Maximising package revenue through improved service delivery and data reporting

Kim Maurits
1Country Referral Unit Implementation

Background
In order to streamline and improve service coordination and delivery to more than 1.5 million residents of country South Australia, Country Health SA Local Health Network approved the staged implementation of a Country Referral Unit. Stage 1 would commence on 2 July 2012.

Stage 1 would see the refurbishment of new premises at Nuriootpa, to house a workforce of up to 33 staff. Staff were originally located at Gumeracha and Angaston, under the auspice of Gumeracha hospital and Inner North Community Health Services. All staff would then move under the auspice of Inner North Community Health Services, and a new team structure. It would also bring together the operational functions of the following four service programs:

Country Home Link—provides rapid response hospital avoidance and supported discharge packages. This program operates from 8am to 6pm across 7 days. Referrals for a Country Home Link package are approved by the Metropolitan Referral Unit and forwarded for actioning. This program operates across all of country.

Transition Care Program—The program is goal oriented, time-limited (average of 8 weeks duration) and therapy-focused. The program may be provided in a residential or a community setting dependent on individual needs. When provided in a residential setting, a less institutional, more home-like environment is expected to aid recovery. The packages are available across all of country.

Access2HomeCare—provides a referral pathway for clients over 65 (or 50 if of Aboriginal or Torres Strait Islander descent) Home and Community Care and Aged Care Assessment services. This service commenced in 2008 for residents of Gawler, Barossa, Lower North and Yorke Peninsula. Access2HomeCare is one of 8 National Access Points.

Healthlink—provides a referral pathway for clients seeking community services. This service commenced in 2005 for residents of Gawler, Barossa, Lower North and Yorke Peninsula.

Prior to implementing Stage 1, the Country Home Link and Transition Care referral Programs were delivered from Gumeracha, whilst the Access2HomeCare and Healthlink referral programs were delivered from Angaston. Due to the similarity of role and function between the two referral units, it made sense to combine the teams into one larger work unit. This would then create a much more sustainable business unit with future opportunities for growth.

Implementation challenges
There were 12 staff affected by the establishment of the new work unit, with a mix of permanent and contract staff. There was extensive consultation with staff, Human Resources, and union representatives throughout the implementation process. The amalgamation of three teams into one, with a single team leader role meant there needed to be a solid understanding of the work functions of each different team.

Not all staff had chosen to transition across and be part of the new team. Staff choosing not to transition would effectively become re-deployees as of the 2 July 2012. As part of the restructure, all staff required new job and person specifications and new contracts. Any staff on existing work contracts were required to re-apply for their positions, once those positions were advertised. All advertised positions would be on a 7 day roster, which was very different for the majority of staff who needed to re-apply for their roles.
As existing programs within Inner North Community Health, the Access2HomeCare and Healthlink operations were already known, and there was significant, current documentation to support business practice. All existing staff from these two programs were also transitioning to the new work unit, so there was no gap in knowledge.

However, as there were up to 3 key staff from Gumeracha not looking at transitioning across, it was necessary to capture the corporate knowledge of those staff that were responsible for the Country Home Link and Transition Care Program service delivery. There were a limited number of business practices that had been documented, and some of the information was out of date. There was also no support documentation around maintaining a 7 day roster, which was a critical component of the program delivery.

Gumeracha key staff were also ending in their roles prior to the implementation date of 2 July, 2012, which meant gaining approval to put agency staff into those roles, to learn the business and to minimise risk to client service delivery. This was achieved with the support of Country Health SA Aged Care Directorate lead staff. The majority of the Gumeracha site business practices were also very time and labour intensive, with a great deal of manual data entry and data reporting processes. Recommendations from a previous business improvement project were not yet implemented and tested, which meant this work also had to be completed during the first months of implementation. Until new procedures were tested, it was necessary to keep using the manual data entry and reporting business practices which were currently in use at Gumeracha.

It was important to transition the staff and programs with minimal disruption to the existing services and the core business of client service delivery. However there was still a great deal of uncertainty about how to actually manage the operations of the Country Home Link and Transition Care programs. Each Country Home Link package attracts $500 for the health unit delivering the service. With 175 packages available each month, this equates to $4,550,000.00 of potential revenue for Country health units. There needed to be decisions regarding how to maintain the business revenue for Country Health, whilst supporting new staff and improving business practice.

Whilst there was a need to review the business practices of all four programs, it was agreed that improving the processes and procedures to support the Country Home Link program was top priority. The packages support the early discharge of country clients, and are integral to saving bed days in the metropolitan hospitals. Health units are only paid for delivering the package once they have returned a discharge summary to the Country Home Link administration staff.

**Business practice pre-implementation—Country Home Link**

Once the transition occurred, there was the opportunity to get a much clearer understanding of what areas of business practice needed to be improved.

The key elements of the Country Home Link program are:

- providing referral confirmation to the Metropolitan Referral Unit, within 1 hour of receiving the faxed referral
- contacting the nominated clinician at the relevant health unit to confirm service delivery capacity
- providing service delivery confirmation to the Metropolitan Referral Unit, within 2 hours of receiving the faxed referral
- entering data to record service delivery, referral timeframes, and financial information
- forwarding discharge summaries to Metropolitan Referral Unit
- production of monthly data and financial activity reports
• referrals taken between 0600 and 1800 over 7 days.

Inherited business practices to support these key elements were:

• an arch lever folder filled with contact details for each community health unit across country South Australia
• no agreed escalation process if health units were unable to accept a referral
• multiple access and excel data bases to capture and report on activity data
• double data entry of package information
• inconsistent follow up of outstanding discharge summaries
• no documented roster system to staff the program over 7 days.

Business and practice improvements post-implementation—Country Home Link

• All details in the contact folder were check and updated. An easily readable and editable spreadsheet was then created and placed in a central file, allowing all staff access.

• An escalation process was drafted and approved by Country Health, showing clear accountability and expectations of all parties.

• Episodes of care within the Country Consolidated Client Management Engine (CC-CME) were enhanced to allow improved data capturing.

• Crystal reports were written for the CC-CME database, which allowed data to be extracted quickly and easily.

• Manual databases were decommissioned after the crystal reports had been validated and staff were trained in their use.

• Reports to identify outstanding discharge summaries are run daily to encourage timely follow up with the relevant health units.

• A robust 7 day roster was implemented with the intake staff, including on-call clinical support.

Financial accountability

Country Home Link is part of Country Health SA Local Health Network’s ‘Out of Hospital Strategy’ to alleviate pressure on hospital beds.

Many health units have increased staffing their capacity to be able to provide a 7 day service response to any Country Home Link referrals. Payment for delivery of the service is dependent on the clinical staff completing a discharge summary, and forwarding this to Country Home Link administration.

Previously it was time intensive to monitor and manage outstanding discharge summaries. This unfortunately results in Country Health not being paid for services that have been delivered. After the Country Home Link work unit transitioned into the Country Referral Unit, it was discovered that there many thousands of dollars worth of outstanding package payments.

After gaining a good understanding of how the processes should be working, our efforts went into finding out why discharge summaries were not being returned in a timely manner. Clear and concise documentation regarding business practice was developed and distributed to all health units.

Improvements were made to the Country Home Link episode that was located within the CC-CME database so that information could be directly entered by intake staff at the Country Referral Unit.
The crystal reports were written and training provided so that administration staff could quickly and easily run reports and follow up on outstanding discharge summaries, thus ensuring health units received package funds in a timely manner.

A snapshot comparison of package funds received and outstanding confirms the improvement in maximising revenue for country health units.

<table>
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<th></th>
<th>No of packages allocated</th>
<th>$ value</th>
<th>$ paid to health units</th>
<th>$ outstanding</th>
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<td>20680</td>
<td>35640</td>
<td>37</td>
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<tr>
<td>Oct – Dec 2012</td>
<td>146</td>
<td>73000</td>
<td>67000</td>
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</table>

Source: R Simmonds

Facilitating client service delivery

In order to meet the strict Key Performance Indicators associated with the Country Home Link program (2 hours), staff at the Country Referral Unit needs to have up to date information on all services available from each health unit across the whole of country. As the packages are available across 7 days, each health unit also must provide key contacts that can be called to confirm service capacity and commencement.

Any difficulty in contacting these key contacts can result in clients being discharged from hospital before service confirmation has been received. This is of real concern when clients may be returning to rural and remote locations, expecting a service to commence the following day. The information must be up to date and easily retrievable so staff can confirm package acceptance with a minimum of time and effort.

There is often a lack of understanding from metropolitan hospitals about the different level of services available within country South Australia, particularly in the more remote areas where vast distances make service delivery difficult.

For Indigenous clients who live in remote Aboriginal communities, the pathways are even more difficult. It requires working closely with Aboriginal Patient Pathway Officers, and the Aboriginal Community Controlled Health Units. Discharging an Indigenous client with a Country Home Link package is no guarantee that the service will be what the client wants, or even that the client will return to their previous location. It is an ongoing effort to balance our mainstream health service delivery with the cultural and family expectations and obligations of our Indigenous clients.

Next steps

Clinical handover

Work is still to occur in developing an agreed clinical handover process between the Metropolitan Referral Unit, the Country Referral Unit, and the local health units providing the service delivery.

An agreed process will assist in reducing clinical error, and facilitate appropriate duty of care of the client throughout the episode of care.

Stage two implementation

With Stage One of the Country Referral Unit completed, work commenced on Stage Two in February 2013.

Stage Two will see the progressive expansion of the Acces2HomeCare program across the remainder of Country South Australia. Commencing with Eyre, Whyalla and Port Lincoln areas in February, the expansion will be concluded by 30 June 2013.
Preliminary work will then commence on the requirements for Stage Three, which is intended to provide a similar streamlined entry into services for clients under the ages of 65 or 50 if of Aboriginal or Torres Strait Islander descent.

Upon full implementation of the Country Referral Unit, there will be one main entry point for clients requiring services within Country South Australia.

A common concern currently is that nursing staff often find it difficult to know where to send referrals for services in the country. It is time consuming and frustrating to have to make several phone calls to determine the correct referral pathway. The difficulty is highlighted when there is new staff or agency staff attempting to make the referral. This can sometimes lead to delays in discharging clients.

Providing a recognised single pathway into services for country clients will greatly assist in discharges from metropolitan and country hospitals, as well as GP clinics and clients.