Fraser Health Congestion Review Report

April 2012

A joint initiative of:
Acknowledgements

The members of the Fraser Health Congestion Review Panel would like to acknowledge the Fraser Health Board, senior executive, clinical and administrative staff, and physicians of Fraser Health for their time, energy and support in conducting this review. Their experience, expertise and openness gave the panel access to crucial insights and information used to identify opportunities to ease congestion and improve patient flow and quality of care in Fraser Health.

The panel would also like to thank staff and physicians from the BC Ministry of Health, other health authorities, BC Bedline and the BC Ambulance Service (BCAS) for sharing their knowledge.
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INTRODUCTION

Fraser Health (FH) has initiated a wide variety of access and flow strategies in an attempt to address congestion and improve capacity; however, the problem continues. This is of concern to both FH and the Ministry of Health (MOH). This challenge is not unique to FH but is seen nationally and even internationally. There are lessons to be learned from the experiences of other jurisdictions.

In late January 2012, FH and the MOH jointly established a Congestion Review Panel of external experts to identify any additional solutions that the organization may have overlooked to ease congestion. The review was to focus on FH’s two largest congested hospitals – Surrey Memorial Hospital (SMH) and Royal Columbian Hospital (RCH). Although the sites and issues at those sites differ, SMH and RCH operate within a larger, inter-related health system – individuals admitted and treated in acute care settings are eventually discharged and may go home, often with support services, or be transferred to community settings such as assisted living and residential care. Congestion, manifesting as waits for service, may occur anywhere along the continuum of care and usually impacts every other part of the system.

The panel was asked to conduct an independent, objective assessment of the overall congestion situation to:

- Assess issues related to operational flow that adversely affect quality in both RCH and SMH
- Identify and document barriers and remedies to optimal efficiency and effectiveness
- Evaluate current strategies to remedy congestion
- Recommend changes to current strategies to improve access and flow at SMH and RCH
- Comment on whether such improvements would assist in relieving congestion in other FH services, given projected trends

While congestion has become an operating reality, many initiatives to mitigate this are in various stages of implementation. Physicians and staff at FH are passionate about creating positive change. This report presents highlights of the panel’s observations and identifies considerations for improving patient care.

The panel identified six broad areas with findings and considerations that should inform FH’s and the MOH’s future action plans to address its congestion challenges: Focus; Authority & Accountability; Clinical Alignment; Role of Hospitals in an Integrated System; Investment in Community; and Process Design & Improvement.

These considerations are intended to support FH and MOH to build on existing strengths, and develop action plans to ease congestion and improve quality. The panel determined that FH’s current access and flow strategies form a strong base on which to build.
BACKGROUND & APPROACH

The panel explicitly approached this review with quality patient care at the centre of its considerations. BC Patient Safety and Quality Council (BCPSQC) quality framework was the reference point for all of the panel’s work, specifically the following dimensions of quality:

- **ACCEPTABILITY** – Care that is respectful to patient and family needs, preferences and values
- **APPROPRIATENESS** – Care provided is evidence based and specific to individual clinical needs
- **ACCESSIBILITY** – Ease with which health services are reached
- **SAFETY** – Avoid harm resulting from care
- **EFFECTIVENESS** – Care that is known to achieve intended outcomes
- **EFFICIENCY** – Optimal use of resources to yield maximum benefits and results
- **EQUITY** – Distribution of health care and its benefits fairly according to population need

In 2011 FH developed a broad Access Strategy (Improving Access/350 Challenge) to ease the congestion that is most visible in emergency departments (ED). However, solutions to ED congestion often lie elsewhere in the system. FH’s Access strategy has the following components:

- **Adoption of a ‘Home is Best’ philosophy**: returning patients home to continue their recovery
- **Development of new options for community capacity**: moving Alternative Level of Care (ALC) patients to appropriate services outside the hospital
- **Implementation of Pull Strategies, Bed Allocation Methodology and other initiatives** to support patient flow
- **Renewed emphasis on Assertive Discharge Planning** and other systems to promote patient flow and accountabilities

The overarching planned outcomes of these initiatives are to reduce the ALC patient population in acute care and to reduce FH’s Average Length of Stay (ALOS).

The panel worked over the course of eight weeks, reviewed relevant materials and conducted site visits, interviews and focus groups that tapped into the experience and expertise of approximately 500 health care workers, clinicians, managers, physicians, administrators and Board members, as well as individuals from other health authorities (HAs) and jurisdictions. The site visits included SMH, RCH, as well as the Jim Pattison Outpatient Care and Surgical Centre (JPOCSC) and Queen’s Park Care Centre (QPCC), as representative of the larger system challenges.

The panel was not expected to undertake an extensive review of all administrative and clinical processes, data and systems. Analysis or considerations about acute care capacity needs today and into the future were excluded from the terms of reference for this work, as were financial implications. The panel’s primary focus was to assess opportunities for reducing congestion in the shorter term, within existing acute care capacity.

The report is structured into six key areas identified during the panel’s mandate: Focus; Authority & Accountability; Clinical Alignment; Role of Hospitals in an Integrated System; Investment in Community; and Process Design & Improvement.

Each key area features a ‘description’, ‘what the panel learned’ and ‘considerations’, based upon panelists’ experience, observations and opinions, as well as the perceptions of staff, physicians and leaders. The high-level considerations are intended to support FH and MOH to build on existing strengths and develop action plans to ease congestion and improve quality.
FINDINGS & CONSIDERATIONS

1) FOCUS

Description

Organizations that focus on a few strategic initiatives are more successful. The core business of FH is to provide quality, patient-centred care. Quality drives strategic directions, goals and indicators across the system.

What the panel learned

People in FH want to excel. The panel heard repeatedly that, despite everyone's best intentions and despite extraordinary efforts at creativity and innovation, there are too many diverse and sometimes competing initiatives across the organization. This leads to a dilution of focus so these initiatives and individuals do not achieve their intended impact. It is not always clear how initiatives link together to achieve the organization’s key strategic goals. Staff and physicians find focusing on the goals and initiatives challenging as a result. As well, frontline staff and physicians do not relate to the ‘management-speak’ often used to describe various initiatives. It is also compounded by the perceptions that quality costs money and that problems are longstanding and cannot be addressed without more resources (money and/or more beds).

Considerations

- Leaders from both the Board and senior executive need to focus on fewer priorities that cascade throughout the entire organization and maintain an emphasis on high quality patient care as a top priority.

Additional opportunities for improvement that should be considered are:

- Bring more focus to the access and flow initiatives already underway, including detailed plans that strengthen execution, such as goals, performance targets, indicators and time frames.

- MOH and FH need to invest greater time and effort in achieving these goals and ensure the plan is widely communicated and executed.

- Improve timeliness of implementation and sustainability of improvements by: utilizing quick tests of change (e.g. more widespread Plan-Do-Study-Act approach); and applying a more rigorous project management approach (e.g. define return on investment, follow project charter, measure outcomes, etc.).

- Careful thought must be given to the sequencing of initiatives, the burden on staff and physicians, and ensuring the appropriate skills and tools are available.
2) AUTHORITY & ACCOUNTABILITY

Description

The previous section was all about focus. Focus is a priority in every successful organization and is achieved through a rigorous process where roles, responsibilities, accountabilities and authorities are delineated and well understood and there is a clear alignment of authority with accountability to ensure follow through on performance improvements. While most organizations are good at identifying what people are expected to do, they are less successful at holding people accountable for these responsibilities and frequently do not give them the tools, techniques or authorities to achieve them.

Bodies that serve oversight functions need to ensure members are educated and trained in their roles as quality stewards, including how to measure, monitor and hold organizations accountable for quality patient care.

In high-performing systems, what gets measured gets managed. Solutions often come from within, and those delivering care are involved in defining what should be measured and how accountability should be ascribed. Those with responsibility must be empowered with the resources and authority to follow through if they are to be held accountable to achieve results.

What the panel learned

All health authorities are legally obligated to maintain a balanced budget; however, the balance needs to weigh heavily on providing the best quality care across the entire system within available resources. The panel heard throughout the organization that the financial perspective is prominent and at times overshadows the quality agenda.

It was not always clear by all who was responsible for addressing and resolving patient access and flow issues. This was particularly an issue when patients crossed program/service lines; for example, when patients were physically transferred from one program to another, staff and physicians were unclear who was responsible for managing the transition and ensuring a comprehensive care plan was in place.

The panel observed some instances where patients could be more appropriately managed – for example, through discharge to community settings or expedited management in hospital – but, at times, it was difficult to ascertain who had the responsibility and authority to enforce the necessary action, including the role physicians were taking in preventing inappropriate admissions and/or expediting appropriate hospital discharge of their patients.

Everybody has a role to play in reducing congestion, including direct clinical programs as well as all support portfolios.

Care providers expressed concern about the quality of care they could provide to patients in overflow situations but had a sense of resignation about these conditions as intractable. As a result, energy seemed to be taken up by managing “hallway-appropriate” patients. Committees can be set up purportedly to deal with a specific issue such as patient flow and end up taking on a life of their own and consuming a lot of time and energy, with questionable results.

Organizational structures have their advantages and disadvantages. No single organizational structure is the right one; each has strengths and areas of weakness that must be managed. FH is organized into programs, a structure that brings many benefits to a large, multi-site organization, although site responsibility and accountability was unclear. Reorganization diverts energy and is a serious distraction to organizational performance.
A notable success in FH is in the provision of high-quality and efficient Mental Health and Substance Use services. Strong program management, clinical leadership and clear authority for the full continuum of services have allowed these services to achieve excellent patient care outcomes, despite ongoing pressure for service from a growing population.

The current implementation of FH’s Quality Performance Management System (QPMS) should be effective and the panel believes this is a strong move in the right direction.

Considerations

Some opportunities for improvement that should be considered are:

- Continue quality and patient safety training for governance to ensure access to professional development in quality and safety knowledge and skills throughout the organization.

- Deploy the QPMS more rapidly across all programs and integrate physician scorecards into QPMS. These will identify clear expectations for all programs, services, units, etc., for supporting quality patient care, access and flow.

- Ensure all portfolios and services are aligned to support access and flow as a strategic priority; for example IMIT, HR, Communications, Strategic Transformation Team, etc.

- Develop stronger clinical and physician leadership at the site level, with appropriate authority and accountability, to align with program management and optimize site functionality.

- More clearly define responsibilities and accountabilities of physicians for quality patient care, including patient access and flow.

- Review and clarify the roles of the committees supporting patient access and flow.

- Review the role of the Clinical Capacity Portfolio to ensure that there is clear alignment between accountability and authority for the intended outcomes.
3) CLINICAL ALIGNMENT

Description

Clinical alignment means providing the right services in the right place by the right provider at the right time, and aligning policies, procedures, processes and practices to support this approach.

What the panel learned

Silos occur in health care across structures, professions, disciplines, services, facilities, etc. Regardless of the silos, inappropriate variations in clinical practice need to be eliminated to improve and sustain quality care. Adoption of standard order sets, Clinical Practice Guidelines (CPGs), Care Plans, and Required Organizational Practices (ROPs) will help achieve these outcomes. The provincial clinical care management program currently being implemented reflects this need across the province.

The implementation of the National Surgical Quality Improvement Program (NSQIP) is an example of a well-implemented and well-managed quality improvement approach.

Fraser Health is a provincial leader in work on advance directives and End of Life (EOL) Care.

A number of areas were identified that may represent opportunities for improving access and flow:

- The number of emergency department patients who are admitted for less than 24 hours.
- Medicalization of elderly patients (e.g., sliding scale insulin/chest tubes/long-term Total Parenteral Nutrition or TPN ) means these patients have to stay in hospitals, as residential care facilities currently do not offer this level of care management.
- Scheduled outpatient intravenous therapy provided in emergency departments.
- Limited number, and inconsistent use, of care pathways, CPGs and order sets.
- Medication reconciliation on discharge is not routinely done, nor is a community-based medication review.
- High-volume, low-acuity activities are occurring in RCH and SMH emergency departments that could be more appropriately managed in outpatient facilities or primary care locations.
- Physician priorities and practices are not always aligned with optimizing patient flow; for example, holding beds pre- and post-procedures and doctors running late cause delays in surgeries.
- Financial incentives are not always aligned with optimizing access and flow and can result in unintended consequences.
- The process for allocating surgical slates to optimally meet urgent and unplanned needs was not clear. Days spent waiting for care within the hospital has been shown to negatively impact recovery and return to function, and prolong patient discomfort and anxiety.
- Priority overall is given to admissions, not to discharges. For example, hospitalists give admissions priority over discharges, resulting in discharges either being deferred or completed late with a greater length of stay. In addition, physicians who are unfamiliar with patients they may be asked to discharge may hold them longer than those who know the patient history.
- Palliative care patients are remaining in acute settings, instead of at home or in a hospice setting, based on a number of factors, including:
  - Reluctance of physicians to designate patients as palliative.
Family physicians have information on advance directives and patient end of life preferences in their information systems but this is not available to the health authority staff and physicians to assist in treatment and decision options.

Provincial per diem co-pay policy for hospice and home support services is perceived to be a deterrent to families. There is also a significant administrative burden in completing co-payment forms.

**Considerations**

Some opportunities for improvement that should be considered are:

- Provincial policy issues that are identified as possible impediments to this shift should be referred to the MOH for immediate review; for example, Pharmanet access for outpatient clinics.

- Ensure that clinical services are aligned with the quality agenda. For example:
  - Explore relocating CTAS 4 and 5 patients to outpatient locations or primary care.
  - Fast track root cause analysis of patients admitted for less than 24 hours at SMH and RCH.
  - Fast track implementation of, and adherence to, standard order sets, CPGs and care pathways and medication reconciliation – using existing evidence-based models and tools, rather than creating new tools – including Medical Orders for Scope of Treatment (MOST), provincial advance directive policies.
  - Identify processes for improving the timeliness of access for patients requiring urgent surgical services.

- Extend the community approach of ‘patients as partners’ to the hospital setting, and develop consistent messaging for patients and families regarding expectations for care and discharge based on care pathways.

- Fast track the hospital bed recovery plan to optimize physical space.

- Continue review of the deployment and performance of the hospitalist service.

- Continue to explore practical options to improve the relationship and communication between hospitalists and family practitioners to support prevention of admission and facilitate earlier discharge.

- Work with MOH to facilitate optimal use of clinical assistants, nurse practitioners and others.

- MOH to examine co-pay policy and administrative burden of completing palliative co-payment forms.
4) ROLE OF HOSPITALS IN AN INTEGRATED SYSTEM

Description
Acute care hospitals operate within a larger health system. Addressing congestion in acute care requires attention to all aspects of the health system. An integrated health system provides the right care, in the right place, by the right provider, at the right time. It is supported by continued improvement of processes, policies, technologies and resource allocation to ensure quality patient care. Partnering is an important attribute of an integrated health system.

What the panel learned
With multiple facilities and programs, FH faces challenges with coordinating patient care across the system.

The role of each hospital is not always clear to staff and physicians. For example, RCH is both a community hospital for the local area and a tertiary referral centre for FH. Staff and physicians repeatedly referred to the need to re-examine the role of this acute care site within the context of the rest of FH and the Lower Mainland.

There is more potential to use Queens Park Care Centre (QPCC), and the Jim Pattison Outpatient Care and Surgical Centre (JPOCSC) capacity to alleviate congestion in RCH and SMH is not being fully realized. Barriers, real or perceived, are cited to using QPCC and JPOCSC, but the panel believes many of these barriers can be overcome with input from staff and physicians.

Considerations
Some opportunities for improvement that should be considered are:

- Complete the work associated with clarifying hospital roles across the system.
- Expedite the planned FH review of ambulatory care, with specific focus on shifting any services at RCH and SMH that could be relocated outside these sites, especially to the JPOCSC.
- Re-examine implementation of and adherence to the higher level of care protocols to ensure appropriate cases are referred and repatriated.
- Continue to strengthen and broaden FH partnerships with community organizations and other health authorities to optimize the patient experience across the continuum of services/care (e.g., seek partners to work with FH in streamlining care, such as BC Bedline, BC Ambulance Service).
- Consider a plan to deliver tertiary services (e.g., neurosciences, trauma, etc.) for the Lower Mainland, in conjunction with other health authorities, to ensure optimal patient outcomes.
5) INVESTMENT IN COMMUNITY

Description

MOH has set the goal of meeting the majority of British Columbians’ health needs with high-quality primary and community-based health care and support services. Evidence suggests primary and community care are best suited for aging populations with an increasing incidence of chronic disease, and can play a critical role in improving health and reducing the need for emergency department visits and hospitalizations. Increasing access to family doctors and linking patients to other community services, such as home health and community mental health care, will improve quality and better support patients, their families and caregivers. FH can improve quality and ease congestion by increasing its focus on care in non-hospital settings.

Improvement in quality patient care does not rest solely on bricks and mortar solutions. Investments in community services, such as home and community care and other elements of community integration, will have a positive impact both short and long term on the patient experience and relieve pressure on acute care.

What the panel learned

The national and global trend in health care is to focus on bringing services closer to home. Staff and physicians made a number of observations about care in the community:

- FH has the lowest per capita investment in community health services of all the health authorities in BC.
- FH has increased services in community programs through the use of process redesign (LEAN), care standardization and skill mix redesign to deliver higher value within existing resources.
- FH currently has limited options for after-hours care; most services are provided Monday to Friday, 8 am to 4 pm. This is not unique to health systems, which are designed to deliver services 9-5, in a 24/7 reality.
- ‘Home is Best’ was viewed as an initiative belonging to the Home Health program delivering specific services, rather than as an overarching philosophy about every program’s role in supporting patients to return home to continue their recovery and to remain safely at home and avoid further hospital admissions.
- Barriers were identified that hinder optimal use of community-based settings; for example, co-payments for services; parking fees; lack of transportation such as shuttle buses between sites such as JPOCSC, SMH and RCH.
- Partnering with family practitioners and the Divisions of Family Practice in the community was identified as an opportunity to help mitigate demand for acute care services.

Considerations

Some opportunities for improvement that should be considered are:

- Examine additional opportunities to invest in community services to support access and flow.
- Minimize barriers to optimal use of community resources.
- Expedite initiatives contained within FH’s community capacity plan, including expansion of community services, such as home health services and residential care and assisted living.
- Explore the benefits of expanding contracted residential care providers to accept new admissions during extended hours, seven days a week.
• Expand community services to enhance the ability to accept patients over extended hours, seven days a week.

• Expand the capability to support higher acuity patients in the community, with services such as rehab, enhanced nursing support, etc.

• Continue to support the Divisions of Family Practice in the identification of initiatives to improve community capacity.
6) PROCESS DESIGN & IMPROVEMENT

Description
High-functioning health systems have a deliberate strategy for understanding, mapping out and optimizing processes to create value for patients. While there may be a stepwise approach to achieve this strategy, the ethic must be embedded within the entire organizational culture to sustain advances in a continuous improvement cycle. Different terminology is used to refer to this process, such as LEAN, Total Quality Management (TQM) and Business Process Redesign.

What the panel learned
Like other industries, health care organizations around the world are focused on analyzing their processes with a view to continuously improving the patient experience and creating value for money for the customer who is both a patient and a taxpayer. As an example, Saskatchewan has adopted LEAN as a province-wide strategy.

The panel heard that there are opportunities for process improvement across the FH system:

- Some processes are not well defined or understood.
- Numerous process delays were identified, such as bed cleaning, handovers between providers and services, waiting for investigations, physicians, allied health, patient transport, etc.
- Patients are being moved continuously – within and between sites – as a result of the congestion; this has become a long-established pattern of operation.
- Many processes vary widely by site.
- Numerous bed management meetings take up a considerable amount of valuable time, with staff moving from meeting to meeting and little actually being achieved. Physicians rarely, if ever, attend and little authority is invested in individuals to move forward decisively.
- Patient flow and discharge planning processes (among others) deteriorate when people are operating under stress (overcapacity) but these occur even in times of lower congestion.

Considerations
Some opportunities for improvement that should be considered are:

- Strengthen the ongoing use of process redesign with particular focus on engagement of frontline staff and physicians. Support staff and physician training in process improvement (e.g., LEAN) and change management across FH to sustain process improvements.
- Fast track the implementation of the Medworxx Bed Optimization System.
- Accelerate implementation and improve sustainability of the discharge processes; identify and work to minimize numerous delays, which are causing significant consumption of clinical resources.
  - Develop and ensure compliance with a standard discharge time policy.
  - Explore opportunities with MOH pertaining to nurse-led discharge or other innovative approaches.
  - Fast track development and implementation of new care planning tools.
- Rationalize the number of bed management/flow meetings to maximize staff and physicians’ time and improve effectiveness. Key physicians should attend these meetings, and the focus should be on discharging patients. The number of ‘pending’ discharges should be reduced/eliminated by taking the required actions to change these into actual discharges.

- Minimize patient movement to the level required to maintain optimal flow into and out of specialty services, while still maintaining high-quality care.

  - Rationalize the number of meetings and/or committees with a focus on patient-centred care, improved access and flow.
  
  - Involve clinicians, frontline staff, physicians and others affected in process redesign initiatives and hold them accountable for their success.
  
  - Continue to implement process redesign at SMH, as part of the planning for the new tower.
  
  - Examine the availability of inpatient services resources, such as rehab, lab, imaging, social work, specialist consults, in terms of supporting patient flow.
  
  - Work with the MOH to identify and address the potentially unintended and negative consequences of policies/procedures that can inhibit smooth, efficient patient flow. For example:

    - Residential care, home support and hospice co-pay policies.
    
    - Lengthy care assessments that involve a significant diversion of clinical time to administrative paperwork.
SUMMARY

The panel’s primary objective was to evaluate Fraser Health’s current congestion strategies and to recommend any changes that would improve access and flow at Royal Columbian Hospital and Surrey Memorial Hospital, and by extension, throughout the network of hospitals and community service in Fraser Health.

The panel did not identify any significant gaps in Fraser Health’s access and flow strategies. While the strategies appear sound, the panel has presented considerations in six key areas that could help Fraser Health expedite their implementation.

The panel has not presented any specific actions. Solutions to ease congestion lie within the organization by building on the strengths, skills and knowledge of staff, physicians and leaders. With attention to the congestion as a priority, Fraser Health has the ability to move forward with appropriate and sustainable changes that will ease congestion and improve patient care. The panel understands that some changes could be difficult and complex, requiring significant energy to ensure success.

It will now be up to Fraser Health, in partnership with the Ministry of Health, to review and assess the panel’s findings and considerations and to create action plans to address specific considerations it believes have merit in the short and medium term. The beneficiaries of the successful implementation of these action plans will be the patients, clients and residents in the Fraser Health region, as well as the staff and physicians who deliver care and services.
APPENDIX A: FH CONGESTION REVIEW PANEL MEMBERS

- Lillian Bayne, Facilitator
- Janet Davidson
- Dr. Mark Matthews
- Donna Towers
- Dr. Kelly Barnard, Ministry of Health
- Barbara Korabek, Fraser Health Authority (until March 15, 2012)