Ambulatory Care Sensitive Condition (ACSC) Pathway Transformation

Cardiff and Vale UHB

Summary of the Project

- Building on priorities identified within cluster plans, with a focus on unscheduled care, develop a set of **evidenced based pathways** that will support patients **more safely** and **closer to home**
- **8** pathways identified through cluster priorities and previous QP evaluation
- 59 of 66 practices signed up (**89%**)
- Software developer commissioned to develop **templates** for each pathway to be embedded in to the practice clinical system
- **Audit** process developed in line with **key process and outcome measures**

Why was it chosen

What problem are we trying to solve?

- Reduce secondary care bed days for ACS conditions
- improve access to services closer to home
- proactive and evidence based management in community settings

Background

Ambulatory care sensitive conditions (ACSCs) are conditions where effective community care and case management can help prevent the need for hospital admission. Even if the ACSC episode is managed well, an emergency admission for an ACSC is often a sign of the poor overall quality of primary and community care.

- Estimates suggest emergency admissions for ACSCs could be reduced by:
  - **8 – 18%**
  - Saving **£96-£238** million *(The Kings Fund, April 2012) or*
  - **£6 to £15** million Wales

Building on priorities identified through cluster plans and previous QP work initial evaluation demonstrated:

- an overall reduction in bed days by **3,054** (2012-2014)
- significant reductions in key ACS areas: **COPD by 32% AF by 22% HF by 21%**

What would Success look like?

- More care provided locally
- Improved access and quality of care for patients
- More patients are managed locally in Primary Care through evidence based practice, with the most appropriate staff being used to manage patients in a planned environment.

What are your Process Measures?

- Process measures are made up of key indicators within each pathway
- Each “care bundle” is made up of read-coded events.
  - Diabetes
    - patients have a self management plan
    - Patients have been referred to a structured education programme
  - Polypharmacy
    - Patients have been risk assessed (using FROP-COM scoring)
    - Patients have received a medication review
  - AF
    - CHA2DS2-VASc CVA risk assessment
    - HAS-BLED risk assessment
- As these events become part of a standardised process (or “pathway”) management of conditions in the community will improve

What will be your Outcome Measures?

Quantitative Data

- Reduce morbidity and mortality (caused by the ACSC pathway conditions)
- Reduction in ACSC bed days
- Reduction in USC attendance for ACSC conditions
- Reduction in condition specific bed days:
  - AF
  - HF
  - COPD
  - Diabetes
  - ACP
  - Falls Related to Polypharmacy
  - Dehydration and Gastroenteritis in under 5's
  - Uptake of Flu/Pneumovax (At Risk Groups)

Qualitative Data

- Capturing Patient Experience in Phase 3 onwards
- Consulting with Practice Managers and Clinicians for user experience

What are your Outcome Measures? Cont.

- User experience
  - "Pathways are clunky and difficult to use in consultation"
  - "Did we consider a gradual roll out?"
  - "Pathway templates should have been right first time. Were they tested?"
  - "How will participation in the pathways be audited?"

Will you have any Balancing measures?

Other work being undertaken which may impact on outcome measures identified for this scheme:

- Prescribing Care Home work i.e. medication reviews may also impact on Poly Pharmacy related falls

- Cluster based Diabetes Specialist Nurse being introduced in the South East Cardiff Locality

What did you Learn ? 1/2

What did you learn from this project?

- Ensure clinical and admin support team have clear communication and guidance throughout
- Ensure IT templates are tested for usability prior to release for clinical input.
- Ensure clarity when using 2 practice software of guidance and user interface.
- Dealing with different levels of IT expertise from practices – ensure support
- Test environment with clinical, admin and practice manager staff

Is it a project that would work elsewhere?

- *Yes*

What did you Learn ? 2/2

If yes, what resources are available that can be shared with other areas?

- The 8 pathways and appendices

Are there any significant barriers to rollout in other areas?

- Ensure information contained in the pathway is Heath Board specific
- IT issues to ensure compatibility for uploading the documents.

How does it fit with / inform the whole system model for Primary Care in Wales ?

- Ensures a standardised pathway to ensure appropriate and effective care closer to home.

Ministerial Priorities

- **Achieving service sustainability;**

  Decrease unscheduled care attendances, and emergency GP appointments

  Reducing variation and ensuring a standardised approach

- **Improving access**

  A reduction in hospital bed days freeing capacity, a reduction in emergency GP appointments making the most effective use of available capacity by the most appropriate Health Professional

- **Moving services out of hospitals into community settings**

  More care will be provided locally via GP practices through a MDT approach to manage ACS conditions.

Next Steps 1/2

What do you plan to do now in relation to your project?

- Baseline reporting is being conducted – this will include primary and secondary care specific data
- 1st audit report in October to be deployed for results between 1 April – 30 Sept 2016
- Feedback reporting from practices on use??

Any major barriers to these plans?

- Relationships with practices currently engaged - due to template issues there has been negativity surrounding the delays.
- Unexpected IT issues may cause further delays
- Timeframes for reporting
- Work with practices not participating in the pathway to get a standardised approach

Next Steps 2/2

Consider if you feel the data is telling you NOW whether your project is successful or not.

No not at this stage, however this was always going to be a project whereby the results were going to be realised after the life of the project.

If not – what is the earliest you will have the results?

Results of the audit data will still be collected on the dates as previously stated.

What are the benefits of continued funding?

Ensure standardised approach
Patients managing and taking control of their own health and well-being

Discussion – 21st Sept 2016

- 1/6 of all hospital admissions are potential ACSCs
- Potential to reduce admissions by 8-18% by promoting ambulatory care
- Outcome measures - % of patients reaching targets; controls are practices not signed up to pathways
- Commissioned a software developer to link EMIS and Vision / develop templates
- Standardised care bundles and pathways for all 8 ACSCs - can be shared
- Unexpected IT issues caused delays – in process of collating baseline data
- Benefits through primary and secondary care focusing on single condition, through the process of agreeing the pathways and templates; design is critical
- Very powerful to have GP and 2ry care lead; bridging 1ry and 2ry care through cluster work
- Barriers: GP attitude and sustaining interest - esp negative initially on templates and interface with IT systems
- Positive feedback now coming through – keep reinforcing the benefits to patients and GPs
- Need involvement of patients to transform pathways
- Learning to share:
  - Framework around pathways
  - Management support
  - Leadership to give momentum and pace
  - Potential to build on cluster plans
  - Evaluation to demonstrate impact – principles of 'beyond QOF'
- Feedback to practices through dashboard would help to keep engagement, show impact of project and variation across practices. Links with PC measures.