Using a Rapid Improvement event to kick start reforms in outpatients

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Health Services Innovation
Commonwealth-funded program for the better health of Tasmanians

Department of Health (DoH) → Tasmanian Health Assistance Package → Innovation in Clinical Services – Clinical Redesign
Context

North West Regional
160 beds
and King Island

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160 beds
and King Island

Mersey
100 beds
Secondary level service
Total population
125,000

Launceston General
260 beds
Population 125,000

Royal Hobart
460 beds
Population 250,000

Royal Hobart
460 beds
Population 250,000

Population 125,000

Total population
125,000
Key Priority Areas selected by Health Partners
Consortium/Commonwealth

- Emergency Access
- Elective Surgery
- Bed demand and capacity
- Specialist Outpatient Clinics
- Mental Health
Building capability in the system

- **Clinical Redesign**
  - 3 THOs
  - State-wide and Local initiatives and outcomes

- **Undergraduate Programs**
  - Nursing
  - Medicine
  - Paramedics
  - Pharmacy

- **Postgraduate Programs**
  - Professional honours in CR
  - Working with People
  - Leadership
Concertinaed time frames

Year One

Year Two

Year Three

Year Four

Year One

Year Two

Year Two +

One Year
Pitfalls of Traditional methods

- Repeat information every time you meet.
- Required to bring new stakeholders up to speed.
- Difficulty with meeting time schedules.
- Not meeting regularly enough to get any actions occurring.
- Loose momentum.

“Here are the minutes from our last meeting:
Marty wasted 12 minutes, Janice wasted 7 minutes,
Carl wasted 27 minutes, Eileen wasted 9 minutes...”
‘Rapid improvement events’

– Sometimes known as ‘Kaizen’ events
  – ‘Kaizen’ meaning continuous improvement
Benefits of Rapid Improvement Events

– Brings all the stakeholders together
– Allows time and head space to actually get things done
– Given resources and the correct people to make decisions in a timely way
– Builds relationships for future work.
– Values staff
What is a Rapid Improvement Event?

Small to large periods of time, ranging from 2-3 hours to 5 days

<table>
<thead>
<tr>
<th>Kaizen method</th>
<th>Scope of Problems</th>
<th>Duration</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Point Kaizen</td>
<td>Small</td>
<td>One – two days</td>
<td>Acute Assessment Unit Outpatients</td>
</tr>
<tr>
<td>Kaizen / Rapid improvement event</td>
<td>Medium</td>
<td>One week Planning extra</td>
<td>Nursing works Planning services</td>
</tr>
<tr>
<td>System Kaizen</td>
<td>Large</td>
<td>One week intensive + 9 – 18 weeks</td>
<td>Safe care after hours</td>
</tr>
<tr>
<td>‘Kaizen plus’ weekly meetings</td>
<td>Small to large</td>
<td>Intensive + Hours to weeks</td>
<td>Discharge flows Regional flows Surgical flows</td>
</tr>
</tbody>
</table>
Pre ‘Rapid Improvement Event’

How did we decide who was to be involved?

High Level diagnostics

- Sorted by volume, opportunities (DNA rate, cancellations, wait list and overboundary numbers and clinical engagement)
- Clinical Lead discussions with Unit heads
- Executive support: crucial

Logistics

- Offsite- balance: but close enough
- Pre-organise equipment and staff that they may require e.g. articles, equipment
Pre ‘Rapid Improvement Event’

Prep work (completed by Clinical champion and lead nurse)

– What does our specialty consist of?
– What are we good at?
– Staffing?
– Governance and Reporting structures?
– Policy/procedures/protocols?
– Workload
  – Including current state data, Bookings, attendances, cancellations, DNA’s, Discharge rate, New to review ratio. New referrals per week?
– Are we accessible? Wait times per category
– Are we sustainable?
– What factors influence our service?
Specialist outpatients

• RIE March 2015 (two day workshop)
  • Units involved
    • Ophthalmology
    • ENT
    • Plastics
    • Neurosurgery
    • Gastro
Typical plan / agenda

– Clinical Champion presents current state (each unit)
– Waste identification training
– Big picture map
– Discuss: What should our core business be?
– Alternative pathways
  – Primary Health Tasmania, GP liaison
– Lean, standard work and visual management training
– What does the patient value?
– Establish a Future State (usually within existing resources)
– Trial experiments or Plan, Do, Study, Act cycles
– Standardise
– Action plan
– Meeting times
Who should you invite to RIE?

Each Unit
- Clinical Champion
- Lead nurse
- Scheduler/Clerk
- Registrars
- Allied Health

Experts in their field

GP Liaison
Primary Health Tasmania

Encourage specialists to discharge patients back to GP

Operational Management

Ability to work with redesign, assist with constraints

Share progress. Ability to work with redesign, assist with constraints at a higher level

Enhance/promote community resources

Executive Report back
- Director of Nursing
- Director of service groups

Ability to work with redesign, assist with constraints
Common Themes identified across specialities

• Referral guidelines outdated and variation in adherence
• Long wait lists
• Waiting list management variation in practices
• No standard clerical audit practices
• Absence of discharge guidelines
• Absence of DNA (do not attend) policy
• Missed opportunities for billing
• Non standard Referral management to wait list
• No visibility of service demand and delivery
• Lack of communication with GP’s of referral status
OPD Program system improvement

• Revised referral guidelines per speciality & uploaded to OPD website
• GP Liaison on each work group
  • Feeding back to the GP community on changes, initiatives
  • Feedback from GP’s: Require timely discharge letter including a clear plan
• GP’s are encouraging specialists to share care and discharge patients
• Primary Health Tasmania (formerly TML) on some workgroups, enhancing Tasmanian Health Pathways

• Optimise billing opportunities
• DNA policy endorsed
  • New Patient x 1 = Discharge
  • Review x 2 + Discharge (clinician discretion)
OPD Program system improvement

• Improving communication with the GP
  • Refined feedback to GP regarding information inquiries versus referrals
  • Letter GP now includes wait list category, instead of just referral acknowledgement
  • Reinforcing referral criteria by referring back to Outpatient website
  • Standardised non-acceptance of referral letter with links to referral guidelines
• Visibility of wait times for GP’s and consumers
• Developing and socialising Discharge guidelines
• Focusing on short term cancellations (in our control)
• Data dashboards
Ophthalmology

• Redefining Core business
  • Working with Ophthalmologists, Optometrists, Orthoptists and patients to reduce follow up of Diabetic retinopathy screening

• Standardised referral management
  • Clerical and clinician

• Cat 1 clerical wait list audit; July 2015

• Paediatric clerical audit

• DNA audit

• Template audit (redefining templates to clinicians available)

• Building capacity to incorporate outsourced patient reviews
ENT

- Created separate wait list for Paediatrics
- Tracking of overburdened staff
- Template audit (redefining templates to clinicians available)
- Imbedded ENT advice form into website (GP emergency contact)
- Revisited Red flagging system
- Auditing over boundary planned appointments
- Developing Nurse led clinic
- Developing postop care/chronic care pathways
Plastics

- Helicopter model
  - Enhances discharge and teaching
- Revised discharge guidelines
- Alignment of nurses & medical officers to rooms
  - Reduced the chaos
- Nurse led clinics
  - Standard Criteria
- Paediatrics to be fast tracked
- Ward reviews (short) now booked directly with clinics
Neurosurgery

- Standardised referral pathway
- Establishing telehealth for NW patients
- Helicopter model adopted
- Developing triage protocol
Outcomes:

- Reducing the chaos on clinic day (reducing overburden)
- Developing capacity to see new patients
- Discharges improving
- Developing teams
Wait list reduction

Rapid Improvement event
Next Round

Gynae

Pre admission

General Surgery
Including Colo-rectal

Ophthalmology