

Mental Health Assertive Patient Flow

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<http://www.archi.net.au/e-library/build/moc>

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Acknowledgments and Advisors

This model of care is based on the model developed by the South Eastern Sydney and Illawarra Area Health Service.

NSW Health would like to acknowledge the contribution of all of the staff who have worked tirelessly to make this model succeed.

Particular thanks goes to Angela Karooz, the Area Mental Health Bed Manager, South Eastern Sydney and Illawarra Area Health Service, for her input and guidance in the creation of this document.

Executive Summary

Patients value timely access to the health care they need. This is especially true for patients living with a chronic condition that necessitates frequent contact with the health system. Patients with chronic conditions are ideally assisted to maintain their health and well being through co-ordinated access to General Practice and community based services. Effective self-management prevents the need for unplanned acute episodes of care.

South Eastern Sydney and Illawarra Area Health Service implemented an Assertive Patient Flow Model in September 2004. The Area developed the model to improve patients journeys through the acute health system to appropriate community based care. The model sought to maximise the efficient use of acute mental health beds, reduce the number of mental health patients inappropriately occupying beds in other wards or facilities (outliers), as well as improve co-ordination between the Emergency Department, in-patient units and community based services.

The Assertive Patient Flow Model of Care takes an area health service-wide approach to bed management, rather than focusing on a single facility. The model differs from operational bed management by:

- viewing the entire patient journey
- managing the flow of patients throughout the patient journey
- proactively forecasting demand and creating capacity at an Area level
- integrating acute and community services to facilitate patients leaving hospital in a safe and timely way.

The model ensures a smooth transition across the continuum of care, helping to ensure quality patient outcomes and effective use of resources.

The model encompasses and joins a range of different initiatives, at an Area level including:

- bed management
- community integration
- assertive care progression
- predicted bed model
- transfers
- repatriation plans
- escalation plans.

Results from the South Eastern Sydney and Illawarra Area Health Service has shown a dramatic impact on the access to mental health beds and a reduction in length of stay in the ED, and in the number of mental health patients inappropriately being cared for in other beds, wards and facilities.

The Assertive Patient Flow Model of Care will help area health services to make timely decisions and optimise the use of acute beds. It will help staff to better manage the entire journey for patients using the range of services available across the continuum of care to ensure safe, high quality care.

Why Implement this Model?

- Consumers receive the type of care that best meets their needs in a timely fashion.
- A focus on keeping Consumers well in community settings, minimising the need for unplanned acute admissions.
- Results demonstrate improvements in access, and reduction in Length of Stay and outliers (patients placed in beds outside of an acute in-patient unit).

The Need for Change

Clare's Story

Clare's Story Prior to the Assertive Patient Flow Model of Care

Clare is no stranger to hospitals and the mental health system. Over the last two years she has had six or seven admissions to hospital. She is young, smart and knows a lot about her condition and the health system. Clare has both a case manager and a GP.

Clare is no stranger to hospitals and the mental health system. She has had six or seven admissions to hospital in the past two years.

The absence of systems to move people quickly and appropriately from inpatient to community care is contributing to Clare's poor experience with the health system.

This is her story.

It is a real story. Only the names have been changed.

If Clare becomes unwell she usually has to go to the Emergency Department (ED). Clare detests this process, particularly if it is "after hours" as she feels that few ED staff have empathy and she feels that she is rarely treated with respect.

Clare feels that as soon as staff realise that she is a mental health patient she is treated differently from other patients.

Clare hates being watched while showering and going to the toilet, particularly as she knows she is not at risk of harming herself. "Would you like that to happen to you?" she asks.

Clare gets very frustrated that staff provide so little information. Clare feels that staff do not give her the time or nurturing she needs. The "special nurse" assigned to her in the ED acts as a babysitter rather than a care giver and advocate.

The police usually bring Clare into hospital and she encourages this because she believes it gets her faster attention.

Clare's Journey



When Clare becomes unwell she always goes to the Emergency Department (ED). She feels many ED staff have little empathy and she is rarely treated with respect.



Because she is mental health patient, Clare gets treated differently from other medical patients.



Clare prefers to be brought to hospital by the police because she feels she gets faster attention.

What's Wrong With This Story?

Clare is used to waiting hours, and sometimes days, in the ED for a psychiatric registrar to arrive. "All that time under fluorescent lights - you never know if it is night or day." Often the registrar will have a hospital security guard stand with her until a "special nurse" arrives or, as she once overheard a doctor say, "until the medication kicks in". She knows the security staff resent the task as they have other duties to perform.

Clare once spent six days in a hospital ED waiting for a bed. In the middle of the night she was transferred to a mental health unit around 100 km away where she spent 13 days before being transferred back to her local mental health unit. It was difficult to be so far away from her family.

- The Emergency Departments is not always an appropriate place for people experiencing mental illness to receive care.
- Clare feels she receives little information about her care.
- Clare has waited for many hours in Emergency Departments and has been transferred 100km away because of a lack of beds.



Clare once spent six days in a hospital ED waiting for a bed. In the middle of the night she was transferred to a mental health unit around 100 km away where she spent 13 days before being transferred back to her local mental health unit.



Clare believes the system is chaotic and is frustrated by the lack of information she is given and the slow response times in treating her condition.

Background to the Model

Timely access to emergency mental health services is essential for appropriate patient care and to minimise the risk of self harm or harm to others. Mental health patients are presenting to Emergency Departments more than ever before. This is not ideal for patients who then experience lengthy delays before admission to an in-patient unit (NSW Auditor General, 2005).

This Model of Care is based on the model the South Eastern Sydney and Illawarra Area Health Service started to use in 2004.

State and local experience demonstrates that people with a mental illness spend too long periods in Emergency Departments.

Contributing to increased access block for patient's with mental health conditions, is the poor transition of patients from acute in-patient units into community based services.

“There is also evidence that some patients spend inappropriately long periods in Emergency Departments while awaiting acute mental health beds or are discharged from the Emergency Department prior to a bed becoming available” (NSW Auditor General, 2005).

Assertive Patient Flow

South Eastern Sydney and Illawarra Area Health Service implemented an Assertive Patient Flow Model in September 2004. The area health service carried out an eight week scoping study that identified the following key issues.

- Increasing numbers of mental health patients inappropriately occupying medical/surgical beds (referred to as “outliers”).
- Increasing numbers of mental health patients in the Emergency Department having to wait more than 24 hours for a mental health bed.
- Limited use of patient flow and predictive bed modelling.

Subsequently the service developed a model to help provide a better journey for patients and their carers. This model also sought to:

- maximise the efficient use of acute mental health beds and reduce the number of psychiatric patients inappropriately occupying beds designated for other patients (outliers)
- ensure improvement and consistency in the management of patient flow across the Area Health Service
- improve co-ordination of services between the ED and MH services to ensure timely decision making and discharge or transfer of patients to a more appropriate setting.

The model takes an area-wide view on patient flow and the model was rolled out simultaneously to all the area health service facilities.





What is Assertive Patient Flow?

Assertive Patient Flow takes an area health service-wide approach to bed management. The model forecasts demand to proactively create capacity.

It differs from operational bed management by taking a proactive approach in managing demand and patient flow. It utilises demand and bed management principles to synchronise and sustain patient flow throughout an entire area health service.

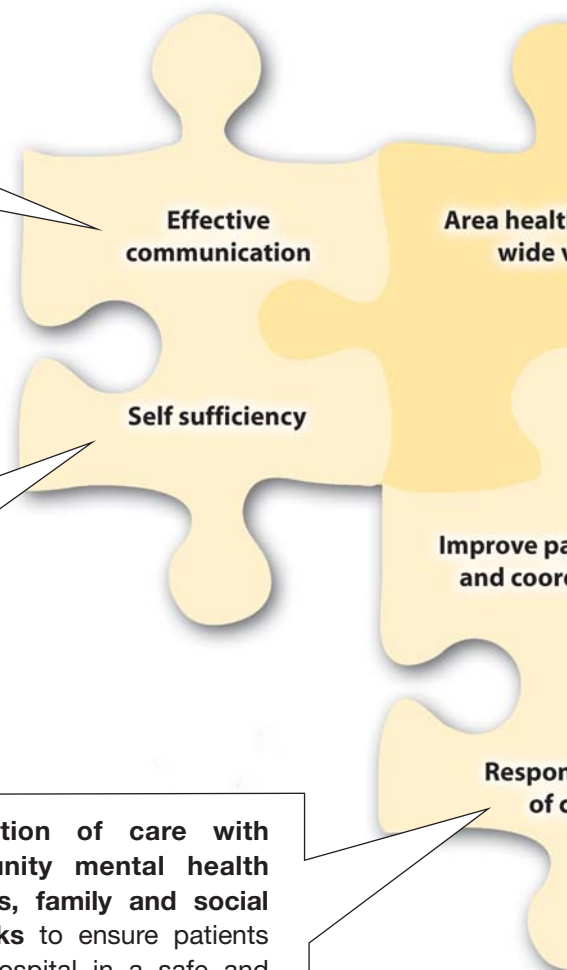
The model integrates inpatient services with community services to facilitate a safe and timely discharge of patients. This end to end approach removes the roadblocks from the patient journey, maximises the use of acute mental health beds and provides quality outcomes for patients.

Principles of Assertive Patient Flow

Effective communication with all key stakeholders. Patients receive consistent and timely information regarding their care, progress and their estimated date of discharge. The model also uses regular team meetings to review patients progress. This principle also extends to multi-disciplinary and community teams, Emergency Departments, bed management teams, and senior executives.

Self Sufficiency - The onus is on each mental health facility to manage their own demand by using a predicted bed model to assertively create capacity. This reduces a facility's reliance on adjacent facilities and area health services.

Integration of care with community mental health services, family and social networks to ensure patients leave hospital in a safe and timely way.



Assertive Patient Flow takes an area-wide approach to bed management.

It differs from operational bed management.

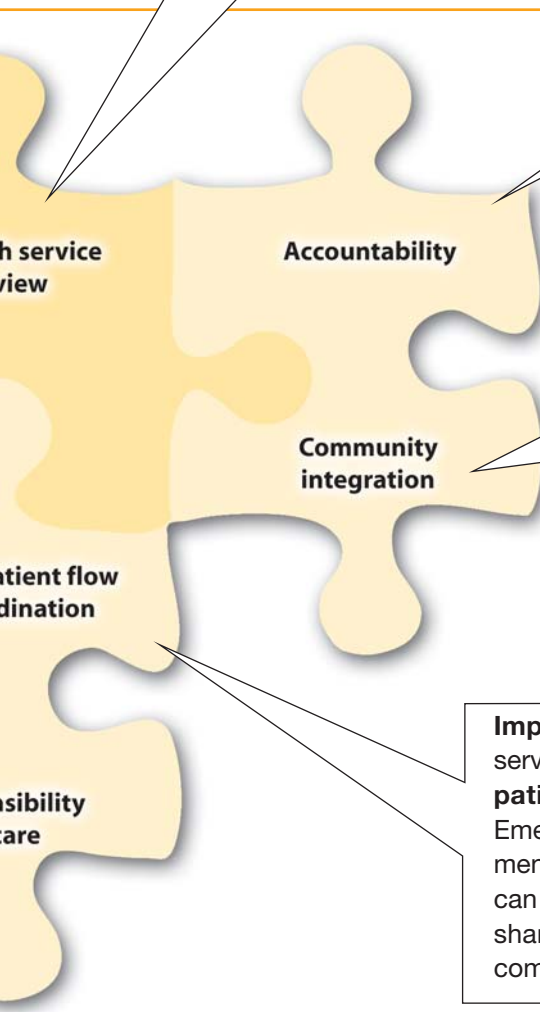
The model forecasts demand to proactively create capacity and provide quality outcomes for patients.

Adopt a coordinated **area health service wide view** on patient flow across all facilities through consistent and transparent processes.

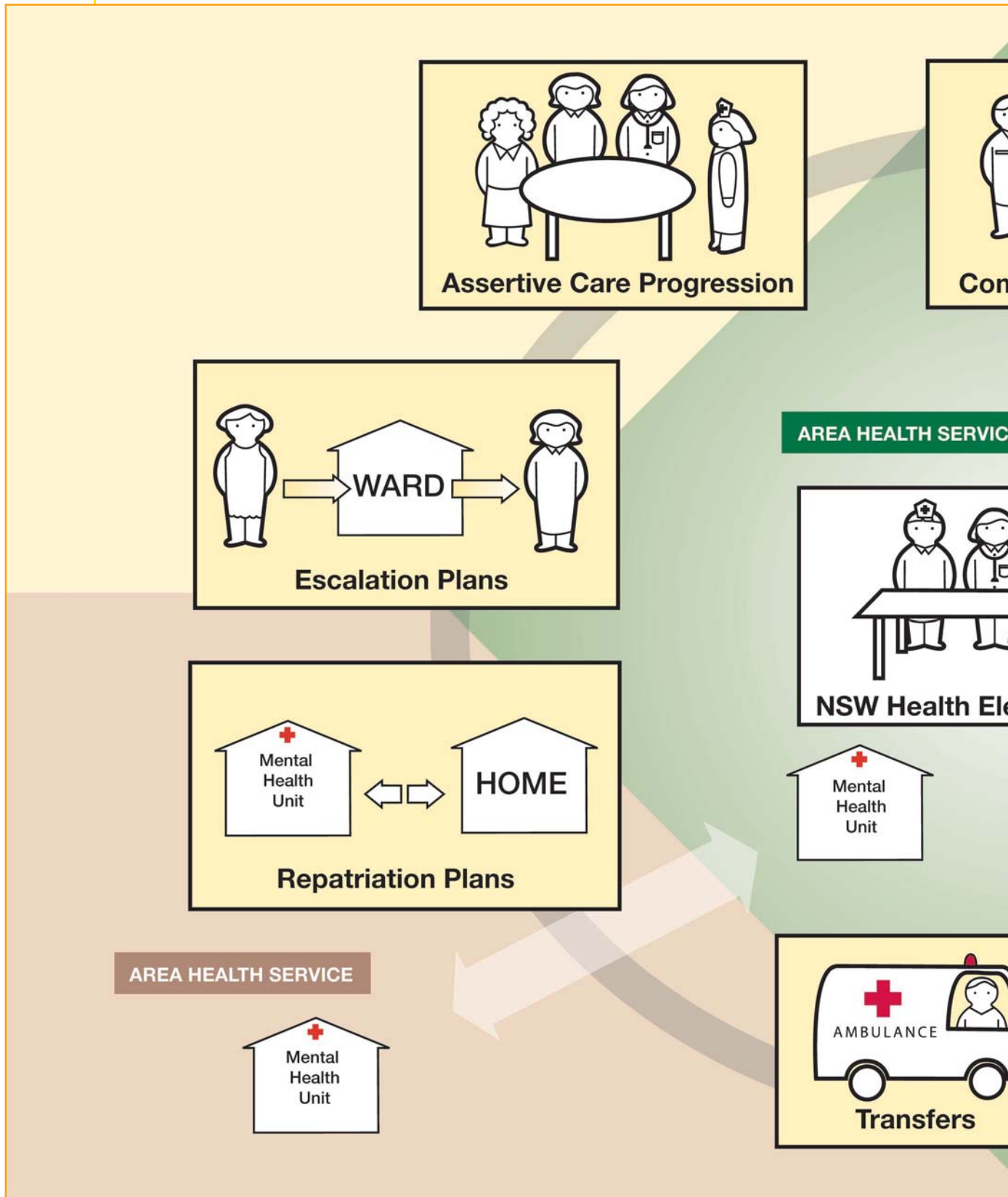
Accountability, ownership and reporting of performance KPI's is essential to drive change through the facility.

Regardless of the patients area of residence, the **service where the patient presents has the responsibility of ensuring appropriate care.**

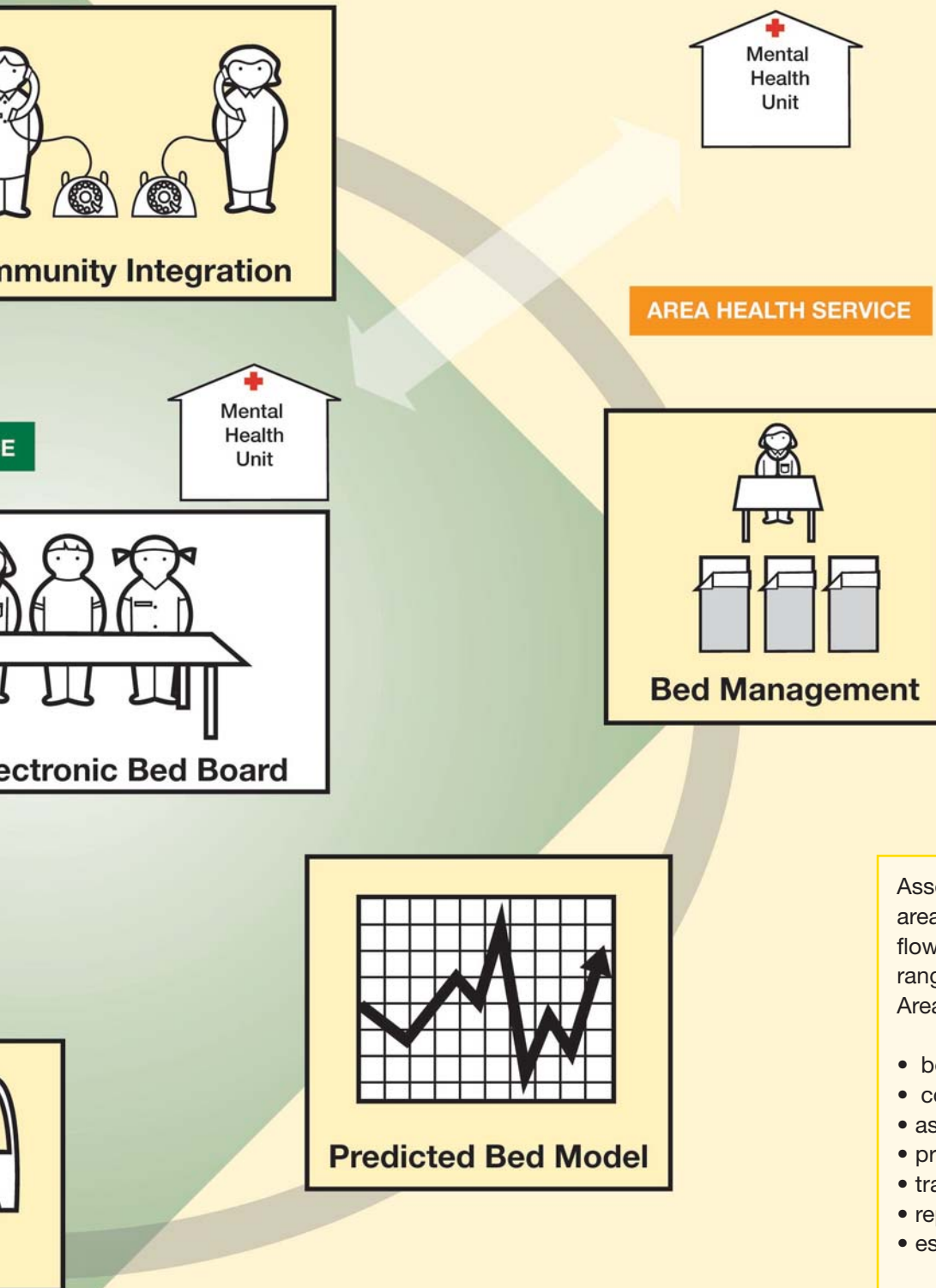
Improved co-ordination of services as well as **improved patient flow** between Emergency Departments and mental health services. This can be achieved through a shared vision and effective communication.



How Does Assertive Patient Flow Work?



Assertive Patient Flow takes an area-wide approach to patient flow. The model encompasses a range of different initiatives. Collectively these initiatives allow an area health service to manage end to end patient flow that facilitates a better managed journey for patients from the time they enter an acute facility to the time they leave hospital.

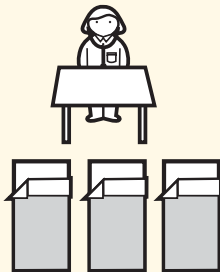


Assertive Patient Flow takes an area-wide approach to patient flow. The model encompasses a range of different initiatives at an Area level including:

- bed management
- community integration
- assertive care progression
- predictive bed modelling
- transfers
- repatriation plans
- escalation plans

to allow an area health service to **better manage the journey for patients.**

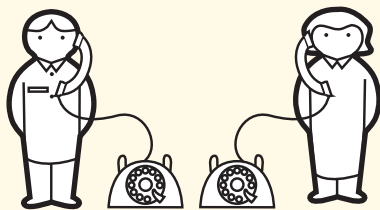
How Does Assertive Patient Flow Work?



Bed Management

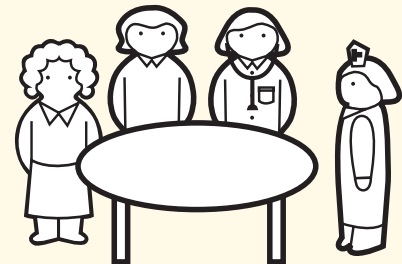
Base mental health staff in Emergency Departments (called Local Patient Flow Co-ordinators). Patient Flow Co-ordinators maximise the use of acute mental health beds and facilitate patient flow by:

- providing timely communication to Emergency Department staff, acute inpatient staff and local bed managers
- actively solving problems and escalating issues
- organising discharges and transfers between facilities.



Community Integration

From the day of admission to an acute inpatient setting, community based clinicians and case managers are involved in management planning processes and treatment of patients. They work with the inpatient based teams to ensure patients leave hospital in a safe and timely way.



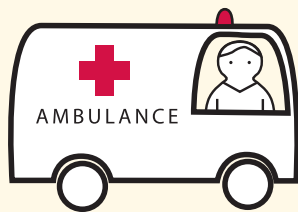
Assertive Care Progression

A multi-disciplinary team in each facility should confer at least twice per week to review each patient's progress, plan and coordinate care. Other outcome based care initiatives include long stay patient reviews by another consultant at predefined time periods and benchmarking length of stay by diagnosis against peer facilities to ensure appropriate facility performance.



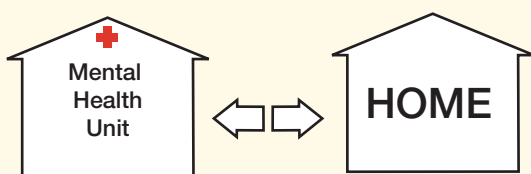
Predicted Bed Model

Allows the mental health unit to manage and predict variances in demand using historical information. This allows the unit to proactively respond to demand and assertively create capacity in order to handle incoming demand.



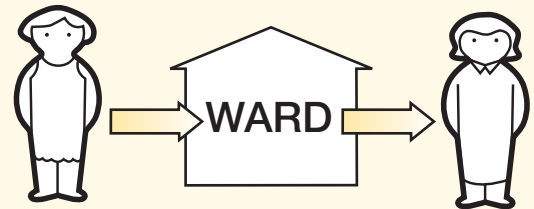
Transfers

Communication of clinical and risk information is carried out by Local Patient Flow Coordinators at the two transferring facilities. This allows the receiving facility to determine the patient's suitability before the physical transfer is carried out. A negotiated care plan is also agreed upon before the transfer takes place.



Repatriation Plans

Treatment in an acute mental health inpatient unit close to a patient's usual residence is preferable. It is the responsibility of the primary (home) facility to organise the repatriation of a patient. This allows the patient to be closer to carers, family and local community based teams.



Escalation Plans

Escalation plans facilitate a consistent and co-ordinated approach to managing peaks of demand and Access Block. The plan specifies pre-determined trigger points to ensure there is clear accountability, and the right person with the right authority is engaged, to make the necessary decisions.

Benefits

Consumers and carers



- Improved safety for the patient through timely decision making and discharge, which leads to reduced waiting time for assessment and for a bed.
- Decreased length of stay in hospital by integrating community teams in acute discharge planning. This leads to a safer transition to community based care for the patient.
- Multi-disciplinary teams review a patient's progress and ensure that there is a co-ordinated care plan.
- Improved communication so the patient always knows what is happening, and a consistent message is given regarding their current state of progress.

Mental Health Facility



- Improvement and consistency in patient flow throughout the facility, leading to:
 - improved mental health access
 - improved inpatient bed occupancy, leading to a reduction in mental health patients inappropriately occupying beds in other wards or facilities
 - reduced inpatient length of stay.
- Assertive care progression ensures that patients don't spend more time in hospital than is necessary.
- Effective demand management by using a predictive bed model and adopting pre-emptive strategies to better manage peaks in demand.
- Repatriation plans ensure patients are transferred to the facility closest to the patient's usual residence.
- Community services are actively and effectively engaged to ensure people leave hospital in a timely manner.

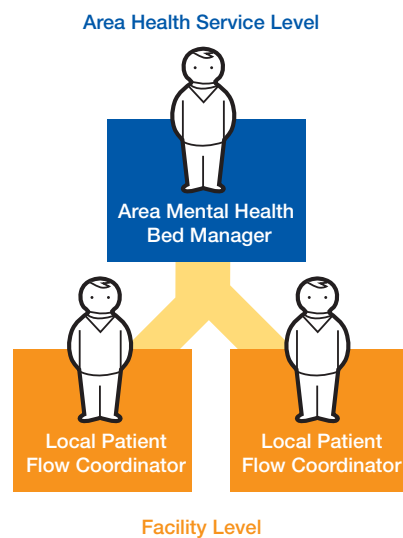
Case Study: South Eastern Sydney and Illawarra Area Health Service - 2005/2006 results

- The highest number of presentations in the State, but **the most accessible ED in the Sydney metropolitan region.**
- A **98% reduction** in the number of mental health patients per day inappropriately occupying medical/surgical beds.
- A **90% reduction** in the average number of mental health patients waiting more than 24 hours for a mental health bed.

Staffing

Key positions that make this model work.

To provide a consistent coordinated approach each facility will need a Local Patient Flow Coordinator to work with the Area Mental Health Bed Manager to drive change at the mental health facilities in the area.



Area Mental Health Bed Manager responsibilities

- Create a strategic vision and provide a repertoire of options to improve access, reduce length of stay and, where appropriate, transfer people to non-acute care facilities
Foster an **area health service-wide zero tolerance philosophy** for barriers to the movement of patients by introducing a set of initiatives that takes an end to end approach to manage the patient journey throughout the continuum of care.
- Ensure that maximum efficiency is extracted from the mental health network's acute beds and teams.
- Provide comprehensive, transparent and timely quality data/information to target variance in clinical practice.
- Adoption of assertive demand management and decision making practices regarding patient flow.
- Support ambulance responsiveness for transporting patients to other area health services.
- Develop and sustaining good working relationships among the staff of hospitals and units.
- Engage key stakeholders such as ambulance, ED, key executive and other staff.

Local Patient Flow Coordinator responsibilities

- Create a local site-based system for the planned flow and discharge of patients.
- Organise the processes to ensure patients leave hospital in a safe and efficient manner.
- Foster local site-based zero tolerance philosophy for barriers to the movement of patients.
- Mobilise internal resources where a patient with complex needs requires a multi-disciplinary approach to allow them to leave hospital (discharge planning).
- Establish ongoing effective communication systems with all stakeholders.

More detailed information can be found in the "Create Roles and Responsibilities" section of the Implementation Process Map.

Implementing Assertive Patient Flow

Process Map

Visit the online version of this process map on the ARCHI website at www.archi.net.au/elibrary/build/moc

Here you will be able to access more information on each of the steps in implementing the model. You will have access to tools and templates as well as hints and lessons learned by others who have implemented the model.

	Planning Where are you now?
Governance	<p>Identify leaders.</p> <p>Develop a Process Map. (Refer to the ARCHI website.)</p> <p>Establish a Steering Committee.</p>
Patient Journey How do patients flow through the model	<ul style="list-style-type: none"> • Map Patient Journey • Include all stakeholders across the continuum of care
Policies and Protocols	Identify and review current policies and protocols affecting patient flow
People Understand who the staff are, how they function and what role they play in the patient journey	<p>Stakeholder Analysis</p> <p>Engage Physicians, GPs, acute inpatient teams and community based teams</p> <p>Develop staff profile</p>
Resources	<p>Survey current resources</p> <p>Identify resources needed to establish and maintain Assertive Patient Flow</p>
Communication	Develop communication plan

	Preparing Make it happen	Operationalise Make it stick
	Develop a Governance Plan Develop service level agreements with community based services (if appropriate) Establish and Mobilise Team Develop Key Performance Indicators (KPIs)	Monitoring, Evaluation and KPIs Provide regular project reports and updates for senior management
	Identify changes that need to happen to improve the patient journey Document 'new' patient journeys that the Assertive Patient Flow Model of Care can enhance Include the perspective of carers and/or family members	Regular monitoring of patient experiences via regular patient journey mapping
	Develop policies and protocols	Implement and monitor compliance with new protocols.
	Develop position descriptions for key staff to facilitate Assertive Patient Flow Develop competencies and an educational program for key staff	Develop a review process
	Deliver required resources	Monitor resource use
	Execute communication plan Identify how results will flow between all stakeholders	Feedback and review process

Assertive Patient Flow

Clare's New Story

Clare's Story Under the Assertive Patient Flow Model of Care

Clare is young, smart and knows a lot about her condition and the health system. Clare has both a case manager and a GP.

Clare is no stranger to hospitals and the mental health system.

Clare has had six or seven admissions to hospital in the past two years.

This story shows how her journey could be better under the *Assertive Patient Flow Model of Care*.

When she becomes unwell Clare always goes to her GP and/or her case manager. Clare also uses the ED. In the past this has been a process that she detested, particularly if it was “after hours”. Clare felt that very few ED staff had empathy and they didn't treat her with respect.

However the last two times Clare has gone to the ED, she has found that it has been a better process.

“The way people treat you does make a difference. The staff have treated me in a similar way to any other patient,” Clare says.

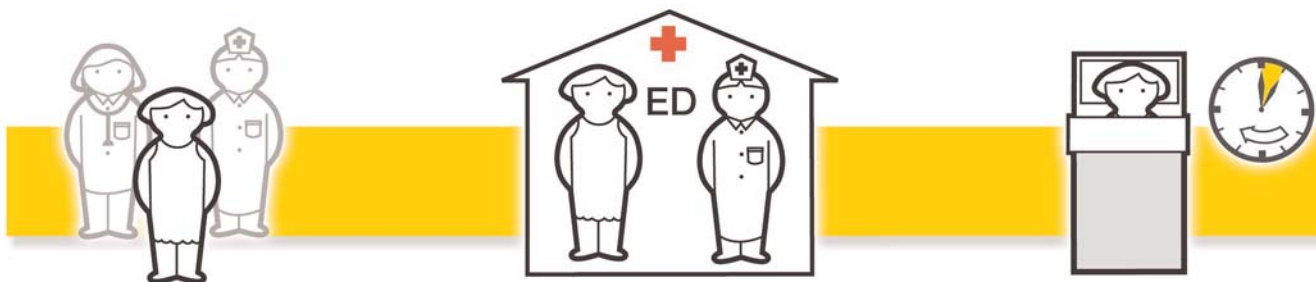
“It's much easier when people take the time and actually talk and explain what is happening,” she says.

Clare says it is still a distressing experience as often she is there against her will. She hates having to be watched all the time.

The last time she came into the ED she didn't wait long to be seen by the triage nurse or the registrar.

“They were able to find a bed for me almost immediately.”

Recently Clare has not spent as long in hospital as on previous occasions. She says that the hospital and community mental health staff seemed to work much more closely together.



Clare is young, smart and knows a lot about her condition and the health system. Clare has both a case manager and a GP.

When she becomes unwell Clare always goes to her GP and/or her case manager. She also uses the ED. However the last two times Clare has gone to the ED, she has found that it has been a better process.

Clare now finds that the staff treat her with respect and that she doesn't wait long to be seen by the triage nurse or registrar.

What is Good About This Story?

“My case manager was more closely involved with me leaving hospital.”

“We had a meeting with the Dr and Nurse from the hospital, and my family and case manager to plan for my discharge”.

“From the time I went into hospital they kept talking about which day I was going home.”

Clare has many stories which she says show a system that has failed her but she is able to see that there has been some positive improvement.

- Clare is seen quickly and provided with information about her treatment and care in the Emergency Department.
- She quickly gets transferred to an appropriate hospital bed.
- Clare is not in hospital for as long as she has been in the past.
- The acute staff and her case manager work closely to allow her to leave hospital as quickly and safely as possible.



Clare had a meeting with the Dr and Nurse from the hospital, as well as her family and case manager to plan for her discharge.

Clare's receives much more information about her condition and treatment.

Reference

For more information about Mental Health Discharge Planning visit the Models of Care section of the ARCHI website www.archi.net.au

Here you will find an electronic copy of this document, resources and have the opportunity to participate in online discussion groups.

NSW Auditor General, 2005. Emergency Mental Health Services: NSW Department of Health, The Audit office of New South Wales.

