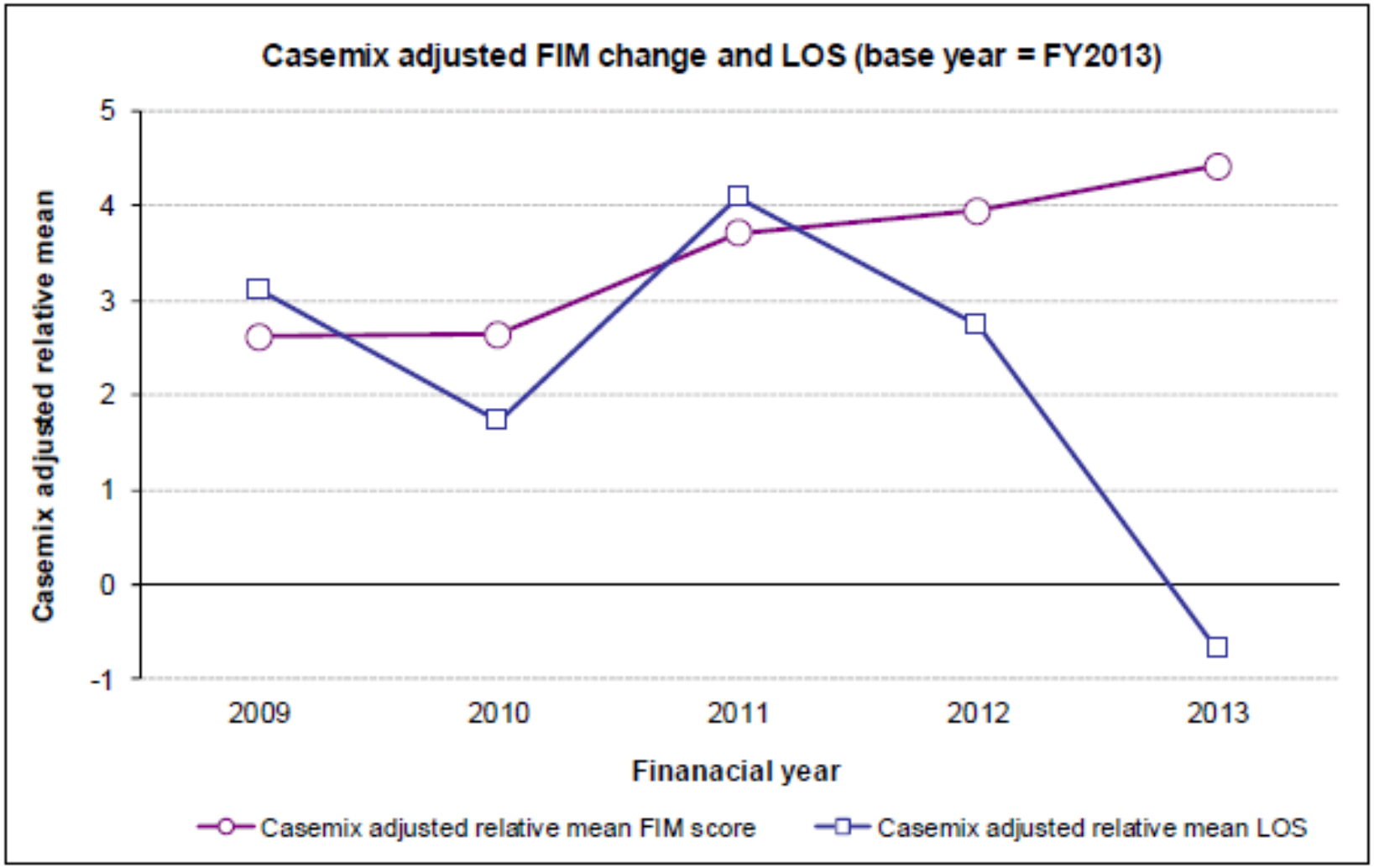
STAFF SATISFACTION

- People and culture survey
- Sick leave/unplanned leave

Implementation….



Casemix-adjusted relative means over time



Rehab only. Data source: AROC report 2013

Next Steps

- Ward governance
  - Improving team function and leadership development to drive interdisciplinary practice
  - Local Nursing, Medical, Allied Health leaders in partnership
  - Shared accountability for safety, quality, operational performance, finances, team function
  - Interconnecting the executive, clinical units and ward

Caulfield HOSPITAL

Good luck with your work