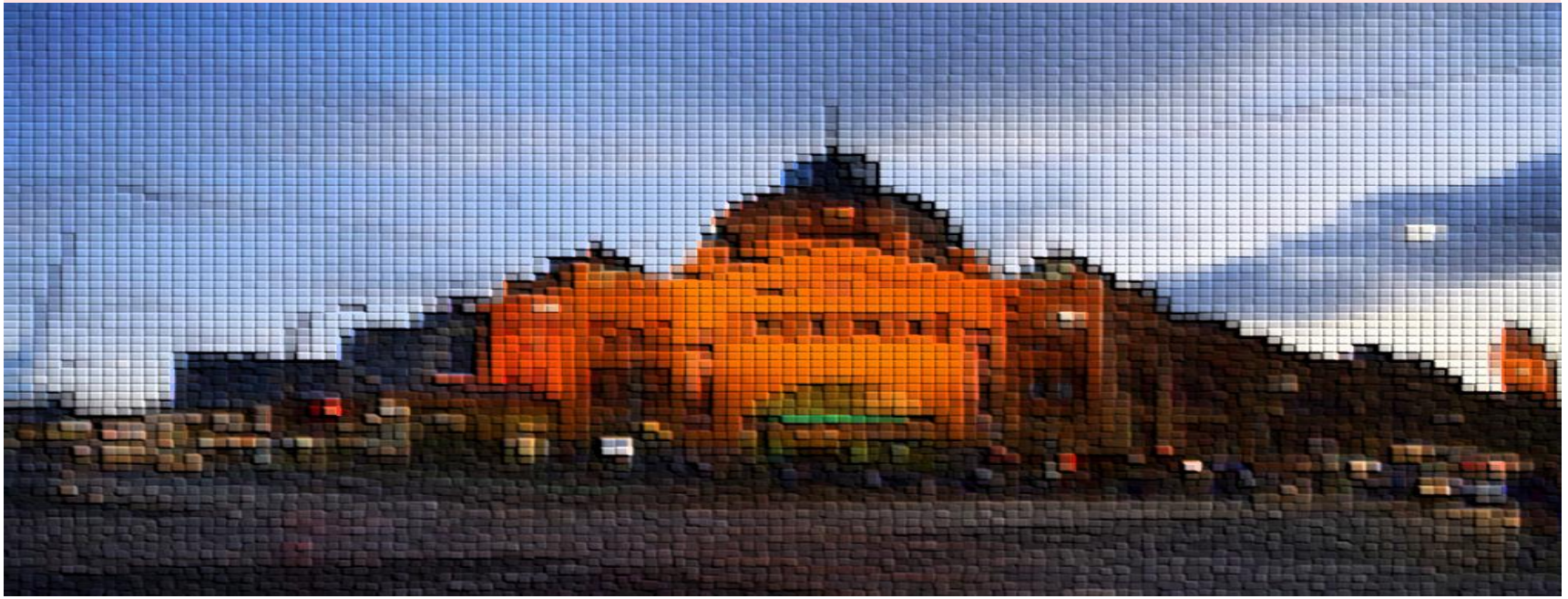
Total Strategy to Facilitate Discharge Through Collaboration

Learning from Melbourne



Serena Ng, David Chung, Donna Fung ,
Irene Kwok, Peggie Lee, Margaret Poon

Sandra Shing

Background

醫院管理局進修學院
Hospital Authority
Institute of Health Care

INSTITUTE OF ADVANCED ALLIED HEALTH STUDIES
專 職 醫 療 深 造 學 院

Overseas Corporate Scholarship Program for AH Professionals 15/16

Canberra & Melbourne Trip

Public Rehabilitation Hospitals

1. Canberra Hospital – Rehabilitation, Aged and community Care Division (140 r-beds)
2. Belconnen Community Health Center
3. Peninsula Health Golf Link Road Rehab Unit (r-60 beds)
4. Heidelberg Repatriation Hospital (112 r-beds)
5. Royal Talbot Rehabilitation Center (SCI 20, Sur 20, ABI 12)

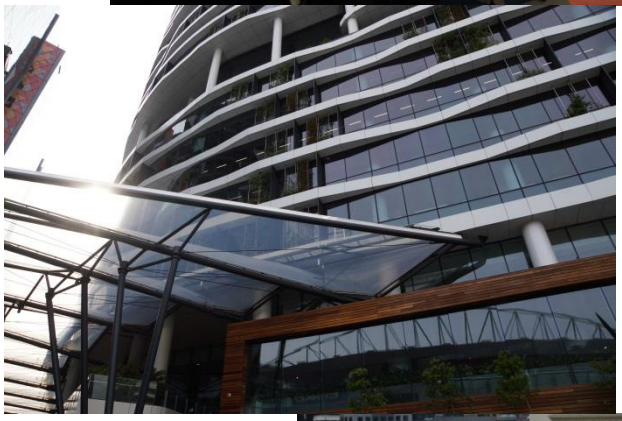
Private Rehabilitation Hospitals

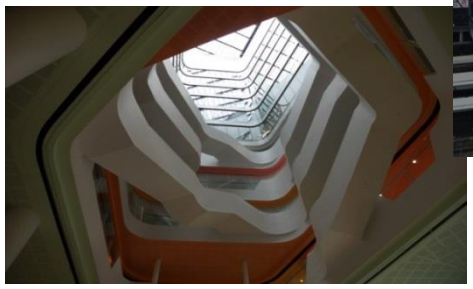
Brunswick Private Hospital (60 r-beds)
Donvale Rehabilitation Hospital (120 r-beds)
Epworth Health Care – Hawthorn (30 r-beds)
Epworth Helath Care – Richmond (86 r-beds)

Medical Insurance Corporations

Private Health Insurance

- Population:
  - 55.2% covered by Medicare (public & 75% private) ;
  - 47.2% covered by Insurance for hospital treatment
- National Market Share (2015)
  - BUPA 27%
  - MediBank 26.9%
  - Australian Health Services Alliance (AHSA) 20%
  - HCF Health Insurance 12%





Medibank History

1976

- The Australian Government established Medibank Private as a not-for-profit private health insurer and an operating division of a statutory authority (the Health Insurance Commission). Medibank Private proved to be a success and had become the second largest insurance funding company in the country within the year.

2014

- In March, the Australian Government announced plans to privatize Medibank, subject to market conditions.

2015

- Medibank has been an integrated healthcare company providing private health insurance and health solutions to 3.9 million people in Australia and New Zealand.

Funding Model
Value Based Purchasing

- **Benchmark hospitals among a peer group on a cost and quality basis**, which enables identification of the best value providers performing with the best quality outcomes at the lowest cost.

- **Daily Dash Board for all member providers with data** on
  - acute Length of Stay (LOS),
  - rehabilitation LOS,
  - referrals to rehabilitation services,
  - percentage to Intensive Care Unit (ICU),
  - readmission within 28 days, and
  - trend of adverse events etc.

- serves **as alertness to own national ranking**.

- **Case mix analysis** is also conducted regularly. In case of extended LOS due **to complications** such as fall, acquired injuries, and infection, **no extra coverage will be paid.**

- **Audits and investigations of substandard performance** relating to hospitals, clinics or doctors will be conducted to ensure pay for quality service is in place.

- International evidence has revealed that **coordinated primary care** helps to reduce hospital admission.

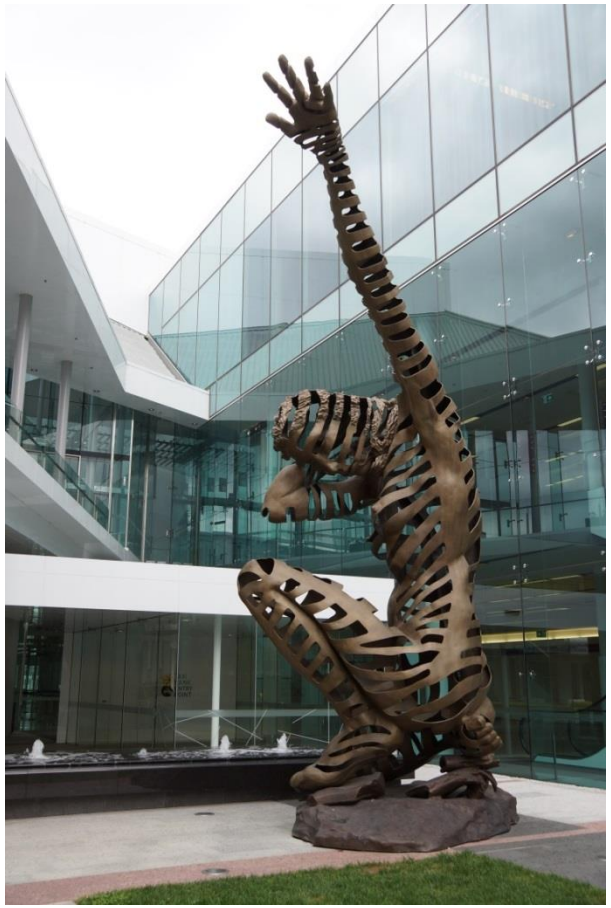
- The new trend is to optimize per diem funding model, **establish outcome benchmarking** and promotion of **home-based rehabilitation**, and to follow funding based on-**patient-reported outcomes**.

Prime Movers in Hospitals

Discharge before -$

Reduction in Cost

Improve Health Outcome



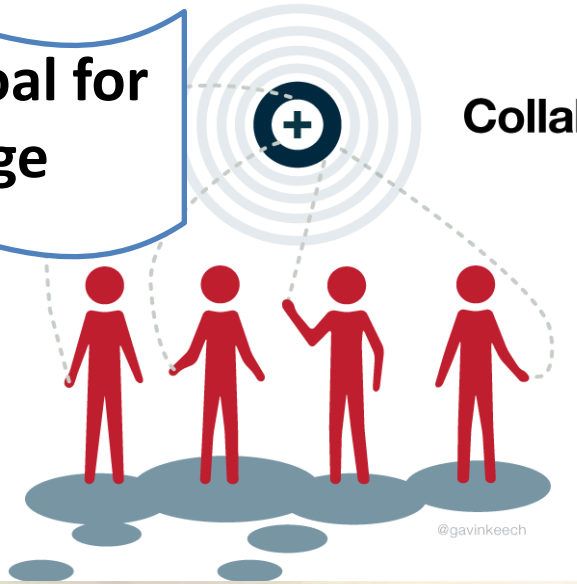
Enhance Patient Experience

Coach for Staff Excellence

Mode of
Multi-disciplines Collaboration in Discharge Planning

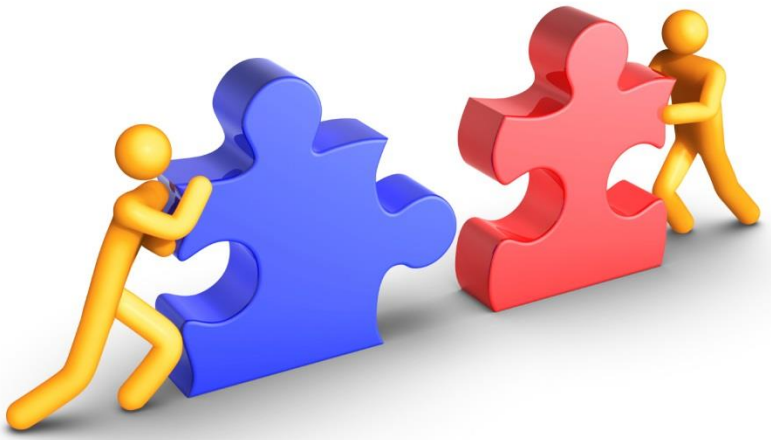
No structured clinical guidelines and protocols are required as the patient service delivery relies very much on case management and close team communication.

Patient's Goal for Discharge

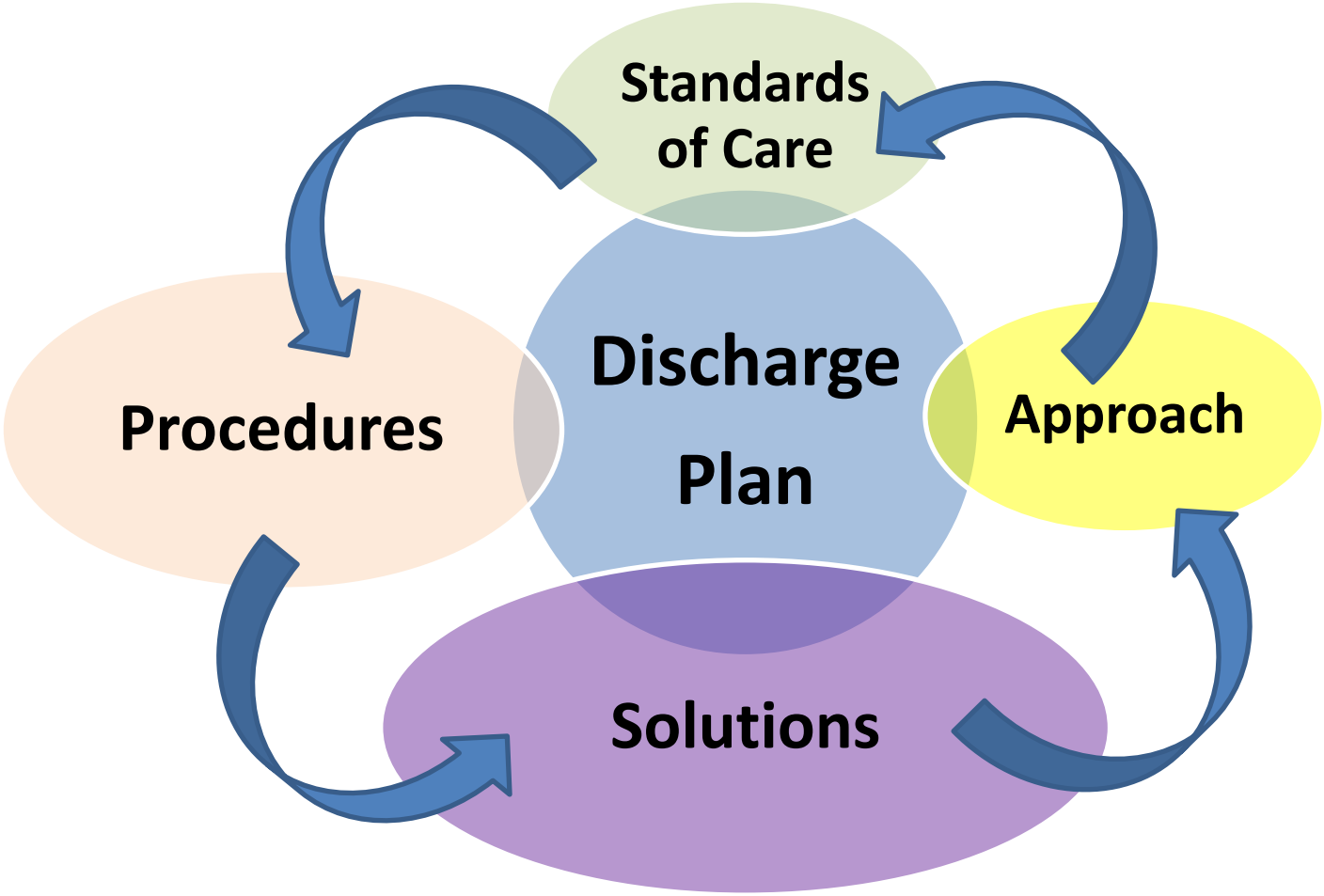


Collaboration

Close Communication



Key-chain to communicate for patient discharge



Standards of Care

Australasian Rehabilitation Outcome Center (AROC)

Benchmarking of Australasian Rehabilitation Outcomes Centre (AROC) is adopted.

Health sector performance is evaluated by:

- Average Length of Stay (LOS)
- FIM efficiency gain
- Time from stroke to admission to rehabilitation ward
- Time from orthopaedic surgery to admission to rehabilitation ward
- Annual credentialing of stroke nurse practitioner including drug formulary and prescription
- Clinical audit meetings for all subacute members regarding cases on falls and skin integrity being transferred back to acute settings.
- Criteria set by service providers – depends on consumption pattern

Standards of Care

The 10 **National Safety and Quality Health Service (NSQHS) Standards**

Provide a nationally consistent statement about the level of care consumers can expect from health service organizations:

- NSQHS Standard 1: Governance for Safety and Quality in Health Service Organizations
- NSQHS Standard 2: Partnering with Consumers
- NSQHS Standard 3: Preventing and Controlling Healthcare Associated Infections
- NSQHS Standard 4: Medication Safety
- NSQHS Standard 5: Patient Identification and Procedure Matching
- NSQHS Standard 6: Clinical Handover
- NSQHS Standard 7: Blood and Blood Products
- NSQHS Standard 8: Preventing and Managing Pressure Injuries
- NSQHS Standard 9: Recognizing and Responding to Clinical Deterioration in Acute Health Care
- NSQHS Standard 10: Preventing Falls and Harm from Falls

Standards of Care

- One therapist (per PT&OT) per 6 Beds + exercise physiologists + AH assistance (3 levels)

- National work load standard per staff is 6 to 12 inpatients daily. For out-patient service, the standard is 20 individual patients per day or 30 minutes session for group training. (Actually, the staff may serve multiple patients at one time for individual therapy regime)

- Staff are 1.5x pay for Saturday and 2x for Sunday/PH work

Standards in Financing (e.g.AHSA)

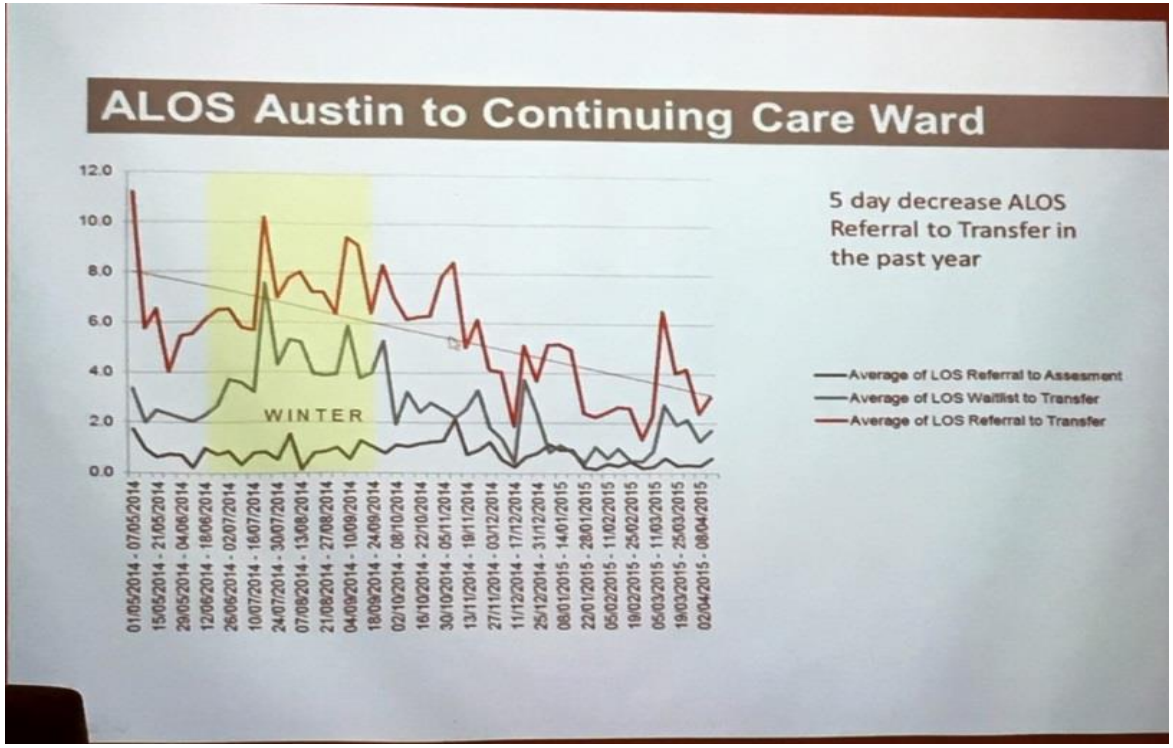
Bulletin Board for monitoring and audit of members:

1. LOS ratio compared to AROC norms
   - <1 better than AROC
   - > 1 worse than AROC
2. FIM efficiency ratio compared to AROC norms
   - >1 better than AROC
   - <1 worse than AROC
3. Additional metrics:

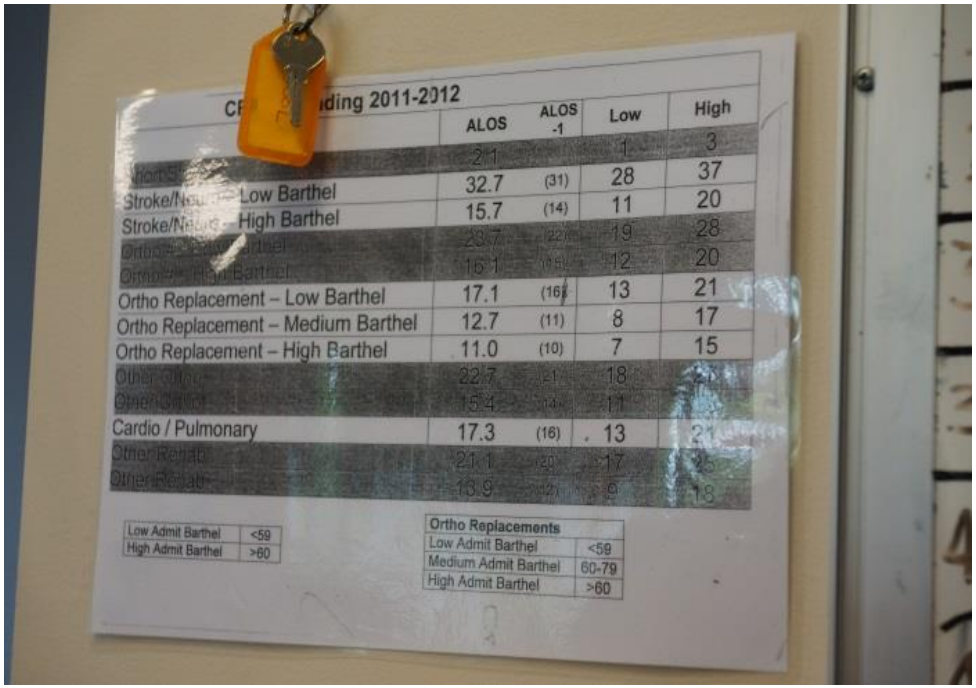
- Charges
- Combined LOS
- % rehabilitation charge
- State comparators (e.g. Victoria vs. New South Wales)
- Group comparators
- Referral rates from acute to rehab

For example:
Escalation of potential cases of deviated ALOS from Clinical Team to Management to solve discharge problem ASVP in weekly review

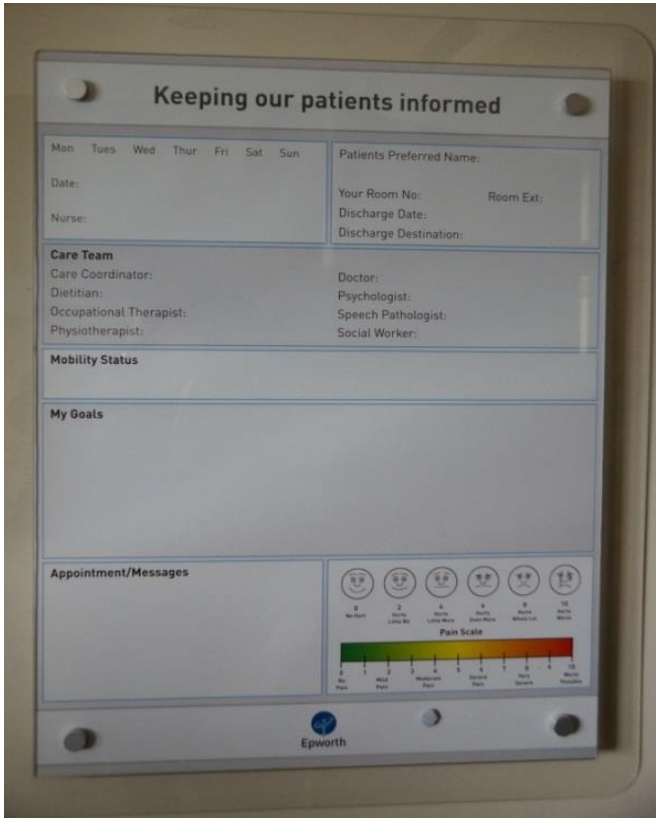
Condition	Length of stay (in day)
Mild stroke	14 - 21
Severe stroke	30 - 60
Acquired brain injury	12 -50
Lower limb amputation	30
Lower limb fracture	10-12
Lower limb joint replacement	14 - 21



Outcome monitoring chart for Stroke and Joint replacement program



Board posted in Staff Room in wards to show ALOS Of @ diagnostic group according to Admission BI score



A board at the end of the patient bed to keep the patient informed, including of the goals and the discharge plan

Integrated Patient Progress Chart

Posted in Staff Room with information of

- Patient name
- Estimated date of discharge
- Nurse in-charge
- Therapist names : PT/OT/ST/Nurse
- Target interventions before discharge
- Actual date of discharge

Daily meeting for case discussion will be coordinated by the Nurse Manager.

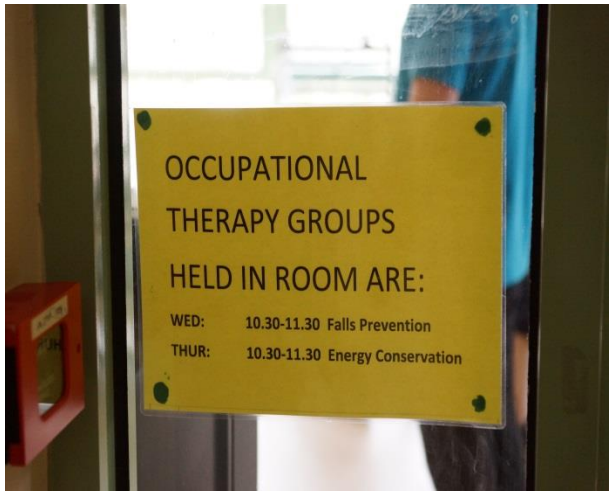
Related medical information of each patient and expected discharge date are written on the white board.

Approach

Shared values in providing ESSENTIAL medical care

Triple aim concept

- Encouraging cost reduction
- Enhancing patient experience
- Improving health outcome



For example:

1. Adopted the ‘Pull’ model rather than ‘Push’ model which ‘Pull’ the patient at the acute hospital to the rehabilitation setting by rehabilitation coordinator. i.e. to recruit right patients for right treatment in their hospital within achievable ALOS
2. AHSA is pushing for 6 days services particularly 7 days service provision. Thus 5-day service is not acceptable. Currently only the physiotherapist and occupational therapists are offering weekend service

Right patient, Right time, Right place to receive Right treatment (e.g. Austin Health)

1. **A model of care for geriatrics "Dual role Tertiary Health with community responsibilities** is being adopted mainly in acute wards with governance coordinated by geriatricians.
    1. 7 day service for admission & discharge, managing unwell pt, emergency medical review, rehab.
    2. Subacute care is not a discharge destination

2. Checklist instead of pathway approach due to individual variation in terms of patients' need.

3. Pharmacists also involve in ward round and patients' concerns and problems can be realized and entertained at the right moment.

4. Optimize patient flow

Stroke Detour Program (Peninsula Health)

Stroke Detour team leader will triage in-patients with stroke suitable for **intensive** rehabilitation taking into consideration of availability of carers and rehabilitative goals to achieve.

1. The program can be **home or centre based** and is free of charge.
2. About 10 patients are taken in per month.
3. Patients are discharged around a month's time.
4. Daily sessions of therapy are provided according to patients' need.
5. Staffing includes 1 Occupational Therapist (leader), 1 Physiotherapist, sessional Speech Therapist and Neuropsychologist, and 1 Allied Health Assistant (level 3).

Health Independence Program (HIP)

1. Ensures the patient can receive the right care, in the right place, at the right time, unhampered by program boundaries & prevent the need for a hospital presentation or stay,
2. Centralised referral system and triaged to the appropriate programs.
3. 90 FTE (of 170 heads) including nurses, AH staff and AH assistants. There is no waiting list for joining the program.
4. Strong partnerships with Community Health Services

The HIP program includes various treatment activities. They are:

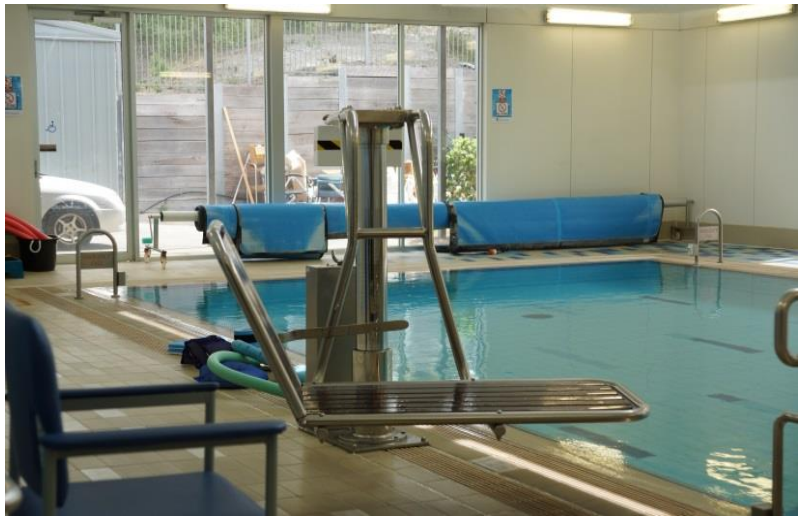
- Centre based and home based rehabilitation
- Fall and balance clinic
- Group exercise programs
- Hydrotherapy
- Functional restoration program
- Fast track orthopaedic service
- Chronic pain

(Self-Training & Education in Pain Session)

Multi-D input & Single-D output

For Example:

- The Rehabilitation Consultant decides the care plan for the patients and triages the need for different AH services.
- Interdisciplinary Care Plan (ICDP)
- Patient / Carer education checklist
- Post discharge Tel-FU checklist



Patient centred care model with IDCP concept is implemented with 7 core domains of care :

- Health status / Pain management
- Cognition / Communication
- Social and Psychological
- Self-management issues
- Mobility / Physical
- Functional status
- Nutrition / Swallowing

Patient weekend exercise in multi-function (inter-disciplinary) room

During visiting hours and weekend, operated by ward nurses and used by carers & patients

Patient Experience

1. Consumer Focus Group: ex-patient come back to talk about their experience and meet quarterly
2. Customer Focus Special Interest Group: staff to share patents' feedback and needs of patients

Keep the patients informed (Epworth)

Condition	LOS
Acquired brain injury	38.25
Neurological	18
Spinal Cord Injury	9
Orthopaedic	14
Pain	10

Solutions

- Flexi workforce (part-time / full time / weekend)
- Rehab coordinators (acute/rehab/out-patient)
- Excellence coach
- Transitional living units
- Aids Loan Service (regional wide / free)
- Rehab in-home

Rehabilitation Coordinator

- The Rehab Coordinator can be of any Nurse or AH background.
- This coordinator assesses admission criteria for the acute patient to rehabilitation taking into account of availability of private insurance, achievable rehabilitation goals and home support.
- Every patient has an assigned Coordinator who screens and refers the patient to relevant rehabilitation services. The patient is also being involved in goal-setting.
- The coordinator coordinates the care path upon discharge and follows the patient throughout the rehabilitation journey to ensure right time for right service.

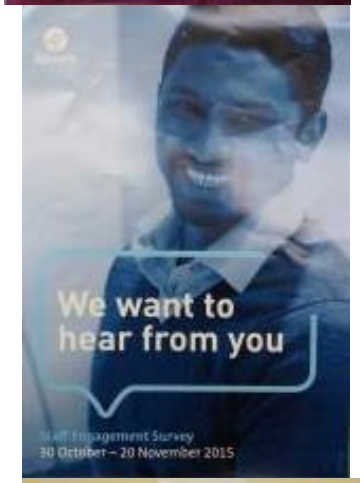
Outpatient Coordinators

- The outpatient coordinator can be a clerical staff.

- This coordinator serves as a one-stop receiving point of online referrals. Medical appointments will then be arranged first, followed by different AH service appointments as indicated. The appointment schedule of each patient can then be better coordinated.

Excellence Coach (Epworth)

- **Excellence Coach develops working culture with focus on patient experience**. The Excellence Coach is actually an occupational therapist by profession.
- Based on the national wide survey conducted, it was found that patients' perception and feelings are different from clinician perspectives. The coach will **phone-call the patients within 48 hours** after discharge to give the patients opportunity to express their needs and to check if any adverse event going on.
- To improve staff engagement about **the value of conversation with patients in order to build on trust.**
- **All ranks were coached** about wrong "doing" and "saying" in a group of 6 to 9 staff per session. Individual coaching in 1:1 format is conducted for staff at manager level.
- **A tool named "Acknowledge, Introduction, Duration, Explanation and Thank you" (AIDET) is a tool to enhance clinicians' communication skill** to patients.



Transitional Living Centre (TLC)

- It is a unique **home and community based program** for persons with acquired brain injury (ABI).
- **facilitation of independent living skills**
- targeted **at in-patients and patients who stay-at home and plan to live independently**. Patients should agree to be admitted before TLC arrangement can be made.
- About 50% hospital patients are found to go home and then come back to Transitional Living Centre.
- The period of stay is from **3 - 9 months followed by a 3-months review**, and normally the whole stay will not last for more than 2 years.
- When longer rehabilitation period is required, patients will be **referred to other community services for further support.**

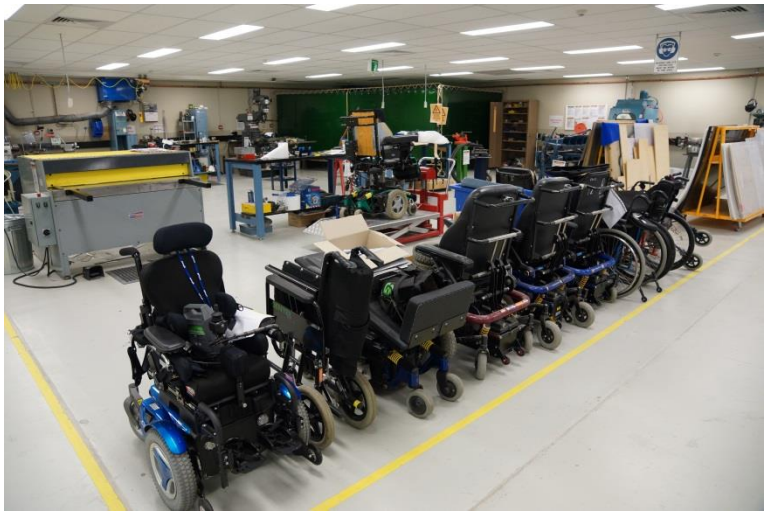
Transitional Living Centre (TLC)

- The TLC is staffed by a team of Occupational Therapists (2.5 FTE), Social Workers (0.5 FTE), Clinical Psychologists (2 FTE) and AH Assistants who stay overnight and over weekend for support. Community team also provides speech therapy, dietetic and physiotherapy services when required. Electronic documentation of clinical information is in place

Rehabilitation in Home Program (Epworth)

- This is a physiotherapist-based program for hip and knee fracture cases.
- Private funding for inpatient hip and knee cases is available for LOS up to 7 days. This program helps to shorten LOS to 5 days with 7 day payment. Patient satisfaction in response to this program is high.
- If more intensive therapy is indicated upon completion of this program, the patient may be referred back to out-patient clinic for further management.

Free Aids Loan Service



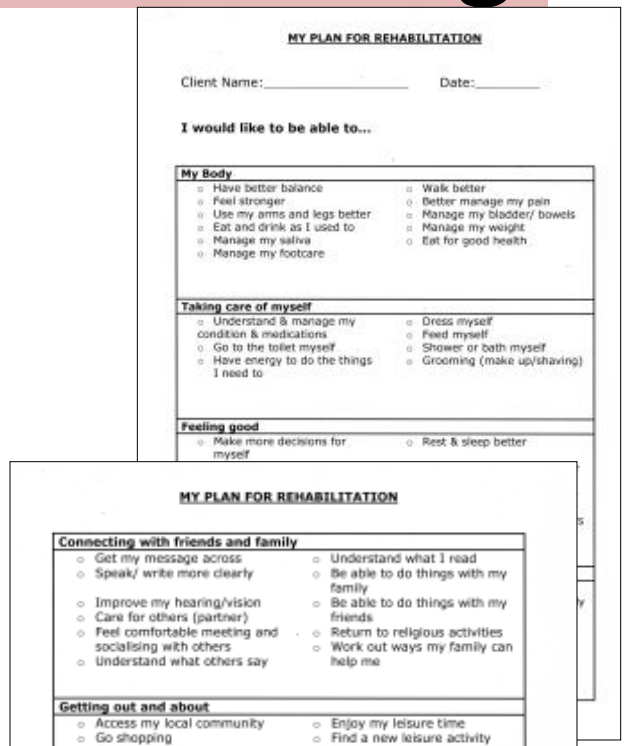
Procedures

- Outcome documentation using AROC V.4 forms
- IT system
- Dash boards
- Audit meetings
  - Interplay between clinicians, managers, funding bodies, government, professional bodies, insurance company
- Process documentation
  - Integrated Rehab Care Plan & Case Conference record

Clear Rehabilitation Care Planning

Starting from the admission date for overall care plan for @ case.

- It includes **case conference on admission, weekly case conference, daily whiteboard meeting**
- goes through all cases with related information on **expected length of stay (LOS) based on AROC criteria, "to-do" lists** (e.g. contact carers, arrangement of assistive devices).
- **Clear goal-setting with each patient is in place.** Therapists work closely with the patients and their families during early phase of rehabilitation
- Get the patient involved in their care plan using **"My Plan for Rehabilitation"**



MY PLAN FOR REHABILITATION

Client Name:_____ Date:_____

I would like to be able to...

My Body

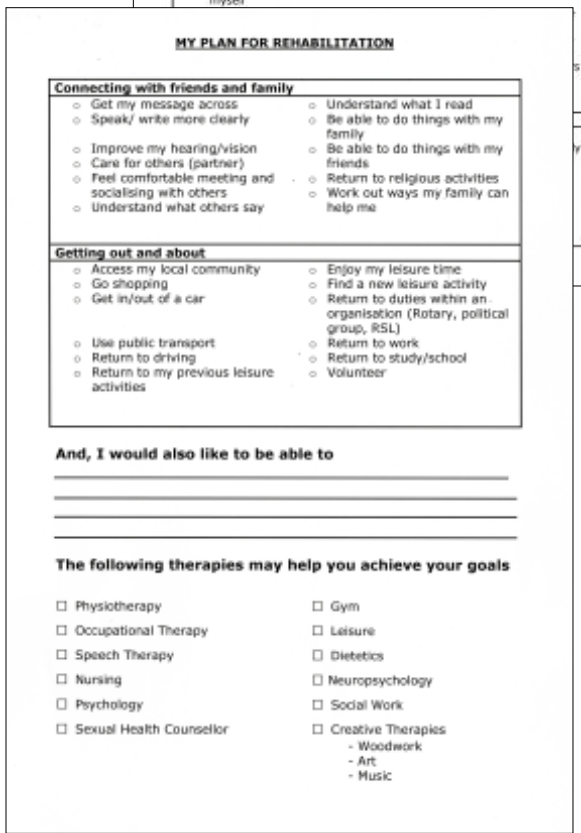
- Have better balance
- Feel stronger
- Use my arms and legs better
- Eat and drink as I used to
- Manage my saliva
- Manage my footcare
- Walk better
- Better manage my pain
- Manage my bladder/ bowels
- Manage my weight
- Eat for good health

Taking care of myself

- Understand & manage my condition & medications
- Go to the toilet myself
- Have energy to do the things I need to
- Dress myself
- Feed myself
- Shower or bath myself
- Grooming (make up/shaving)

Feeling good

- Make more decisions for myself
- Rest & sleep better



MY PLAN FOR REHABILITATION

Connecting with friends and family

- Get my message across
- Speak/ write more clearly
- Improve my hearing/vision
- Care for others (partner)
- Feel comfortable meeting and socialising with others
- Understand what others say
- Understand what I read
- Be able to do things with my family
- Be able to do things with my friends
- Return to religious activities
- Work out ways my family can help me

Getting out and about

- Access my local community
- Go shopping
- Get in/out of a car
- Use public transport
- Return to driving
- Return to my previous leisure activities
- Enjoy my leisure time
- Find a new leisure activity
- Return to duties within an organisation (Rotary, political group, RSL)
- Return to work
- Return to study/school
- Volunteer

And, I would also like to be able to

_____

_____

_____

_____

The following therapies may help you achieve your goals

- ☐ Physiotherapy
- ☐ Occupational Therapy
- ☐ Speech Therapy
- ☐ Nursing
- ☐ Psychology
- ☐ Sexual Health Counsellor
- ☐ Gym
- ☐ Leisure
- ☐ Dietetics
- ☐ Neuropsychology
- ☐ Social Work
- ☐ Creative Therapies
  - Woodwork
  - Art
  - Music

My joint replacement daily goals

Austin Health

Tick the box when you've met your daily goals.

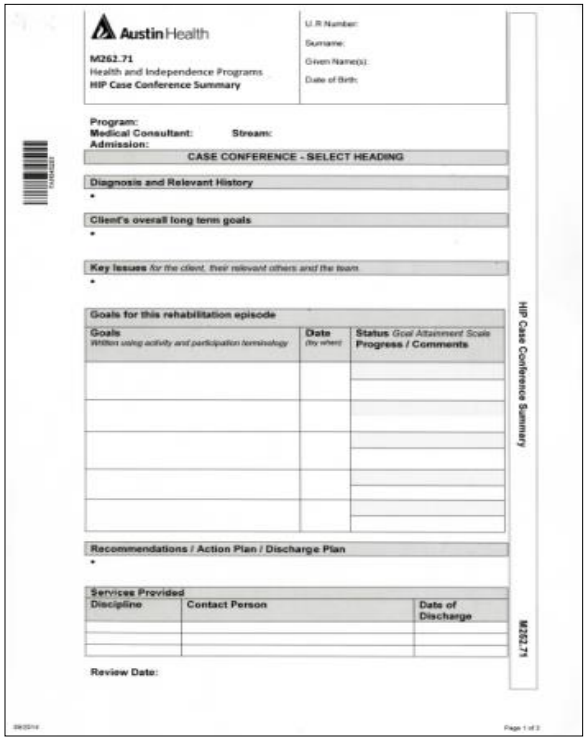
Patient name: _____ Discharge Date: ___/___/___

DAY 0	DAY 1	DAY 2	DAY 3	DAY 4
My operation was today.	I will start exercising + walking with assistance today.	If I progress very well, I may go home today.	If I progress very well, I may go home today.	I will be ready to go home by 9am.
I may begin exercising this afternoon.	I will tell my nurse if I'm feeling sick or have pain.	I will walk around today and attend physiotherapy gym classes at 11am + 3pm.	I will walk and exercise at least 3 times per day.	I will remind the nurse to return my own medications or valuables to me.
I will be fitted with a support-ive stocking.	I will have an X-ray of my hip/knee. A blood sample will be taken.	I will sit out of bed at meal times.	I will walk to the toilet and shower by myself where possible.	**I need to know the plan for:**
	I will be helped to wash or shower.	I will have a shower today.	I will tell my nurse if I have not used my bowels.	My medications – the pharmacist will see me before I leave.
	My drain tube + catheter may be removed today.	An occupational therapist will discuss how I will manage daily activities at home.	**I'll need to organise:** • How I will get home • Someone to pick up my equipment for home.	Physiotherapy after hospital.
	I will learn how to do my own injections.	I will work with my nurse on managing my pain.		Medical appointments.
		I will practice giving my own injection.	I will do my own injection today.	

Reached your daily goals? ☐ YES ☐ NO If not why? _____

Daily goals setting for joint replacement

Development of electronic case conference summary template



Austin Health

M262.71
Health and Independence Programs
HIP Case Conference Summary

U.R Number:
Surname:
Given Name(s):
Date of Birth:

Program:
Medical Consultant: **Stream:**
Admission:

CASE CONFERENCE - SELECT HEADING

Diagnosis and Relevant History
•

Client's overall long term goals
•

Key Issues *for the client, their relevant others and the team*
•

Goals for this rehabilitation episode

Goals *Written using activity and participation terminology*	Date *By when*	Status *Goal Attainment Scale* Progress / Comments

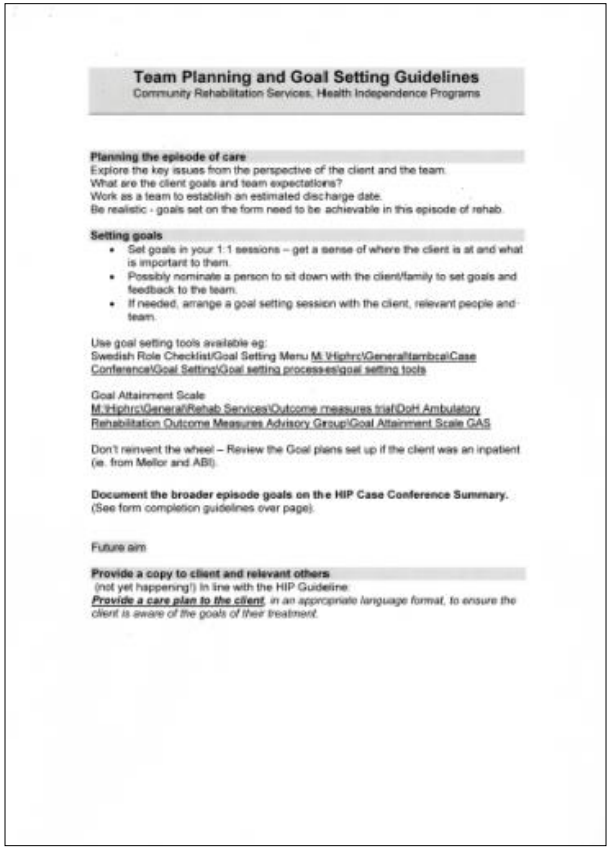
Recommendations / Action Plan / Discharge Plan
•

Services Provided

Discipline	Contact Person	Date of Discharge

Review Date:

HIP Case Conference Summary M262.71



Team Planning and Goal Setting Guidelines
Community Rehabilitation Services, Health Independence Programs

Planning the episode of care
Explore the key issues from the perspective of the client and the team.
What are the client goals and team expectations?
Work as a team to establish an estimated discharge date.
Be realistic - goals set on the form need to be achievable in this episode of rehab.

Setting goals
- Set goals in your 1:1 sessions – get a sense of where the client is at and what is important to them.
- Possibly nominate a person to sit down with the client/family to set goals and feedback to the team.
- If needed, arrange a goal setting session with the client, relevant people and team.

Use goal setting tools available eg:
Swedish Role Checklist\Goal Setting Menu M:\Hphrc\General\tambca\Case Conference\Goal Setting\Goal setting process-es\goal setting tools

Goal Attainment Scale
M:\Hphrc\General\Rehab Services\Outcome measures trial\DoH Ambulatory Rehabilitation Outcome Measures Advisory Group\Goal Attainment Scale GAS

Don't reinvent the wheel – Review the Goal plans set up if the client was an inpatient (ie. from Mellor and ABI).

Document the broader episode goals on the HIP Case Conference Summary.
(See form completion guidelines over page).

Future aim

Provide a copy to client and relevant others
(not yet happening!) In line with the HIP Guideline
Provide a care plan to the client*, in an appropriate language format, to ensure the client is aware of the goals of their treatment.*

Useful For HA

- Common OUTCOME language
- Patient-Need-Based Standards of Care
- Integrated e-platform to document process
- Transitional Care provision
- Targeted Intensive Rehab
- Patient-involved Goal setting
- Coaching Staff and Patient Experience
- Final Report http:\\corp.ha.org.hk\ha\HO\CSD\AH\AH Office\Training Program for Allied Health Professionals in Rehabilitation Services

Focus for Rehabilitation Services

Cloud of Information
Patient's Home


KEEP
CALM
AND
START
COLLABORATING


ThaNK
YOU