
Delivering the best care in a bigger place

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Bigger Place ... Best Care?

- Introduction to 'The Bigger Place'
- Context - reform in WA
- 'Best Care' - Area Integration, HITH & RITH
- How and what has been achieved?
- The challenges along the way!



Rottneest Island

Carnac Island

Perth

Armadale

Byford

Medina

Rockingham

Warnbro

Peelhurst

Singleton

Mandurah

Falcon

Pinjarra



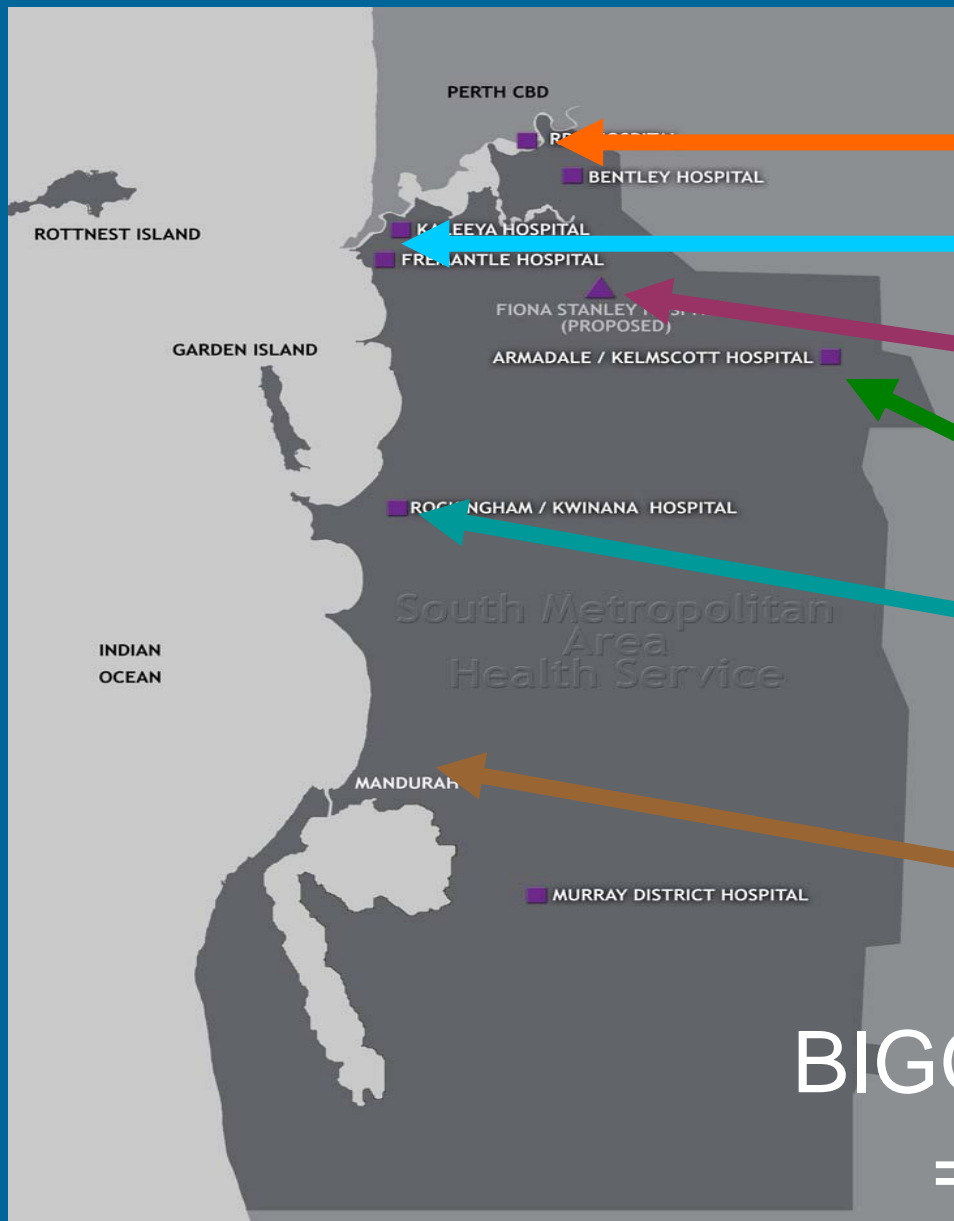
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Royal Perth Hospital

Fremantle Hospital

Fiona Stanley Hospital

Armadale Hospital

Rockingham Hospital

Peel District Hospital,
Mandurah

BIGGER place = SMAHS
= 600 square kms

Background = Reform

- Western Australia Health = Reform
 - Reduce tertiary hospital activity
 - Increase ambulatory care
 - Provide care closer to home
- Create Area Health Services = North & South
 - Reconfigure metropolitan hospitals
 - South = area of population growth
 - South = from 2 tertiary hospitals to one tertiary with several secondary hospitals
- State Government Corporate HCN = Reform



Before the Bigger Place ...

Fremantle

- RITH project funded for winter 2005
- HITH established ~20 beds



Royal Perth service

- Allied Health @ Rehab site
- 'HITH' nursing service ~ 20 bed equivalent








Rockingham

- 6months '05 project funded

- What does 'Best Care' look like?
- Common intent, philosophy and model of care
- Integration between hospitals and professions, between private care organisations, aged care and primary care
- Clear links with upstream and downstream providers
- Common referral criteria & processes
- Equity of access; promotion; choice
- Responsiveness to demand
- Safe growth
- Flexibility; local ways
- Good IT & infrastructure support;



■ What has SMAHS achieved?

- Stated philosophy, model and transfer agreements 
- Integration with primary, aged care, community- partially
- Clear links with referrers & providers 
- Common referral criteria and processes 
- Equity; promotion of service; patient choice - partially
- Responsive and flexible 
 - marked increase in capacity
 - ability to respond to variation
 - quality care and safe growth 
- Good IT & infrastructure support - not yet!

What has made it possible?

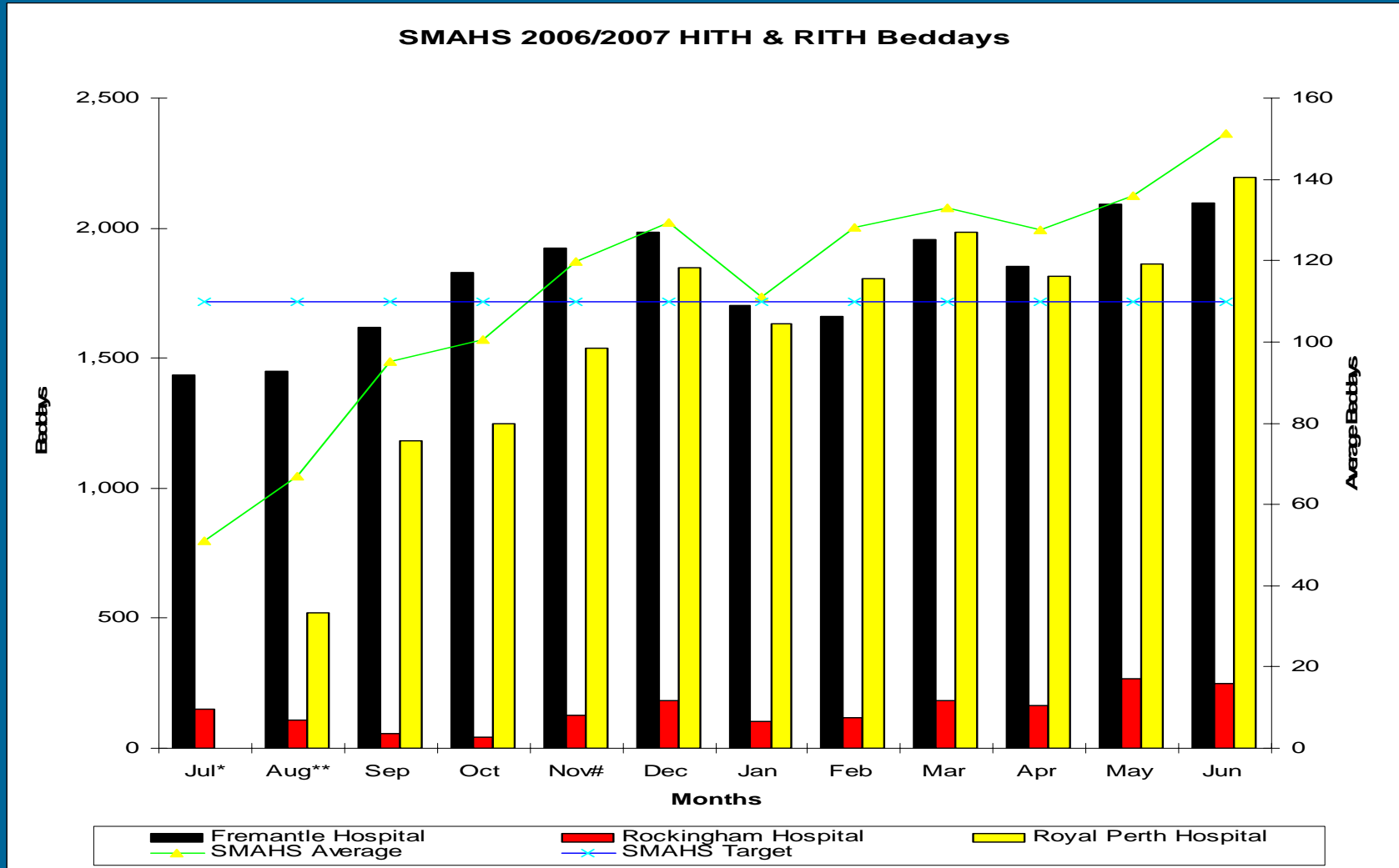
- Moments of bold leadership
 - Clear KPIs, expansion goals and targets
 - Structure & governance - outside of hospitals, management groups, local site committees
 - Area wide managers - business, budget, HR & service development
- Excellent effective site managers
 - Positive work team culture
 - Engagement medical teams at each Hospital site; specific consultant and departmental enthusiasm



Firstly .. kick start with data & KPI's

- Focus on need by DG's Health Reform Team
 - Set KPIs that were specific; even if not realistic!
 - KPI's demanded attention of multiple teams
 - Clinical measures - specific DRG's: DVT, cellulitis
 - Bed days saved - 100% increase in 12 months
 - Processes of referrals - engage ED and wards
 - Clear goals for team, steering committees, reference groups, site Ambulatory Group
 - Then some specifics ...
-

Specifics - SMAHS exceeding targets!



Patient/Carer satisfaction survey

- Very high satisfaction
- Improved confidence
- Preferred home
- Appreciate familiar environment & habits



“Gave me encouragement to work on my own and at my own pace”

“So nice to eat my own food and be in my own bed”

- *Negative = untimeliness of visits*

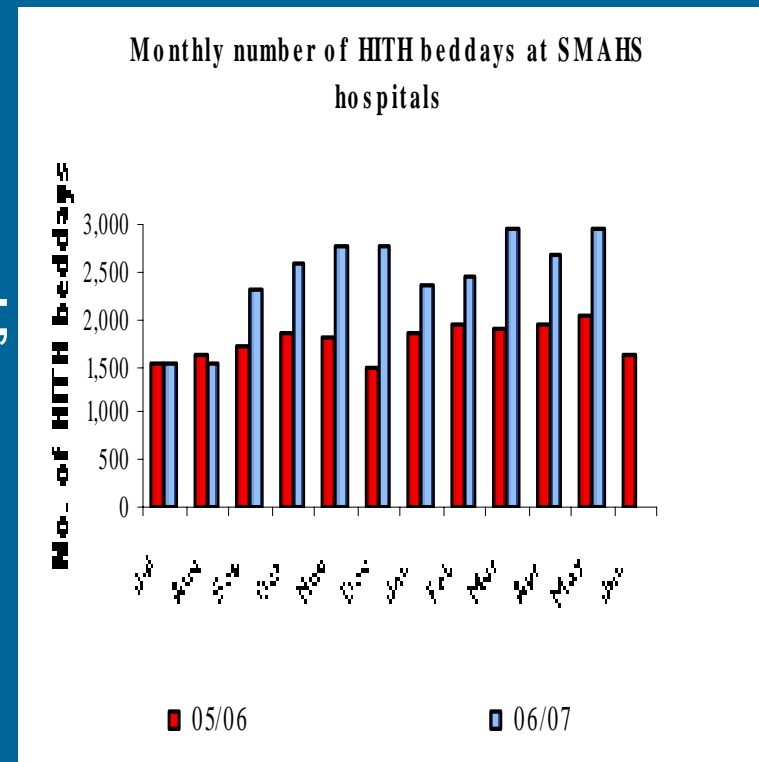
Outcome data

- Length of stay
 - RITH = 13 days
 - HITH = 9 days
- Variation is large
- Case mix influence
 - surgical 2 days versus IVAB's 40 days
- RITH often transfer from HITH ward



'Savings' versus increased capacity?

- Total bed days = 41,000
- Total average beds/day = 120
 - June 2007 = 151 beds
 - Beds flexibility; June = to 175
- Over 50% increase on last year; 200% over 2 years
- Estimated 'savings' = \$20.5 million @ \$500/day saving
- Estimate ~ 0.5 true bed =
- Spend = \$7M



And what were the challenges?

- Concept and disseminating a vision
- Culture changes
- Multiple hospitals, multiple referral sources
- Relationships with multiple medical specialties
- Geography of the Area - delivering over many miles
- Resources
- Leadership changes



Clarity of concept

- **Issue:** domiciliary outpatient versus hospital substitution

- **Solution:**

- Encourage all referrals
- Understand other providers
- Clarity and strength - is it true substitution?
 - Don't substitute gaps, even if heart says yes & discharge
- Positive about good referrals



Culture Change

- **Issue:** New concept
- **Solution:**
 - Target change management for each profession
 - Hospital staff's goals
 - ED referral processes
 - Education and relationships+
 - Notices, newsletters, stickers
 - Be seen.....
 - Staff work exchanges; flexible employment
 - Embrace the willing



Embrace the willing ...

- Example: Chronic disease respiratory team
- Pathway of referral for acute on chronic exacerbations developed
- For success = requires availability medical team and nursing
- Not always available
- Limitation = contingent; use when can; if available



Embrace the willing ...

Example: RACF GP referral

- Local GP Division staff, GPs and RAC Line interest
 - 2 enthusiastic GPs service 28 local RACF's
 - GPs refer to ID consultant (IVAB's); hospital employees
 - Avoids ED presentation
 - Direct admission to virtual ward
 - **More examples**
- ‘Big Wins’ Hilda Tansley, Royal Perth HITH Friday's session



Referrals from multiple sites

- Issues: Multiple!
Governance. Size. IT.
Request = fill gaps.
- Solutions:
 - Vision and concept
 - Targeting
 - hospitals, clinicians and clinical areas expressing interest; relationship building; explaining
 - Identifying barriers - 'can do'; even if difficult process; 'transfer' processes & agreements
 - **Example:** Armadale surgical referrals = 'can do' with Area!



Linking with multiple medical specialties

- **Issue:** Service available patients of any surgical or medical speciality
- **Solution:**
 - Service not aligned to any one speciality
 - Governance must be by admitting physician - important cultural change
 - 'HITH won't admit patient' ! ED*
 - Targeting areas; regular meeting with teams



Issue: Delivering care across large area

■ Solutions:

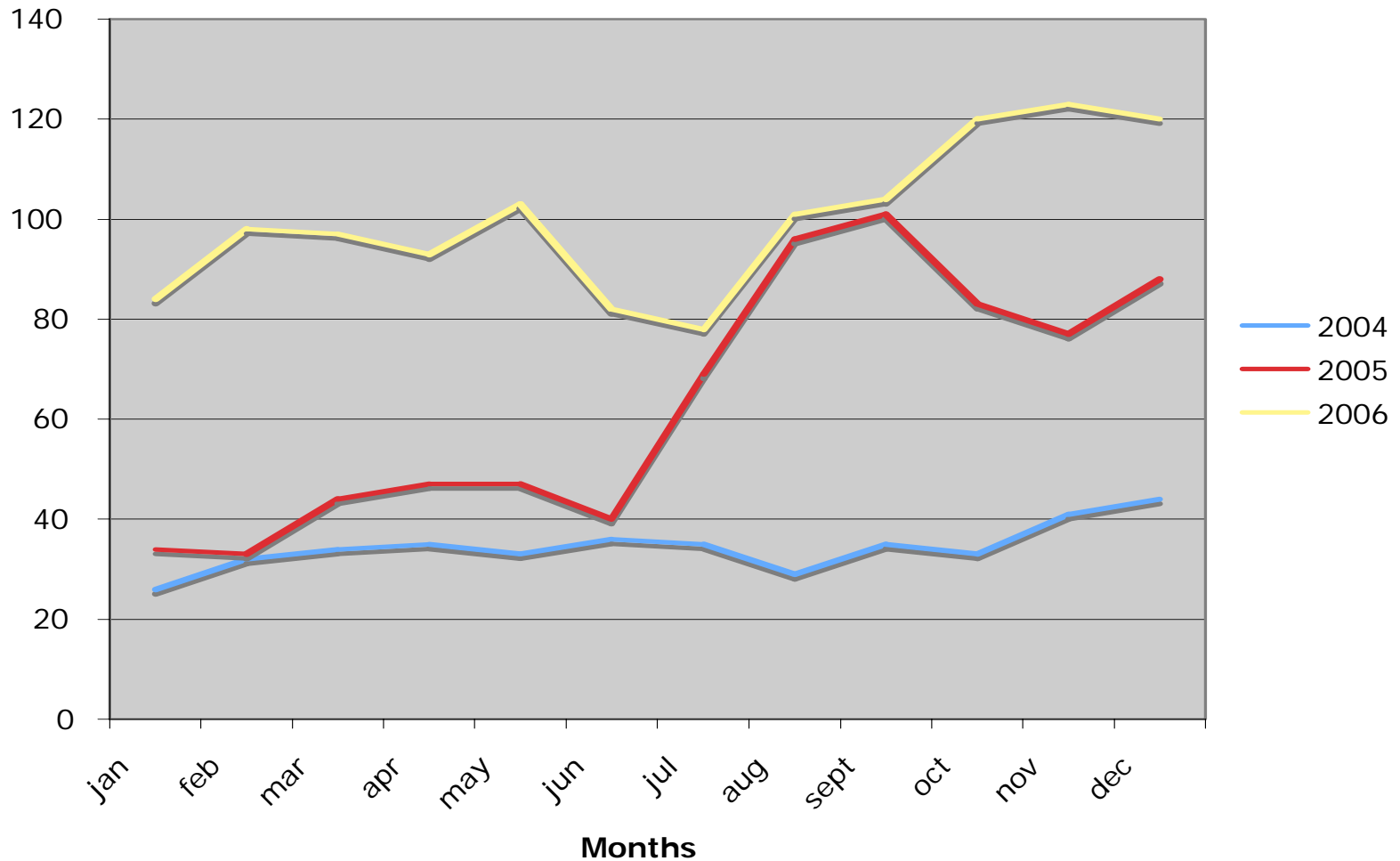
- ❑ Reciprocal transfer of patient agreement
- ❑ Reciprocal care provision = issues of protocols; discrepancy with funding

Example: Care provision by Rockingham base



Admissions increase 150%

- 30% caseload to Rockingham base



Resources

- **Issues:** Limited allocation of cars; lag time with equipment acquisition, eg PICC service ultrasound, computers
- **Solution:**
 - Flexible staffing
 - Nine-day fortnights
 - 4-day weeks - Allied Health
 - Staggered starts
 - Dedicated administration time
 - Goodwill and borrowing
 - Between sites, from Hospital Departments and wards



Leadership and others ...

- **Issues:** Lag time with employment; conflicting expansion directives; workforce shortages
 - **Solutions:**
 - Predict, anticipate, plan flexibly
 - Demand modelling and match workforce capacity
 - Employment recruitment pool; casual staff pool
 - Budget versus reform tensions with grain of salt
 - Keep overall vision, original directive in mind
 - *“This too will pass”*
-
- And so has going bigger been worthwhile?

Advantages of integrated Area service

- Benchmarking between sites
- Coordinated approach to service
- Support of site managers
- Growth 200%+
- Flexibility
- Economy of scale



Thank you



SMAHS

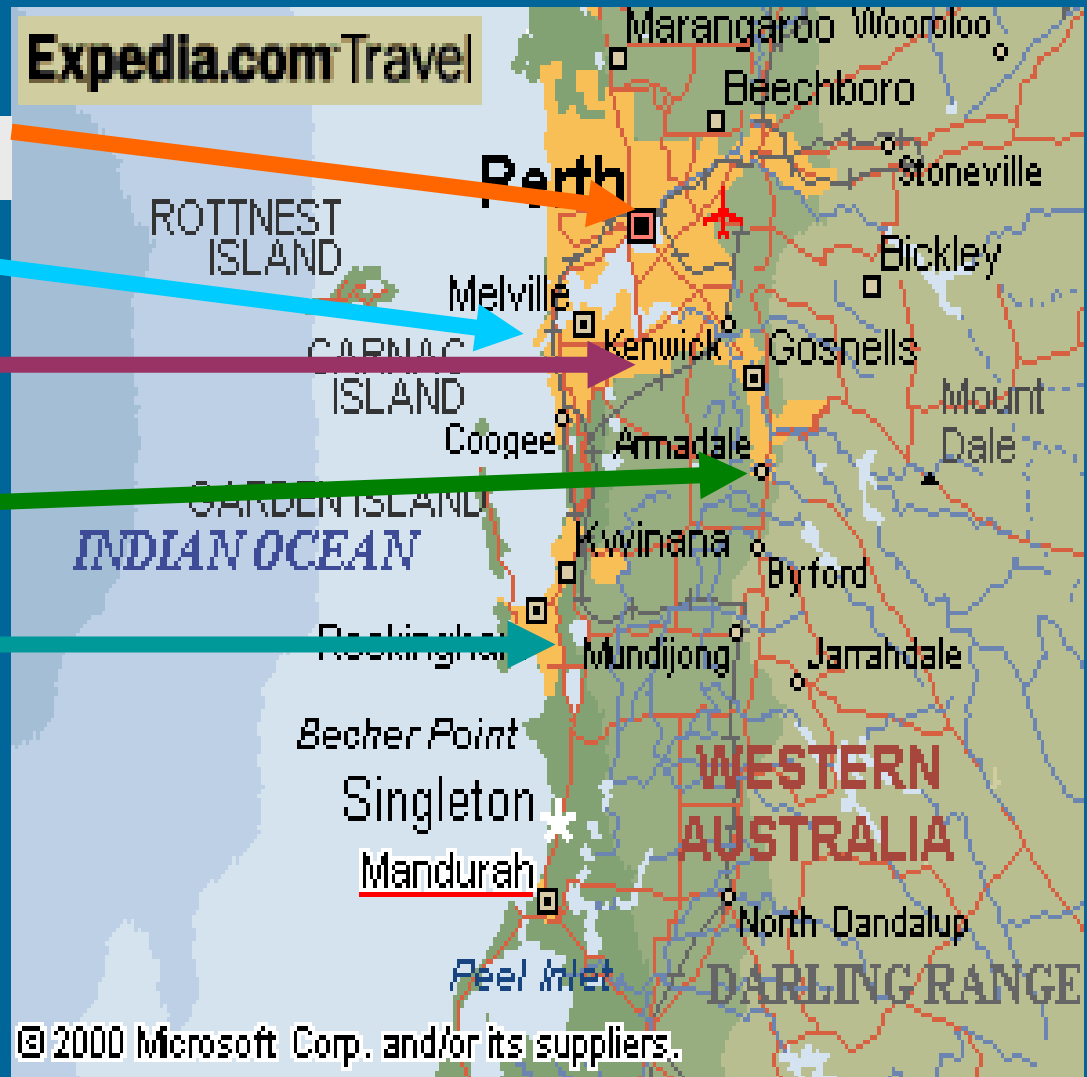
Royal Perth Hospital

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New expanding client niches

- RACF infections and hydration/'noro' virus
- Orthopaedic - revisions of joint surgery; ambulatory surgical initiatives
- Post surgical VAC dressings
- Failed discharges, with no acute issues
- Cognitive impairment; functional 'dyscopia'
- Clients requiring dialysis
- Insertion of first time PEG tubes; dietetic input
- Clients unwilling to accept services/ACAT

Where to from here?

- Targeting specific DRGs
 - long LOS compared to Health Roundtable
- New relationships, new pathways
 - including Aged Care
 - avoid hospital presentations and admissions
- Await IT improvements
 - timeliness and reliability of patient information and written communication and authorisations
- Embrace change
 - clinical decision making tools, eg tele-consulting
 - workforce - skills and scope changes