HEALTH WAIKATO
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Waikato District Health Board

The challenges of working across the care continuum

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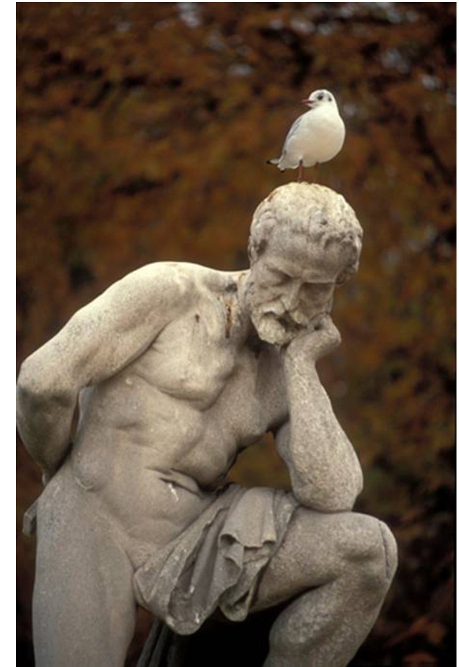
We had a dream…

- We dreamt of seamless, continuity of care for patients across all health care delivery services, with no duplication

- – yeah, really



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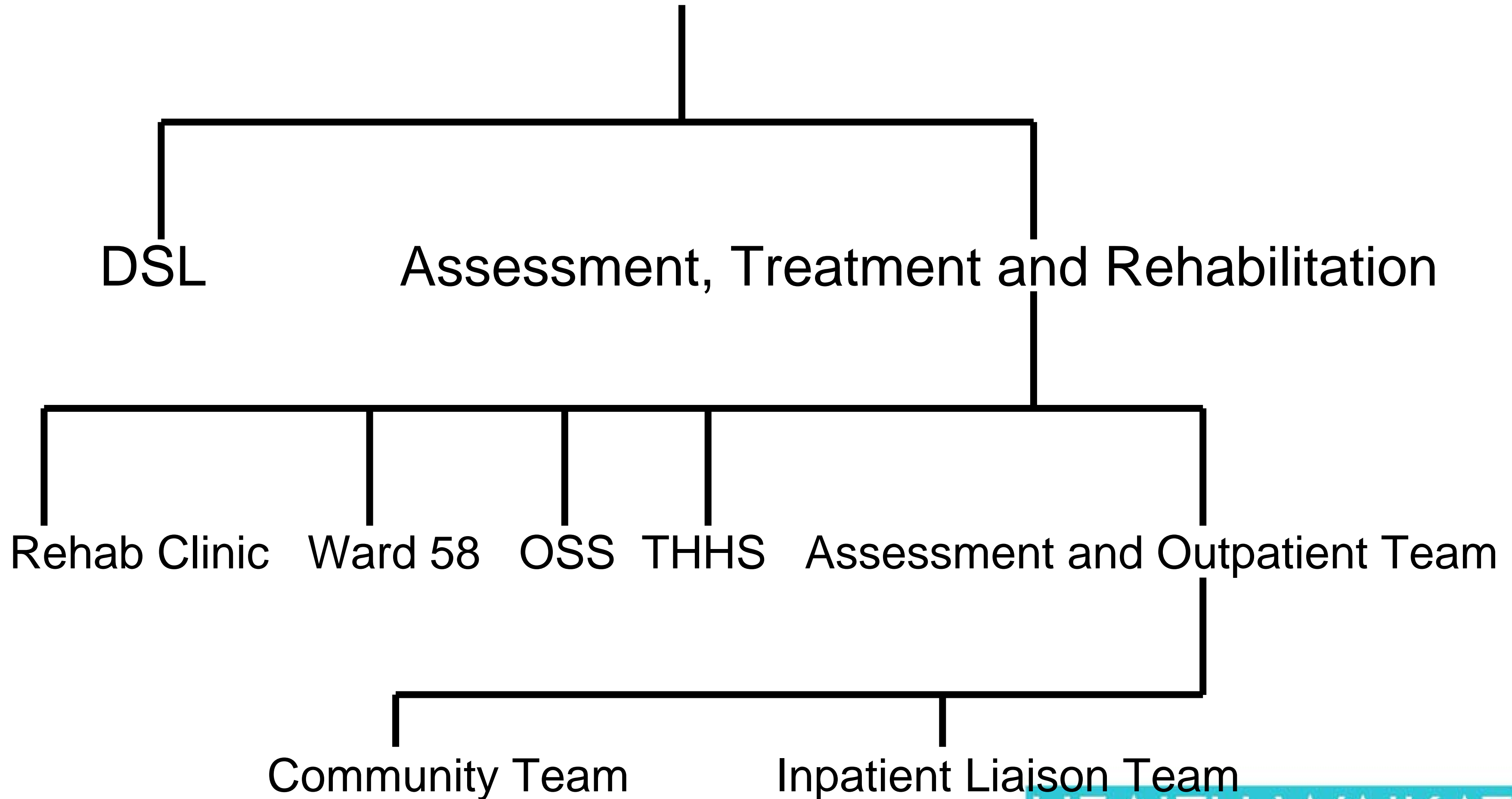
Our Journey So Far…

- We have tried and to some extent succeeded – this is our journey so far.
- We want to share with you our successes and challenges.
- We saved $80,000, by reducing length of hospital stay by 2 days per patient in our audit sample.
- There was no extra resource to help us to make the change it was driven by the assessment and outpatient team, with management support.

Why did we decide to change our practice?

- Increasing referrals from GP’s to undertake urgent visits to older people recently discharged from Waikato Hospital
- Concerns for the quality of care delivered within the acute hospital to older people
- OP and RS were perceived to be slow to respond to referrals
- The in patient liaison nurses were stressed and demoralised.

What were we doing?



How did we come up with the concepts?

- Monthly innovative practice meetings
- Meetings with stakeholders
- Changes to internal processes – convalescent care
- Joining forces in Hockin
- Desire to be proactive and make a difference
- Reduce multiple assessments and work with patients and their families across the hospital and community interfaces

Objectives

- To deliver a proactive service, which was not referral driven
- To offer seamless care delivery across services
- To improve the care of older people in Waikato Hospital.

Pre-Audit

- Audit pre change – 9th September 2008, all patients over 75 admitted under the care of general medicine, general surgery, orthopaedics, cardiology and respiratory.
- Variables investigated were referral patterns to OP and RS, length of stay in acute wards, and discharge destination and re-admission rates.

Kick Off

- 1st October, 2008 – International Older Persons Day
- New style of service commenced
- The Assessment and Outpatient Team now combined with the Inpatient Liaison Team to provide a continuous service follow through from hospital to home
- Despite consultation mixed responses were received for our proactive approach
- With senior management support we continued, but almost under the radar.

Evaluation Audit

- Evaluation audit was undertaken on 9th February, 2009 – the same over 75 years sample and variables.
- Feedback from the nurses undertaking the liaison role was also collected to give a qualitative perspective to the results.

Statistics

Speciality	ALOS (difference between audits)	No. of patients	Bed days changed	Average Unit cost per bed day ($)	Total cost change ($)
General surgery	-1.25	14	-17.5	640.04	-11200
General medicine	0.19	27	5.13	771.07	3956
Orthopaedics	-6.08	11	-66.88	554.86	-37109
Cardiology	-3.92	13	-50.96	622.92	-31746
Respiratory	-0.72	7	-5.04	572.77	-2887
Total	**-11.78**	**72**	**-135.3**	……….	**-78986**

Comparisons of Average Length of Stay

Comparison of average length of stay

	General surgery	General medicine	Orthopaedics	Cardiology	Respiratory	Overall
Sep-08	10.54	10	21.58	12.69	9.86	12.54
Feb-09	9.29	10.19	15.5	8.77	9.14	10.52

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Referral Rates to OP and RS

	Sep-08			Feb-09		
	Total admissions	Referrals to OPRS	%	Total admissions	Referrals to OPRS	%
General surgery	13	5	38.5	14	3	21.4
General medicine	30	13	43.3	27	10	37
Orthopaedic	12	12	100	11	5	45.4
Cardiology	13	3	23.1	13	1	7.6
Respiratory	8	5	62.5	7	2	28.5
Total	**76**	**37**	**48.7**	**72**	**21**	**29.1**

Discharge Destination

Table 4: Discharge destination on leaving acute ward

Discharge destination	Sept 08 (%)	Feb 09 (%)
Home	59.72	66.66
Rehabilitation unit	18.05	22.22
^ level of care	16.67	8.3
Deceased	5.56	1.4

Readmission Rates

Table 5: Readmission rates at four weeks post discharge

	Sept 08 (n=68) (%)	Feb 09 (n=71) (%)
Readmitted to Waikato Hospital	22	25
Deceased (not readmitted)	10.3	4.2

Feedback

- Feedback from the liaison nurses has highlighted that their roles and interactions have evolved in different ways.
  - Some attend weekly team meetings, i.e. orthopaedic, general surgery where the specialities are ward based.
  - Others use iPM in-patient listings to identify patients across the wards, i.e. blue team, neurology.

Feedback Continued

- The assessing nurses identified the following roles included in their liaison work:
  - Providing patients with information
  - Discharge planning with ward staff
- Suggesting referral to OP and RS for specialist rehabilitation / gerontology services
- Suggesting referral to allied health, e.g. OT for MMSE
- Arranging follow-up in the community post discharge by AOT, and
- Suggesting further investigations, monitoring, e.g. use of CAM tool for delirium.

We have made a difference.

- The future – look at general medicine and change the approach?
- Involve the audit department and quality facilitator to measure any change more robustly.
- Developing new service in ED
- New building for Older Persons and Rehabilitation Services