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## To the city and back: developing a quality framework to guide the patient journey

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### Background

Country Health SA Local Health Network (CHSALHN) provides a wide range of public acute, residential aged care, community health and mental health services throughout 61 public hospitals across rural and remote South Australia.

Diverse geography covering approximately 1 million square kilometres presents significant personal, logistical, and financial challenges for patients requiring care in a metropolitan setting.

While a committed network of health care providers will guide the patient as they navigate the complex system, the lack of coordinated connectivity between country and metropolitan health services often results in inefficiencies – delays, cost (to both the individual and the broader system) and the risk of poor patient outcomes as access to tertiary services can be overtaken altogether by demand management strategies rather than a system wide architecture designed to effectively and safely manage patient flow in a timely manner.

Impact metrics designed to measure performance are perceived as a punitive measure; rather than driving a culture of continuous improvement.

The end result is an operating system that underachieves in its attempt to draw all the moving parts into what seems should be an achievable goal – a patient centred, adaptive and responsive system.

### The complex system: 'The whole is more than the sum of its parts' (Aristotle)

Kannampallil (2011) explored the concept of applying complexity theories to health care systems; advocating the use of the term due to the inherently 'non-linear' nature of the system which is exposed to the influence of outside agencies.

While it is recognised that complex systems aspire to 'collaborate' to create a functioning whole (Bogenschutz 2009) through self-organisation and pattern formation, the overall picture is intimidating; large numbers of internal networks include hospitals, clinics, nursing homes, rehabilitation units, mental health inpatient units, and outpatient units – just to mention a few. When considering how we interact with the system it is important to recognise the difference between the number of components in the system (which make a system 'complicated'), and the interrelatedness of the components which result in 'complexity'.

Under the burden of increasing pressure and demands within the health care system, good governance suggests regulatory structures should be applied in order to manage the challenge however a strategy that sees the number of levers increased assumes a linear 'action/reaction' response; and that the output can be controlled by manipulating each of its parts.

In the end, at the centre, surrounded by constantly moving components, with unclear relationships, compounded by a seemingly infinite number of systems within an organic non-linear system, suffering under the weight of and increasing and unprecedented demand – is the patient.

For patients and their families this is almost impossible to understand.

## **The case for simplicity: Country Health SA patient flow**

Across SA Health in both the Metropolitan, rural and remote health services, a variability of structures dictate patient flow. Drivers may be based on individual preference e.g. personal relationships between the primary health referrer and the specialist or system focussed based on supply and demand. Regulatory structures such as departmental policy directives play a role; but implementation is difficult given the scale and 'complexity' of the health system.

Objectives:

- Seamless patient journey
- Minimise delay
- Improve multidisciplinary communications

## **The framework**

The development of the CHSA Patient Flow framework is based on simple principles centred around the system and patient care that are based on the mandate of CHSA Strategic Plan – to provide country South Australians equitable access to healthcare services.

In 2008 the NSW Ministry of Health produced a Patient Flow Systems (PFS) framework based on an audit of patient flow in 20 hospitals across NSW. While the PFS is not designed to describe the flow challenges related to rural and remote services, the 7 core elements that form the best practice foundation of the PFS are an attractive foundation for the CHSA flow model:

1. Care Coordination: Navigating patients through the health system to prevent delays.
2. Standardised Practice: Promote best practice to lock in expected outcomes.
3. Variation management: Smoothing the peaks and troughs to distribute the load.
4. Demand escalation: Act early to preserve capacity.
5. Demand and Capacity Planning: Organising your service to build capacity.
6. Quality: Structuring systems around an expected outcome.
7. Governance: Transparent accountable leadership.

(NSW Health, "Overview and Introduction of Patient Flow Business Rules", January 2012)

The challenge for CHSA was to adapt these principles to our own unique context.

## Approach

### Quantitative

To understand the patient movements we began to look at the numbers of interhospital transfers between country sites and metropolitan Adelaide.

**Table 1 Interhospital Transfers over a 5 year period from 2014 to 2018 (CHSA Data Mart)**

	2014	2015	2016	2017	2018
Country to Metro	8,654	8,941	9,591	10,096	10,397
Metro to Country	2,457	2,731	2,724	2,997	3,041

Using the latest census data from the 2016 Australian Bureau of Statistics this data shows that approximately 5.5% of the population outside of the metropolitan area are travelling to receive medical care *\*some patients may appear in both groups.*

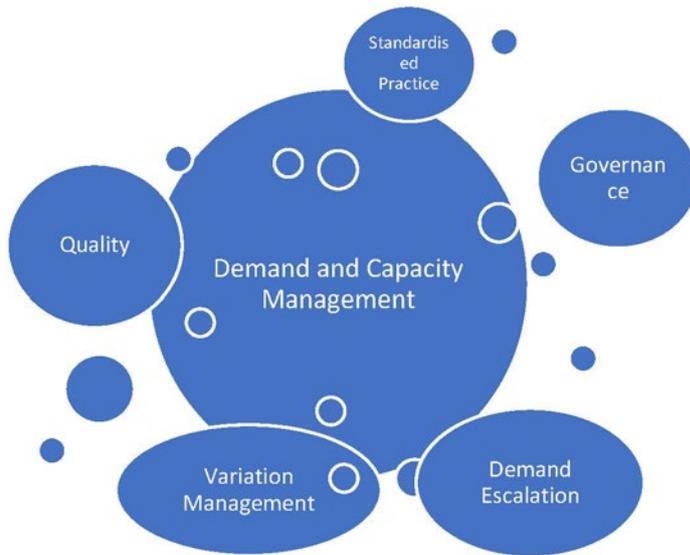
### Qualitative

While the numbers provided a broad picture of the quantity, the true value of the framework was to establish the quality of the transfers and began to capture the issues and barriers identified by internal stakeholders against the best practice principles developed by NSW Health. E.g. how well are we doing?

Patient journey stories captured from CHSA flow coordinators highlighted barriers and issues including:

- Coordination of accepting site and treating specialist is time consuming- and often the patient transfer is not a consultant to consultant conversation,
- Lack of standardised transfer documentation including input from medical and nursing staff, and other relevant disciplines including pharmacists and allied health,
- Delays in transfers due to logistics, transport options and availability of air and land transport assets,
- Coordination of outpatient appointments,
- Bed availability in the metropolitan site.

When we compared the feedback against the elements of the NSW PFS, we fared poorly against Demand and Capacity management and marginally better against the other elements.

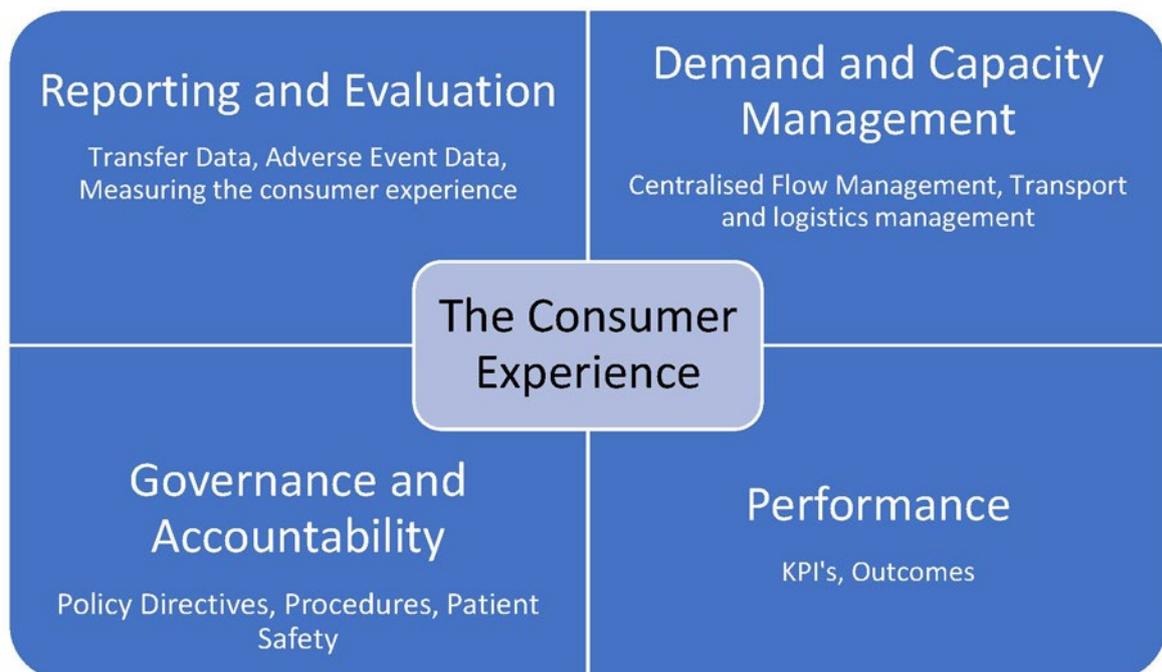


### The opportunity

Understanding the current state allowed us to structure the framework to support opportunities for improvement based on three basic principles; any strategies developed within the framework needed to be:

1. cost effective
2. support system efficiencies
3. be patient centred.

Any proposed strategies, projects, initiatives would be measured against these three core principles, the framework would provide the architecture to support the patient journey.



## Implementation: enablers and barriers

### The consumer

The qualitative and anecdotal feedback on patient journeys are often provided through safety and quality systems as a complaint when a journey is delayed or there are measurable negative patient outcomes and rarely come about as a result of a consumer complaint. Through several patient flow initiatives, we have struggled to capture the consumer experience and as we move to the implementation phase of the framework it will be important to establish a quality enabler from the outset and provide the consumer with a voice.

### Policy base

Governance structures and policy directives often attempt to tackle parts of the system rather than the whole. The political environment, funding and workforce pressures and the silo'd structure of the system create barriers to the development policy directives to address a system wide problem using policy levers. We are beginning to see an improvement in some cohorts however such as the SA Stroke Pathway where decision making is time critical with senior consultant level input.

### Political context

The 2017 SA Election saw a change of Government instigating significant governance reform resulting in restructure of local health networks – a game changer for initiatives like the framework. While arguably the implementation of the framework has become even more important to ensure smooth transition for patients moving from country to metropolitan sites and visa versa however it is challenging to manage change within a changing system.

Ultimately though, regardless of our structure we will still be faced with managing the ongoing tension between capacity management, capability and clinical need. The baseline shifts and turns with little predictability; and current demand pressures within our system which have largely driven workloads since the influenza season of 2017 have continued; and that innovation and collaboration are the only way forward.

## References

Bogenschutz E, "Complex Systems", Max Planck Institute for Dynamics and Self Organisation, Gottingen (2009)

Kannampallil T, "Considering complexity in healthcare systems", Journal of Biomedical Informatics 44(2011) 943-947

## Presenter

Over her 30-year career in health **Julia Waddington-Powell** has held senior clinical and non-clinical roles across both the private and public health care sector; developing a strong interest in communicable disease, emergency management and disaster preparedness with a particular focus on health service resilience. As the Operations and Emergency Management Coordinator for Country Health SA, Julia has been involved in a number of major incidents affecting the SA Health system most notably as a part of the incident management team for CHSA during the state-wide power outage. In addition to her interest in emergency management, she has been involved in the development of operational projects in relation to patient flow, which fostered a passion for the integrity of the patient journey between metropolitan and country health services. In 2017 she was involved with the Royal Adelaide Hospital move, which required system wide coordination and collaboration under extraordinary circumstances; providing a rare glimpse into what can be achieved for patient flow through an integrated patient-centred system.