Redesigning sub-acute care at Alfred Health

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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
• 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
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.
Key findings:
- Correlation between day of admission and LOS
- 90% admission occur between Tues-Friday
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

Change from 2010 to 2011 — Stroke

- Age (years)
- Length of stay (days)
- FIM admission score
- FIM discharge score
- FIM change (adm to disch)
- FIM efficiency (per week)
- Disch private residence (%)
- Proportion of total episodes

Lower than 2010
Higher than 2010

AROC report — Caulfield Hospital from January 2011 to December 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
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**

- No delays or duplication
- Smooth Transitions
- Daily senior decision making & interdisciplinary care
- Make every day count
- Contextual Therapy
- Truly patient centred in design and delivery

### Process

**The Way We Work**

- Patients will access sub-acute services without unnecessary duplication and delay with direct admission where possible
- Patients will be safe and comfortable, with appropriate and clearly defined processes for clinical handover at all transition points and plan clarified
- Patients will be admitted to the most appropriate place the first time and reviewed daily by senior clinical decision makers
- Rehabilitation is a continuum, patients and their interdisciplinary team will be actively working towards therapeutic and discharge goals 7 days a week
- Rehabilitation will be evidence based and contextual. Patients will receive ongoing therapy and care in the least restrictive environment to promote independence.
- Patients have confidence in their discharge plan, through early discharge information and involvement

### People & Culture

**The Way We Align**

- Trust the referrer
- Clear and consistent communication
- Effective team decision making
- Interdisciplinary teams are aligned to patient care delivery
- Trust the receiver
- Committed to continuous improvement
- Truly patient centred in design and delivery
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<thead>
<tr>
<th>Access</th>
<th>Effectiveness</th>
<th>Efficiency</th>
<th>Organisational Learnings</th>
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<tbody>
<tr>
<td></td>
<td>Quality</td>
<td>Safety</td>
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<td><strong>TIMELY ADMISSION</strong></td>
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<td>• Assessed as ready, to admission to RACC inpatient bed (Time, bed days waiting for Rehab, Aged Care)</td>
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<td>• Acute referral to admission to RACC inpatient bed (Bed days, Rehab, Aged Care)</td>
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<td>• Inpatient d/c (Alfred Health) date to date of initial Ax, (Community Rehab)</td>
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<td><strong>DIRECT ADMISSIONS</strong></td>
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<td>• Alfred to inpatient RACC direct admission (count, % total transfers, time between referral and admission)</td>
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<td>• Alfred to Community Rehab (count, % total referrals)</td>
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<td><strong>PATIENT EXPERIENCE</strong></td>
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<td>• Patient experience (RACC inpatient and community rehab)</td>
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<td><strong>ASSESSMENT/CARE PLAN</strong></td>
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<td>• % IDAT A complete within 24 hrs</td>
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<td>• % IDAT B complete within 48 hrs</td>
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<td>• Time initial Assessment to first team mtg (Inpatient RACC, Community Rehab)</td>
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<td>• % patient with EDD and Destination</td>
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<td>• Time initial Ax to first team meeting (Community Rehab)</td>
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<td><strong>FUNCTIONAL OUTCOMES</strong></td>
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<td>• FIM Change (Unit, AN SNAP)</td>
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<td>• % Discharge destination to accommodation that allows for same or greater independence</td>
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<td><strong>RIGHT BED FIRST TIME</strong></td>
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<td>• % Unplanned readmits with 24 hours (all RACC admissions, direct admissions)</td>
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<td>• % internal transfers within 72 hours (all RACC admissions, direct admissions)</td>
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<td>• Count discharge home ≤ 7 days from time of admission</td>
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<td><strong>ADVERSE EVENTS</strong></td>
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<td>• Code Blue calls, inpatient</td>
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<td>• Patient falls with serious injury, inpatient</td>
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<td><strong>HANOVER/DISCHARGE PLANNING</strong></td>
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<td>• Handover (% internal transfer handover completed, % discharge summaries completed)</td>
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<td><strong>SEAMLESS TRANSFERS</strong></td>
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<td>• Internal ward transfer within 72 hours</td>
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<td>• % Readmission to Alfred(Acute) within 72 hours</td>
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<td>• % Unplanned readmission to Alfred Health within 28 days</td>
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<td><strong>EFFICIENCY</strong></td>
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<td>• LOS (inpatient RACC by unit, ANSNAP, combined)</td>
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<td>• FIM Efficiency (Rehab, Aged Care, ANSNAP)</td>
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<td>• Average client contacts per month (Community Rehab)</td>
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<td>• Completed Initial Ax (Community Rehab)</td>
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<td><strong>CAPACITY</strong></td>
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<td>• Bed Occupancy</td>
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<td><strong>TEAM PERFORMANCE</strong></td>
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<td>• Project Expenditure</td>
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<td>• Cost benefit of new model</td>
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<td><strong>STAFF SATISFACTION</strong></td>
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<td>• People and culture survey</td>
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<td>• Sick leave/unplanned leave</td>
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Implementation....

AN SNAP LOS predictor
Establish RACC TQC metrics
GMU Direct
Patient Journey Boards
Rehab Realignment
Better Notes

Review Complex Care/Escalation
Interdisciplinary Briefs
Leadership/ Teamwork Capability
Community Redesign

2014
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
Good luck with your work