Discharge Planning Initiative (DPI)  
(& Complex Case Navigation Project)
Overview

• The Need to Reduce LOS: FM & Surgery
• Objectives & Metrics
• Outcomes to Date
• Re-Engineered Discharge Practice
• Our Challenges
• Our Next Steps
• Recommendations
The Need

- 2007- one of the highest LOS in Canada
- # Admissions > # Discharges
- 100% ++ occupancy
- No standard discharge process
- Gap in continuity of care
- Discharge: key patient experience
- Bed availability for ED volume and acuity
- New renal patient pop (PD & Hemo)
Total ED Visits by CTAS
Sept 2010 - Aug 2011

CTAS Level

ED Visits

CGH
GGH
HSC
SOGH
SBGH
VGH

Unknown
Patient Perceptions about Discharge

• Inadequate notice
• Poor communication and consultation
• Inadequate involvement in arrangements
• Uncertainty around coordination of services
Staff Perceptions about Discharge

- Unclear roles & responsibilities
- Difficulty procuring community services
- General process issues (no EDD, simple/complex, no dedicated tool)
- Lack of education about process
DPI Purpose

To develop an efficient, effective, integrated, and patient-centred approach to discharge planning
DPI Objectives

- Reduce LOS & ALC in FM & Surgery
- Improve weekend rate of discharges
- Reduce bed occupancy by unit
- Improve patient experience
- Reduce delays in hospital care provision
- Improve gap in continuity of care (between hospital & community)
- Pilot new processes and evaluate
Outcomes

- Reduced ALOS by .5 days (FM) & .4 days (Surg)
- Reduced ALC by 65% (FM) & 69% (Surg)
- Increased average # discharges per day
- Reduced delay for therapy services (PT and OT)
- Improved patient experience
- Improved relationship/partnership with community

- No change in discharges by day/week
- FM bed occupancy increased (126%+): ED volumes & renal pop.
## Average Typical Length of Stay: (At Performance Level Benchmark LOS) (Hay Group)

### Yearly Data

<table>
<thead>
<tr>
<th>Year</th>
<th>CH</th>
<th>GH</th>
<th>SOGH</th>
<th>VGH</th>
<th>National Mean</th>
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</thead>
<tbody>
<tr>
<td>2007/08</td>
<td>7.4</td>
<td>6.8</td>
<td>5.8</td>
<td>7.2</td>
<td>4.3</td>
</tr>
<tr>
<td>2008/09</td>
<td>6.9</td>
<td>5.7</td>
<td>5.5</td>
<td>8.5</td>
<td>4.9</td>
</tr>
<tr>
<td>2009/10</td>
<td>5.8</td>
<td>6.1</td>
<td>5.7</td>
<td>6.2</td>
<td>4.1</td>
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</tbody>
</table>
ALC Days as a Percent of Total Inpatient Days (Hay Group):

<table>
<thead>
<tr>
<th></th>
<th>CH</th>
<th>GH</th>
<th>SOGH</th>
<th>VGH</th>
<th>National Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>2008/09</td>
<td>23.0</td>
<td>12.0</td>
<td>28.3</td>
<td>16.2</td>
<td>13.6</td>
</tr>
<tr>
<td>2009/10</td>
<td>18.1</td>
<td>11.4</td>
<td>19.3</td>
<td>16.5</td>
<td>13.7</td>
</tr>
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</table>
% Avg. ALC Days vs Avg. Acute LOS Days

<table>
<thead>
<tr>
<th>Year</th>
<th>Surgery</th>
<th>Medicine</th>
</tr>
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<tbody>
<tr>
<td>2006</td>
<td>52%</td>
<td>56%</td>
</tr>
<tr>
<td>2007</td>
<td>44%</td>
<td>75%</td>
</tr>
<tr>
<td>2008</td>
<td>39%</td>
<td>53%</td>
</tr>
<tr>
<td>2009</td>
<td>9%</td>
<td>29%</td>
</tr>
<tr>
<td>2010</td>
<td>4%</td>
<td>30%</td>
</tr>
</tbody>
</table>
## Pt's Waiting Placement vs. Placed Pt's (July 14, 2010 - October 11, 2011)

<table>
<thead>
<tr>
<th></th>
<th>SOGH</th>
<th>CH</th>
<th>GGH</th>
<th>VGH</th>
<th>HSC</th>
<th>SBGH</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Pt's Waiting (Average)</strong></td>
<td>18.43</td>
<td>14.09</td>
<td>15.55</td>
<td>15.28</td>
<td>8.65</td>
<td>14.17</td>
</tr>
<tr>
<td><strong>Pt's Placed (Average)</strong></td>
<td>4.06</td>
<td>4.22</td>
<td>4.42</td>
<td>4.12</td>
<td>2.48</td>
<td>4.74</td>
</tr>
<tr>
<td><strong>% Pt's Placed vs. Waiting</strong></td>
<td>22%</td>
<td>30%</td>
<td>28%</td>
<td>27%</td>
<td>29%</td>
<td>33%</td>
</tr>
</tbody>
</table>
Total Discharge Per Day of Week
(2008-2011)
Phased Approach

• Phase 1: Complex Case Navigator Project
• Phase 2: Pilot - with PMO
• Phase 3: Re-engineer Discharge Process
• Phase 4: Refining Process: based on outcomes
Phase 1: Complex Case Navigator Project

Who are our complex cases accounting for prolonged LOS:
- CIHI data, interdisciplinary team feedback
- Complex pop many of risk factors identified by “Overstay Study”

What can we do internally to decrease LOS for this population:
- Hired navigator to lead project
- Established consistent and systematic approach to case management
- Provided training and established care targets to guide health care team
- Checklist (early communication with pt and family within 48 hrs)

Learnings:
- Average case management time to complete checklist targets 15.4 days (target 14)
- ALOS remained same during period of project
- Unable to affect LOS
- Final Disposition – Over 50% home (home care 41.4%), remaining PCH, rehab, deceased
- Need to have community involvement

Outcomes:
- DPI integration of learning’s
  - Interdisciplinary approach
  - Case management and integration of care planning efforts
  - Early communication with patients and families
  - Importance of community
Phase 2: Re-engineered Discharge Practice…

- Preparation begins at admission
- EDD with 24 - 48hrs of admission (using ELOS)
- Standardized planning tool/protocols
- Set explicit discharge goals
- Daily Discharge Rounds – nurse led
- Simple = nurse led
- Screen for complex at admission
- Complex Discharge Team (early disposition planning)
- Manage patient expectations: EDD within 48 hrs & throughout stay
Re-engineered Discharge Practice:

- White Boards – patient rooms
- Flight Boards
- Defined role/acct of interdisc team members
- Developed joint inter-agency discharge process & practice
- Bi-weekly Com/Acute Leadership LOS meetings
- LOS & ALC - key performance indicator
Discharge Planning starts on admission or in pre-admission clinic

Admitting nurse performs Discharge assessment within 48 hrs of admission

D/C Assessment Tool ‘Score’ determines pt’s d/c needs as ‘simple’ or ‘complex’

Simple

Nurse-led Daily D/C Rounds (continuity of care, est. date of D/C & disposition)

Change of case status – referral to Weekly Complex Case Rounds

Complex

Weekly Complex D/C Rounds:
- Review new complex cases;
- Organize Case Conferences;
- F/U on Case Conf. outcomes, incl. family meetings;
- Document case status in pt record & ensure pt/family receives communication.

Case Conference (PCTM, SW, HC, LTCAC)
- Complex case presentation (PCTM)
- Discussion of disposition options
- Determine date of D/C

Family Meeting
- Discussion of disposition option(s)
- achieve consensus
- document & communicate results
- provide feedback @ weekly complex D/C round

ON DAY OF DISCHARGE

Patient is medically fit and safe to transfer from the acute sector

Discharge checklist completed

D/C to disposition
Phase 3: Pilot Implementation

• Lean analysis of current process
• Selected tools to improve the process
• Identified process flow for complex and simple discharges
• Chosen units to pilot the process & tools

How do we implement to ensure successful adoption & sustainability?
### Phase 3: Pilot Project Plan

<table>
<thead>
<tr>
<th>Activity</th>
<th>Dates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Design Tools</td>
<td>Oct 5 – Oct 26</td>
</tr>
<tr>
<td>Educate</td>
<td>Nov 2 – Nov 13</td>
</tr>
<tr>
<td>Implement Tools</td>
<td>Oct 26 to Nov 6</td>
</tr>
<tr>
<td>Activate Pilot</td>
<td>Nov 9</td>
</tr>
<tr>
<td>Assess</td>
<td>Nov 16 – Dec 4</td>
</tr>
<tr>
<td>Adjust</td>
<td>Dec 4 – Dec 21</td>
</tr>
<tr>
<td>Evaluate</td>
<td>Dec 21 – Jan 13</td>
</tr>
</tbody>
</table>
Phase 3: Pilot Structure

Carrie Solmundson
Executive Sponsor

Monique Constant
Project Sponsor

Discharge Planning Initiative
Steering Committee

Cyndy Park
SOGH Project Lead

WRHA
Project Management Office

Heidi Adamko
Project Manager

Research & Evaluation
Communications Consultant
Collaboration Group
Education Consultant

Discharge Related Roles and Responsibilities Working Group
Daily Rounds Whiteboards Working Group
Patient/Family Communication Working Group
Discharge Checklist Working Group
Discharge Rounds Working Group
Working Group Mandate

X WORKING GROUP

Purpose
The purpose of

Membership

Key Deliverables
The X Working Group is responsible for developing the following deliverables:

Tasks
The following tasks are required to complete each deliverable:

<table>
<thead>
<tr>
<th>Task</th>
<th>Assigned To</th>
<th>Due Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Timeframe

Contributors
The following individuals may provide input on tasks and/or review and provide feedback on the final product:

Approval
The following approvals are required for each deliverable:

<table>
<thead>
<tr>
<th>Deliverable</th>
<th>Approver(s)</th>
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# Working Group Design Summary

## Design Summary

<table>
<thead>
<tr>
<th>Description</th>
<th>Provide a brief description of the tool</th>
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</thead>
<tbody>
<tr>
<td>Purpose</td>
<td>Why is this tool needed? What purpose does it fill, what need does it meet? What problems does it resolve (from lean exercise)?</td>
</tr>
<tr>
<td>Design Considerations/ Criteria</td>
<td>What were some key design criteria considered in the design and the evaluation of the design (what measures did you use to decide if the design was good)?</td>
</tr>
<tr>
<td>Key Decisions</td>
<td>What were some of the key decisions made in designing the tool?</td>
</tr>
<tr>
<td>Sources</td>
<td>What sources of information or working examples did you use to design the tool?</td>
</tr>
<tr>
<td>Critical Success Factors</td>
<td>What are some of the critical success factors for implementing and using this tool. What things need to happen so that this tool can be used successfully? Or What things could cause the tool to fail?</td>
</tr>
<tr>
<td>Assumptions</td>
<td>What assumptions were made in building this tool?</td>
</tr>
<tr>
<td>Constraints</td>
<td>What constraints were considered when designing the tool?</td>
</tr>
<tr>
<td>Risks</td>
<td>Define risks associated with using this tool</td>
</tr>
</tbody>
</table>

## Instructions for Use

<table>
<thead>
<tr>
<th>#</th>
<th>Description</th>
<th>Trigger</th>
<th>Who</th>
<th>When</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
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<td></td>
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<td></td>
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</tbody>
</table>
Training

• Develop the training plan
  – Schedule
  – Materials
  – Methods
  – Location
  – Trainers
• Develop training materials
• Train staff
• Obtain feedback from training
• Reinforce training as needed
Assessment & Evaluation

• Assessment
  – Observational feedback
  – Staff and champion feedback
  – Adjust tools and training as needed

• Evaluation
  – Staff surveys
  – Tool Audits
  – Patient surveys
Phase 4: Next Steps Underway…

- Discharge Policy, Process & Training
- Electronic Flight Board roll-out
- Refresh White Board Content
- Monitoring compliance by audit
- Refining Complex Discharge process: Early Disposition Planning
- Benchmarking LOS against best national performance
- Focus on Top Admissions: Pilot “Condition Specific Integrated Care Pathways”
Electronic Flight Board

- Trialed on 3 units
- Staff communication and continuing care tool linking info from UM
- Sharing of care planning info, ELOS (CIHI) and Complex Discharge Rounds
- ELOS - able to identify ELOS 70% of time

Next Steps
- Comparing ELOS to ALOS for population
- Analyzing variances (community, medical, functional)
- Expansion to other areas

Learnings
- Significant care planning underway however could be leaner if had greater clarity on disposition potential earlier on
- Need for process for key community leads to be engaged in disposition planning decision making
Complex Discharge: Early Disposition Pilot

- Initiated in October
- Developed Standard Operating Practice for Team
  - Team includes: Utilization, PCTM, Home Care and LTC
  - Identification of previous 7 day admissions
  - Each team member reviews history, documentation
  - Team discusses disposition and directions
  - Inter-disciplinary Bullet Rounds held next day (ELOS, care plan)
  - Referrals to Complex Case Rounds
Early Disposition Pilot…

Predicted Discharges By Percentage

- Simple: 89.7%
- Complex: 10.3%
..Early Disposition Pilot..

Types of Discharges

<table>
<thead>
<tr>
<th>Type</th>
<th># of Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Simple D/C Home/HC</td>
<td>28</td>
</tr>
<tr>
<td>Simple PCH</td>
<td>7</td>
</tr>
<tr>
<td>Complex Home</td>
<td>3</td>
</tr>
<tr>
<td>Complex PCH</td>
<td>1</td>
</tr>
</tbody>
</table>
…Early Disposition Pilot

Actual Patient Discharge Outcomes

<table>
<thead>
<tr>
<th>Category</th>
<th># of Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Expected Outcome</td>
<td>26</td>
</tr>
<tr>
<td>Changed Outcome</td>
<td>0</td>
</tr>
<tr>
<td>Still Here</td>
<td>10</td>
</tr>
<tr>
<td>Other</td>
<td>3</td>
</tr>
<tr>
<td>C-A-R</td>
<td>CMG</td>
</tr>
<tr>
<td>---------</td>
<td>------------------------------</td>
</tr>
<tr>
<td>139-S-2</td>
<td>139:Chronic Obstructive Pulmonary Disease</td>
</tr>
<tr>
<td>196-T-1</td>
<td>196:Heart Failure without Cardiac Catheter</td>
</tr>
<tr>
<td>139-T-2</td>
<td>139:Chronic Obstructive Pulmonary Disease</td>
</tr>
<tr>
<td>139-S-1</td>
<td>139:Chronic Obstructive Pulmonary Disease</td>
</tr>
<tr>
<td>138-T-1</td>
<td>138:Viral/Unspecified Pneumonia</td>
</tr>
</tbody>
</table>

1) Top 5 ranked on number of cases in C-A-R; excludes electives by Admission Category = Urgent/Emergent


3) Benchmark average LOS and benchmark site from the 2009 Hay Group CE analysis based on FY 2008-09 DAD and CMG 2009

** based on year to date data loaded into regional DSS at February 16 2011
COPD Integrated Care Pathway

An organized, proactive, multidisciplinary approach to COPD mgmt that will:

• Coordinate COPD responses across acute, specialty, primary and home care
• Provide consistent, integrated care wherever the patient is in his/her trajectory of disease.
• Develop mechanisms to support patient self-management.
• Improve quality of life and productivity for COPD patients
• Improve the skills of participating health professionals in managing COPD care
• Achieve a reduction in admissions for COPD patients
• Reduce readmissions of COPD patients
• Reduce LOS for COPD patients to meet national benchmark
• Create mechanisms for info and tool-sharing for prevention by creating partnerships
COPD Patient Care Pathway – An Overview

**Diagnosis of COPD**
- Diagnostic Algorithm for multiple input points
- Spirometry Clinic
- FM Office Spirometry
- CREC

**Structured Care in Primary Care**
- Clinical Guideline Development/implementation
  - Inhaled Therapy for COPD
  - COPD template
- Structured care according to severity (CTS Guidelines)
- LTOT referral criteria
- Patient information pack

**Exacerbation Management**
Assessment Criteria with care plan options:
- Option 1 - self management (discharge action plan)
- Option 2 – Acute Hospital Assessment/Admission*
- Option 3 – Hospital at Home (Virtual ward)

**Pulmonary Rehabilitation**
- Referral Pathway to community based pulmonary rehabilitation
- Referral Criteria
- Feedback reports to referrers

**Referral to Respiratory Specialty Services**
- LTOT assessment and initiation in acute care
- Specialist Clinic referral
- Community Respiratory Education Centre Support
- Home Care O2 Program
- Long Term Mechanical Ventilation (Sleep Disorder Centre)

**Palliative Care**
Preferred Place of Care
Challenges

- Changing Behaviors – all disciplines
- Hurry up and wait: ALC patients
- Timely access to community placements for ALC
- The cost of caring for ALC patients (behavior patients)
- Urgency, ownership and accountability for ALC in community: “pull” mentality
- Discharge 7 days/week
Recommendations

- Activate HC process improvement recommendations (ie. plan for discharge based on EDD)
- Ensure adequate homecare baseline staffing.
- HC and allied health all days of the wk.
- Panel process improvements
- Timely ALC data as a performance indicator for community.
- Integrated Care Pathways for top Admissions/Re-Admissions
- Invest in a broader range of residential care supports
- Joint accountability structures for true integration