ACI NSW Agency for Clinical Innovation

ACI Initiatives

February 2015

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Agency for Clinical Innovation website at: www.aci.health.nsw.gov.au

Foreword

The Agency for Clinical Innovation (ACI) works with clinicians, consumers and managers to design and promote better healthcare for NSW.

Our initiatives are developed by teams of expert clinicians, consumers and managers, who share a common goal of wanting to make a real difference to patient care.

Identifying an area of need, building a case for change and seeking to define the problem through open consultation, data analysis, evaluation and review are the hallmarks of an ACI initiative.

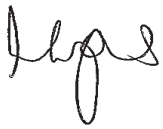
Supported by our Clinical Networks, Taskforces and Institutes this approach helps us to develop a clear vision for what integrated services should look like, and design and test our solutions in partnership with healthcare providers.

Once our initiatives are ready to put into practice, our teams visit every part of the state to explain the benefits to healthcare providers – to listen to local priorities and to support frontline teams.

This report contains an update on 20 priority ACI initiatives that made significant progress or impact during the period August 2014 to February 2015.

I encourage you to partner with us to put the lessons we learn into practice – to continuously build health capability to make the best use of the health dollar and improve patient's experience of care.

Together we can deliver better health for NSW.



Dr Nigel Lyons
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Introduction

The Agency for Clinical Innovation (ACI) works with clinicians, consumers and managers to design and promote better healthcare for NSW.

Our goal is to be recognised as the leader in the NSW health system for delivering innovative models of patient care.

We provide a range of services to healthcare providers including:

- service redesign and evaluation
- specialist advice on healthcare innovation
- initiatives including models of care, guidelines and frameworks
- implementation support
- knowledge sharing and
- continuous capability building

To learn more about ACI and Clinical Excellence Commission (CEC) initiatives visit the Excellence and Innovation in Healthcare portal available through ACI and CEC websites or at: www.eih.health.nsw.gov.au

Glossary

ACI	Agency for Clinical Innovation
ARCHI	Australian Resource Centre for Healthcare Innovations
ALOS	Average Length of Stay
CATE	Critical, Acute Care, Trauma and Emergency
CEC	Clinical Excellence Commission
CIP	Clinical Innovation Program
CHOPs	Care of Confused Hospitalised Older Persons program
ePOCC	Electronic Persistent Pain Outcome Collaboration
ESKD	end stage kidney disease
HCV	Viral Hepatitis C
HDU	High Dependency Unit
ICU	Intensive Care Units
LHD	Local Health Districts
MAU	Medical Assessment Unit
ML	Medicare Local
MoC	Model of Care
MoH	Ministry of Health
NGO	Non-Government Organisations
NHMRC	National Health and Medical Research Council
OT	Operating Theatre
PET	Patient Experience Trackers
PREMs	Patient Reported Experience Measures
PROMs	Patient Reported Outcome Measures
RSC	Renal Supportive Care
SHN	Specialty Health Networks
STARS	SLHD's Targeted Activity and Reporting System
SST	Surgical Services Taskforce

Burns Telehealth Project

Strategic Initiative

Facilitate and support the implementation of innovation with healthcare providers.

Aim

- To examine and identify gaps in current use of telehealth in the delivery of burn care
- To design sustainable solutions and implementation utilising telehealth to improve access, efficiency and efficacy of burn care for burn patients in NSW.

Benefits

- Allow patients to receive their care and treatment closer to home, saving their time and money.
- Reduce the demand on tertiary burn units and save on bed days.
- Increase rural/non-burn unit clinicians' experience and knowledge in the treatment of burn care and provide a support mechanism.

Summary

The project will involve:

- an assessment of:
    - o current practice and gaps in telehealth use at the three tertiary burn units targeted rural and regional NSW facilities
    - o patient surveys using Patient Experience Trackers (PETs)
    - o analysis of data from state health data bases and the Agency for Clinical Innovation (ACI) Statewide Burn Injury Service Data Registry.
- development of telehealth solutions that best meet the needs informed by the diagnostic findings
- implementation of solutions
- evaluation of implementations
- ensure sustainability of any new telehealth program solutions.

A Steering Committee is reviewing existing uses of telehealth.

The diagnostics of the project are well underway. All three burn units have been visited. Established Perth and Brisbane burn telehealth services have been reviewed.

Background

The use of digital photography and video teleconferencing for the care of burn injured patients is occurring across the three NSW burn units (Royal North Shore Hospital, Concord Repatriation General Hospital and the Children's Hospital at Westmead). However, this is being undertaken differently at each site and with varying degrees of process structure and governance.

Improving Telehealth services for burn injured patients has the support of the clinicians in the three NSW burns units.

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NSW Intensive Care Service Model: Level 3 and 4 Units

Strategic Initiative

Work with clinicians, consumers and partners on prioritised work programs.

Aim

To develop a Service Model for level 3 and 4 NSW Adult Intensive Care Units (ICUs) which incorporates:

- a framework of standardised service delivery
- care provision and management of critically ill patients
- integrated networks across Local Health Districts (LHDs).

Benefits

- Improved intensive care patient experience and outcomes.
- Standardised provision of intensive care services across level 3 and 4 units.
- Networked approach to management of LHD intensive care resources.

Summary

The High Dependency Unit (HDU) Model of Care (MoC) Steering committee, comprised of key stakeholders, was established in 2013. In October 2013, seventeen level 3 and 4 HDUs completed a MoC survey. A business case for change and literature review was completed June 2014. An Intensive Care Service Model document was later developed then endorsed by the Steering Committee.

External consultation is expected to be completed by February 2015. Resources will be developed as part of a Service Model toolkit and Chief Executives will be asked to nominate key LHD implementation contacts in early 2015.

Background

Established in 2013, the Intensive Care Services Network: Model of Care Working Group's initial priority was to review Models of Care within level 3 and 4 ICU/HDUs across NSW. This aligned with the current review of NSW Role Delineation and Intensive Care Services Plan.

The level of intensive care service provided is determined by role delineation, attributed to the level of service the unit and the hospital can provide to deliver a minimum standard of safe care. Despite NSW units' service levels being pre-defined, intensive care services have developed to meet local needs and variation exists in: case mix, quality, care, unit management, configuration, scale, efficiency and purpose within the hospital, LHD and State.

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Improving Efficiency of Operating Theatre in NSW Hospitals

Strategic Initiative

Work with clinicians, consumers and partners on prioritised work programs.

Aim

Following the Auditor-General's report, *Performance Audit: Managing operating theatre efficiency for elective surgery*, the ACI has worked with the Ministry of Health (MoH) to support LHDs in meeting three of seven recommendations outlined in the report.

Benefits

Increased collaboration and support for Operating Theatre (OT) efficiencies.

Summary

Three recommendations within the Auditor-General's report have been assigned to ACI. These are:

- Strengthen OT management
- Improve efficiency measures
- Identify strategies to enhance OT capacity for elective surgery.
- Three working groups focussing on OT metrics, Whole of Surgery and OT costs met throughout 2014. Expert recommendations from these working groups form the basis of the OT Guidelines.
- The Guidelines have been developed as a best practice guide for the management and governance of OTs in NSW public hospitals for OT committees, managers and staff that manage OTs at hospital and LHD levels.
- Including information on OT efficiency measures, management processes and cost considerations based on expert recommendations, the Guidelines have been reviewed by the Surgical Services Taskforce and are available at www.aci.health.nsw.gov.au/resources/surgical-services/efficiency/theatre-efficiency
- An OT Standard Cost Template has been developed by the Activity Based Funding team to improve the collection and allocation of OT costing data. The template calculates an average cost per minute/session for a standard OT to facilitate modelling of OT costs for various scenarios.

Partnerships include MoH, LHDs and Surgical Services Taskforce.

The ACI is working with the MOH to incorporate the Surgery Efficiency Guidelines to the 2015 planned schedule of hospital visits.

Opportunities will also be taken to combine the implementation of the Minimum Standards for the management of Hip fracture patients and the OT Guidelines in hospital visits.

Background

The Auditor-General's report, Performance Audit: Managing operating theatre efficiency for elective surgery, was released in July 2013. Seven recommendations were provided to support LHDs improve surgery and OT efficiency.

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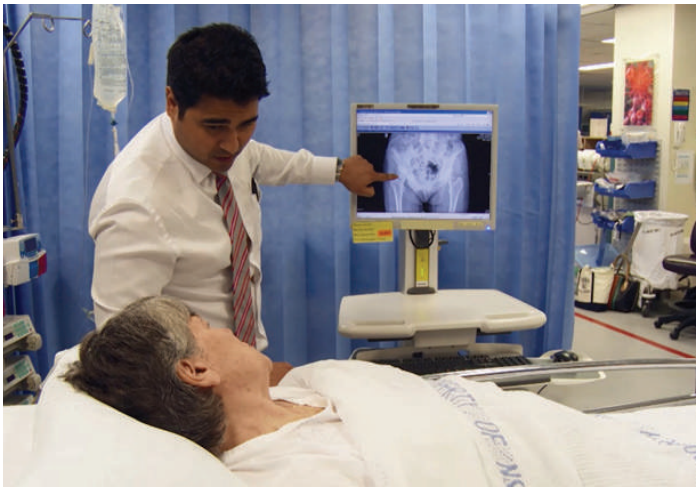
Minimum Standards for the Management of Hip Fracture in the Older Person



Strategic Initiative

Work with clinicians, consumers and partners on prioritised work programs.

Aim

To improve the outcomes of patients with fractured hips requiring surgery and management in NSW.

Benefits

- Reduced medical complications
- Improved management of co-morbidities
- Reduced hospital stay
- Improved patient outcomes.

Summary

The ACI has developed the Minimum Standards for the Management of Hip Fractures to assist hospitals to identify key components of best-practice management to support optimal patient care across NSW.

The Standards are available at www.aci.health.nsw.gov.au/resources/aged-health/hip-fracture/min-standards-hip-fractures. The Minimum Standards are supported by a suite of tools that assist their implementation in hospitals.

Partners in this project include ACI Unwarranted Clinical Variation Taskforce, ACI Surgical Services Taskforce (SST) and ACI Aged Health Network.

The Minimum Standards project team has communicated with all 37 hospitals that perform surgery for a fractured hip. The majority of hospitals have had at least one visit to assist the implementation of the Minimum Standards. Most of the hospitals had already started to implement the Standards.

In 2015, ACI's Minimum Standards project team will focus on those hospitals where Minimum Standards implementation projects are just starting. Support for these projects will assist in accelerating the implementation of the Standards. The SST and the Aged Health Network will also support hospitals that require audits, project planning and process mapping.

A formative evaluation of the Minimum Standards project has commenced. The Patient Experience and Consumer Engagement team is conducting patient and staff surveys at four of the six evaluation hospitals in EDs and on the wards.

Background

NSW Health has long recognised the challenges posed in managing hip fracture patients. The ACI in 2010 released the *Orthogeriatric Model of Care: Clinical Practice Guide* that provided a practical guide to the management of frail, older orthopaedic patients. This was followed in 2011 by the CEC report *Fractured Hip Surgery in the Elderly*, that identified a number of key care-elements that are necessary to improve patient management and reduce 30-day mortality.

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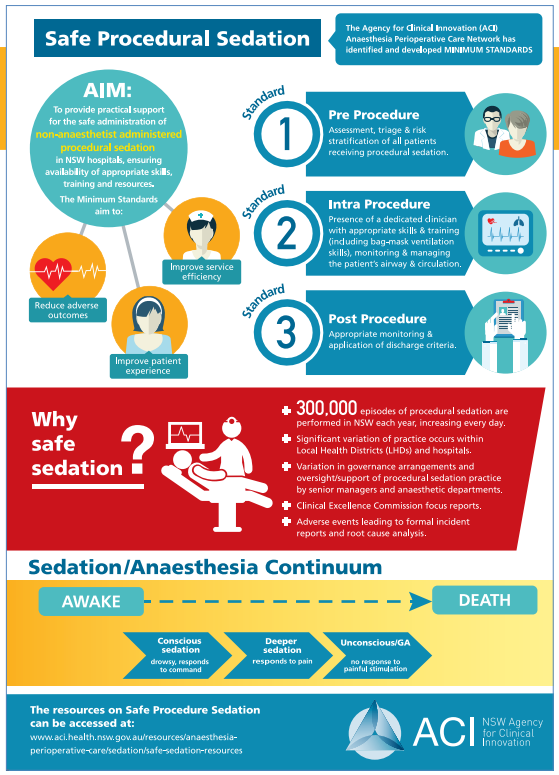
Safe Procedural Sedation Project



Strategic Initiative

Facilitate and support the implementation of innovation with healthcare providers.

Aim

To support the safe administration of non-anaesthetist administered procedural sedation in NSW hospitals.

Benefits

- Improve patient experience
- Improve service efficiency
- Reduce adverse outcomes
- Reduce clinical variation
- Improved skill sets for staff involved in procedural sedation.

Summary

Three Standards were identified to be essential to the practice of safe sedation where a non-critical care specialist provides the sedation:

- **Standard 1: Pre Procedure**
  Assessment, triage and risk stratification of all patients receiving procedural sedation.
- **Standard 2: Intra Procedure**
  Presence of a dedicated clinician with appropriate skills and training (including bag-mask ventilation skills), monitoring and managing the patient's airway and circulation.
- **Standard 3: Post Procedure**
  Appropriate monitoring and application of discharge criteria.

Partners in this project include MoH and LHDs.

In May 2014, the Minimum Standards for Safe Procedural Sedation and an accompanying implementation toolkit were launched at the Directors of Clinical Governance meeting and are available on the ACI website at www.aci.health.nsw.gov.au/resources/anaesthesia-perioperative-care/sedation/safe-sedation-resources

It is proposed that the Minimum Standards Project will be implemented statewide in a coordinated approach to ensure that each LHD has the necessary tools and resources to provide safe provision of procedural sedation to patients within NSW public hospitals.

The collaborative approach to implementation with LHDs is underway and an infographic has been developed for public hospitals to assist with the implementation in 2015.

The Anaesthesia Perioperative Care Network Forum was held in September 2014 which included a workshop on Minimum Standards for Safe Sedation. Strategies identified at the workshop will be used to support implementation.

Background

In November 2012, the ACI's Anaesthesia Perioperative Care Network commenced a project to scope the extent of non-anaesthetist clinician led procedural sedation across NSW public hospitals. The objectives were to identify challenges and innovations across the system and to develop minimum standards to ensure that every episode of sedation is as safe as possible.

Following site visits to, and interviews with 52 specialty departments across NSW public hospitals, the Safe Sedation Working Group developed the Minimum Standards for Safe Procedural Sedation with the Anaesthesia Perioperative Care Network.

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Medical Assessment Unit Model of Care

Strategic Initiative

Facilitate and support the implementation of innovation with healthcare providers.

Aim

To facilitate best practice management of patients with complex, chronic and undifferentiated hospital presentations.

Benefits

- Significant reduction in
  - inpatient mortality
  - length of stay
  - waiting times for patient transfer from EDs to medical beds
- No increase in 30-day readmission rates following unit commencement
- Improvements in patient and staff satisfaction with care.

Summary

The NSW Medical Assessment Unit (MAU) MoC was launched in October 2014 at the second annual ACI MAU Forum.

Implementation of the Model is supported with a self-assessment tool that generates an action plan for teams.

Support from ACI will be available to complete and action the plan generated from the self-assessment.

As the MoC was developed after an evaluation by the then Department of Health, the evaluation approach will be revisited once the state-wide compilation of the self-assessment tool has been completed.

Background

ED crowding has been increasingly prevalent and acute hospitals have continued to experience a rise in admissions, coupled with a pressure on inpatient bed availability.

Growing admission rates are influenced by the increasing numbers of emergency presentations of elderly patients with multiple chronic diseases, young Aboriginal people with multiple chronic diseases, raised expectations of care and lower thresholds for admission.

When presenting to hospital via an ED, these patients may not be triaged as high urgency; their wait for assessment, diagnosis and treatment can cause delayed care for patients and therefore contribute to ED overcrowding.

In recent years, health authorities and hospitals have responded to these challenges by introducing initiatives aimed at managing the increasing demand for services and reducing the impact of the fragmentation across the system. One such initiative is a MoC designed to provide patients with complex, undifferentiated medical problems access to an interdisciplinary team to conduct rapid assessments and faster diagnoses.

The MoC was developed for LHDs, Specialty Health Networks (SHNs) and individual MAU teams following an evaluation of the 29 MAUs across the state in 2012 by the then NSW Department of Health.

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Renal Supportive Care Model

Strategic Initiative

Facilitate and support the implementation of innovation with healthcare providers.

Aim

To provide better care for patients who are struggling on dialysis and for those who choose not to have dialysis.

Benefits

- Provides for training and ongoing support to nurses, doctors and allied health practitioners, statewide
- Is nurse-driven and hospital- and community-based
- Is strongly supported by clinicians
- Is innovative and cost-effective.

Summary

Renal Supportive Care (RSC) is a process that incorporates the skills of palliative care medicine and renal medicine to improve the lives of patients with end stage kidney disease (ESKD).

Under currently available resources, renal patients in many LHDs do not have sufficient access to symptom control and palliative care. The RSC Model provides a way of up-skilling staff and enabling services close to where the patients live, whilst maintaining connections to networked hubs for ongoing guidance and support. It also provides options and improved support for ESKD patients considering commencing or withdrawing from dialysis services.

An evaluation plan is currently under development.

Background

The need for improved supportive care of patients with ESKD is increasingly recognised at national and international levels. This care incorporates palliative medicine to improve symptom control and holistic care for these patients and their families, whether they are managed via a conservative non-dialysis pathway or continuing to have poor quality of life despite dialysis.

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Tracheostomy Care Guidelines

Strategic Initiative

Facilitate and support the implementation of innovation with healthcare providers.

Aim

To improve the patient experience and reduce the number of serious adverse events involving adult patients with a tracheostomy.

Benefits

Improved safety and quality of care for adult patients with tracheostomies in acute care hospitals in NSW.

Summary

State-wide implementation of the Care of Adults in Acute Facilities with a Tracheostomy Guideline is a collaborative effort by the ACI, CEC and LHDs.

Implementation will improve the process of care and quality of care provided to adult patients with a tracheostomy in hospitals in NSW.

The ACI has completed analysis of Tracheostomy length of stay data by Diagnosis Related Group and LHD.

The data has been reviewed by the Tracheostomy Steering Committee and Unwarranted Clinical Variation Taskforce, and ACI will collaborate with LHDs to analyse and interpret the apparent variation.

ACI Tracheostomy Guidelines State-wide Implementation Approach and Data Analyses posters were presented at the Australasian Tracheostomy Symposium in October 2014.

The state-wide approach to service improvement received significant international interest. An implementation and Baseline Data Analysis Report was completed and sent to LHDs and SHNs in January 2015.

A community of interest teleconference has been held monthly with LHD/SHN implementation leads where implementation strategy has been shared.

- Next steps include: ACI Tracheostomy Forum to be held 6 March 2015 in Sydney.
- ACI will conduct further average length of stay (ALOS) analysis and work with LHDs/SHN to investigate the apparent variation in ALOS and the factors associated with extended ALOS.
- Continue to support local tracheostomy working groups to implement all domains of tracheostomy care.
- Evaluate the state-wide Tracheostomy implementation approach and outcomes.

Background

A review of reported adverse events in in-patients with tracheostomy during 2007-2008 and 2009-2012 identified clinician skill and knowledge, and equipment as significant factors contributing to 82% and 64% of adverse events respectively.

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Viral Hepatitis C Model of Care

Strategic Initiative

Work with clinicians, consumers and partners on prioritised work programs.

Aim

- To streamline access to curative treatments in NSW
- To assist with achieving the Targets of the NSW Hepatitis C Strategy 2014 – 2020.

Benefits

- Provide a practical approach to prioritisation, with a focus on the needs of patients and underpinned by ethical and economic principles
- Improve the experience of care
- Improve the health of the population
- Achieve the strategic targets and manage health expenditure.

Summary

The Model of Care Working Group was established in June 2014 and included expert clinicians, academic partners and peak non-government organisations (NGOs). The business case for change and international literature review were completed in August 2014, and key consultations and a service capacity survey in December 2014. This project is funded by the NSW Ministry of Health.

Stakeholder consultations are due to be completed by March 2015, with the aim of finalising the model of care by April 2015 with a high level implementation plan.

The Gastroenterology Network will work with the ACI Health Economics and Evaluation Team to evaluate the process using the *Understanding Program Evaluation: An ACI Framework* tool.

Background

Viral Hepatitis C (HCV) continues to be a significant public health issue in Australia. There are an estimated 310,000 people exposed to HCV, 230,000 people living with HCV of whom 58,000 have moderate to severe liver disease. It is estimated that by 2030, 414,000 people will be living with HCV.

In 2013, a new medication *Sofosbuvir Sovaldi*® (Gilead) became available in the global market that effectively cured Hepatitis C. This medication has received TGA approval for use in Australia, however is not available on the PBS. The Viral Hepatitis C MoC is a pre-emptive response to the potential increase in the demand for this treatment as currently, less than 2% of the HCV population access treatment per year.

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Implementation and evaluation of Care of confused Hospitalised older Persons program

Strategic Initiative

Develop a reputation for delivery by focusing on completing strategic projects of significance to ACI and partners.

Aim

- To improve the experience and outcomes for older people with confusion, their carers and families, while in hospital.

Benefits

- Hospitals will design and prioritise best practice care for older people with confusion
- The implementation of Care of Confused Hospitalised Older Persons program (CHOPs) is tailored to the needs of the older person, their carers and families as well as the hospital teams.
- Achievements, innovation and knowledge gained during implementation is shared with other teams to embed systems into practice, and to sustain and spread improvements in the care of confused people in hospital

Summary

CHOPs was chosen by National Health and Medical Research Council (NHMRC) Cognitive Decline Partnership Centre as one of a number of activities to promote research and best practice for people with dementia in Australia. Seven key principles have been developed and the principles are being implemented in 12 sites across NSW, through a staged rollout, as nominated by interested facilities.

A range of resources, including a website, has been developed to assist in the roll out of CHOPs and promote best practice care for older people within NSW Hospitals, including a

- CHOPs website – A resource for staff, consumers and carers at www.aci.health.nsw.gov.au/chops and
- Dementia Carers' Experience Videos at www.aci.health.nsw.gov.au/chops/education/dementia-carers-video

Partnerships in this project include NHMRC Cognitive Decline Partnership Centre, CEC, Australian Commission on Quality and Safety in Healthcare and DementiaCare resource and training network.

An Evaluation Framework includes a formative evaluation that measures patient, system and staff outcomes.

Background

More than 30% of older people present with or develop confusion during their admission to hospital. This confusion is most commonly due to dementia and/or delirium.

Confusion is distressing for older people and their carers. The older person with confusion may refuse care, attempt to leave, be disruptive or aggressive.

If left unrecognised and untreated, confusion can result in serious health consequences. Early identification of confusion, treatment of the underlying cause and management of symptoms can prevent these adverse effects and minimise their duration and severity.

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Electronic Persistent Pain Outcome Collaboration

Strategic Initiative

Develop a reputation for delivery by focusing on completing strategic projects of significance to ACI and partners.

Aim

To improve services and outcomes for patients suffering with chronic pain through data collection and analysis of care and treatment outcomes.

Benefits

- Enables pain services to collect and review outcome data from their clinics and compare to other services and a national benchmark
- Facilitates research and better understanding of the elements of pain services which offer maximum benefit to patients
- Promotes discussion regarding best practice interventions
- Facilitates adoption of evidence based practice and encourages disinvestment of ineffective management strategies

Summary

ePPOC is a new quality monitoring and benchmarking program, involving the collection of data items by specialist pain services throughout Australia and New Zealand to measure outcomes for their patients as a result of treatment.

This information will be used to:

- develop a national benchmarking system for the pain sector, which will lead to better outcomes and best practice interventions for patients in chronic pain.
- enable development of a coordinated approach to research into the management of pain in Australasia.

ePPOC is an initiative of the ACI in partnership with University of Wollongong, endorsed by the Faculty of Pain Medicine.

The development and design phase has involved:

- identifying a minimum data set, endorsed by all participating pain services
- Working with the University to build a program and system to be managed within each LHD

- Installation at every public pain clinic in NSW
- Training and support all offered through the University of Wollongong
- Reporting and analysis of outcomes.

Background

ePPOC began in 2013, with eight adult pain services in NSW trialling the measures, process and software for collection. At this time, all 19 NSW pain services have been installed and been trained in ePPOC. The first benchmarking workshops will be held in 2015 following the release of the second report.

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Building Partnerships Implementation and Support Package

Strategic Initiative

Establish mechanisms for determining priorities and working with LHDs, clinical service networks and other health providers e.g. Medicare Locals.

Aim

The Building Partnerships Framework aims to make sure older people with complex health needs, their carers and families have access to appropriate, high quality, evidence-based healthcare that is provided in a timely, equitable and coordinated manner, delivered safely as close to home as possible.

Benefits

- Engaging older people, their carers and families
- Supporting providers to deliver care
- Aligning policy, resources and performance initiatives

Summary

The Building Partnerships Implementation and Support Package aims to support local partnerships of agencies to redesign and implement improved MoCs. Participating sites will create a local vision and governance structure for Aged Health services, then undertake a diagnostic and solution design process to identify actions to implement the components of the framework.

Evaluation will include:

1. Locally-tailored, pre-post outcome evaluations to explore the impact of each pilot site's chosen activities on their chosen target group, in relation to their chosen outcomes.
2. A standardised, overarching process evaluation to explore:
   - o the overall impact of the Framework on care integration;
   - o the extent to which various MoCs and other health initiatives are implemented; and
   - o patient, carer and staff feedback about the integrated care approach.

ACI has developed a Support Package to complement the Building Partnerships Framework, which includes:

- Resources
  - o Building Partnerships Framework and website
  - o Self-assessment tools
  - o Toolkit with exemplar MoCs
- Capability Development in Clinical Redesign
  - o Sponsor training and engagement
  - o Frontline 'Core' Redesign Training
- Funding for a panel of consultants to assist local project teams
- Consumer Engagement and Experience Tools
- Evaluation, economic analysis, monitoring tools and resources.

Background

The Building Partnerships Framework was led by the ACI Aged Health Network and is the product of extensive consultation and review. The Framework was identified as a priority area in the NSW Whole of Government Ageing Strategy and aligns with NSW Integrated Care Strategy.

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Musculoskeletal Primary Health Care Initiative

Strategic Initiative

Develop a reputation for delivery by focusing on completing strategic projects of significance to ACI and partners.

Aim

To plan, implement and evaluate a 'one-stop' program of care within primary care settings for people who meet the criteria for either the Model of Care for Osteoporotic Refracture Prevention, Osteoarthritis Chronic Care Program or acute low back pain management.

Benefits

- Will identify the processes required to implement the musculoskeletal MoCs in primary health care settings with equal or superior outcomes compared to current methods of providing coordinated musculoskeletal health care in hospital based settings.
- Will enhance patient outcomes as they feel more comfortable receiving their care in a familiar setting of their choice.

Summary

In early 2014, the ACI Musculoskeletal Network invited proposals from primary health care organisations and their partner LHDs to participate in a two year trial of delivering three musculoskeletal MoCs at a 'one stop shop' in a primary care setting.

The MoCs are:

- Osteoporotic Re-fracture Prevention
- Osteoarthritis Chronic Care Program
- A new MoC for people with Acute Low Back Pain

The following partnerships commenced implementation processes in their localities in July 2014.

- Murrumbidgee Medicare Local (ML) in partnership with Murrumbidgee LHD
- Northern Sydney ML and Sydney North Shore and Beaches ML in partnership with Northern Sydney LHD
- North Coast ML in partnership with Mid North Coast LHD.

Each implementing site will evaluate the Musculoskeletal Primary Health Care Initiative in collaboration with the ACI Musculoskeletal Network and the ACI Health Economics and Evaluation team.

Background

The Musculoskeletal Primary Health Care Initiative builds on the work of the Musculoskeletal Network since 2009 that aims to deliver improved healthcare to the residents of NSW who live with chronic diseases of the bones and joints.

In evaluating the models of care for Osteoporotic Refracture Prevention, the Osteoarthritis Chronic Care Program and evidence regarding the management of Acute Low Back Pain, it is determined that delivery of these models of care is ideal for primary care settings.

General Practitioners already manage these conditions in their patients in large numbers, so to support their interventions that will improve patient outcomes, including self-management, is the obvious next step in achieving the Network aims.

Photo: R. Speerin

Musculoskeletal Primary Health Care Teams participating in the first mentoring workshop for the Musculoskeletal Primary Health Care Initiative.

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Rehabilitation for Chronic Disease Guidelines

Strategic Initiative

Establish mechanisms to support collaboration across the clinical networks.

Aim

- To improve access to evidence-based and appropriate chronic disease rehabilitation programs
- To provide LHD administrators, managers and clinicians with an understanding of the requirements for providing these programs
- To enhance access where participant numbers are low and access to specialist clinicians and multidisciplinary teams is difficult
- To support better integration of health services so as to provide client centred care
- To increase the understanding amongst health professionals of the potential outcomes of chronic disease rehabilitation.

Benefits

- Reducing admissions to hospital and subsequent length of stay
- Reducing morbidity and mortality
- Improving functional and exercise capacity, improved psycho-social wellbeing and reduced stress
- Recognising the unique needs and promote access for Aboriginal people
- Developing collegial referral pathways and communications channels with other health providers, including service providers for Aboriginal peoples
- Actively promoting access to chronic disease rehabilitation for high risk population including culturally and linguistically diverse communities.

Summary

Rehabilitation for Chronic Disease primarily targets people with a diagnosed chronic disease and may also target people with recognised pre cursor signs or symptoms such as chest pain.

There are five core components to chronic disease rehabilitation. Service providers should be able to offer participants of rehabilitation access to each of the components (although not all individuals will require all components). The core components of chronic disease rehabilitation are shown in Figure 1.

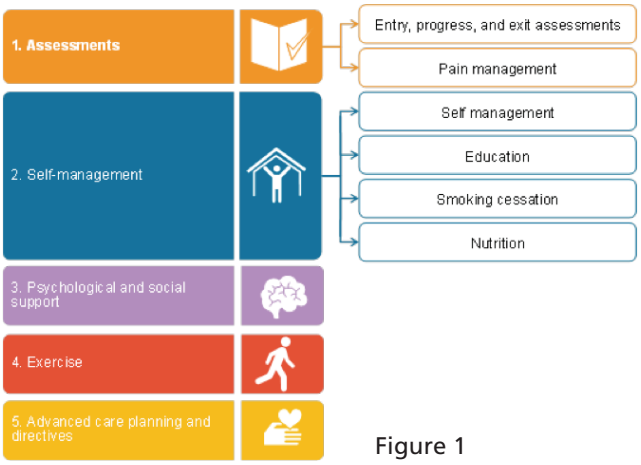

Figure 1

Service providers need to collect both service and patient level data on an ongoing basis.

Chronic disease rehabilitation services should collect accurate and consistent service and activity data, including the number of:

- referrals
- patients who commence chronic disease rehabilitation
- patients who complete chronic disease rehabilitation.

These will continue to be the key performance indicators to support the understanding of the need for service enhancements that will increase access for participants.

Background

The rehabilitative needs of people with chronic disease vary widely, depending on the individual and their stage of the patient journey. As such, service delivery models for chronic disease rehabilitation should be more flexible to meet these individual needs.

'Traditional' structures of services that follow a set program of interventions (often six to eight weeks duration) are 'service' orientated and not necessarily 'person' orientated in line with chronic care philosophies.

The Rehabilitation for Chronic Disease Guidelines aim to encourage an approach to chronic disease rehabilitation that is 'fit for purpose' and tailored to the specific needs of individuals.

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Clinical Innovation Program – Implementation of ACI Initiative

Strategic Initiative

Facilitate high quality translational research within the health system.

Aim

- To use the ACI's CIP to accelerate the implementation of the Minimum Standards for the Management of Hip Fracture in the Older Person, and in doing so
- To improve the outcomes for patients in NSW who require surgery for a fractured hip.

Benefits

The CIP aims to put additional resources into the implementation of the Project so that it has the greatest chance of success.

Summary

Minimum Standards were an ideal CIP choice as they were highlighted through Bureau of Health Information data and the Unwarranted Clinical Variation Taskforce as an area of clinical risk that needed addressing across the state.

The implementation of Minimum Standards has benefited from ACI's CIP in the following ways:

- Additional resources allocated to implementation. ACI offered more time and workforce to support local implementation,
- The project team has invested in SLHD's Targeted Activity and Reporting System (STARS), which enables clinicians to look at their own individual data, patient length of stay and cancellations as soon as the data is input into the hospital systems.
- The Institute for Healthcare Improvement's project management team software program is being trialled. This enables local project managers to share innovation ideas, project success and have a forum for asking questions.
- The project team undertook a medical record level audit and worked with Liverpool Hospital as a pilot site.
- The project team partnered with the CEC using its Quality Audit Reporting System to input some of the audits electronically and explore the data analysis potential of this system. If successful, there may be opportunities to partner with CEC in further development of this system.

- The project team has been to a large number of sites conducting project initiation meetings, undertaking audits and supporting local teams and project managers in implementation.

A formative evaluation is currently underway with six sites to identify factors for success which can be shared with the other sites. A summative evaluation will also be undertaken at the end of 2015.

Background

The Clinical Innovation Program (CIP) was established in 2014. This stream of the Program aims to support large scale implementation of an initiative or model that has been prioritised through our Networks, Taskforces and Institutes.

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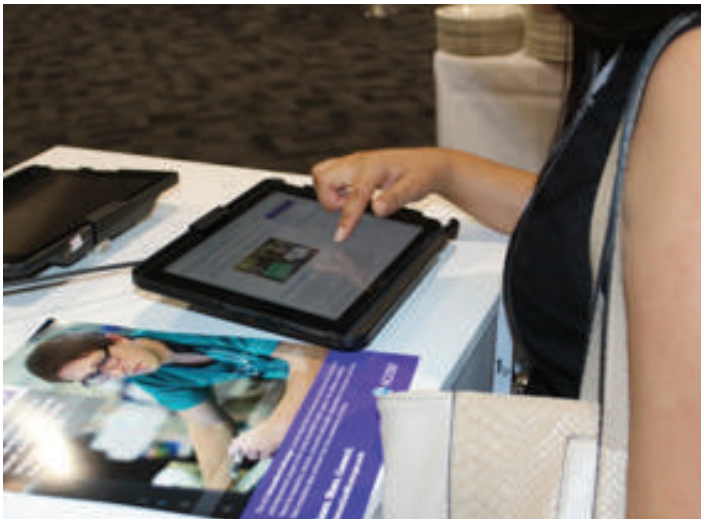
Clinical Innovation Program – Spread of Local Innovation



Strategic Initiative

Develop the innovation skills and capability of our health care partners.

Aim

To find, explore, develop and provide support to LHDs and SHNs for the successful implementation of clinical innovations of statewide significance.

Benefits

- Enable the sharing of local innovations across the state by developing and implementing models of care:
    - for use across metro, regional, rural and remote areas
    - based on current practice that is delivering significant benefits to patients, staff and the health system
    - to meet an emerging issue or share an identified opportunity.

The CIP also supports implementation of the models.

Summary

The following steps are taken to ensure that initiatives identified for replication are innovative and address emerging issues:

1. Prioritisation – Innovations are identified through the NSW Health Innovation Symposium and the Centre for Healthcare Redesign School. These innovations are compared against a framework for prioritisation by a panel of health system representatives.
2. Assessment – Due diligence is performed to ensure that the initiatives are viable at scale, including data analysis, service utilisation, resourcing, service capacity and a qualitative assessment of staff and patient satisfaction.
3. Network Alignment – ACI Network(s) are consulted to ensure the initiative is contemporary and evidence-based.
4. Environmental Scan - Similar models are reviewed to confirm how each element of the model best meets the identified need, to ensure that the documented innovation provides the best outcomes,
5. Document Innovation – A concise resource is developed to support implementation success. Key principles are described, allowing greater flexibility implementation.
6. Implementation – Each model includes a self-assessment to allow sites to identify potential areas for improvement or opportunities for implementation of a new care element. The ACI will host a knowledge sharing forum for sites implementing models.

Implementation of the following models will start in the coming months in partnership with LHDs:

- Home First Dialysis - based upon South Western Sydney LHD with additional input from Nepean Blue Mountains LHD, Northern NSW LHD and Western Sydney LHD
- Service Access and Care Coordination Centres - based upon South Western Sydney LHD with additional input from Hunter New England LHD, Illawarra Shoalhaven LHD and Northern Sydney LHD
- Specialist Geriatric Outreach - based upon South Eastern Sydney LHD with additional input from Hunter New England LHD, Mid North Coast LHD, Nepean Blue Mountains LHD, Northern Sydney LHD and NSW Ambulance.

Background

The Clinical Innovation Program (CIP) was established in 2014. This stream of the Program seeks to identify local innovations that other parts of the health system may benefit from. These models are formally evaluated and written up to be implemented across NSW.

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Innovation Exchange

Strategic Initiative

Develop the innovation skills and capability of our health care partners.

Aim

- To consolidate and promote information and experience about clinical innovation and improvement projects across healthcare in NSW and beyond.
- To encourage the spread of successful healthcare innovations to improve efficiency and quality of healthcare delivery.

Benefits

Benefits include:

- Promoting achievements with health professionals and across organisations
- Showcasing improved ways of working and health innovations to enhance the quality and efficiency of our services
- Achieving more by pooling knowledge and resources to work collectively
- Accessing current information that is relevant to clinicians and healthcare professionals.

Summary

The Innovation Exchange provides a single, collaborative place to share and promote local innovation and improvement projects and resources, from all healthcare organisations across NSW and beyond.

Both small and large scale innovations and improvements generated across the local services are recognised and shared to benefit the broader health system.

Through sharing knowledge, information and resources, the Innovation Exchange is designed to encourage health services to learn and build on others' improvements, foster innovation and formulate their own improvements to benefit the NSW health system.

The Innovation Exchange helps health professionals to learn, share, and connect by:

- collecting and promoting information and resources about current clinical projects, the latest quality innovations and improvements in healthcare from across NSW and beyond
- providing resources to assist and encourage health professionals to make improvements and foster innovation in their own healthcare setting
- delivering a platform for health professionals to learn new ways of improving and innovating for their local needs and share their experiences and lessons.
- connecting health professionals with others.

Partners in this project include all NSW health organisations including LHDs, SHNs, Health Pillars, MoH, Primary Health Networks and other health related organisations.

Health organisations outside NSW may also submit innovations which benefit healthcare delivery for consideration, provided they fit the assessment criteria (relevant, useful, current, and concise).

An evaluation and measurement approach for the Innovation Exchange will be developed to include qualitative feedback from users and quantitative data usage metrics such as Google Analytics and website engagement measures.

Background

As part of a review in 2013, LHDs highlighted the value of the (former) Australian Resource Centre for Healthcare Innovations (ARCHI) and the need for a central online space to share and find useful information and resources about clinical innovation and improvement projects.

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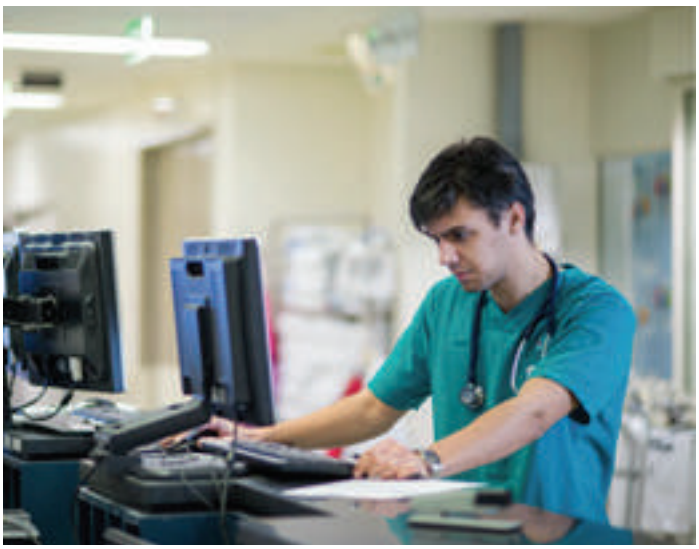
NSW ACI Critical, Acute Care, Trauma and Emergency (CATE) Public Health Register



Strategic Initiative

Measure and monitor impact on health outcomes.

Aim

To make better use of information held or utilised by the ACI via the creation of linked, de-identified datasets under the Public Health and Disease Registers provisions of the *NSW Public Health Act*.

Benefits

- Improved access to linked datasets
- Substantially easier monitoring of health outcomes
- Support healthcare quality improvement and management activities
- Improved information for the planning, monitoring and evaluation of health services.

Summary

The NSW ACI Critical, Acute Care, Trauma and Emergency (CATE) Public Health Register will comprise linked de-identified records of data collections such as Burns; Trauma; Spinal Cord Injury and Intensive Care with links to datasets including but not limited to:

- Admitted Patient and Emergency Department Data Collections;
- Death records from the Register of Births, Deaths and Marriages and Cause of Death information;
- NSW Ambulance Service data.

The sponsor of the Register is the Chief Executive, ACI and the Data Custodian of the Register is the Director, Clinical Program Design and Implementation, ACI.

As part of a best practice governance model, the Public Health Register will be securely stored and accessed via the Ministry of Health's Secure Analytics for Population Health Research and Intelligence population health data warehouse, analysis and reporting system.

Releases of unit record data will be governed and/or approved via the MoH and ACI's release of information approval processes.

Partners in this project include ACI Networks, Taskforces and Institutes, NSW MoH, NSW Registry of Births, Deaths and Marriages and Ambulance Service of NSW.

The first iteration of the CATE Public Health Register is expected to be operational in the 3rd quarter of 2015.

Background

Since 2012, the NSW Public Health Act has provided the legislative support to establish linked, de-identified Public Health Registers. The Chief Health Officer, as a delegate of the Minister can approve the establishment of Public Health Registers.

A review of ACI data holdings in 2013 recommended that better use be made of its' datasets.

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PROMs and PREMs

Strategic Initiative

Ensure continuous input and feedback mechanisms from consumers, clinicians and partners.

Aim

To develop and implement Patient Reported Outcome Measures (PROMs) and Patient Reported Experience Measures (PREMs) that enable patients to provide direct feedback on their health-related outcomes and experience to drive improvements and integration of health care in NSW.

Benefits

- More person-centred, coordinated and integrated health care
- Increased involvement of patients in health care planning and decision-making
- Improved health status including clinical indicators, quality of life and functional ability
- Improved patient and carer satisfaction and experience of health care
- Better identification of patient and carer needs
- Better access to timely health care and related services.

Summary

The ACI is working with key partners to develop PROMs and PREMs and facilitate real time patient feedback to support the NSW Integrated Care Strategy. It is anticipated that PROMs will inform the patient's care plan and pathway and ensure more timely and appropriate referrals leading to more person-centred and integrated health care. Understanding and measuring the patient experience using PREMs will provide information to inform local service improvement and enable a more rapid response to identified issues.

In 2015, PROMs and PREMs will be piloted in NSW health services delivering integrated care to a defined target population, either in the LHD demonstrator sites or through the Planning and Innovation Fund, before being rolled out across the State.

Partners in this project include Bureau of Health Information, CEC, Cancer Institute NSW, eHealth NSW, LHD Demonstrator Sites, LHD Planning and Innovation Fund recipients, Health Consumers NSW and the MoH.

The evaluation of the NSW Integrated Care Strategy is being led by the Health System Information and Reporting Branch, MoH. The evaluation of PROMs and PREMs will be undertaken as part of state-wide evaluation.

Background

The NSW Government has committed $120 million over four years to implement new, innovative locally-led models of integrated care across the State. The ACI has been commissioned to lead the development and implementation of PROMs and PREMs as a key enabler of the NSW Integrated Care Strategy.

Patient reported outcomes capture the patients' perspectives about how illness or care impacts on their health and general well-being. PROMs are the standardised and validated tools used to directly elicit patient reported outcomes. PROMs can be generic, and assess the patient's health related quality of life, or specific to a disease or condition.

PREMs commonly assess the patient's experience and satisfaction with their health care. Various indicators are included in existing patient experience surveys and questionnaires and new indicators are being developed to assess a patient's experience of integrated care.

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NSW Model of Care for People with Diabetes Mellitus

Strategic Initiative

Develop a reputation for delivery by focusing on completing strategic projects of significance to ACI and partners.

Aim

To develop a platform for best practice of the management of type 1 diabetes, type 2 diabetes and gestational diabetes mellitus.

Benefits

- Prevent or delay the onset of diabetes and diabetic complications, thereby reducing preventable hospital admissions and average length of stay.
- Improve the quality of life of people who have diabetes.
- Improve access to evidence based Diabetes services, particularly for Aboriginal people and other disadvantaged groups.
- Provide a framework for locally-led solutions of integrated care.

Summary

The key objectives of the NSW Model of Care for People with Diabetes Mellitus are to ensure that diabetes services are optimally configured to:

- improve the quality and quantity of life for people who have diabetes
- prevent or delay the onset of type 2 diabetes
- prevent or delay progression of diabetic complications, especially heart disease, renal failure, impaired vision and lower limb amputations
- improve access to evidence based diabetes services, particularly for Aboriginal people and other disadvantaged groups
- reduce preventable hospital admissions and average length of stay for diabetes related conditions.

An accompanying self-assessment tool has been developed to assess key elements outlined in the document regarding the service provision of:

- Type 1 diabetes
- Type 2 diabetes
- Gestational diabetes mellitus.

The MoC remains in draft as the pilot sites progress with strategy implementation to gather learnings and strengthen the MoC which will be finalised in 2015. ACI will work with interested LHDs in completing the self-assessment to identify priorities, which will inform implementation plans.

Background

As of 2011, nearly 1.1 Australians had been told they had diabetes, with 369,000 of those residing in NSW. The NSW 5.4% diabetes prevalence rate is just slightly higher than the national average of 5.1%.

Across the state, there is growing demand for healthcare services associated with the increasing prevalence of type 1 diabetes, type 2 diabetes and gestational diabetes. An integrated care approach that provides seamless, effective and efficient care that responds to all of the person's needs will lead to improved outcomes for people with diabetes.

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