A team-based approach to improving out of hospital care on the Central Coast

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Examples of initiatives under way on the Central Coast

- PARC (Paediatric Ambulatory Review Clinic)
- COPD (Chronic Obstructive Pulmonary Disease)
- COAST (Care of Acute, Sub-Acute and Transfer of Care)
- Community Health Review

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Paediatrics

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ED Presentation Flow

Triage ED

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ED Kid's Corner

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Assessment- including if PARC appropriate

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Treatment

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Discharge | Admit | PARC

PARC Flow

PARC Referral

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Treatment in ED

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Send home with IV Cannula in situ after treatment

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Return next day to PARC

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Further assessment & treatment if needed → Discharge back to GP/Paediatrician

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≥ 1 day PARC needed

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Discharge back to GP/Paediatrician

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Hours Medical/Nursing Care

Child 1 Journey - 21 Month Old

Day 1
Emergency
1830

- Presents to ED at 1830 with h/o vomiting, runny nose, sore throat for 2 days
- Low grade fever
- Increasingly lethargic, increasing dehydration.

Day 1
Emergency
1100

- Triage 1100hrs
- Presents with h/o vomiting, fevers, runny nose and cough.
- Decreases oral intake
- Lethargic, dehydration

Day 1
Seen by ED staff
1830

- Seen by ED staff O/E Dehydrated, Viral illness
- Plan: Trial of oral fluids (TOF).

Day 1
ED Paediatric corner observation
1300

- Seen in ED by PARC team
- o/e dehydration. Treated with Rapid IV rehydration
- CXR, NPA, Bloods
- Single dose IV Ceftriaxone whist

Day 1
Emergency
2350

- Vomiting persisted despite TOF.
- Plan: IVF commenced 5.5 hours after arrival.
- Bloods collected
- Decision to admit
- IVF only @ maintenance
- No rapid rehydration.

Day 1
Discharge Home 1400

- Sharon improved with IV rapid rehydration.
- Began to drink
- CXR - no consolidation,
- RSV + on NPA
- Since she improved she was discharged home for review in PARC following day.
- Discharged @ 1400hrs – 3 hours after presentation

Day 2
Children's Ward
1200

- Arrived in CHW 17.5 hours after presentation
- Kept on maintenance fluids

Day 2
Follow up by PARC team 1130

- PARC follow up. Day 2
- No further fever or vomiting.
- Sharon drinking
- Given 2 hours more IVF @ 10mls/kg/hr. IVC then removed and discharged with planned follow up call the next day.

Day 3
Children's Ward

- Day 2 of admission.
- Half maintenance fluids,
- Vomiting ceased Grizzly % URTI.
- Reluctant to take oral intake

Day 3
Phone call follow up PARC
1200

- Phone call follow up. Mother states that Sharon was back to her normal self

Day 4
Discharged home
1800

- Day 3 of Admission
- Half maintenance fluid
- Discharged at 1800

Total 72hrs

Total 6.10hrs

Child 2 Journey - 2 Years

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Adult Services

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Over time multiple specialty community roles and services have evolved in response to funding allocations and areas of priority- these include but are not limited to:

- Community Nursing
- Acute, post-acute care
- Aged Care Outreach Services
- Dementia Care Services
- Chronic and Complex Care
- Transitional Aged Care
- Multiple single discipline Allied Health Services
- Community Outreach Teams
  - Community Stroke Support
  - Community Rehabilitation

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External Review Outcomes identified several opportunities

- To combine existing small scale programs, resulting in a fewer number of high-impact programs that are interconnected
- Introduce information systems to support improved clinical care and ensure improved access to information and service efficiencies
- Engage teams to use innovative approaches to client care and management
- Adopt a more proactive approach to setting and scheduling of workforce to minimise travel time and maximise service efficiency and capacity
- Reduce avoidable inpatient admissions and bed days

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Benefits Projected

- Reduced administration costs
- Reduced travel time and costs
- Improved quality of services delivered
- Increased visibility of clinical data in the system
- Standardised internal processes for Community Care
- Improved scheduling and workforce efficiencies
- Improved reporting capabilities
- Increased internal referrals avoiding hospital admission
- Improved governance around staff skill sets in delivering care
- Increased ‘capacity’ within the community health system

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Change of this magnitude requires innovative thinking, new approaches, the creation of different models, and the refinement of existing ones

- Defining a platform for change
- Defining a business model
- Redesigning models of care
- Challenging existing ways of working and entrenched practices
- Establishing desired outcomes
- Developing evaluation plan
- Using tight project management controls

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Challenges: staff are habituated to current ways of working in specialised, non-integrated teams

- Stakeholder buy-in
- Project timelines
- Change management
- Availability of accurate data
- Availability of stakeholders
- Workforce/Human resource processes
- Competing Priorities

Points of Leverage - there is a shared understanding of the requirements for safe/quality service delivery

- Willing, innovative staff
- Integrated services and models of care
- Improved service delivery and capacity Clinical outcomes, LOS, financial, workforce
- New models of care – e.g. mobile Multidisciplinary Teams, priority based access to care, rapid response, reduce presentations to ED
- Engagement with acute services for the development and communication of community plans (client escalation plans)
- Improved access to information to improve client care
- Improved accuracy of service data to facilitate accurate evaluation and planning of services for the future.
- Consistency of expectation
- Improved referral pathways and access to services

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A proven, structured project management approach is being used to plan, design and implement change to improve performance

- Project management:
  - Task control
  - Risk management
  - Change management
- Governance Structure:
  - Governing Committee
  - Implementation Taskforce
  - Working Party
- Phased Approach
  - Design future state
  - ComCare (Information System) Implementation Planning Study
  - Service reconfiguration
  - Information system implementation

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The project has defined key goals aligning to the Districts strategic goals.

Objectives have been defined to deliver an integrated, client and carer centred service.

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Progress has seen strong staff engagement and ‘hands on’ effort to deliver a detailed understanding of current services:

- Completed project planning phase:
  - Detailed project brief containing objectives, scope, risks, milestones
  - Project Plan
  - Communication plan
- Understanding the ‘As Is’
  - Map current services and functions
  - Completion of Implementation Planning Study
  - Currently finalising Future State Models of Care
  - Evaluation planning

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Next Steps

- Finalise adult community service model for CCLHD to support integrated and improved clinical care
- Finalise Business Units, organisational structure and teams
- Establish the Service Delivery Centres
- Establish intake model including triage capabilities (including results of COAST project) and formulate team
- Develop criteria to support decision making and service linkage at Intake – incorporating information on new clinical redesign projects e.g. COPD project
- Information system implementation

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Thank you for your attention.
Questions welcome.

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