Waiting times: The search for equitable solutions

Case study: Mater Misericordiae Adult Public Hospital Continuum of Care Model

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Abstract

For the survival of any health care organisation, evidence-based practice is fundamental, particularly in today's economic climate. The Mater Misericordiae Adult Public Hospital in Brisbane is committed to providing a flexible health care system that is responsive and accountable to the needs of the customers. As part of the Mater's continuous quality improvement program, a Continuum of Care Service Delivery Model was developed. This model comprises many innovative clinical management systems which have evolved over recent years. Clinical pathways, care management, pre-admission clinics, variance management and evidence-based practice are core components of the model.

Introduction

The 1990s is an era of dramatic development and change within the delivery of health services. There is strong pressure to do more for less; to deliver quality care within balanced budgets; to become more efficient and effective; to provide equity of access for all requesting and requiring care. The list goes on.

Within hospital surgical departments frustration is something experienced by many as it often appears that access to hospital inpatient services is reserved primarily for the more 'acute' patient. The need for clinical assessment to remain as the determinant of admission priority is not in dispute. However, hospitals

in their strategic planning and operational management can, and should, recognise the needs of elective surgical patients.

Success in today's Australian health care environment is determined by an organisation's ability to recognise the core business of health care as being clinical service delivery, with the customers of the service central to all aspects of the system. Achieving such success is a dynamic process and is reflected in health care organisations which demonstrate a synthesis between customer and organisational values and expectations.

In addressing these issues the Mater Misericordiae Adult Public Hospital, South Brisbane, has continually searched for and developed new ways to improve the quality of service delivery to patients and their carers. This has resulted in a redesign of surgical services, improved admission and discharge planning, and development of a Continuum of Care model, all of which are aimed at matching community needs to organisational values and service provision.

With the development of a model of health care, there has been a commitment to the highest possible standards of patient services – standards which are reflected in the provision of a flexible and responsive system. A 'quick fix' was not the solution, rather, long-term system changes have been necessary to achieve success.

The process of change

The Mater Misericordiae group of hospitals, South Brisbane, consists of four hospitals. The Adult, Mothers', and Children's hospitals are all tertiary referral public hospitals. A separate private hospital of 192 beds also forms part of the group, which is owned and administered by the Sisters of Mercy and offers services to patients in collaboration with Queensland Health.

About six years ago the hospitals were experiencing difficulties, as were many other major public institutions. Elective surgery seemed to be continually cancelled as there were no available beds. Patients with acute conditions were being admitted through the emergency department and occupying elective beds. Patients and staff members were dissatisfied, and the hospital staff appeared to be running around in ever increasing circles.

At that point in time the Mater Adult Hospital made three significant changes in the surgical division, changes which resulted in being selected as one of seven lead hospitals in the National Demonstration Hospital Program. Those changes related to structure; admission and discharge planning; and developing the Mater Continuum of Care model.

Structure

Rearranging the structure of the established surgical services resulted in units designed to meet patient needs and optimise hospital resource utilisation. The structure was converted to a day surgery unit, a short-stay surgical unit, and a high-dependency unit. This introduced the 'wellness' focus of care, while at the same time improving outcomes and patient and staff satisfaction.

The reduction in length of stay has led to a further refinement of this structure. In April 1996 the 16-bed day surgery unit was incorporated into a 32-bed ward, with the remaining beds classified as 24-hour stay.

Admission and discharge planning

An admission and discharging planning program was the impetus for us to develop and shape our continuum of care. In our experience, admission and discharge planning is the fundamental component in any service delivery model. One strategy for improvement has been to map the established process with the multidisciplinary team, identify the rework and then redesign the system to reflect a synthesis between customer and organisational values.

Admission and discharge planning is dominant in all components of our model and ward staff are educated to act as discharge planners. Effective discharge planning, particularly with elective surgical patients, has contributed to a marked reduction in cancellation of cases, a shift to day of surgery admissions, an increase in day-only surgery, and an increase in the number of patients who are better informed and are in 'partnership' with the clinical staff.

The Mater Continuum of Care model

Today, through the work of our clinicians, with representation from all disciplines, we have developed a model of service delivery that will facilitate, educate, integrate and communicate our continuum to customers and community health service providers.

The established processes and work practices were evaluated in line with best practice resource utilisation, quality service delivery, and desired outcomes from a patient, clinical and organisational perspective. This change has enabled us to provide quality care, ensure continuity of care, increase patient satisfaction with services, empower employees and reduce costs.

The components of this collaborative and integrated model of care are:

- pre-admission assessment (day surgery) and pre-admission clinics (inpatients)
- clinical and patient pathways
- care management
- discharge planning, beginning at pre-admission and continuing across the episode of care
- development of links with the community health service providers
- routine monitoring of health outcomes following hospitalisation
- variance analysis and management.

Commencing at the pre-admission phase, the clinical staff from all relevant disciplines assess and plan for all aspects of the episode of care. Tailoring an admission and discharge plan which is specific to each individual patient also occurs.

Multidisciplinary clinical pathways have been developed to facilitate management of care across the continuum. These pathways are an abbreviated version of the patient's expected plan of clinical management, and are formulated internally. They specify the essential events and interventions which occur in an anticipated and timely sequence in order to achieve satisfactory patient outcomes within an appropriate length of stay.

The pathway is designed by the multidisciplinary team of health professionals for specific groups of patients and incorporates standards, interventions, and actions of all relevant clinical disciplines.

We have also developed associated patient pathways. These reflect the clinical pathway but are written in a language which the patient and carer can understand. They are educational, informative, offer the patient choices and a partnership in the delivery of health care.

Approximately 80 per cent of patients will benefit from the use of a pathway system. This is the high volume, less complex group of patients. However, the remaining 20 per cent have more complex needs, are likely to stay longer in hospital and use more health care resources. These patients require a coordinated approach to care by an identified advanced clinical practitioner. To meet the needs of this complex group of patients, our research has led us to explore a system of case management first developed by Karen Zander in the USA (Zander 1991). However, we have adapted and changed this system at the Mater to address the needs of the consumer and health system in Australia. We have called this adaptation 'care management'.

Care management is a clinical system which focuses on the accountability of an identified health professional to coordinate care of a patient across the continuum. These clinicians are invested with the responsibility and accountability for ensuring that predetermined outcomes, developed by the multidisciplinary team, are achieved.

This system targets low-volume, complex case types – those cases which do not 'fit' a clinical pathway or may 'fall off' the clinical pathway. Care management is open to all clinical disciplines and is incorporated into the routine practice of the more advanced clinician.

Care management involves health assessment, planning, service delivery, coordination and monitoring of the multiple service needs of the patients in the target group. It provides a vital link between the hospital and the community service providers, while providing the patient and their carer with a single point of contact within the hospital. Feedback from the patients, general practitioners and community health groups has been very positive.

Queensland Health (1995) identified the following as key best practice criteria: customer focus; process improvement; people involvement and employee empowerment; information and analysis; leadership; organisational performance; and policies and plans.

Implicit in the Mater model is the belief that patients need to be given basic information so as to make suitable choices during the episode of care. The patient becomes a partner in the decision-making process and staff ensure that the values of individual patients are recognised and respected.

The clinical management systems which make up the Mater service delivery model are developed, implemented and evaluated within a quality improvement framework. Process improvement is paramount, and evaluation in-built in the systems. Collaborative practice, involving all relevant disciplines, is central in the design, development and function of the clinical pathway system, pre-admission clinics, and care management.

With the integration of continuous quality improvement and a customer focus into service delivery, quality patient outcomes are the impetus for change. In our experience, cost-effectiveness follows on from the change.

The core business of health care is clinical service delivery and therefore the service structure and function should be responsive to the needs of both the direct and indirect receivers of the service – the customers. Our systems have all those concerned with the process of clinical service delivery working together to achieve the desired outcome. They also acknowledge that the patient is only in

hospital for a short time – 3.4 days on average at the Mater – therefore, to be effective the continuum proactively strives to reduce the traditional barriers between the hospital and community.

To enable routine monitoring of health outcomes, the multidisciplinary teams developed expected outcomes for each case type. These outcomes have been incorporated into the clinical and patient pathway system and the care management system. They are used by all relevant health professionals for evaluation. Outcomes are structured to correspond with the appropriate phase of recovery and continuing treatment.

Regular review of expected outcomes is conducted and, following discharge, a copy of the expected outcomes is forwarded to the general practitioner for evaluation and to note patient variances. This enables hospital staff to evaluate care and the discharge planning process, and be fully informed about the patient's recovery. Evaluation is essential to any program and our model uses variance analysis and management as an in-built evaluation system.

Conclusion

The search for solutions to problems confronting the surgical division at the Mater Adult Hospital, South Brisbane, was addressed in three ways: firstly, through restructuring the way surgical services were delivered, resulting in a move towards day surgery and a focus on wellness rather than illness; secondly, by improving admission and discharge planning; and, finally, using this as the impetus to pilot innovative clinical management systems in order to develop a Continuum of Care service delivery model.

Introduction of the Mater Continuum of Care model has involved cultural change, breaking down the traditional barriers when planning and delivering care, and moving away from control to empowerment. It also involved development of a dynamic and adaptable model of care to take us into the next century. There has been a focus on accountability for the outcomes of care, and a better response to patient needs and expectations. This model must be capable of being changed in terms of casemix of the hospital, that is, hospital in the home, and more outreach.

The transformation of services at the Mater has required consultation, facilitation and collaborative support within the multidisciplinary team. Staff in the clinical units led the change process but were supported by others willing to run with the vision.

The development of a model of care built on past achievements has enabled clinical staff to manage all groups of patients in a way that enhances quality, adds value, and allows further development of our integrated continuum of care.

We have learned that if you don't take the opportunity to ensure that quality is the dominant focus in health care, you may never know what can be achieved.

References

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