

Building a Blueprint for Improvement in NSW

Palliative Care: Fit for the Future :: 4 Sept 2015

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Collaboration. Innovation. Better Healthcare.

The Agency for Clinical Innovation (ACI)

 The ACI works with clinicians, consumers and managers to design and promote better healthcare for NSW.



The ACI

- 40 Networks
 - Specialty specific and medically defined ones
 - System-oriented
- Acute Care Taskforce
- Emergency Care Institute



Why Networks?

...[they] engage stakeholders in negotiating agreements about what is necessary, desirable, feasible...and elicit people's commitment to realising those agreements in practice.

ledema, R., Verma, R., Wutzke, S., Lyons, N. and McCaughan, B. (under review)
A network of networks? Novel governance of collaborative approaches to healthcare reform and improvement. *Journal of Health Services Research & Policy*[submitted for review in Sept 2014]

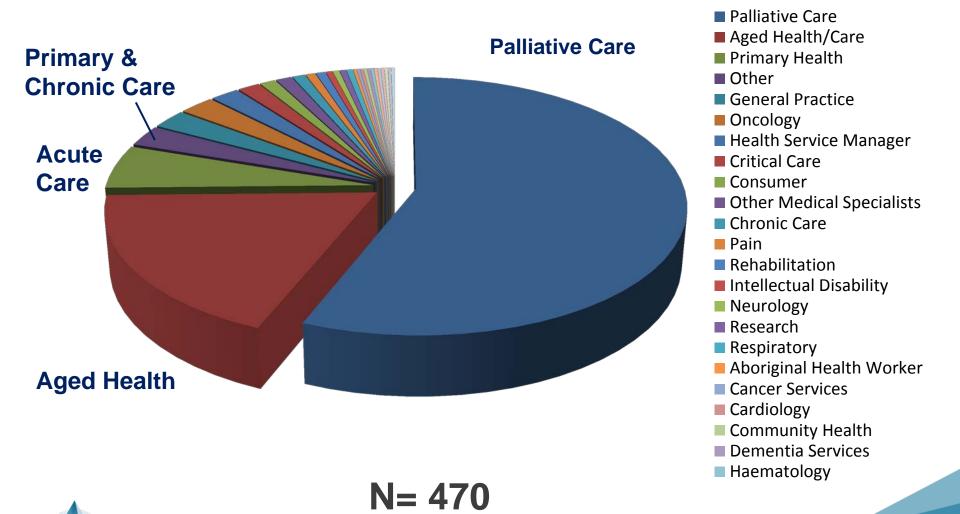


Who are we?





Who are we?



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Authors

470 +

clinicians, researchers, carers, consumers, health service managers, advocates



Vision

 To ensure that all NSW residents have equitable access to quality care based on assessed need as they approach and reach the end of life.



Wicked Problem

- Socially complex no clear solutions
- Differing perspectives
- Multiple, interrelated factors
- No single source of responsibility
- Affects everyone



Diagram 1: Process Flow Chart for developing a Model of Care (MoC)

This document is used to illustrate the process for developing a Model of Care. It encompasses the work owned by the project manager and the functions that the Clinical Redesign and Implementation Team assist with.

PROJECT INITIATION

Identify an area of need, build a case for change and obtain sponsorship to proceed with the program of work

Issue or opportunity arises:

- Clinician/ACI Network/Consumer identified innovation
- Unwarranted clinical variation
- Priority area (Minister/ DG/LHD/CEC
- Out of date MoC

Create the initial high level 'case for change' — quantify the extent of the issue and the cost of continuing business as usual.

Develop and agree project aim, objectives and scope.

Generate Sponsorship

- ACI executive sponsorship/ prioritisation for the program of work
- Seek direction from LHD clinicians, managers and stakeholders – is this a piece of work they will value?

DIAGNOSTIC

Define the problem
– understand the
root cause to treat
the real problem
and not just the
symptoms

Define the problem using a variety of tools:

- Consultation such as workshops, interviews and brain storming
- 'As is' analysis what does it look like now?
- Data review including demand analysis, epidemiology and service utilisation
- Financial analysis of the cost of continuing business as usual
- Review literature and analyse any innovation already in this field

Finalise case for change.

Identification and prioritisation of issues.

Revisit aims and objectives to ensure project is on track.

SOLUTION DESIGN

Develop and select solutions. Create and document the MoC

Define the change clearly.

Develop the business case.

Assist LHDs to conduct a self assessment/gap analysis.

Seek endorsement of the business case/ resourcing strategy.

Generate local executive sponsorship and create a governance structure.

Build the capability of front line clinicians and manager to change the process/system.

Develop a Communication plan and identify risks to implementation.

Develop reinforcement strategies for LHDs.

IMPLEMENTATION

Support the health system to execute the changes needed to implement the MoC

The health economics team can prepare key documents to support implementation including:

- · Economic Appraisal
- · Resourcing Strategy
- Business Proposal

The team can advise on implementation issues such as quantifying potential increases in service capacity; quantifying potential avoidable future costs; identifying the need for additional seeding or recurrent funding; and identifying areas of potential savings where services may be discontinued and resources redirected.

SUSTAINABILITY

Optimise use of the MoC, monitor the results and evaluate the impact

Ongoing monitoring and local accountability.

Review the impact of the MoC and adjust practices to optimise use.

Ensure disinvestment

Final evaluation of economic and clinical outcomes

Knowledge Management 'sharing our lessons'



Improvement journey



Methodologies



- 1200 semi-structured individual and group interviews
- Fact of Death Analysis
- Grounded Theory Analysis
- 12 Key Learnings
- Proposal of architecture
- Modified Delphi Technique with the Network
- CareSearch sourced Tools and Resources



Fact of Death Analysis

 An exploratory analysis of the use of NSW public hospital services by people who died in 2011/12 and were hospitalised and/or presented to ED a year prior to their death



Analysis undertaken by the Health Economics and Evaluation Team, ACI using NSW Combined Admitted Patient Epidemiology Data and ABS population estimates (SAPHaRI). Centre for Epidemiology and Evidence, NSW Ministry of Health



Headline Findings

- There were around 38, 282 deaths relevant to this analysis
- 164,794 hospitalisations
- Relatively intense use of admitted acute hospital services
- 76% of all people who died in 2011/12 presented to ED in the year prior to the persons' death
- Average length of stay considerably higher (13 days when day only admissions excluded)



Headline Findings - costs

\$977.4 million for inpatient admitted care (1.4 million bed days)

\$32.5 million for non-admitted presentations to ED

Analysis undertaken by the Health Economics and Evaluation Team, ACI using NSW Combined Admitted Patient Epidemiology Data and ABS population estimates (SAPHaRI). Centre for Epidemiology and Evidence, NSW Ministry of Health



Headline Findings

Total cost of hospitalisations and nonadmitted emergency presentations was about \$1 billion

Analysis undertaken by the Health Economics and Evaluation Team, ACI using NSW Combined Admitted Patient Epidemiology Data and ABS population estimates (SAPHaRI). Centre for Epidemiology and Evidence, NSW Ministry of Health



What we learned?

- Myths
- Gaps
- Goodwill and passion
- Risk
- Scepticism and disagreement
- Innovation and pride
- Language is confusing



Rural

'We're very good at thinking outside the square. We cobble together a service that is appropriate for the patient – try to help, rather than explain to people why we can't help.'

Rural Remote Palliative Care Specialist

'We provide a good, flexible service for our community, often reaching after hours, but as long as we do this there will be a feeling that all is fine with the way we're resourced and supported – and it's not okay. Some staff work 7 days a week or well into the evening.'

Rural Palliative Care Specialist

Communication

A big issue with clinicians is not knowing how to communicate with families. One of the biggest issues for the clinicians is the family's expectations. They don't expect to have an end of life conversation...

Intensive Care Nurse

I try to work with families on the wards. It takes a lot of time talking to families and defining the limitations of care...

Rural Intensive Care Liaison Nurse



12 Key Learnings – hooks to hang our concepts from

People's needs change

Geography matters

Hospitals are the 'default' carers for many

Language can be confusing



Developing a Blueprint for Improvement

10 Essential Components & their Intended Beneficial Outcomes

Principles

Enablers

Vision



10 Essential Components

- 1. Informing community expectations and perceptions
- 2. Discussions...and planning future goals
- 3. Access to care providers across all care settings
- 4. Early recognition
- 5. Care is based on assessed needs
- 6. Seamless transitions across all care settings
- 7. Access to specialist p.c. when needs are complex



10 Essential Components

- 8. Quality care during the last days of life
- 9. Supporting people through loss and grief
- Quality care is supported through access to reliable, timely clinical information and data



Sourcing tools and resources

 CareSearch sourced local, national and international tools and resources (n=62)



A Blueprint for Improvement

- Flexible online guide for health services
- Whole of system, integrated approach
- Sharing Platform
- Structure based on the Vision, Principles, Enablers, and 10 Essential Components
- Self-assessment
- Tools and resources to implement the Components
- Capability development

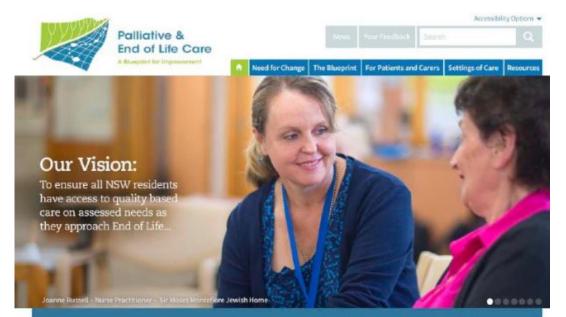




Everybody has a role to play

Everything starts with the patient, family and carer





Palliative and End of Life Care – A Blueprint for Improvement

"The Blueprint"

This Blueprint was developed and informed by research based evidence and developed in consultation with over 450 members of the ACI Palliative Care Network to provide guidelines for best access to quality care in any location, including rural locations, aged care facilities, hospitals and in the home.



This online resource aims to guide services and Local Health Districts in constructing their own, localised models of care. It emphasises that everyone can have a role to play in supporting or providing care to people approaching and reaching the end of life.

Palliative and End of Life Care—A Blueprint for Improvement ('the Blueprint) has been developed to provide a flexible guide for health services to meet the needs of people approaching and reaching the end of life, their families and carers. The Blueprint is for everybody in NSW and will benefit care providers as well as those approaching end of life and their loved ones.

To find out more watch the film.



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