Welcome: Redesign for Hospital Avoidance

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Acting Deputy Director General, NSW Health
September 2008
Why do we need to avoid the ED
...review of the current environment
ED Attendances are increasing in NSW

NSW: Total ED Attendances by Year 2000-01 to 2007-08 (Annualised)

- Long period of no real growth followed by major increase from 2005

1,300,000
1,500,000
1,700,000
1,900,000
2,100,000
2,300,000
2,500,000

Ambulance presentations are increasing in NSW

Hospital admissions are the highest volumes ever recorded and the strain on our health system is continually increasing.

Total admitted patient episodes in NSW:

- 2001-02: 1,200,000
- 2002-03: 1,250,000
- 2003-04: 1,300,000
- 2004-05: 1,350,000
- 2005-06: 1,400,000
- 2006-07: 1,450,000
- 2007-08: 1,500,000

*Note: Data for 2007-08 is estimated.*
Our largest and fastest growing patient groups present a challenge...

Half of all hospital beds are occupied by people aged over 65

Hospital presentations by the over 75 age group are growing 20% per annum

Average length of stay in hospital is 4 days. For people aged over 75 this jumps to 9 days

77% of Australians over the age of 65 have at least one chronic condition
The rising incidence of Chronic Disease is a challenge to our current Health System

70% of the burden of illness and injury is attributable to chronic disease.

Incidence of chronic disease increases with ageing.

Current models of hospital based care do not adequately cater for the needs of older people or people with chronic diseases.

An external report in 2007 projected that growth in demand would require additional beds equivalent to a small hospital each year.
What are the patients telling us…

• “I was comfortable in hospital but to stay at home was what I wanted”

• “If my cancer treatment is considered a journey, I’d rather stay at home”

• “if I could change one thing about my hospital stay it would be that I could stay at home with my family & come in daily for tests and treatment”
The GP workforce is ageing…

Source: General Practice Activity in Australia, 2004/05 and 2005-06.
GPs across Australia are much less likely to be providing their own after hours services.

Percentage of GPs providing their OWN or cooperative after-hours services

<table>
<thead>
<tr>
<th>Year</th>
<th>% of GPs</th>
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<tbody>
<tr>
<td>2000-01</td>
<td>65%</td>
</tr>
<tr>
<td>2001-02</td>
<td>56%</td>
</tr>
<tr>
<td>2002-03</td>
<td>63%</td>
</tr>
<tr>
<td>2003-04</td>
<td>60%</td>
</tr>
<tr>
<td>2004-05</td>
<td>52%</td>
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<tr>
<td>2005-06</td>
<td>47%</td>
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Source: General Practice Activity in Australia, 2004/05 and 2005-06
Let's hope that we will never have to do this....
Clinical Services Redesign is part of the strategy to transform the NSW health system

Process Improvement
Changing the way we do things to improve processes and deliver better patient journeys

Performance Management
Increased managerial focus on targets and performance

Increased capacity
An additional 1800 beds added between 2004 - 2006
Since June 2005 we’ve implemented over 85 projects in eight areas that were creating the most stress on the health system

1. Mental Health
2. Surgery
3. Emergency Care
4. Acute Care
5. Integrated Aged & Chronic Care Services
6. Cardiology
7. Performance Management Development
8. Patient Flows
These projects have resulted in new ways of delivering better care

**New Models of Care**
18 best practice Models of Care have been captured  [www.archi.net.au](http://www.archi.net.au)

**New Tools**
Including ambulance arrivals board, Ambulance Clinical Services Matrix, electronic bed board, surge beds, risk assessment tools (e.g. falls, delirium), and demand management tools

**New Approaches**
Including fast track zones, Medical Assessment Units, Patient Flow Units, hospital avoidance initiatives, Hospitalists
In order to deliver better patient journeys we have invested in learning from real patient experiences

- In-depth interviews of over 250 patients and carers in the last 18 months
- Conducted NSW Health’s first system wide patient survey of 75,000 hospital, outpatient department and community health services patients
Redesign follows a robust framework for improving clinical processes

- Frontline staff use the methodology
- Ensures we analyse problems before developing solutions
- Delivers long-term sustainable changes
Redesigning for Hospital Avoidance in NSW...
We recognise the need to improve the patient journey by providing...

**Right Care**
Evidence-based care, community focused

**Right Provider**
Teams working together across sites independent of funding source

**Right Time**
Early Intervention, accessibility, equity of access

**Right Place**
Close to home in the place of their choice, maximise primary care, tailored to individual needs
We’re designing better journeys and smarter care to ensure patients avoid unnecessary hospitalisation.

- **Person in Community**
- **Emergency Department**
- **Inpatient Care**
- **Discharge**
  - **Person in Community**

**Steps:**
- **Intervene Early to keep @ home**
- **Minimise ED LOS**
- **Minimise inpatient LOS/ Promote function**
- **Prevent readmission/ sustain care**

**Support:**
- **Contact Centres, Healthy at Home & SCDM** (Severe Chronic Disease Management)
- **MAU**
- **ComPack, CAPAC & Rehab for Chronic Disease**
Intervening early to keep people safe at home

Severe Chronic Disease Management (SCDM)
Proposed program is a new approach to managing the health of those with severe chronic disease by providing access to care coordination and telephone coaching.

Contact Centres
Previously SPA (Single Point of Access). One phone call to help navigate through the existing complicated system to access all types of care in the community.

Healthy at Home
Previously the SAFTE Care Program. Is an interagency approach between GP, health, home & community care teams to support the frail elderly safely at home.

Total Care Navigation
Flags and targets the most vulnerable aged, chronic care & complex needs patients to improve their experiences and outcomes by coordinating & integrating care & services.
If patients require hospitalisation we need to minimise ED LOS & inpatient LOS and promote patient function.

The Medical Assessment Unit (MAU) provide rapid assessment, treatment & diagnosis by senior clinicians for non critical medical patients.

Patients within the MAU can expect to stay for a period of up to 48hrs, after this time most will be discharge home (with community services where appropriate), while some who require specialised care will be transferred to an in-patient bed.
Helping prevent hospital readmissions and sustain care

Community Post Acute Care (Com Packs)
Case managed discharge program between health teams and community case managers to ensure they can manage a functional recovery at home.

Community Acute/Post Acute Care (CAPAC)
Patient receives acute care in their home environment rather than hospital e.g. cellulitis, COPD, DVT, pneumonia, urinary tract infection

Rehabilitation for Chronic Disease
Enabling self management of a chronic condition or effective long term case management in a community setting
We need to invest in community strategies to cope with an expected 2.2% increase in bed day usage

<table>
<thead>
<tr>
<th>Model of Care</th>
<th>Impact on Average LOS</th>
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<tr>
<td>MAU</td>
<td>1 day &amp; 4hrs in ED</td>
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<tr>
<td>CAPAC</td>
<td>2.5 days &amp; 4hrs in ED</td>
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<tr>
<td>ComPack</td>
<td>5.7 days</td>
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<tr>
<td>Rehab for Chronic Disease</td>
<td>3.5 days &amp; 67% ↓ in ED attendances</td>
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The total investment is now an additional $60M in NSW for community based strategies...

CAPACs, ComPacks & Rehab for Chronic Disease
What are you doing…?