Patient Flow

June 28,2018

Debby Hill-LeBlanc

Debby Hill-LeBlanc
Southwest Manager Utilization/Patient Flow & Staffing
Yarmouth,Digby and Shelburne sites

License Practical Nurse:
- Graduated Burridge Campus NSCC,1990

10 years long term care experience

Leadership Experience:

2000-2007
- Supervisor Alternate Level Care of Unit (previous SWNDHA)

2007-2009
- ALC Manager & Utilization Manager (previous SWNDHA)

2009-Present
- Southwest Utilization/Patient Flow & Staffing Manager, Southwest sites
- Southwest Patient Flow System Lead

Service Area/Scope of Responsibilities

Overall accountability for utilization /patient flow and staffing clerks across Southwest sites

- 3 Acute Care Facilities:
  - Yarmouth Hodspital (Regional site)
  - Digby and Roseway Hospitals (Community sites)
- Responsible for utilization management and patient flow within Southwest area, Western zone, and across community sectors and agencies to facilitate the effective use of system resources and the smooth transfer of patients, clients, and residents between sites, organizations, and community programs.
- Southwest Patient Flow System Lead

Daily Life for a Regional Flow Team

- Over 10 admitted patients in ED with more admissions expected.
- 32 ALC and 8 palliative service inpatients
- Between 2 and 6 same day admission surgeries scheduled and 2-3 expected add on.
- 1-2 cardiac catheter patients returning from QEII.
- 2-4 patients waiting repatriate to regional site but no beds(closer to home).
- 1 new admission for palliative care from community.
- Call from oncology with need to admit patient post chemo.
- Call from renal with need to admit patient who needs admit post dialysis to ICU.
- Call from community hospital to transfer patient for internal medicine consult & ICU admission.
- Call from AP to advise that client from community needs to be taken to ED as can no longer be cared for safely at home.
- Call from nursing home to advise that client with responsive behaviors needs to be taken to ED as can no longer be cared for safely in facility.

AND

- Only 4-5 predicted medical/surgical discharges to start the day.
- Patients in lounges and hallways
- One empty ICU bed

Bed availability remains the main operational focus for flow managers and clinicians on a day-to-day basis within the NSHA.

- We see surgeries cancelled at the last minute due to bed availability
- Elderly loved ones kept on stretchers in the ED hallways for hours or days
- High occupancy rates with patients are in lounges/hallways on inpatient units
- High ALC numbers waiting LTC on our med/surg and Mental Health Units.
- Longer length of stay (adverse complications and more pressures on resources)
- Complex discharge needs

Information Sources

Patient Flow System:
- Appropriate for Service (MET/NOT-MET)
- Readiness for Discharge (RFD)
- Reasons preventing discharge (Organization / Community / Physician)

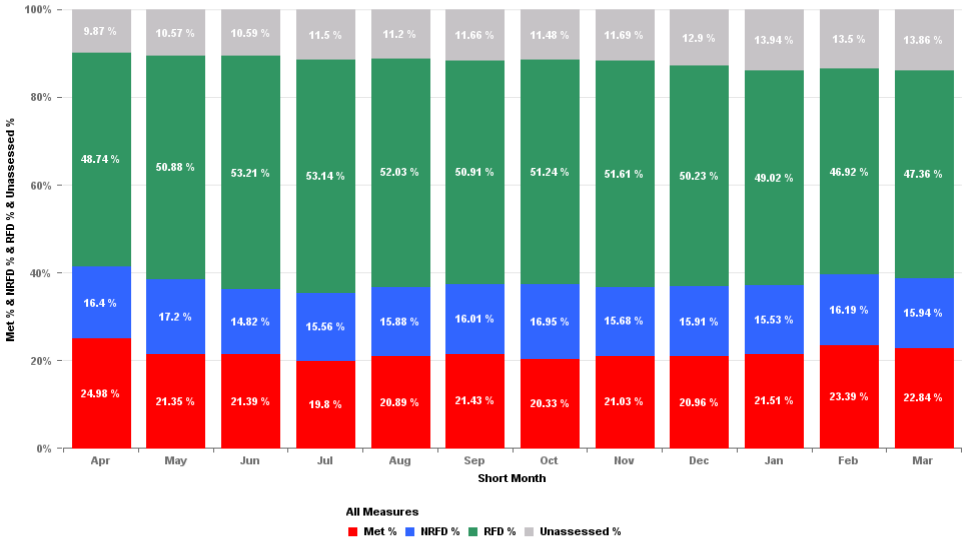
Patient Length of Stay in Hospital:3M(DAD)
- Actual Length of Stay (ALOS)
- Expected Length of Stay (ELOS)

The Medworxx Patient Flow System was implemented on all Acute Medical/Surgical, Intensive Care, and Adult Acute Mental Health Units across the NSHA. It is used to monitor and report on the proportion of patients **appropriate** for the level of service provided in these care settings on a daily basis.

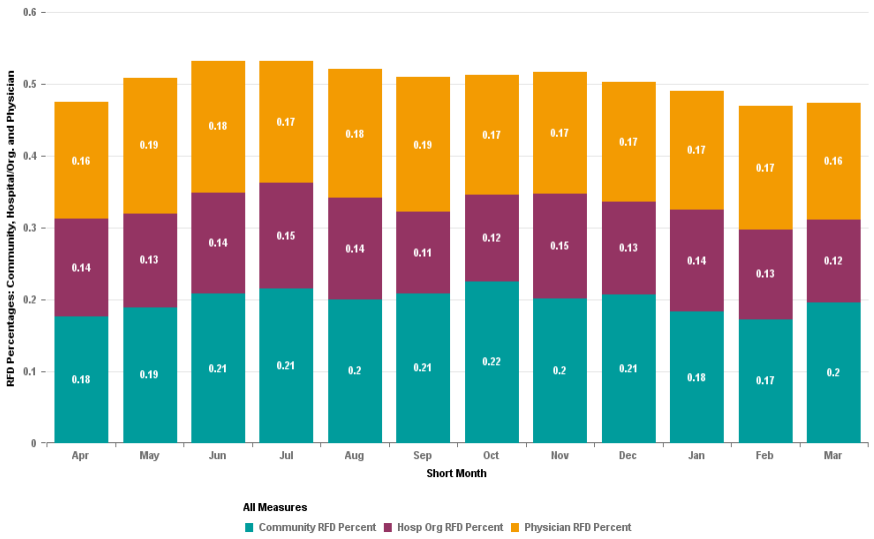
The system also identifies the primary **barriers/delays to transition** to the next appropriate level of care for those assessed to be **R**eady **f**or **D**ischarge (**RFD**)

Definitions:
- **Met** – Service intensity appropriate for patient's care needs
- **Not Met NRFD** – Service intensity different than care needs (not appropriate), but patient not yet clinically stable (**N**ot **R**eady **F**or **D**ischarge)
- **Not Met RFD** – Service intensity different than care needs (not appropriate), and patient clinically stable (**R**eady **F**or **D**ischarge) – RFD days are recoverable days
- **Unassessed** – Assessment was not entered

MET, RFD, NRFD and Unassessed Percentages for 2017-2018, for multiple Criteria Sets



Ready for Discharge (RFD) Percentages: Community, Hospital/Org. and Physician for all Fiscal Years and Quarters, for multiple Criteria Sets



Western Zone Length of Stay -ALOS & ELOS

Institution	Total Cases	Total Days (acute + ALC)	Avg. Total LOS	Avg. ELOS	Conservable Days Total	% Conservable Days	Total Acute Days (No ALC)	Avg. Acute LOS	Conservable Acute Days	% Conservable Acute Days	% of Unplanned Readmits
Valley Regional	26820	175166	6.5	4.8	47,180	26.9%	148359	5.5	20,373	13.7%	4.0%
Yarmouth Regional	15809	152046	9.6	5.1	72,001	47.4%	115910	7.3	35,865	30.9%	4.1%
South Shore Regional	11505	105439	9.2	5.2	45,543	43.2%	91375	7.9	31,479	34.5%	3.3%
Queens General	2633	30577	11.6	5.4	16,434	53.7%	24847	9.4	10,704	43.1%	9.3%
Annapolis Community	743	7139	9.6	5.7	2,937	41.1%	5179	7.0	977	18.9%	2.8%
Soldiers Memorial	495	11100	22.4	6.8	7,747	69.8%	4698	9.5	1,345	28.6%	4.2%
Digby General	234	5135	21.9	19.1	675	13.1%	3457	14.8	-1,003	-29.0%	2.1%
Roseway	206	5489	26.6	7.8	3,889	70.9%	2647	12.8	1,047	39.6%	5.3%
Fishermans Memorial	151	6025	39.9	6.7	5,017	83.3%	1567	10.4	559	35.7%	0.7%
Grand Total	**58596**	**498116**	**8.5**	**5.1**	**201,423**	**40.4%**	**398039**	**6.8**	**101,346**	**25.5%**	**4.1%**

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Common Myths

- Hospitals are the best place to get better
- The hospital unit environments are appropriate and safe for wandering patients or people with responsive behaviors
- People with dementia and responsive behaviors are appropriately cared for in mental health units
- Flow is a Monday –Friday 08:00-16:00 a day job
- Hospitals are well resourced to care for those who need sitters, need assistance with mobility and help with activities of daily living.
- Everyday spent in hospital is productive for the care of patients

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Our Realities

Demand out ways capacity and resources especially in regional centres.

One additional bed space can make a huge difference.

Delayed discharge at the smallest site can have a significant impact across the system of care in maintaining flow (flow in/ flow out (e.g.)Emergency Room overcapacity, EHS, Surgeries, patient outcomes.

Delays with inter-hospital transfers impact access to critical and specialty care

Complex discharge planning needs impact LOS

Concern about provider burnout, high pressured workplace.

Patient experience is challenged (palliative experience in emergency, multiple moves for frail patients)

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The Challenges

- Complex system/ continuum of care– communication, joint planning etc. may be siloed
- An increasing population receiving care are frail elderly, behavior challenges, complex health needs due to chronic illness, cognitive decline and decreasing social supports
- Hospitals serve as a social safety net, etc increasing caregiver breakdown
- Absence of appropriate settings for care; expensive care setting that is not built or staffed appropriate. Cost of an Inpatient acute care bed at a Regional site $1450.00/day and at a Community site $835.00/day.
- Ability to give right care to right patient at right time
- Mobility-mobility-mobility….deconditioning
- Utilization Management four main barriers for discharge: Processing Placement; Hospital Activation; Waiting Community and Social Issues

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Our Ask

- Enhanced collaboration and communication across continuum
- Frailty informed care planning- work together so care happens in the right setting, with appropriate care providers
- Earlier communication and intervention; perhaps transfers can be avoided
- Easier access to resources -who to call in other sectors
- Explore 7 days/week re-admissions to LTC
- Admissions within provincial policy timelines
- Consistent paper work/processes to improve care transitions
- Common language e.g. placement process/ data reporting
- Elimination of home support waitlists
- Elimination of nursing capacity alerts
- 24/7 home support

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The Opportunities

- Improved client experience with better outcomes
- Increase clients knowledge and accountability of their role in own care management
- Reductions in missed care, critical incidents and near misses
- Decrease Emergency Department length of stay for admitted patients
- Reductions in acute length of stay and Alternate Level of Care rates
- Reductions in transfers/moves of frail seniors; timely access to appropriate resources and care setting
- Improved access to resources and services across the health system
- Improved collaborative transitions in care and discharge planning

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Top Priorities for Collaboration & Change

- Earlier identification of care management gaps and modification of community management plans
- Collaborative person-centered care planning for the frail elderly and individuals with responsive behaviors
- Home First Philosophy –home with supports explored before LTC
- Improve access to primary care for LTC residents
- Understand each others realities

When, how & where care is provided is often as important as what care is provided.

Timely access to appropriate care is fundamental to high quality care.

Key Patient Flow Contacts

Vanessa Quigley

Interim Director Health Services, Medicine and Patient Flow and Health System Leader (VRH)

902-679-2657 ext 3611

vanessa.quigley@nshealth.ca

Michelle Ouellette

Patient Flow Manager (VRH)

902-679-2657 ext 25011

Michelle.Ouellette@nshealth.ca

Debby Hill-LeBlanc

Utilization/Patient Flow/Staffing Manager, Southwest sites

902-742-3541 ext 1376

Debby.Hill-LeBlanc@nshealth.ca