Case study: Urgent Care - Manaaki ohotata Service Level Alliance using data and small working groups to make a big impact

Case study series

This case study series demonstrates how we work collectively, by documenting critical elements from the alliance model that have led to positive outcomes. These elements include partnership / relationship building, use of data in decision making, engaging with communities and working towards equity.

The Urgent Care Service Level Alliance (SLA) is made up of a motivated, dynamic and skilled group of people from across the health system who use data to inform decisions and predict pressure points and bring together small working groups to delve into issues and make adjustments to the system. This work can have a big impact on our community. This case study explores the key elements of this group's success.

Key elements

Diverse mix of people, who have the mandate to make changes and adapt quickly
Many of the SLA members are leaders and decision-makers from across the health system and beyond, so they have the mandate and knowledge to make change and adapt quickly to shifting situations. The Chair has always been strong and skilled to ensure the SLA is working system-wide.

Interrogation of data
This SLA dedicates time to look at the data at every meeting to inform their actions and to closely monitor their impact on the system. They do this by having dedicated analytical support, so data can be presented and explained from across the system. This includes data from the Emergency Department (ED), Christchurch Hospital, Primary Health Organisations, ACC and St John.

Small time-limited working groups - bringing the right people together quickly
The SLA often sets up small time-limited working groups, so they can take a closer look at an issue or opportunity for improvement. They bring people together quickly, either selected members of the SLA or people from outside the group that have a specific skill set and/or perspective to explore the matter, decide if they are the right group to progress the work and then report back to the SLA. These working groups are identified during most SLA meetings, allowing the group to make the most of their time.

Diverse mix of people, who have the mandate to make changes and adapt quickly

Clear purpose of the Urgent Care SLA

The purpose of the Urgent Care SLA is to develop processes and services across the health system that plans resources to ensure people get the right service, at the right time. People are supported to stay well in their own home, reducing the rate of ED attendances and hospital admissions.

The group also aims to:

- provide leadership to improve the equity of access to urgent care services;
- support urgent care service providers to implement service models and deliver on expectations; and
- define models to meet the needs of the population and prioritise and reallocate resources across the system as the needs for services change.

"The group members are conscious that things are constantly changing and will often review the outcomes and purpose, so it reflects the work the SLA is doing."

Rebecca Muir,
Urgent Care SLA Facilitator

Methven General Practitioner Dr Gayle O'Duffy, who joined the SLA not long after it was formed in late 2009 providing a rural primary care perspective, believes that the group is a trailblazer both locally and nationally by demonstrating how secondary and primary care services should work together.

Who is on the SLA and what do they bring to the table?

Members are selected not as representatives of specific organisations or communities, but because collectively they provide the range of knowledge, experience and influence required for the SLA to achieve oversight of the whole system.

"We are fortunate to have a diverse mix of people with different perspectives from across the system, including primary care, secondary care, St John, ACC, community services, Non-Governmental Organisations (NGOs), pharmacy, urgent care services and Planning and Funding, as well as a consumer and up until August 2020 an ALT member who was also the Chair.

Many of these members are leaders for their services, so they have the knowledge and are in a good position to suggest changes and provide contributions at the table," says Urgent Care SLA Facilitator Rebecca Muir.

Gayle says, the group has strong leadership and is really connected with a large number of players that come together and are very frank and honest in their talking.

"There is a strong focus on prevention, so we need to have everyone involved to ensure the whole system works together to help prevent people from needing acute care, for example one of our first projects involved working with St John, primary care and secondary care to develop protocols for Ambulance Officers, which ensures patients with Chronic Pulmonary Obstructive Disease are treated in the best place, which is often not hospital. It great to have such strong input from clinical people and ACC to work on preventative care," says Gayle.

Other important roles include:

- a **Planning and Funding perspective** who can provide data, 'bring it to life' and support the SLA to navigate funding pathways;
- a strong **Chair** to ensure people think system-wide; and
- a **Facilitator** to connect with the members of the SLA and ensure the small working groups get together in a timely manner and progress work.

"Each member has a preferred method of communication, so I adapt how I connect with them, for example face-to-face, text or email," says Rebecca.

Interrogation of data

"One of the pleasures of this SLA, is that we are incredibly data driven and data rich."
Dr Greg Hamilton

The SLA sees having a **Planning and Funding perspective** as really important, particularly with the connection it gives them to the data. "They can bring up the data at each meeting for interpretation and telling the story about what the data is showing us. This helps the members of the group who have various levels of understanding of the data," says Rebecca.

Dr Greg Hamilton has been the Planning and Funding member of the SLA since its inception in 2009. Until July 2020, Greg was the Planning and Funding Team Leader for Intelligence and Transformation, which largely supports system change and uses data to help do this.

The groups' working relationship with Planning and Funding has been integral, because it had given us permission to think outside the box and try news things." says Gayle.

Data is key for this SLA

Each meeting involves a session to explore some elements of data.
There are two parts to this process:

- They look at what has been happening in the system and whether it is **reflected in the data.**
- They look for **opportunities** together and start thinking about how they can do things differently.

"This process means it doesn't come down to the strongest voice or opinions in the room. We have a look together to see whether there is an issue that parts of the system are seeing, and if it needs to be explored more deeply. This is when a smaller working group may be set up," says Greg.

Where is the data from?

The data comes from different parts of the system, but the data from the hospital (especially ED) is collected routinely and has lots of depth, so the group spends more time on this.

They also look at community data from Primary Health Organisations, St John and ACC. This gives them more insight to what is happening across the system.

"There are a range of tools, some of them are static and some of the hospital data tools allows us to drill down and answer questions in real time during our meetings. This is really important, because we can follow the train of thought of people in the room who have good ideas, and narrow it down using the data to what is really important," says Greg.

The group use a live data tool called 'Signals from Noise," which follows data over time and looks at what is a natural variation and what is actual change. The different perspectives across the SLA can help to explain these changes. They also use an analytic platform called Tableau.

"This ability to answer things on the spot, is part of a discovery we all have together and this is what brings the data to life."

Using data to make decisions, identify opportunities and drive changes

"We are really looking at the data to see why these patients have ended up in hospital, sometimes acutely unwell and whether there are opportunities to change community services, so people can be cared for in their own homes. Therefore, we are looking at the data from a reverse or preventative perspective," says Greg.

For example, last year the SLA looked at how many times people with long term/complex conditions were in and out of hospital over winter. The group explored whether they were getting the services they needed in the community and asked if there was more they could do to reduce or prevent their visits to hospital.

"Obviously their health journey was not great, so we proactively made plans and took steps to provide them with more support in the community over the winter months, such as a funded Winter Wellness Check with their general practice."

"After winter we looked at the data again, which showed a slight decrease in hospital visits, but not substantial, so this tells us we need to try other things. This year there has been a focus on supporting people with Chronic Obstructive Pulmonary Disease (COPD), including the use of Shared Care Plans." (For more information about this work refer to the small group examples on page six.)

"There is a lot of clinical input in this group and with the use of data and our relationship with Planning and Funding, we can safely experiment with ideas. You have to have failures to show you have tried lots of things," says Gayle.

"Over time we have matured in how we have approached data - we are more organised and better at making linkages with other services and people."

What have these decisions or changes meant to the patient?

The ultimate goal for the Urgent Care SLA is to help support people to stay well in their own homes with proactive and planned care.

"If you are looking at it from a patient perspective, they will notice that over the year they didn't have to go to hospital as often, because they had some planned care in place. In some ways it's more about what didn't happen – the iceberg missed," says Greg.

How does the group examine the data?

The group displays the data on the projector at each meeting and allows some free-flowing questions, so it's not all planned.

"When I first started we used to go away and work really hard on how to present the data to the group, but it seldom answered the questions the group had and we had to go away again and find more data and so on. This way left some members feeling we only found data to prove a certain point we had," says Greg.

"We now discover together as a group and everyone has their perspectives and they can ask questions and we try to answer them as we go and solve issues. If something needs more investigation we can ask a smaller groups to have a closer look at it, because we can't solve everything during the meeting."

"Data informs how we tackle things. There is a lot of problem-solving with clinical knowledge in this SLA. Those involved are comfortable with data or have become that way over time," says Gayle.

Use of data to pre-empt need

The group has become well-versed at looking for variation and what doesn't look normal in the data.

"For example, we have seen interesting variation occurring on public holidays and when the weather is cold. Having the SLA group look over this data can generate lots of new questions not just about the data, but what can be done differently next time this happens," says Greg.

Reduction in ED attendances and hospital admissions

The Canterbury Health System has worked hard for many years to ensure our population is cared for in the community. The Urgent Care SLA is part of this work, but not the only contributor.

This work means that if you live in Canterbury, you are:

- 25% percent less likely to end up in ED than other people in New Zealand;
- And nearly 30% less likely to end up in an acute medical bed than other people in New Zealand.

"Which means the care provided in the community is of a really high standard, and it's indicative of a system that works really well together," says Greg.

> "Is the job finished? No, there is more we can do and that's why we keep coming together."
>
> Dr Greg Hamilton

Equity of access to urgent care services and how data is used for this

"Equity remains at the heart of what we do. We have had higher rates of Māori and Pasifika people attending ED for a long time, so addressing this is a focus of everything we do," says Greg.

"Compared to other parts of the country there is a lower differential between Māori and non-Māori in terms of acute hospital admissions."

One of the reasons for this is the Acute Demand Management Service, which works closely with the SLA. The service treats people in their own home to help prevent them needing hospitalisation. It can be seen in the data that this service is used by Māori at a higher level. This is due to the service being needs-based and Māori on average have higher needs.

"This is a great example of why we don't have the same level of inequity than other parts of the country, but there is still work to do."

"For Pasifika it is less positive, because we have higher acute admissions, which is why we (Canterbury DHB) are partnering with Pasifika Futures, which is a Whānau Ora agency, to work on social and health wrap around services for this population."

"We are starting to see progress, for example acute hospital admissions for upper respiratory infections for Pasifika children is reducing, because we are addressing the determinants of health in a more holistic way."

"We are always searching for differentials in the data; and when developing a new service we are always looking for opportunities to close the inequity gap. It's progress and it's central to our thinking."

Flexible and responsive

"The time we spend on data helps us determine our areas of focus. We then either use the knowledge / experience of the group members to resolve issues during the meeting; or we set up a working group to explore it further. These groups then respond fairly rapidly to determine a plan or recommendation," says Rebecca.

Small time-limited working groups - bringing the right people together quickly

If an issue is identified in the SLA meeting, rather than spending too much time on it, a small time-limited working group is often set up to dive deeper into the issue.

These groups are often identified through a data session or from an issue that has been brought to the SLA's attention by one of their members, which highlights an area that needs to be explored further to see if changes can be made to improve processes and/or services.

"Members of these small groups become involved because the work aligns with their area of work, interests and/or connections they have across the health system. They either volunteer or are invited to join, and are not always members of the SLA, as we often look wider to ensure it's a system-wide response and the right people are involved," says Rebecca.

"The small groups move quickly; within a few weeks they come together to identify what work is needed and if they are the right fit, or if it should sit elsewhere."

Either way, the group is responsible to ensure the work is completed and they then report back to the SLA at the next meeting.

Small group examples

During the February 2020 SLA meeting there was a concern discussed around the amount of mild to moderate Chronic Obstructive Pulmonary Disease (COPD) exacerbation admissions to hospital.

A small group was set up to see if these patients could be cared for in the community and as close to home as possible. The group used data to identify patients at risk and provided these lists to the relevant general practice teams. The practices were encouraged to contact these patients to provide preventative and proactive measures, such as COPD Blue Cards (self-management plans) and shared care plans, including acute plans and advance care plans.

Another example, which came about during the COVID-19 response, was a virtual ward concept. A presentation was given at the SLA May meeting about a virtual ward process, which was set up to manage COVID-19 positive patients in the community. The concept was designed to enable rapid decision making to expedite hospital admission if needed, review patient conditions/progress and prevent any rapid deterioration in the community. It was a structured process that saw good collaboration between primary, secondary, community and public health and the acute demand management service. A small group was set up to see and identify opportunities and key areas this concept could also be used. This work is ongoing.

"This SLA is one of the favourite parts of my work, because you feel like you are getting something done and that you have made a difference," says Gayle.

Maturity of the SLA

"I think one of the successes of this group is the length of time it has been working together. Sometimes it can take a while for people to have trust in what you are doing. You actually need to make a few steps forward before people will engage with you and get going," says Gayle.

Communication is key

"We weren't quite sharing the same messages before, but we have now got to a point where we are all, 'singing from the same song sheet. It can also be easy to lose traction, so we must constantly refresh our messaging," says Gayle.