Patient Flow and Care Transitions Strategy 2013-2018

Updated September 2014

island health

Introduction

Island Health's Patient Flow and Care Transitions 2013-2018 Strategy builds on the existing work within the organization to address access and flow for all patients across the continuum of health care needs and services, and sets out a framework that will underpin further development over the coming years. Improving access to services and optimizing transitions in care for our patients requires strategies and improvements across the full continuum of the health system, and this is the foundation of the Strategy.

Patient flow, access, meaningful transitions and partnerships in care are all integral contributors to quality. By improving flow and access, and ensuring that the full system best meets the care needs of our patients, we will improve patient outcomes and reduce morbidity and mortality. This will have a positive impact on quality for not only our patients, clients and residents, but also on our staff and physicians, as poor patient flow is a key enabler of quality improvement.

Vision and Values

In support of Island Health's vision of *Excellent care – for everyone, everywhere, every time*, the Strategy is guided by our organizational values:

Courage: to do the right thing – to change, innovate and grow
Aspire: to the highest degree of quality and safety
Respect: to value each individual and bring trust to every relationship
Empathy: to give the kind of care we would want for our loved ones.

The Strategy will help focus us further on improving patient flow and ensuring that Island Health patients receive the right care, in the right place, all the time. The Strategy supports our staff and partners to have the courage to contribute to improving the whole patient journey, while respecting and trusting staff to identify and implement solutions to challenging problems. We aspire to having no delays in accessing care, which is what we would want for our loved ones.

Current Context

The need for improvements to access and transitions in care for our patients stems from increasing demand on services from an aging population; more people needing care for multiple chronic diseases and greater numbers of patients and clients with complex health needs.

As is the case in health care jurisdictions across Canada, Island Health continues to be challenged by:

- High hospital occupancy rates of over 100%;
- Long waits in emergency departments;
- High Alternate Level of Care (ALC) rates of over 25% at our community hospitals and over 15% organization-wide;
- Less than optimal turnover of beds; and
- A significant proportion of hospital patient days accumulated by a small number of patients with very long lengths of stay.

Patients identify transitions in care as an area of low satisfaction, and family physicians often do not know their patients are receiving services from Island Health because of poor integration of communications and

information systems. There are significant opportunities to address these challenges by changing the way we work together, and ensuring strong focus on providing timely care for our patients.

This Strategy provides the framework for program-specific and local actions to improve access and transitions in care for patients, including activities such as implementing clinical pathways, clarifying communication and transitions in care processes, identifying provider and care team accountabilities, and ensuring we incorporate *process improvement and waste reduction* into all of our efforts.

Desired Outcomes

It is our expectation that our clients, patients and residents will receive care in the right place, at the right time, and by the right provider. When health care needs arise or change, we want our patients to experience optimal transition between home, community and hospital, while recognizing that health services may be accessed in many different settings with potentially multiple caregivers. While hospital admission may sometimes be required, it should usually be short-term with strong linkages with community providers to ensure patients remain connected to community care options so they can get the care they need in the appropriate setting.

Hospital occupancy is an indicator of how well our health system is functioning, and is a sign of how effectively the sectors and programs are working together. When hospital occupancy declines, we know patients are receiving care in the right place, patient safety and health outcomes are optimized, and adverse events are minimized. As such, hospital occupancy is as much an indicator of how well the community services are functioning as it is about our efficiency within the walls of the hospital.

Based on modeling undertaken in early 2013, Island Health has established a long term goal of **85% occupancy in our acute care facilities**. We recognize this is an ambitious target – but it is important to recognize that this target has been attained in health jurisdictions internationally. To achieve this goal we must see several things happen **concurrently**:

- We must reduce avoidable hospital admissions;
- We must reduce length of stay for patients in hospital; and
- We must reduce the number of Alternate Level of Care cases and patient days.

These goals are achievable with cross-continuum action, close collaboration with physicians and community partners, and by the adoption of the *Home is Best* philosophy across all sectors. Our hospital settings will become less congested, and patient transitions will be smoother and more effective with greater provision of service in less intensive settings, ideally at home or as close to home as possible. Achievement of the target will be supported by a single Electronic Health Record, robust care planning, enhanced primary health care case management – with full engagement of family physicians – a robust suite of evidence-based community services, development of innovative alternatives to acute care, and by managing both acute care and residential care capacity appropriately, proactively and rigorously.

From an operational perspective, outcomes expected to be achieved over the next four years by implementing this strategy will include:

- Increased patient and staff satisfaction overall;
- Health services delivered to patients, clients and residents in the right place – most often outside a hospital; and, most importantly,
- Improved health outcomes for our patients.

Our Accountabilities

Improvements in flow and transitions in care for patients is a key area of focus for Island Health.

Provincially, the Ministry of Health is working with health authorities to develop a system-level patient flow approach intended to:

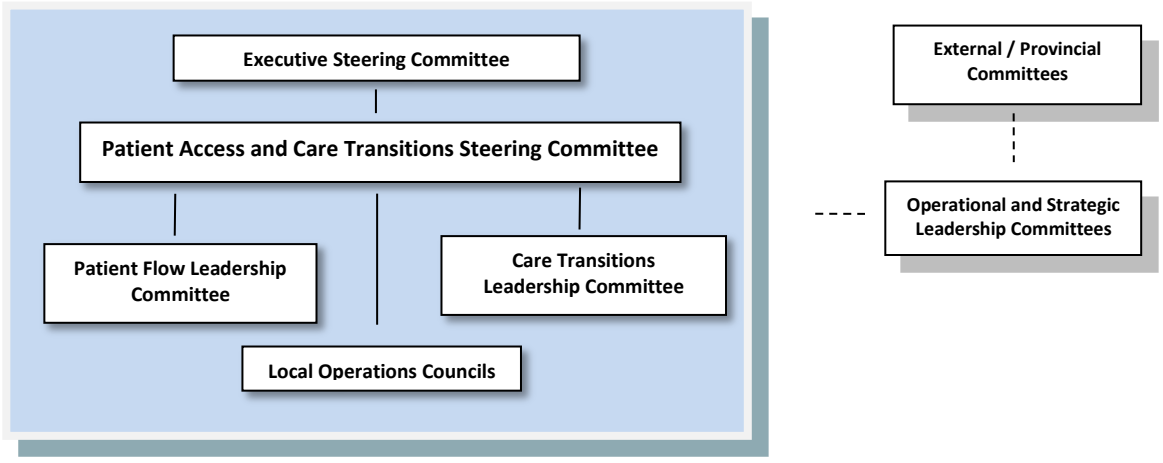
- Reduce the number of patients in non-patient care areas;
- Reduce the time admitted patients spend in the Emergency Department;
- Reduce acute length of stay and Alternate Level of Care rates;
- Reduce the number of postponed medical and surgical procedures due to bed unavailability; and
- Improve discharge planning processes.

Island Health's Patient Flow and Care Transitions Strategy is fully aligned with the Ministry's Key Result Area (KRA) 19, to *increase access and care through improved patient flow within hospitals and between hospitals and communities*. KRA 19 is dependent on KRA 3, which is to integrate delivery of primary and community care services. This is because the desired outcomes are the same: that Island Health residents have access to the medical care, treatment and health care supports they need in the right setting and as close to their home communities as possible.

Governance

Reporting to the *Executive Steering Committee*, the *Patient Access and Care Transitions Steering Committee (PACT)* provides the leadership and direction to support the work required to achieve the desired strategic outcomes. PACT is supported by three sub-committees:

- *Patient Flow Leadership Committee* provides oversight and direction when operational challenges/risks are identified, or when issues arise that are related to capacity management and patient flow within our acute sites;
- *Care Transitions Leadership Committee* provides oversight to strategies and initiatives related to transitions of patients and clients between hospital and community; and
- Local *Operations Councils* are being established to ensure engagement at the local level; the councils have representation from all programs and service areas – including those within acute care, community care, residential care, mental health and substance use, and primary care – with the goal to improve access and capacity within and across acute care sites.



Measuring Success

Island Health's Patient Flow and Care Transitions focus over the next four years will be on our overarching goals:

- **To reduce avoidable hospital admissions;**
- **To reduce length of stay for patients in hospital; and**
- **To reduce the number of ALC cases and ALC patient days.**

The Patient Flow and Care Transitions Strategy will be monitored through several key metrics:

1. Percentage of admitted cases placed in an inpatient bed within 10 hours of triage in the Emergency Department;
2. Hospital occupancy rate;
3. Alternate Level of Care Days as a Percentage of Total Inpatient Days;
4. Percentage of Acute Days used by patients with Length of Stay greater than 30 days;
5. Percentage of Acute Discharges that met Expected Length of Stay; and
6. Rate of admission of people with Ambulatory Care Sensitive Conditions;

In addition, we will use our existing performance monitoring and reporting framework, including the Patient Flow and Care Transitions Scorecard and the Patient Flow Dashboard reports, and continue regular reporting to Executive and the Board. We will also ensure that staff across the health authority are aware of the results this initiative is having – both when we need increased focus on access, flow and transitions for patients, and when we see positive changes occurring.

Implementation

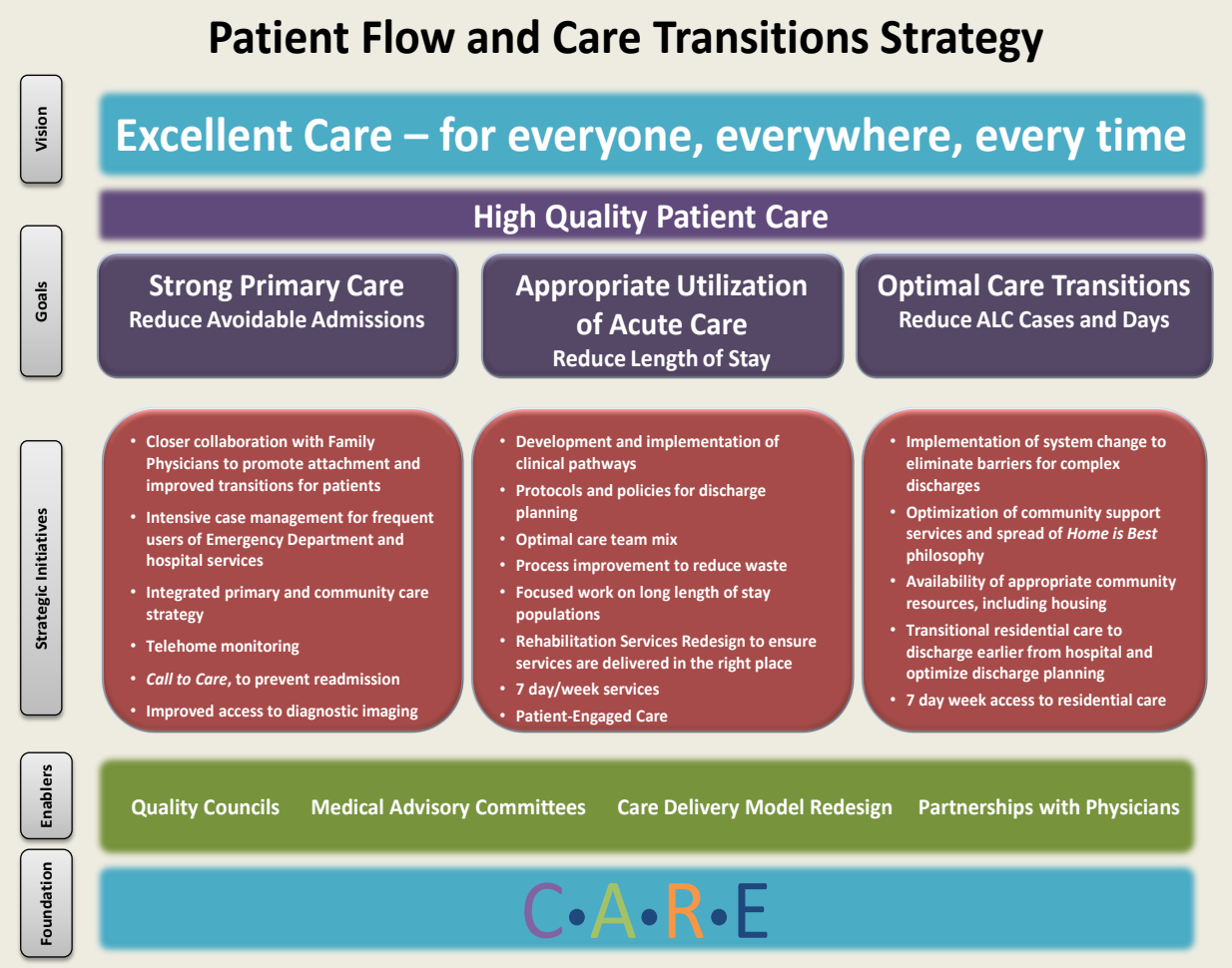
Over the coming four years, it will be essential that the activities we undertake to improve access, flow and transitions in care are focused and evidence-based, with intended outcomes that will support achievement of the strategic goals.

Strategic initiatives will be focused on achieving of the outcome measures, and will be developed and executed through collaboration with physician partners and across all program areas. Island Health programs and portfolios are accountable to develop and implement plans based on this strategic framework, with progress monitored and reported through PACT.

The Strategy relies on implementation of specific clinical and service actions that need to be continued or initiated in the short term, as well as longer term actions to ensure change is sustained and embedded within the organization. Strategic initiatives include:

- Close partnerships with family physicians;
- Development and implementation of clinical pathways;
- Optimal care team mix and improved care planning;
- Focused process improvement; and
- Optimization of community resources, including residential services.

Activities focused on the goals will ensure sustained improvement and continued support of the strategic direction.



Conclusion

Successful implementation of the Patient Flow and Care Transitions Strategy is dependent on coordination among multiple partners in many different program and geographic areas. As the activities are linked across multiple programs, independent and isolated actions are not as likely to have the impact that is needed to contribute to success.

While an ambitious target, an **occupancy rate of 85% is possible in our acute care sites** by:

- Continuing the focus in every program and portfolio on the key deliverables;
- Continuing the full engagement and participation in the Strategy by all staff and partners, particularly those at the front-line who deliver our services; and by
- Changing the culture in which we work – to embed a different way of thinking about the services that our patients, clients and residents require, and where these services are delivered most appropriately.

This Strategy is an organization-wide initiative, and every program and portfolio has accountabilities to ensure that access to services is optimized for people who live in the Island Health region. Island Health is committed to making sure patients get the care they need in the most appropriate care setting for their medical needs, and this Strategy will help us achieve this goal.