The Advisory Board Company

International
Clinical Operations Board

STUDY

The Discharge Strategy Handbook

Creating Capacity by Eliminating End-of-Stay Delays

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Creating Capacity by Eliminating End-of-Stay Delays

Clinical Operations Board

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In Service to Our Health Care Members

4,200+
Hospitals and health care organisations in our membership

2,500+
Health care professionals employed

2,000+
Hospitals using our performance technologies

RESEARCH AND INSIGHTS

Memberships Offering Strategic Guidance and Actionable Insights

- Dedicated to the most pressing issues and concerns in health care
- 300+ industry experts on call
- 200+ customisable forecasting and decision-support tools

PERFORMANCE TECHNOLOGIES

Global Peer Collaboratives Powered by Web-Based Analytic Platforms

- Millions of admissions flow through our technology platforms
- Over 3 million user sessions annually
- Key challenges addressed: margin improvement, doctor alignment, payer contracting, quality improvement, and patient experience

CONSULTING AND MANAGEMENT

Seasoned, Hands-On Support and Practice Management Services

- 3,600+ years of "operator" experience in hospital and doctor surgeries
- Principal terrains: growth, margins, doctor alignment, and the transition to value
- Range of engagements from strategy to best practice installation to interim management to fully managed services

TALENT DEVELOPMENT

Partnering to Drive Workforce Impact and Engagement

- Impacted the achievement of 88,000+ executives, doctors, clinical leaders, and managers
- 19,500+ outcomes-driven workshops tailored to partners' specific needs

Survey Solutions

- Customised strategies for improving employee and doctor engagement

238,000+
health care leaders served globally

$700+
million in realised value per year

2,300+
engagements completed

8,400+
employee-led improvement projects

Available Within Your Clinical Operations Board Membership

Over the past several years, the Clinical Operations Board has developed numerous resources to assist members in improving efficiency. The most relevant of these resources are outlined on the right. All resources are available in unlimited quantities through the Clinical Operations Board membership.

Collected Best Practices for Creating Capacity

2013 Clinical Operations Board Survey on Transitions
Discharge benchmarks surveyed from the Clinical Operations Board global membership

Next Generation Capacity Management
Collaborating for Clinically Appropriate, Efficient Inpatient Throughput

Improving Provider Communication and Patient Transitions
Hospital-Based Best Practices

Hub of the Enterprise
Transforming the Emergency Department's Role in Delivering Agile and Coordinated Care

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The Highly Productive Cardiovascular Enterprise
Imperatives for Operating at Optimal Efficiency to Safeguard Margins

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Further Resources

Advisory Board International Membership Programs

CLINICAL OPERATIONS BOARD	HEALTH CARE EXECUTIVE BOARD	GLOBAL CENTRE FOR NURSING EXECUTIVES	GLOBAL eHEALTH EXECUTIVE COUNCIL	CLINICAL INVESTMENT INSIGHTS
Transforming Care Quality and Efficiency Best practice research to support senior clinical and operational leaders who work tirelessly to provide safe, effective, and efficient care for their communities.	*Strategy and Business Leadership for Enduring Success* Research and insights for chief executive officers and other senior executives to support their efforts to guide their organisations to sustainable excellence and prosperity.	*Building the World Class Nursing Organisation* Research for an international network of nursing executives charged with leading the largest and most critical element of the health care workforce in a time of great challenges.	*IT Strategy and Planning* Research and analysis to help hospital information technology (IT) departments effectively plan and implement key initiatives and achieve organisational strategic IT goals.	*Service Line Strategic Planning and Investment Guidance* On-demand service-line strategic guidance and customised technology investment advice to help leadership make sound investment decisions around challenging and complex clinical investment choices.
• Improving clinical quality and patient safety • Maximising capacity utilisation • Partnering with clinicians • Ensuring efficient use of resources • Cultivating clinical leadership • Managing patients with chronic disease	• Strategy and planning amid disruptive change • Maximising value from clinical innovations • Strengthening financial management • Marketing to doctors and patients • Increasing staff productivity and engagement • Providing leadership for organisational performance	• Achieving excellence in care quality and safety • Improving the patient experience • Recruiting and retaining high-quality nurses • Managing nursing diversity and culture • Developing next-generation nursing leaders • Enhancing nursing staff efficiency and productivity	• Improving governance and management of IT • Leveraging IT to improve care quality • Achieving return on IT investments • Engaging doctors in IT adoption • Analysing vendors, applications, and industry trends • Optimising business intelligence and executive data strategy	• Identifying strategic investment opportunities • Optimising investment decisions • Aligning clinician and executive priorities • Minimising risk of capital investments • Increasing efficiency in investment evaluation processes • Creating insights into future disruptive innovations
Serving Senior Clinical and Operational Leaders	Serving Chief Executives, Strategy and Business Leaders	Serving Chief Nursing Executives and their Senior Teams	Serving Chief Executives and Chief Information Officers	Serving Chief Executives and Senior Planning Leaders

Advisors to Our Work

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Executing on the Efficiency Imperative

A Quest for Efficiency

Hospitals around the world are searching for opportunities to improve efficiency.

Many organisations are running at high occupancy levels, yet tight financial times rule out building additional beds for most. Even where physical expansion is an option, new bed capacity take times to design, construct, and staff.

For the foreseeable future, the major challenge will be to manage rising demand without an equivalent rise in budget, while maintaining–or even improving–standards of quality and access.

Hospitals Under Pressure on All Fronts

Global Hospital Imperatives

Reduce Cost

- Many governments challenging acute sector to reduce spending without impacting care through efficiency savings

Expand Access

- 30-day readmission penalties increasingly common
- Emergency department and elective procedure wait-time violations incur financial penalties

Improve Quality

- Payment increasingly linked to quality of care
- Quality performance increasingly transparent; hospitals face public pressure to improve

Budget Cuts, by Country

	Proposed Cuts	National Debt as Percentage of GDP[1]	Budget Deficit as Percentage of GDP[1]
Austria	€5.1B by 2013	72.9%	3.5%
Denmark	€3.2B in 2012	46.5%	2.7%
France	€45B annually	86.5%	7.5%
Germany	€80B by 2014	82.0%	3.0%
Italy	€24B in 2012	120.9%	5.3%
Netherlands	€18B by 2014	65.9%	5.4%
Poland	€14.4B in 2012	56.3%	7.2%
UK	£83B by 2015	85.7%	10.4%

Resources Not Guaranteed

"It's all carrots and sticks. We only get full income if we deliver top results. If we don't deliver, there's a financial challenge. It's about a quarter million pounds. It may not sound like a lot of money, but on top of what we have already had to take out for savings targets, and what we need to take out going forward, it is a lot of money."

Hospital Executive
NHS Acute Trust, UK

1) Gross Domestic Product.

Source: Organisation of Economic Co-operation and Development, *StatExtracts*, "Health Expenditure and Financing" http://stats.oecd.org/Index.aspx?DataSetCode=SHA# , accessed 13 September 2012; Advisory Board interviews and analysis.

Demanded by Patients

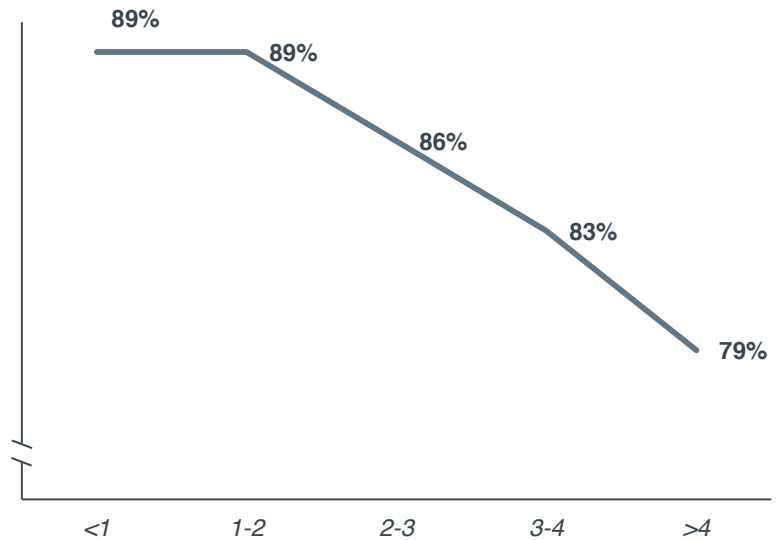
Efficiency also is strongly linked to patient satisfaction. Hospitals looking to increase volumes experience an opportunity cost when long wait times cause prospective patients to seek care elsewhere.

In addition, all providers must recognise the heightened risk to patient health posed by additional days of stay and overfull wards.

Patient Satisfaction Linked to Efficiency

Patient Satisfaction by Hours in ED[1]

n = 1,501,672 patients at 1,893 US hospitals



Longer Stay Puts Patients at Greater Risk

85% Maximum hospital capacity level before patient safety is put at risk

18% Risk of infection with hospital admission

2% Infection risk increase with each additional night in hospital

1) Emergency Department.

Source: Dr Fosters, "Fit for the Future? Dr Foster Hospital Guide 2012," drfosterintelligence.co.uk; Hauck K and Zhao X, "How Dangerous is a Day in Hospital? A Model of Adverse Events and Length of Stay for Medical Patients," Medical Care, December 2011, Vol. 49, Iss. 12; World Health Organisation; Rev Panam Salud Publica; Pan American Health Organisation; Advisory Board interviews and analysis.

No Relief in Sight

Demand pressure on hospitals will only be exacerbated in the future by dramatic demographic changes.

For hospital leaders to treat a greater number of sicker patients, at a lower cost, without having a negative impact on care quality, hospitals must use existing capacity more efficiently.

Demographics and Continued Austerity Guarantee Challenges Persist

Demographics Deal Hospitals a Difficult Hand

82%

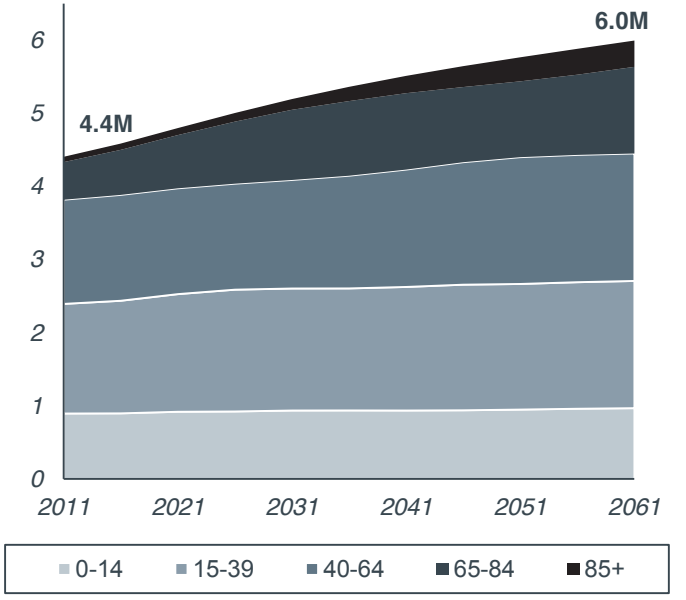
Increase in Scottish population aged over 75 years in 2035

50%

Of those over 65 have at least one chronic condition

Demand Increase Projected to Continue Indefinitely[1]

Population by Age Group



Unprecedented Challenges Require New Solutions

"The financial pressures are huge. We had to take out 10% of our budget last year. We are having to take out 7% this year, 5% next year, and the same the year after that. Unless we do something radically different, this isn't going to happen. Meeting the challenge requires a different way of working, a different culture."

Director of Strategy
NHS Foundation Trust

1) Population projection for New Zealand.

Source: Statistics New Zealand; *National Population Projections: 2011*, 2012; Ham, Chris, et al., "Transforming the Delivery of Health and Social Care: The Case for Fundamental Change," The King's Fund, 2012, pp. 4; The BBC, "Number of elderly in Scotland 'to rise by 82%,' published 2/29/2012, www.bbc.co.uk; Royal College of Physicians, "Hospitals on the Edge," September 2012, pp. 2; Advisory Board interviews and analysis.

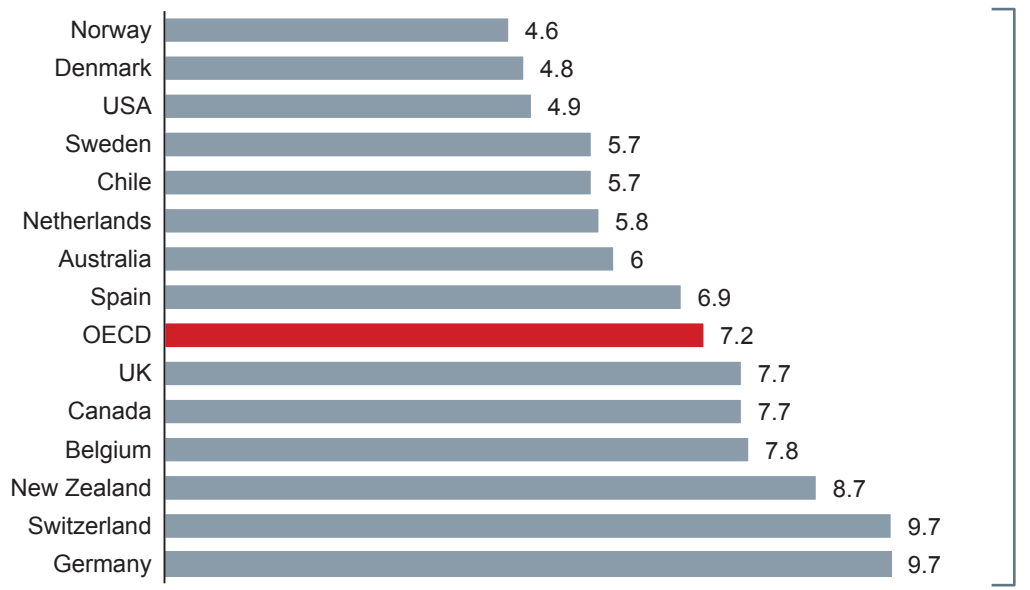
An Opportunity for Improvement?

Length of stay can be considered a measure of how efficiently beds are used.

Data from the Organisation for Economic Cooperation and Development (OECD) suggest that there is wide variation in length of stay among countries. Additionally, these country-level averages disguise length of stay differences among individual hospitals in a particular country. This suggests that hospitals have an opportunity to rapidly create capacity by working to reduce length of stay, without adding cost or impacting quality.

More Efficient Bed Use Could Provide Breathing Room

OECD[1] Member Average Acute Length of Stay[2]



Variation of 5.1 days represents significant opportunity for most hospitals

1) Organisation for Economic Cooperation and Development.
2) The OECD calculates average length of stay (ALOS) by dividing the number of days stayed (from the date of admission in a hospital or other in-patient institution) by the number of discharges during the year. It includes deaths in hospitals, but excludes same-day separations. Cited country data all exclude same day separations in calculating ALOS.

Source: Organisation for Economic Co-operation and Development. *OECD health data: frequently requested data.* London: OECD, 2012; Dr Foster Intelligence, "Fit for the Future? Dr Foster Hospital Guide 2012; Advisory Board interviews and analysis.

Numerous Reports of Wasted Capacity

While making length of stay comparisons across countries can be difficult, the majority of hospital staff agree that there is room to improve.

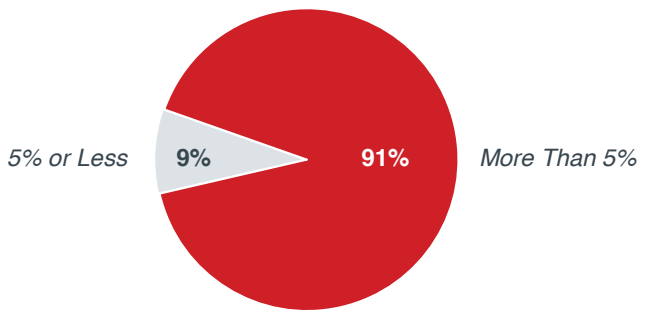
The Clinical Operations Board conducted a global survey to study discharge challenges at hospitals. Most respondents considered that more than 5% of their bed days were clinically unnecessary and 29% thought that at least one in five bed days was unnecessary.

To access the **2013 Clinical Operations Board Survey on Transitions**, visit: advisory.com/cob/TransitionsSurvey

Patients Staying Longer than Medically Necessary

Acute Inpatient Bed Days Occupied by Patients No Longer Needing Acute Care[1]

n = 332 international hospital executives and clinicians



21,900

Bed days released by avoiding 10% waste per year in a 600-bed hospital

490,808

Number of unnecessary bed days in England in 2012

Widespread Room for Improvement

"Overall, it is very unusual to encounter trusts that do not still have internal opportunities around improving processes in ways that will have a positive impact on length of stay and capacity pressures."

NHS Executive, UK

Inconsistent Criteria for Discharge

"When I go around the wards, often I find people sitting in beds reading a paper, perfectly fine, just sitting there, waiting, based on somebody's view that they aren't ready to go or because they don't have somewhere to go."

Chief Operations Officer
Public hospital, Australia

1) Reponses to the question "In your opinion, are more than 5% of acute inpatient bed days occupied by patients who no longer need acute care?".
2) CAD.

Source: 2012 Clinical Operations Board Survey on Transitions; The Independent, "Delays 'cost NHS £324m,' 30 April /2012, www.independent.co.uk; "Patient-focused funding starts to pay off for NRGH," published 11/18/2011, www.canada.com; Advisory Board interviews and analysis.

Creating Virtual Capacity

Reducing length of stay offers hospitals the opportunity to create "virtual capacity." Here, we model the impact of reducing length of stay on hospitals of various sizes.

For most organisations, reducing average length of stay by a day is the equivalent of building at least one additional ward, at a fraction of the cost.

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Length of Stay Reduction Provides a Pressure Release

"Effective" Beds Gained from Reducing LOS[1]

Hospital size / LOS Reduction	100 beds	200 beds	300 beds	400 beds	500 beds	600 beds	700 beds	800 beds
0.25 days	4	8	12	16	20	25	29	33
0.50 days	8	16	25	33	41	49	57	65
0.75 days	13	25	37	49	61	74	86	98
1.00 days	17	33	49	65	82	98	114	131
1.25 days	21	41	61	82	102	123	143	163
1.50 days	25	49	74	98	123	147	172	196

For average 400-bed hospital, reducing LOS by one day can be the equivalent of adding 65 new beds

1) Length of Stay; Assumes 85% occupancy rate and 5.2 days average LOS.

Source: 2012 Clinical Operations Board Survey on Transitions; Advisory Board interviews and analysis.

Achieving Critical Hospital Objectives

Creating virtual capacity supports a range of hospital goals and challenges. Virtual capacity can be used to improve access to care by treating additional patients, reduce cost by reducing the number of staffed beds, or in some circumstances to generate additional revenue by increasing patient volumes in profitable service lines.

Decreased Length of Stay Supports Key Goals

Imperatives Faced by Hospitals Supported by Decreased LOS[1]

Improve Access to Care

Maximise Resources

Improve Access

Hospitals facing pressure to reduce wait times and meet growing demand for services

Reducing LOS enables a more timely treatment of greater patient volumes

Reduce Cost

Hospitals seeking to decrease number of staffed beds and reduce fixed cost

Reducing LOS decreases bed days per patient, enables treatment of same volumes with fewer beds

Generate Revenue

Hospitals seeking to capture additional reimbursement through increasing volume

Reducing LOS enables treatment of greater volumes of revenue-positive patients resulting in increased funds

1) Length of Stay.

Source: Advisory Board interviews and analysis.

Typical Focus on Front End of Stay

Where should hospitals focus their efforts to reduce length of stay? Access targets and media coverage typically focus on how the patient enters the hospital. Likewise, a long emergency department wait is more likely to cause patient disatisfaction than a slow discharge.

As a result, many organisations have focused their patient flow efforts on the beginning of the patient's stay.

This approach is correct in hospitals that have free bed capacity but are experiencing admissions delays. Empty beds and long emergency department waits are indicative of inefficiencies at the front door.

However, this is not the case in most hospitals: operating at or near capacity is the norm. For these hospitals, a counterintuitive approach is most effective: to gain virtual capacity, hospitals should start at the end of the patient journey by improving discharge efficiency.

Attention to Emergency Department, Admissions Reinforced by Media, Public Pressure

Selected Newspaper Headlines Focused on Hospital Efficiency

The long wait in the ER
Toronto Sun, 04-09-2011

South London Healthcare Trust on course to miss Q4 A&E wait target
HSJ, 24-10-13

Commissioning board fumbles on waiting times
HSJ, 21-10-13

Long A&E waits 'rising steeply'
BBC News, 30-04-12

An unpleasant night at the Lakeshore ER
Montreal Gazette, 07-06-13

Long emergency department waits a hard pill to swallow
New Zealand Herald, 16-06-13

Funding for extra beds designed to cut emergency waiting times
Brisbane Times, 4-06-13

Millions could be lost as state hospitals fail emergency test
Sydney Morning Herald, 13-06-13

Australia Emblematic of Political Attention, Financial Incentives Focused on Front of Stay

4 hours

90% of public emergency department patients to be admitted, transferred or discharged within four hours by 2016

$400M

Reward funding available for hospitals meeting Emergency Access and elective procedure wait targets

100%

Public elective surgery patients at all urgency categories to be treated within clinically recommended time by 2016

Source: Council of Australian Governments, "Expert Panel Review of Elective Surgery and Emergency Access Targets under the National Partnership Agreement on Improving Public Hospital Services," *Report to the Council of Australian Governments*, 2011; Council of Australian Governments, "National Health Reform Agreement - National Partnership Agreement on Improving Public Hospital Services," 2011; Advisory Board interviews and analysis.

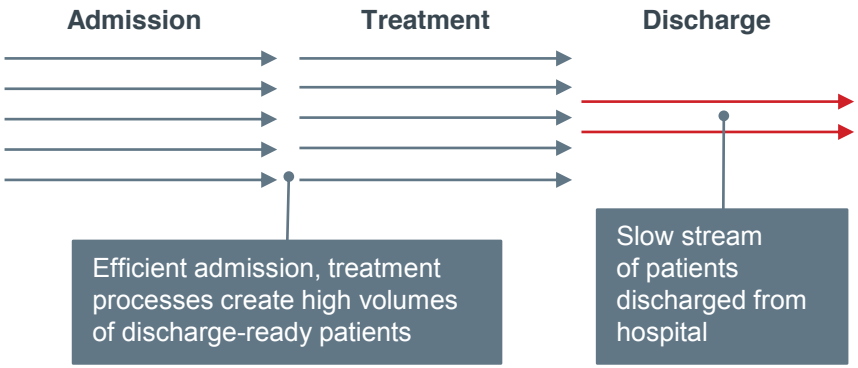
Beginning at the End

When patients are not efficiently discharged from hospital, they linger in beds even when medically fit to leave. In full hospitals, this means delayed admissions in the emergency department and cancelled elective procedures as the rest of the hospital slows down to match the rate of patient discharge.

In effect, a bottleneck at discharge undermines any other efficiency improvements in the hospital.

Improvements Earlier in Patient Stay for Naught if Discharge Delayed

Patient Flow at Each Acute Care Stage



Discharge the Essential Element to Maximise Capacity

"As the last step in the value stream, discharge is a significant constraint on patient flow, because newly admitted patients cannot move into a bed until a bed is available for them. Thus, **the discharge process becomes the flow regulator, and efficiency of the discharge process can have significant impact on overall patient flow**. Often the discharge process is considered an extra step, outside of the patient care plan, when in fact it is a critical element of patient care."

Michelle Johnson and Vin Capasso
Journal of Healthcare Management

Significant Drain on Resources

122,000

Bed days lost in Scotland due to delayed discharges from July to September 2012

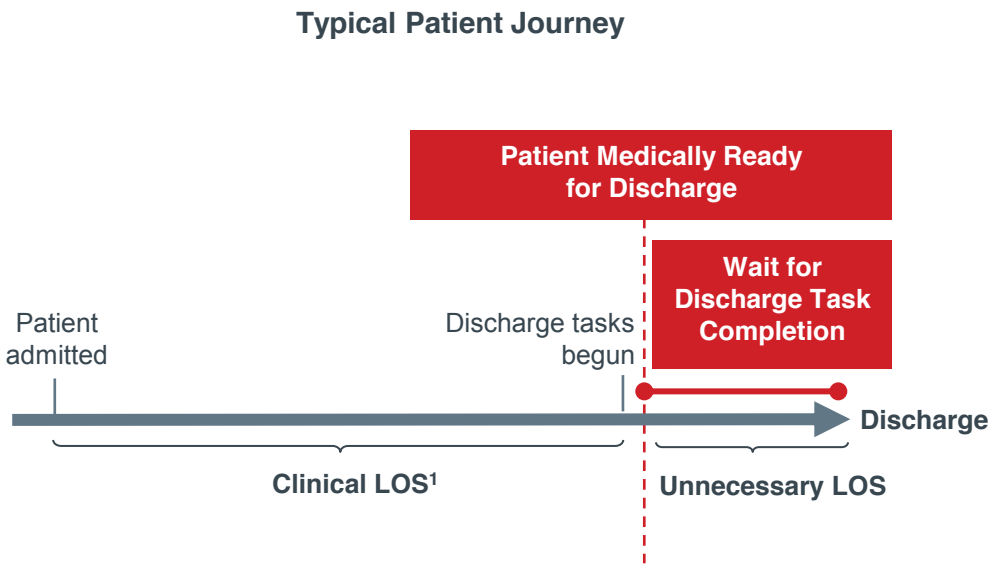
Source: Johnson M, Capasso V, "Improving Patient Flow Through a Better Discharge Process," *Journal of Healthcare Management*, March/April 2012; 57, 2; iSD Scotland, "Delayed Discharges in NHS Scotland: Figures from October 2012 Census," available at http://www.isdscotland.org; Advisory Board interviews and analysis.

Discharge Planning Often an Afterthought

In a typical patient journey, preparation for discharge only begins when the patient is already medically fit to leave the hospital. Therefore, time-consuming tasks such as educating patients, reconcilling medication, scheduling follow up appointments, and arranging transportation may only begin only when the patient could safely leave and thus, inevitably cause delays.

This schematic is simplified: many organisations are trying to complete some discharge preparation tasks earlier in the patient stay. However, despite hospital policies and redesign efforts, in most cases this reactive approach to patient discharge is still the general rule and results in endemic delays.

Planning for Discharge at End of Stay Inevitably Causes Delays



1) Length of Stay.

Source: Advisory Board interviews and analysis.

Discharge Last Priority in Acute Environment

Many hospitals have already made considerable efforts to avoid discharge delays, but two obstacles limit their success.

First, clinicians deprioritise discharge preparation. Doctors and nurses are rightfully focused first on the acute clinical needs of patients. Many also do not draw a connection between discharging a healthy patient and providing high-quality, timely care to an acute patient waiting in the emergency department. Clinicians may also fail to understand their personal responsibility for discharge, or lack the specialised knowledge required to discharge complex patients.

For all these reasons, discharge is often placed at the bottom of a long list of clinician tasks.

Overburdened Clinicians Focus on Immediate Concerns

Drivers of Discharge Neglect

Time
Clinicians use limited time to focus on treatment of acute illness; discharge planning takes place at last minute as a result

Awareness
Many clinicians do not understand impact discharge delays have on critical aspects of hospital operations and performance, including safe and timely care for acute patients waiting for admission

Responsibility
Clinicians, and doctors in particular, often do not view themselves as personally responsible for discharge-related tasks

Complexity
Complex patient needs and multiple post-acute care service options mean bedside nurses and attending doctors may lack necessary knowledge to plan appropriate discharge

No Time for Discharge Planning?

"There is still a tendency among doctors to treat someone's acute problem, because it is a very doctor-led service and that is what we do, but not to actually take on dealing with all the other aspects of a complex patient's care that need to be addressed. There's an ongoing failure to acknowledge these other aspects and instead leave it up to other people, who maybe don't have the same authority over the movement of a patient as does a treating clinician."

Director of Medicine, Private hospital, Australia

Not Part of the Routine

"Most of the time it was decided that a patient was medically ready and then we started to arrange discharge"

Chief Development Officer, General hospital, Netherlands

Source: The Telegraph, "Nurses stretched to 'breaking point' as 60,000 frontline health service posts under threat, says RCN," published 14 May 2012, www.telegraph.co.uk.; Advisory Board interviews and analysis.

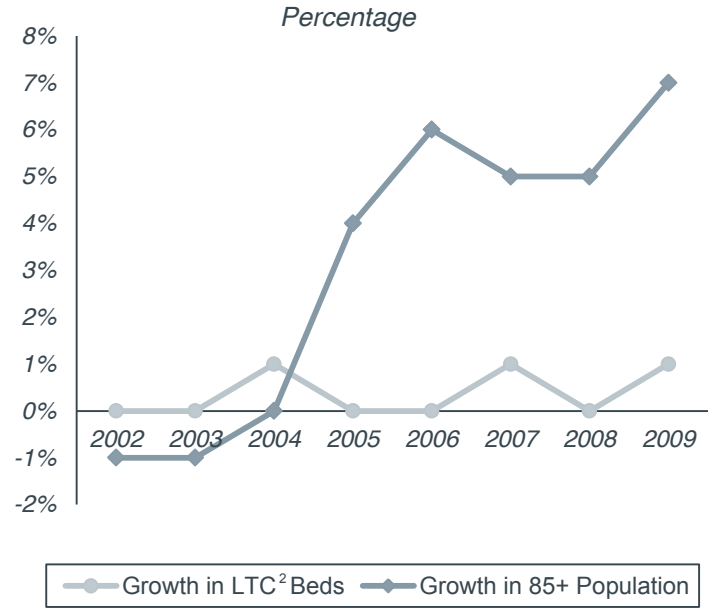
Some Delays Beyond Hospital Control

Second, it is important to recognise that not all delays are internal. In some situations, discharge delays are beyond the hospital's control.

Acute care providers around the world report significant discharge delays due to lack of post-acute care provider capacity, or caused by patients, families and bodies which approve funding for post-acute care services.

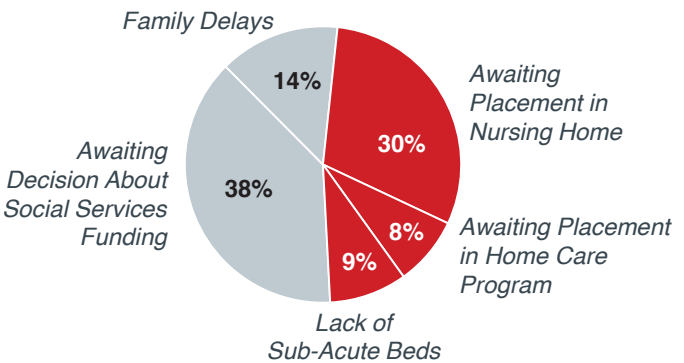
Many Discharge Delays Originate with Post-Acute Care Providers

Growth in Population Over 85 Years Against Growth in Long-Term Care Beds in Rehab and Nursing Facilities[1]



Causes of 21+ Day Delays in Southern England

n=97 patients



Impossible to Inflect?

"One of our objectives this year is early discharge planning, but the frustration lies in not having the proper community services in terms of nursing and rehab to put the patient back into the community."

Chief Medical Officer
General hospital, Europe

1) In Belgium, Netherlands, and Switzerland.
2) Long-term care.

Source: Bryan, K, "Policies for reducing delayed discharge from hospital," *British Medical Bulletin*, 19 July 2010; Eurostat, "Long-term care beds in nursing and residential care facilities," 5 March 2012; OECD, "Population," *StatExtracts;* Advisory Board interviews and analysis.

An Excuse for Inaction?

A common misperception among hospital clinicians and managers is that the majority of discharge delays are due to factors beyond the hospital's control.

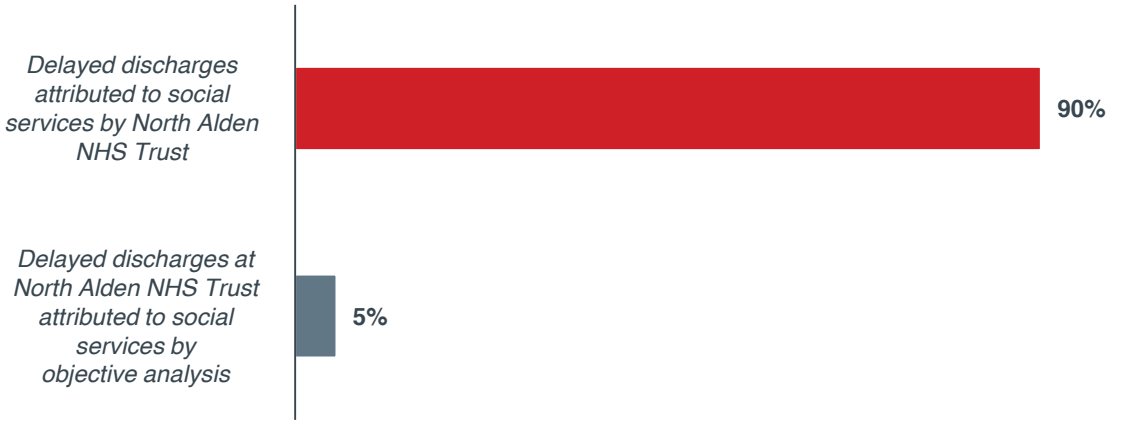
It is true that a number of delays are caused by post-acute care providers and other non-hospital factors. As a result, there is a strong perception that discharge delays are unavoidable. Hospital staff may feel that work to prepare for an on-time discharge is wasted since external delays will inevitably occur. This perception causes a further deprioritisation of discharge.

However, organisations that have analysed the root causes of their discharge delays have found that a considerable number of discharge delays are caused by internal hospital actions and processes, not external service providers. Indeed, focusing on external delays puts hospitals at risk of missing significant internal opportunities for efficiency improvement.

Focus on External Delays Can Prevent Internal Improvement

An Extreme Example

Discharge Delays Attributed to PAC Before and After Data Analysis



Case in Brief: NHS North Alden Trust[1]

- Trust initially identifies 90% of discharge delays as caused by social services
- Analysis of trust and social service records demonstrate trust responsibility for vast majority of delays

Dispelling the Myth

"About 7% to 8% of our bed capacity is patients waiting for care external to acute….Yes, we have this cohort of patients and there is a whole lot of work that we have to do there, but **70% of our delays are within our own hands**. Timely scripts, timely specialist consultations, all of those sorts of things are things that we can fix and are a larger part of our delays than waiting for sub-acute care."

Director of Operations, Public hospital, Australia

1) Pseudonym.

Source: Advisory Board interviews and analysis.

Not On Anyone's To-Do List

Staff reluctance to focus on discharge—either due to low prioritisation or a perception of futility—cannot be solved by asking staff to place a higher priority on discharge. To avoid internal delays to discharge, hospitals must take a new approach to discharge preparation.

Organisations that have successfully avoided discharge delays have built systems and processes that ensure discharge preparation begins proactively, before a patient is medically fit to leave the hospital.

With solid infrastructure and clear accountability in place, organisations can embed proactive preparation for discharge into daily practice.

Management System Required to Overcome Reactive Approach

Drivers of Delay Deeply Entrenched

Discharge challenges result in discharge preparation tasks only being completed when patient is medically ready to leave, inevitably causing discharge delays

System to Ensure Proactive Management Required

Infrastructure to embed proactive preparation for discharge necessary to avoid delays

Key Drivers

Lack of Prioritisation

Natural low priority placed on discharge tasks; high patient load and entry-oriented incentives impede frontline focus on discharge efficiency

Perception of Futility

Complexity of patient discharges and belief in external nature of the problem reduces will to improve discharge efficiency

Critical System Components

Effective Advance Planning

Late discharge planning creates rushed, inefficient attempts to complete necessary preparation tasks in last days of stay, contributing to delays

Infrastructure to Execute Plans

Low prioritisation of discharge and lack of accountability results in discharge preparation tasks left until end of stay, inevitably delaying discharge

Source: Advisory Board interviews and analysis.

The Discharge Strategy Handbook

Creating Capacity by Eliminating End-of-Stay Delays

An effective discharge infrastructure must include two components: early planning and strong processes to ensure that discharge preparation tasks are completed. We have divided our work into these two main sections.

To improve, leaders must first ensure that patients receive a predicted date of discharge early and consistently. Second, any necessary planning for post-acute care needs must be made early in the patient's stay. Third, when possible discharge tasks must be completed in advance.

Fourth, tasks that cannot be proactively completed in advance must be appropriately prioritised.

Although the greatest opportunities for most lie within the walls of the hospital, some organisations will find that despite their best efforts internally they still face delays due to external factors. In the final section, we present tactics from organisations that have found innovative ways to avoid these delays.

Planning for Discharge Early

1 Ensure Reliable Discharge Date Prediction

- Practice #1: Low-Acuity Standard Discharge Date
- Practice #2: Accountable Date Prediction

2 Forecast Post-Acute Needs and Destination

- Practice #3: Intensive Planning Need Algorithm
- Practice #4: Comprehensive Caregiver Assessment
- Practice #5: Barrier-Eliminating Discharge Plans
- Practice #6: Specialised Planning for Specialised Care

Embedding an Infrastructure to Execute Discharge Plans

3 Install Proactive Preparation for Discharge

- Practice #7: Workflow-Centred Journey Boards
- Practice #8: Staff-Designed Scripted Multidisciplinary Rounds
- Practice #9: Specialised Case Management Staffing
- Practice #10: Patient-Oriented Discharge Scripting
- Practice #11: Patient-Centred Staff Education

4 Coordinate End-of-Stay Processes

- Practice #12: Night Shift Task Organiser
- Practice #13: Localised Nurse-Led Discharge Rollout

Beyond the Hospital:

Leveraging Post-Acute Capacity to Avoid Delays

- Practice #14: Financially Accountable Transfer Agreement
- Practice #15: Hospital-Hotel Care Partnership
- Practice #16: Hospital Driven Outreach and Collaboration
- Practice #17: Co-located Decision Making
- Practice #18: Integrated Acute-Post-Acute Management
- Practice #19: Home-Centred Demand Management

Hospital Leaders Play Key Role

As with any major change in a hospital, sustained success depends in large part on hospital leadership.

To avoid discharge delays, leaders must first champion change at all levels of the organisation. This requires leaders to establish a clear vision and goals, while challenging staff to develop solutions.

As progress is made, the executive role shifts to providing support and ensuring accountability.

Success Hinges on Executive Commitment

Most significant demands at inception of challenge

Executive involvement decreases as priorities embed in hospital culture

Promote Prioritisation of Discharge Initiatives

- Identify discharge as key organisation priority
- Establish best practice discharge policy
- Stress central role of discharge in achieving other key hospital goals
- Set clear high level goals and challenge staff to develop workable solutions

Support Clinical Leaders

- Recruit leaders to champion effort
- Contribute to development of specific practice and policy changes
- Provide visible, consistent support

Recognition and Accountability

- Recognise progress and achievements
- Enforce accountability measures for non-compliance with policies and practices

Map the Route, Let Clinicians Drive

"Having a vision about where we are going as an organisation has been very helpful. There is a vision from the top, but how we get there has been very much from the bottom up. All of the little pieces of work [on discharge] are coming together towards that vision."

Clinician
NHS Acute Trust, UK

Source: Advisory Board interviews and analysis.

Targeting Areas of Greatest Opportunity

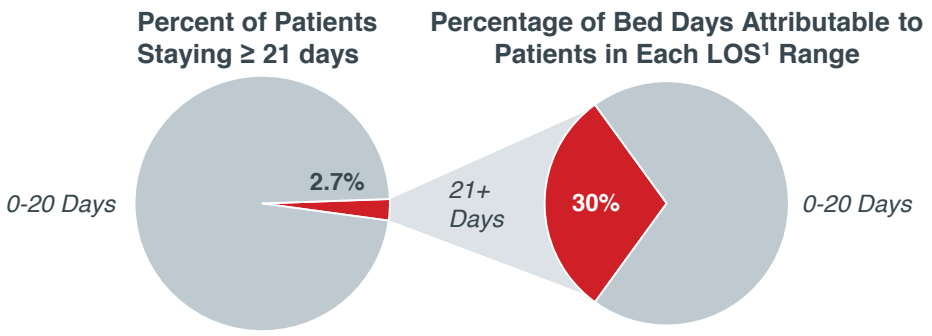
For many organisations, a small minority of acute patients account for a substantial proportion of hospital bed days. These patients are typically complex, with multiple co-morbidities, and usually cannot be safely discharged without post-acute care arrangements.

Reducing length of stay for this patient group represents the greatest opportunity for most hospitals to create virtual capacity.

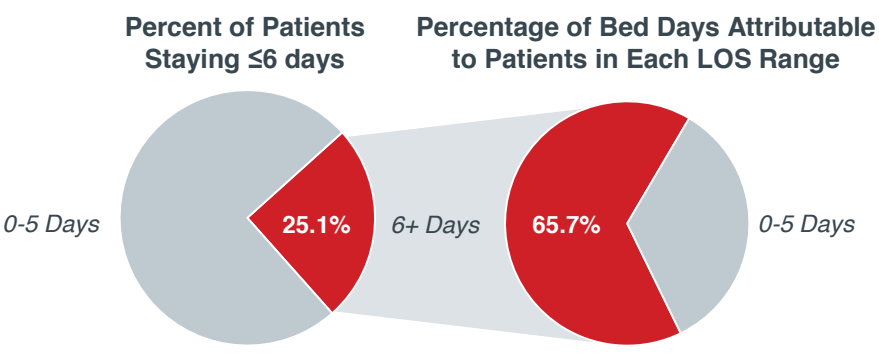
Majority of Bed Days Occupied by Complex Patients

79%
Percentage of Australasian hospitals where more than 20% of patients are discharged to post-acute care

Distribution of Bed Days at 400-Bed Australian Hospital



Distribution of Bed Days at 500-Bed Dutch Hospital



39.1%
of all bed days attributable to

9%
of all patients (those staying 11 or more days)

1) Length of Stay.

Source: Advisory Board interviews and analysis.

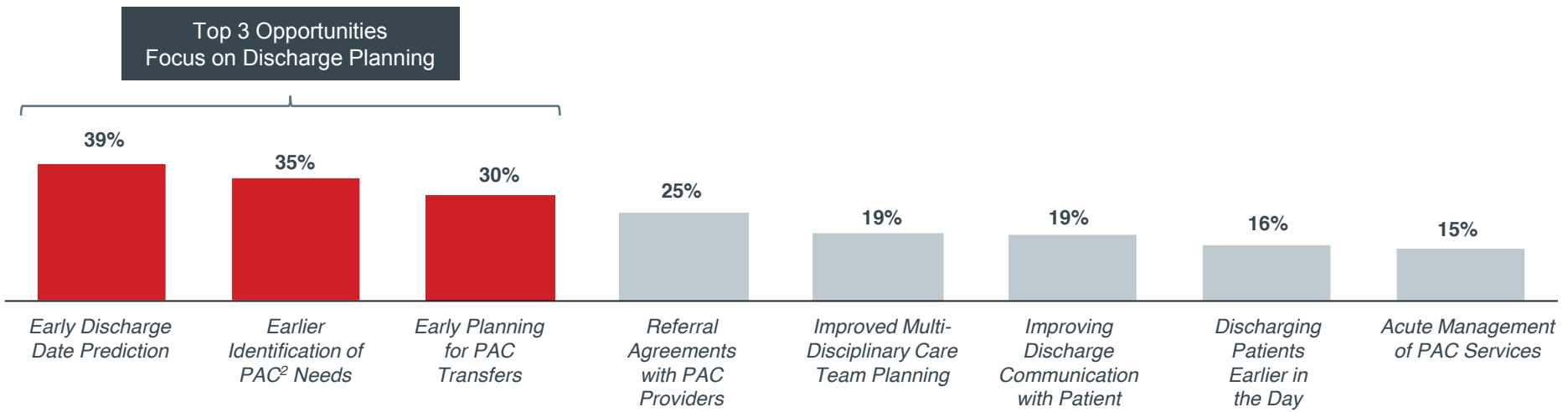
Planning for Discharge Early

According to the Clinical Operations Board member survey, three of the four greatest opportunities for reducing discharge delays are related to early planning for the patient's transition out of the hospital.

Proactive, timely patient discharge is only possible when staff consistently plan ahead to complete discharge tasks and provide for patient post-discharge needs.

Factors Identified by Hospital Staff as Greatest Opportunity to Reduce Discharge Delays[1]

n = 655 international hospital executives and clinicians



Chapter 1: Ensure Reliable Discharge Date Prediction, p. 33

Chapter 2: Forecast Post-Acute Needs and Destination, p. 47

1) Responses to Clinical Operations Board 2012 Transitions Survey Question: "In your opinion, which two areas within discharge management and care transitions in acute inpatient hospitals do you believe present the greatest opportunities to reduce discharge delays?" Response counted include: "Earlier identification of a patient's post-acute or community care needs during their acute care stay," "Predicting the date of discharge for all patients early in their stay," "Planning for post-acute care transfers earlier in the patient's acute care stay," "Establishing referral agreements between acute inpatient hospitals and post-acute care providers for timely transfers," "Acute hospitals directly managing post-acute care facilities and services," "Enhancing patient multidisciplinary care team planning for complex patient transfers," "Improving discharge communication with patients and their caregivers," "Discharging patients from acute hospitals earlier in the day" and "other" (5%).
2) Post-acute care.

Source: 2012 Clinical Operations Board Survey on Transitions; Advisory Board interviews and analysis.

Chapter 1

Ensure Reliable Discharge Date Prediction

Planning Early for Discharge Early

Practice #1: Low-Acuity Standard Discharge Date

Practice #2: Accountable Date Prediction

Common Practice?

To make effective discharge plans, the first requirement is a goal: a predicted date of discharge that the whole care team can work towards.

Hospital leaders have long understood that predicting a discharge date early in each patient's stay plays an important role in efficient patient throughput. Indeed, virtually all hospitals have policies requiring a predicted discharge date for each patient early in their stay.

However, 92% of hospital staff thought that policy did not always translate into practice. In fact, 44% thought that patients received an early discharge date prediction less than half of the time.

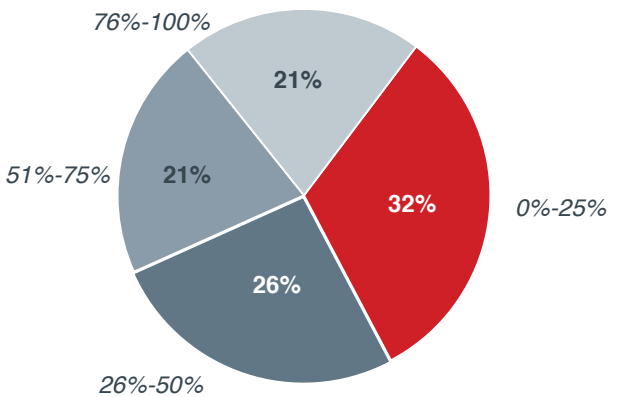
Benefits of Discharge Date Prediction Widely Acknowledged

Primary Benefits of Predicting Discharge Date Early

- Decreased length of stay
- Increased patient satisfaction and engagement
- Increased percentage of daily discharges before 12 p.m.
- Reduced emergency department and elective procedure waiting times
- Better organisation of care team workflow
- Better organised patient care planning process
- Fewer unnecessary bed days while waiting for post-acute care placement

Percentage of Patients Receiving Discharge Date Prediction within Two Days of Admission[1]

n = 559 international hospital executives and clinicians



Policy But Not Practice?

"Predicting discharge dates is a known tactic…and it's in place at many hospitals, but it's not consistently done well. In the few where it is done well, it does help with the patient flow through the system."

Hospital Executive, NHS Acute Trust, UK

92%

Say their hospital's predicted discharge date policy could be more effective[2]

1) Responses to Clinical Operations Board 2012 Transitions Survey Question: "What percentage of the time do patients receive an estimated date of discharge within two days of admission?".
2) Refers to UK hospitals indicating predicted discharge policy in place. Responses to Clinical Operations Board 2012 Transitions Survey Question: "Please indicate whether the following discharge efficiency strategies are utilised at your organisation: Predicted discharge dates," response options included, "Yes, very effective, "Yes, could be more effective," "No, not utilised," and "I don't know." Results: 8% "very effective," 86% "could be more effective," 4% "not utilised," 2% "I don't know."

Source: 2012 Clinical Operations Board Survey on Transitions; Advisory Board interviews and analysis.

Ensuring Consistent Prediction Presents Challenge

At most hospitals, the medical staff is primarily responsible for discharge date prediction. Yet doctors are often reluctant to predict or share discharge dates, for three primary reasons laid out in the graphic.

Overcoming these factors is an essential element in any effort to improve the consistency of discharge date prediction.

Medical Staff Reluctant to Predict Discharge Date

Three Primary Reasons for Reluctance

Failing to Understand Purpose

Doctors may not recognise impact of predicting date of discharge on length of stay, hospital throughput, and care team workflow

> "Doctors are generally more oriented towards the diagnostic and treatment part of the process of hospital admissions—they don't really work toward discharge."
>
> *Senior Executive*
> *Public hospital, Australia*

Fearing Inaccurate Predictions

Doctors fear making incorrect predictions which could expose them to criticism from staff, and patients

> "I try to explain to my doctors that they don't have to give the exact PDD[1], but to give what they *think* it could be... We have a long way to go."
>
> *Chief Medical Officer*
> *General hospital, Belgium*

Responsibility Unclear or Not Assigned

Doctors believe responsibility falls on multidisciplinary group or discharge planning staff

> "I think many of them don't think they can predict because all of the other things involved in organising care and patient's needs after discharge are very much a mystery to the doctors. They can't account for that."
>
> *Hospital Executive*
> *NHS Acute Trust, UK*

1) Predicted date of discharge.

Source: Advisory Board interviews and analysis.

Overcoming Obstacles to Compliance Challenges

Hospitals with timely and consistent discharge date prediction follow one of two paths.

The first method bypasses medical staff intervention in the discharge date prediction process, handing primary responsibility to nursing staff or other care providers.

The second method requires the involvement of hospital leadership to communicate the importance of timely date prediction to doctors, and hold them accountable for their performance.

Two Options to Ensure Timely Date Prediction

Circumvent Medical Staff

Predict date of discharge for patients without input from doctors

Elevate Importance

Involve hospital executives in ensuring date prediction compliance

Source: Advisory Board interviews and analysis.

Communication of Discharge Date Critical

At Cardiff and Vale NHS Trust in Wales, ward nurses print the predicted date of discharge on a laminated piece of paper. They called this the "Ticket Home".

Clinician, Patient Require Date for Effective Discharge Planning

A Simple Solution

Ticket Home

Name	Maggie Smith
Consultant	Dr. Dickens
Planned Date for Going Home	18 April 11 a.m.

For complete version of Cardiff and Vale's **Ticket Home,** please see appendix, p.153

Case in Brief: Cardiff and Vale NHS Trust

- 480-bed hospital, part of the Cardiff and Vale University Health Board
- Orthopaedic ward in University of Llandough Hospital displays predicted date of discharge on a "Ticket Home" for all patients on the ward to facilitate communication among patient and care team
- Following successful reduction of post-operative LOS[1] by 49%, practice implemented on several wards, including renal, rehabilitation and some medical-surgical wards

1) Length of Stay.

Source: Cardiff and Vale University Health Board, Wales, UK; Advisory Board interviews and analysis.

Key Elements of High-Visibility Discharge Date

The bedside nurse predicts each patient's discharge date as part of the patient workup, and creates the Ticket Home. The Ticket Home is then prominently displayed on the patient's bedside locker.

The visibility of the date is key: patients report feeling more psychologically prepared for their departure; families are able to make necessary arrangements, and care teams can proactively plan for the patient's discharge.

Robust Date Prediction a Two-Step Process

Patient and Family Communication Essential to Ensuring Impact

Predict Date of Discharge Early

Nurse responsible for ensuring date predicted on admission

Ensure Discharge Date Visibility

"Ticket Home" posted on patient's bedside locker to communicate estimated discharge date to clinical staff, patients and family

Improving Planning and Workflow

Allows all stakeholders to target planning around visible endpoint for completion of care

Source: Cardiff and Vale University Health Board, Wales, UK; Advisory Board interviews and analysis.

Using Standardised LOS to Predict Discharge

To ensure timely date prediction for their "Ticket Home," Cardiff and Vale transferred the responsibility to their nursing staff.

So that the entire care team was comfortable with the dates predicted, a multidisciplinary team of nurses, doctors and other care team leaders met to develop a list of standardised lengths of stay to guide nurses in making the initial date prediction.

The group began by examining national average length of stay for Diagnosis-Related Groups. However, the working group felt that the national averages reflected widespread inefficiencies, and revised figures downwards based on their own understanding of the clinically necessary length of stay. All clinicians on the pilot ward agreed that these standardised lengths of stay could be safely used as a baseline for date prediction by nurses, with the understanding that any predicted discharge date could be revised at any time, should the patient's condition change.

Development Process for Ticket Home

Cardiff and Vale's conceived and implemented idea for "Ticket Home" within 48 hours

↓

Developed standardised LOS[1] list, understanding that LOS standards could be revised later if inaccurate

↓

Set standardised LOS goals lower than national averages based on clinical judgment that leaner management was feasible and safe

Standardised LOS for Selected Procedures

Procedure	LOS post-operation
Primary total hip replacement	4 days
Primary total knee replacement	3 days
Revision trauma/complex joint replacement	7 days
Spinal fusion	4 days
Spinal decompression	3 days
Discectomy	3 days
Scoliosis	7 days

Cautiously Optimistic LOS Goals

"There's no harm in setting the PDD[2] too early—there's more danger in setting it too late, because then people would relax and take their time—as long as the patient knows that if they don't achieve the predicted date it's not a failure. It's a guide, something to aim towards, and if they don't make it it's not their fault."

Melanie Webber-Maybank, Ward Manager
Cardiff and Vale University Health Board

1) Length of Stay.
2) Predicted date of discharge.

Source: Cardiff and Vale University Health Board, Wales, UK; Advisory Board interviews and analysis.

Overcoming Doctor Reluctance

Cardiff and Vale attribute their success to three key elements.

First, medical staff and other key stakeholders were involved in the process throughout, to communicate the importance of date prediction and cultivate buy-in.

Second, all members of the care team were given the flexibility to update predicted discharge dates at any point in the stay as needed. The possibility that the predicted date may change is also clearly communicated to the patient and their family to establish appropriate expectations. This helped to overcome staff concerns that an initial prediction might be inaccurate.

Third, the guiding principle of the project was that no patient would be discharged if it was not clinically safe to do so. As length of stay decreased and no negative outcomes emerged, clinicians developed trust in the efficacy of the standardised date prediction system.

These elements act to overcome the primary barriers to date prediction.

Three Key Elements to Overcome Doctor Reluctance

Involve Key Stakeholders

Doctors and care team members involved in standardisation of post-operative length of stay predictions, creating consensus for project

Ensure Flexibility

Clinicians encouraged to update PDD[1] whenever necessary to reflect most recent medical status of the patient

Build a Culture of Trust

Constant reinforcement to doctors, patients and families that achieving safe discharge takes top priority; doctors confident that patients will not be discharged before medically ready

Fundamental Flexibility

"If somebody's PDD is set for three days, and on the second day they're ready to go home, we're not going to keep them here any longer. It's quite flexible and we explain to the patient that it works both ways: you might be leaving before, you might be leaving after, and **our medical staff knows that if our patient is not safe they won't go**…there's no harm in setting the date early and then if they're not well or need further investigation you can increase as the days go by."

Melanie Webber-Maybank, Ward Manager
Cardiff and Vale University Health Board

1) Predicted date of discharge.

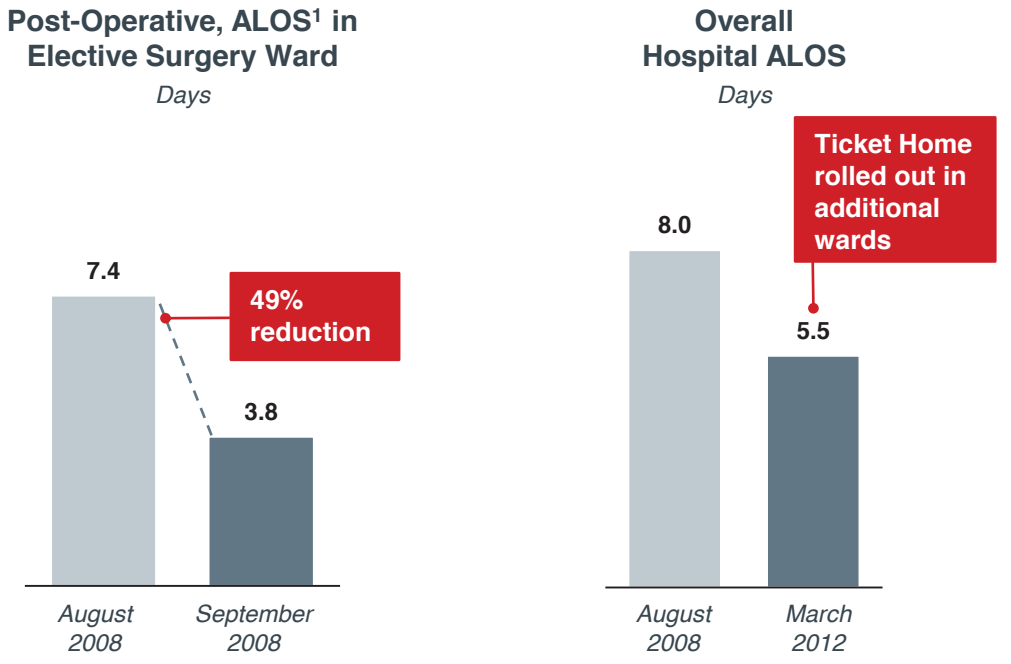
Source: Cardiff and Vale University Health Board, Wales, UK; Advisory Board interviews and analysis.

Significant Gains Achieved

The consistency of date prediction at Cardiff and Vale has substantially increased. Prior to implementation of the project, medical staff predicted discharge dates about 40% of the time; now, 95% of patients on wards where the project has been implemented receive a predicted date of discharge within 24 hours of admission.

On the pilot ward, the Ticket Home yielded demonstrable impact on length of stay within three months of implementation. Based on this success, the Ticket Home is now used across the organisation, including for complex patients. Although other interventions such as care pathways have also had an impact, the organisation attributes a significant part of their successful length of stay reduction to the Ticket Home.

Visible Discharge Plan Highly Beneficial



90%

Patients discharged before noon

Notifying Patients and Families

"Patients get more warning that they're going home. The relatives know that the patient is going home in the morning and they'll have to collect them and get the house ready...The Ticket Home lets them know that it's going to be a morning discharge."

Melanie Webber-Maybank, Ward Manager
Cardiff & Vale University Health Board

1) Average Length of Stay.

Source: Cardiff and Vale University Health Board, Wales; Advisory Board interviews and analysis.

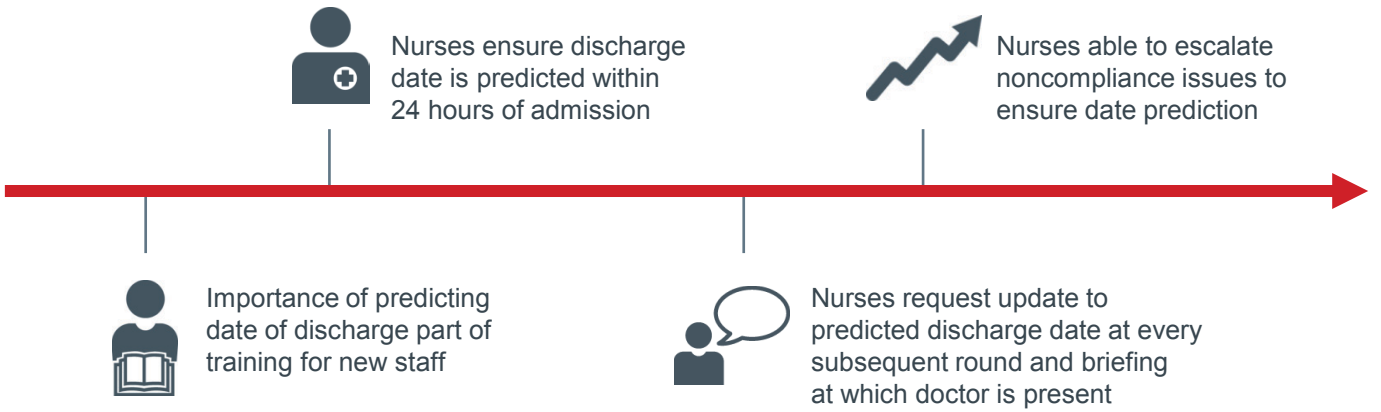
Embedding Date Prediction into Daily Routine

Standardised discharge dates are not appropriate for all situations. In some cases, patients may be too complex for standardised dates to be accurate; in others, doctors may be unwilling to relinquish control over date prediction. In these cases, to achieve consistent, timely discharge date prediction senior executives may have to expend political capital to ensure compliance.

Facing significant overcrowding, Maasstad Ziekenhuis embarked on a whole-hospital campaign to improve throughput, beginning with a policy requiring all patients to receive discharge dates within 24 hours of admission. To achieve this goal, nurses were charged with asking doctors to predict discharge dates on admission, as well as to provide regular updates.

A comprehensive hospital-wide education program on the importance of date prediction, as well as training for adhering to the new policy, helped to mitigate nurse and doctor resistance.

Date Prediction Process at Maasstad Ziekenhuis



Case in Brief: Maasstad Ziekenhuis

- 600-bed hospital in Rotterdam, Netherlands
- Required estimated date of discharge to be recorded for all patients within 24 hours of admission
- Empowered nurses to ensure discharge date prediction by doctors, supported by clearly defined escalation steps
- Additional throughput interventions implemented and guided by Theory of Constraints analysis
- Achieved 95% compliance rate for discharge date predictions and observed four-day decrease in LOS[1]

1) Length of Stay.

Source: Maasstad Ziekenhuis, Rotterdam, Netherlands; Advisory Board interviews and analysis.

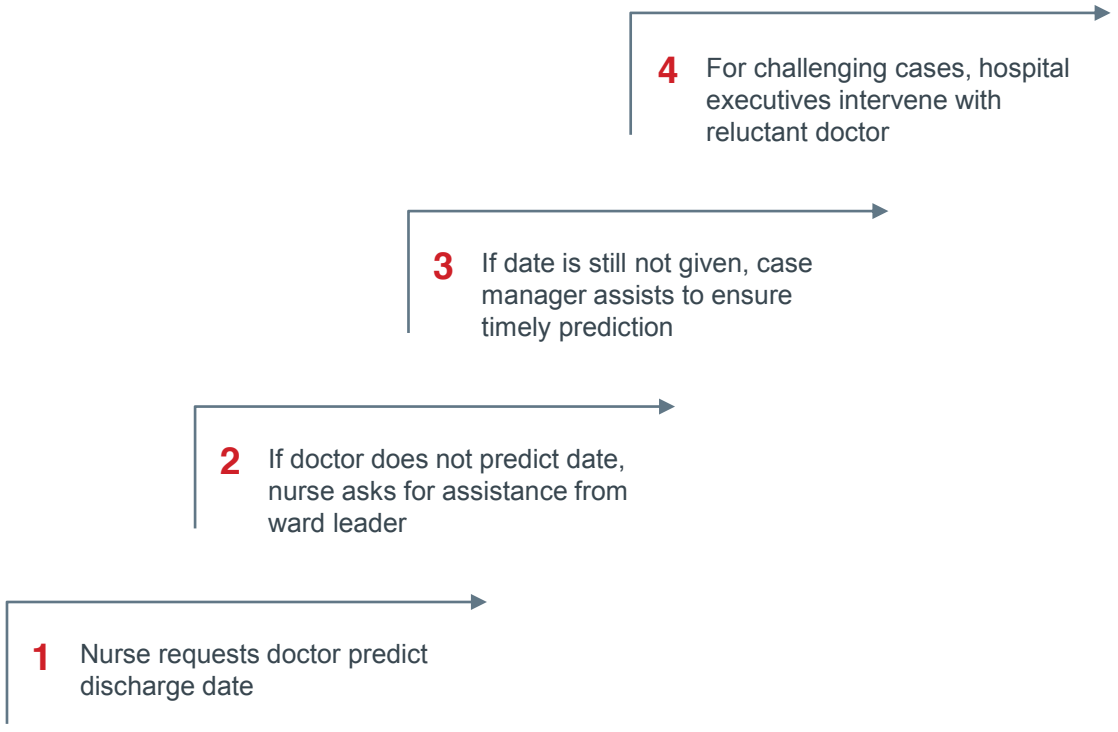
Executive Support Critical for Success

Most importantly, the date prediction policy was reinforced by clearly defined escalation steps to address noncompliance. Executives understood nurses alone could not enforce doctor compliance.

While there was initial concern at Maasstad that this would require a significant executive time commitment, the final escalation step is seldom used in practice. However, the escalation process serves as a clear signal to doctors of the initiative's importance to leadership.

Escalation Procedures Support Nurse-Driven Process

Standardised Escalation Steps at Maasstad Ziekenhuis



Source: Maasstad Ziekenhuis, Rotterdam, Netherlands; Advisory Board interviews and analysis.

Addressing Medical Staff Concerns

In addition to clearly establishing responsibility and accountability, the hospital worked actively to address medical staff concerns.

Maasstad's leaders recognised that unnecessary complexity would frustrate staff and undermine the initiative. Doctors objected that there were too many factors affecting discharge that were outside their control, such as radiology test delays and post-acute care availability. As a result, doctors were asked to predict dates based only on their medical judgment. Nurses and support staff were then challenged to organise care to meet these predicted dates.

In addition, the new policy and subsequent education made it clear that predicted dates could be revised as frequently as doctors felt was necessary, eliminating fears of an inaccurate prediction and concerns about a too-early, potentially unsafe discharge.

These tactics addressed the same three barriers outlined at the beginning of this section.

Three Factors Encouraging Discharge Date Prediction

Removing Confounding Factors

Doctors asked to take only medical factors into account when predicting date of discharge to simplify prediction process

Offering Flexibility to Change Date

Frequent updates to EDD[1] throughout patient's stay address concerns about incorrect predictions

Responsibility and Accountability Clear

Clear assignation of doctor date prediction responsibility and non-compliance escalation ensure high level of participation

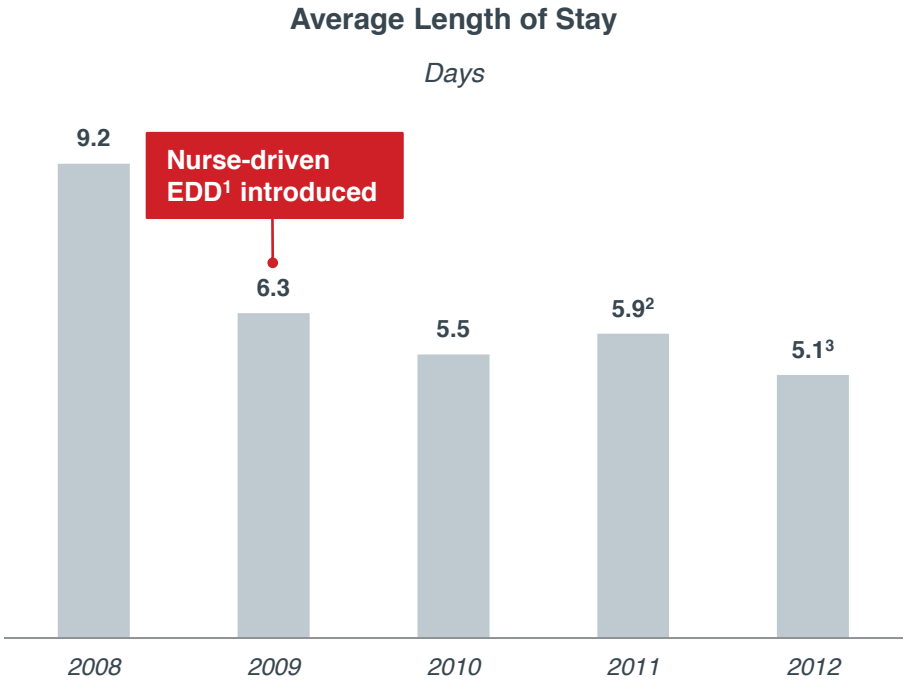
1) Estimated date of discharge.

Source: Maasstad Ziekenhuis, Rotterdam, Netherlands; Advisory Board interviews and analysis.

Executive-Supported Process Decreases Length of Stay

Maasstad's program has consistently delivered near-universal date prediction. Together with additional work to make discharge logistics more efficient, the initiative has also resulted in substantial decreases in length of stay.

It's also clear that the initiative has won acceptance among medical staff: executives report that the escalation process is now rarely used.



95%

Patients with an estimated date of discharge

1) Estimated date of discharge.
2) Move to new hospital building reduces discharge focus.
3) January–March 2012 data only.

Source: Advisory Board interviews and analysis.

Chapter 2

Forecast Post-Acute Needs and Destination

Planning for Discharge Early

- Practice #3: Intensive Planning Need Algorithm
- Practice #4: Comprehensive Caregiver Assessment
- Practice #5: Barrier-Eliminating Discharge Plans
- Practice #6: Specialised Planning for Specialised Care

Finding the Right Discharge Destination a Challenge

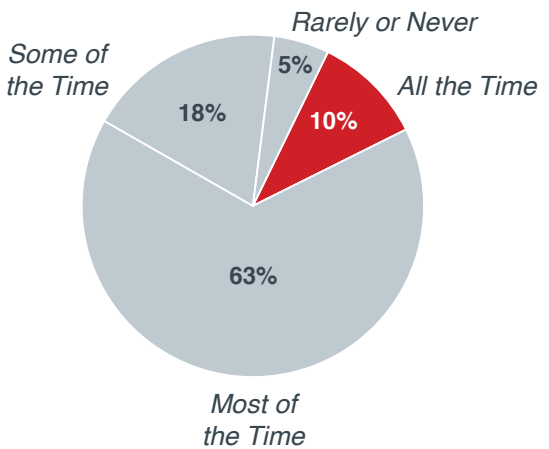
Good planning requires more than a predicted date of discharge. Hospitals need to forecast patients' post-acute care needs, as well as determine their post-discharge destination as early as possible in their inpatient stay.

Early and accurate planning is essential to avoiding costly discharge delays, but also challenging to achieve. Only 6% of hospital staff indicated confidence that patients were discharged to the correct post-acute care setting every time.

Poor Post-Acute Placement Prevalent, Damaging

Patient Placement in Appropriate Post-Acute Care Setting[1]

n = 182 international hospital executives and clinicians[2]



Delays Endanger Patients

"Steps in the discharge process are not followed through and as a result patients end up languishing in hospital beds. This increases the likelihood of further complications arising, such as hospital acquired infection."

"Fast-forward to quicker discharge"
Health Service Journal

1) Responses to 2012 Clinical Operations Board Survey on Transitions Question: "In your opinion, your organisation refers patients to the appropriate post-acute care setting". Options included: "All of the time," "Most of the time," "Some of the time," "Rarely," and "None of the time".
2) 4% of respondents answered "I don't know."

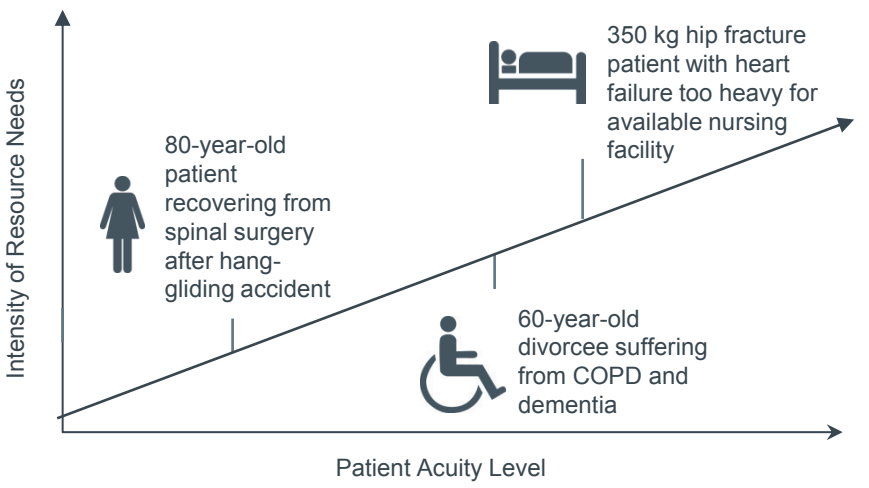
Source: 2012 Clinical Operations Board Survey on Transitions; Health Service Journal, *Fast-forward to faster* discharge, hsj.co.uk, 21 December 2012; The Independent, "Delays 'cost NHS £324m,' 30 May 2012, www.independent.co.uk,; Advisory Board interviews and analysis.

One Size Does Not Fit All

Timely post-acute care placement is made more challenging by the complexity of patient conditions. There is no single factor that indicates patient need for continuing care after discharge, so successful planning requires careful evaluation of multiple risk areas.

Many Factors Determine Post-Acute Care Resource Needs

Intensity of Resource Needs Varies with Patient Acuity



Customising Care

"We've got an 80 year old that was in a hang gliding accident…and 60 year olds with comorbidities that are diabetic [and] on dialysis. The key is tailoring to the individual, not to the age."

Care Coordinator
Public health system, Australia

Source: Advisory Board interviews and analysis.

Multiple Perspectives Required

To add to the discharge planning challenge, no single stakeholder has all the information required to make an accurate decision about the most appropriate post-acute care destination for the patient. For this reason, the input of all stakeholders is required.

Key Stakeholders Offer Different Insights into Potential Barriers

Stakeholders in Post-Discharge Care Planning

Doctors

- Clinical needs, treatment and recovery plan
- Pathology and radiology test results, specialist consultation status

Social Workers

- Post-acute care coordination
- Family and support network capacity

Patient and Family

- Living situation, carer availability and capability
- Patient and family medical history, medication, other allergies, disabilities

Nurses

- Recovery progress
- Psychosocial readiness for discharge

Allied Health

- Rehab and occupational recovery necessary for discharge
- Build patient confidence of readiness for discharge

Source: Advisory Board interviews and analysis.

Time, Complexity, Coordination Hinder Planning

Four main challenges must be overcome to make an early and accurate decision about patients' post-acute care needs and destination

Obstacles to Early Decision on Post-Acute Care Destination

1 Lack of Time

- Clinical staff overburdened, attention given to patient care tasks perceived as more pressing
- Lack of time hinders staff from gathering necessary information to make accurate and proactive decisions about patient post-acute care needs

2 Necessary to Collect Wide Array of Data

- Many patient details necessary to make accurate patient placement decision
- Information must be gathered from multiple sources, including medical and nursing staff, allied health, government assessment teams, patient and family

3 Difficult to Coordinate Input From All Disciplines

- Correct post-acute care placement requires clinical knowledge of patient needs combined with in-depth understanding post-acute services
- Individual care team member unlikely to possess all relevant details
- Care team schedules and workload cause challenges in gathering necessary input

4 Effective Planning Requires Specialised Knowledge

- Nonspecialised staff lack time and knowledge to develop effective discharge plans for chronically ill and complex patients
- Wide array of post-discharge care services and settings too numerous for clinical staff to appropriately refer
- Application processes and securing placement time consuming, complicated

Source: Advisory Board interviews and analysis.

Limited Time Requires a Targeted Approach

Given the realities of limited hospital resources and staff time, conducting detailed discharge planning for every patient is not possible, and for many patients it is not necessary. However, more complex patients do require more intensive planning to ensure a safe discharge.

How can a hospital ensure that patients requiring intensive discharge planning are adequately served without squandering resources on unnecessary assessments?

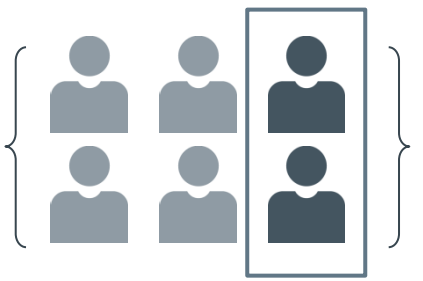
Intensive Discharge Planning Impossible for All Patients

Targeted Discharge Planning Approach

Routine Discharge Planning

- For noncomplex patients without need for post-acute care
- Discharge planning coordinated by bedside nurses with doctors and clinical nurse specialists

Admitted Patients



Intensive Discharge Planning

- For complex patients, e.g., frail elderly, who require further in-depth assessment to identify care needs
- Discharge planning involves additional personnel including case managers, social workers and community care providers

Wide Variation in Risk Tolerance Results in Inconsistent Care

"There's a spectrum of risk tolerance that health care workers have. One individual might tolerate more risk, and say, 'this patient looks healthy, his wife is sitting at the bedside and I think he'll probably do fine', and other people might say, 'just to be safe, let's call in the discharge planner to have them take a look at him'."

Diane Holland, Ph.D., Nurse Scientist
Mayo Clinic

Source: Advisory Board interviews and analysis.

Using Evidence to Develop a Simple Filter

The Mayo Clinic developed a time-saving method to standardise referrals for specialised discharge planning. Their goal was to ensure high-risk patients received needed services while minimising unnecessary assessments.

Recognising that variations in clinician risk tolerance resulted in uneven discharge planning practices, a clinician working group developed a standard screening process for intensive discharge planning referrals. The group used existing literature to evaluate patient variables such as age, comorbidities, cognitive status, and admission in the past year. Their analysis found that only four such variables were statistically significant predictors of patient need for intensive discharge planning.

Statistically Significant Variables to Identify Discharge Planning Needs

Disability | **Lives Alone** | **Walking Limitation** | **Age**

Case in Brief: Mayo Clinic

- Two-hospital health system in Rochester, Minnesota, US with total of 1,951 beds
- Evaluated 24 patient variables to identify those that are statistically significant in predicting patient need for non-routine discharge planning
- Based on results, developed Early Screen for Discharge Planning score to identify need for intensive planning services upon admission
- Scores range from zero to 23 points; score 10 or above indicates need for intensive discharge planning services with a sensitivity of 75.2%[1] and specificity of 78.5%[2]
- Algorithm embedded into hospitals' EMR[3] in 2009
- LOS[4] for intensive discharge planning patients decreased by 20% following algorithm implementation

1) Sensitivity measures the proportion of patients who need specialised discharge planning that are correctly identified by the tool.
2) Specificity measures the proportion of patients who do not need specialised discharge planning that are correctly identified by the tool.
3) Electronic Medical Record.
4) Length of Stay.

Source: Mayo Clinic, Rochester, Minnesota, US; Holland D, et. al., "Predicting Use of Specialized Hospital Discharge Planning Services"; Advisory Board interviews and analysis.

Patient Receives Risk Score Upon Admission

Using a regression analysis of the four statistically significant variables, the clinician working group developed the Early Screen for Discharge Planning Algorithm. The algorithm calculates a patient score of between zero and 23. A score above 10 indicates the need for intensive discharge planning.

The algorithm is easy to use and enables busy nurses to conduct a quick assessment on admission and, if necessary, refer the patient for intensive discharge planning immediately.

A Simple Calculation Leads to Reliable Assessment

Early Screen for Discharge Planning Algorithm

Variable	Scoring Algorithm Points
Age (years)	
18-44	0
45-64	4
65-79	**6**
80+	8
Disability[2]	
No significant disability	0
Slight disability	3
Moderate or greater disability	**9**
Prior living status	
With others	0
Lived alone	**3**
Lived in facility	0
Self-reported walking limitation	
No	0
Yes	**3**

Profile of Nancy[1]

- 67 years old
- Moderate or greater disability
- Lives alone
- Self-reports walking limitation

21

Nancy's risk score; indicates need for referral to discharge planning specialist

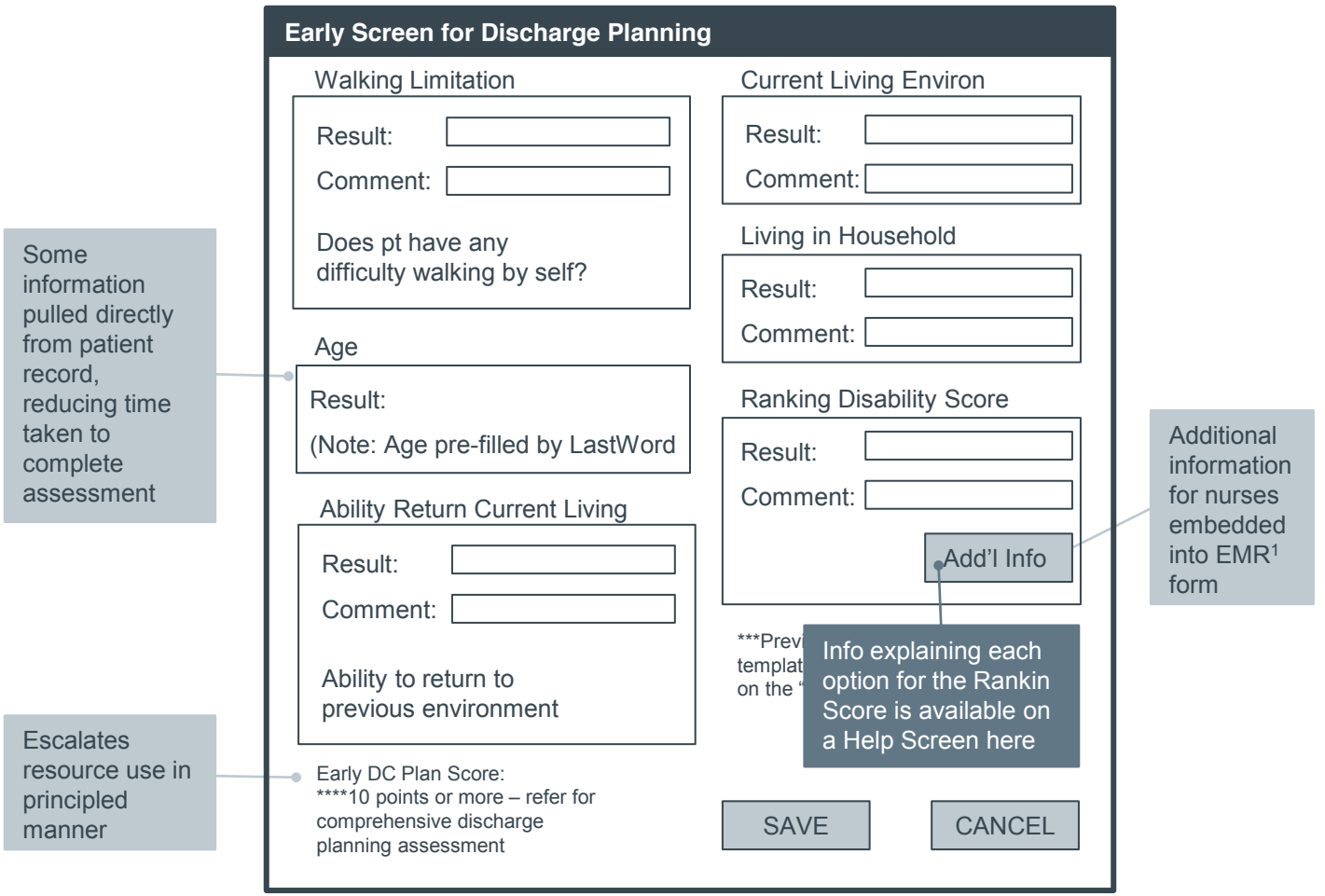
For complete version of **Mayo Clinic's Early Screen for Discharge Planning Algorithm,** please see appendix, p.153

1) Fictional patient.
2) Calculated using Rankin disability score, availability in appendix.

Source: Advisory Board interviews and analysis.

Calculating Score Using Hospital EMR[1]

The Mayo Clinic first developed the algorithm in 2006. In 2009, to further simplify the process, the algorithm was embedded into Mayo's electronic medical records system.



For further screenshots of **Mayo Clinic's Early Screen for Discharge Planning Tool** and **Rankin Disability Score**, please see appendix p.153

1) Electronic Medical record.

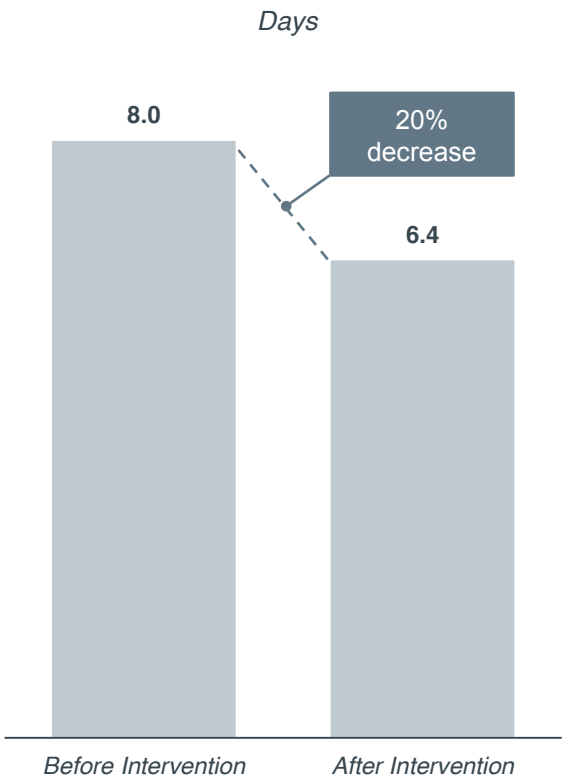
Source: Mayo Clinic, Rochester, Minnesota, US; Bowles K, et al., "A Research and Clinical Partnership to Improve the Identification of Hospitalized Patients in Need of Post Acute Care," Presentation, *2010 National Association for Home Care and Hospice,* 2-6 October 2010; Advisory Board interviews and analysis.

Early Notification Avoids Wasted Days

Since the implementation of the Early Screen for Discharge Planning Algorithm, the Mayo Clinic has seen a 20% decrease in length of stay for complex patients that are referred for intensive discharge planning. With a more targeted, standardised approach, clinicians have been able to more accurately predict patients' discharge needs. Likewise, the intensive discharge planning team has seen an increase in early referrals, enabling them to proactively make arrangements for post-acute care.

Critically, the assessment has also reduced the time wasted on unnecessary assessments, while maintaining staff confidence that all patients are receiving safe and appropriate discharge planning.

Average LOS[1] of Patients Receiving Specialised Discharge Planning



1) Length of stay.

Early Notification Essential

"When arranging for post-acute services you have to start the implementation phase early. Facility placements, making the proper home health care choice...is very difficult to do well without taking some time...Now the discharge planners and social workers [have time to] develop a plan A *and* a plan B, because they've been alerted to pay attention to this person."

One Step in a Larger Process

"Screening is just one step in a process…it directs you to people you should pay attention to, but without…attempting to standardise the process and the implementation, it's still going to be difficult to understand that the discharge planning process alone can be tied to outcomes."

Diane Holland, Ph.D., Nurse Scientist
Mayo Clinic

Source: Mayo Clinic, Rochester, Minnesota, US; Holland D and Hemann M, "Standardizing Hospital Discharge Planning at the Mayo Clinic," *The Joint Commission Journal of Quality and Patient Safety*, January 2011, vol.37(2); Advisory Board interviews and analysis.

Covering the Basics

The next step in effective post-acute care planning is to accurately assess the patients' needs. To do this, most hospitals already assess the patient's living situation, mental and physical health, and level of care needs.

However, many organisations fail to evaluate one crucial element: the patient's caregiver.

Most Evaluations Capturing Common Elements

Common Patient Assessment Elements

Living Situation

What are the patient's living arrangements?

Does the patient live with a caregiver?

What health care resources did the patient utilise at home?

Mental Health Status

What was the patient's mental status prior to admission?

How well can the patient make their needs known?

Is the patient taking any psychoactive drugs?

Does the patient have any addictions?

Level of Care Needs

Where was the patient admitted from?

What is the patient's prior medical history?

Does the patient require an assistive device?

What types of health care resources has the patient **utilised in the past?**

Physical Status

What is the patient's functional status?

Does the patient have difficulty climbing stairs?

Does the patient require a wheelchair?

Is the patient at risk for a fall?

For further information on patient assessments, please see **Clinica Universidad de Navarra's Comprehensive Assessment** in appendix, p.153

Source: Advisory Board interviews and analysis.

Assessing Caregiver Abilities and Needs

Lutheran Medical Center found that discharges were frequently delayed by a last-minute discovery that the patient's caregiver was unable to safely provide care.

In response, the hospital adopted a Family Caregiver Assessment. The assessment includes specific questions targeted to determine a patient's family or caregivers capacity to provide sufficient support. It also helps the caregiver to communicate their own needs to the care team.

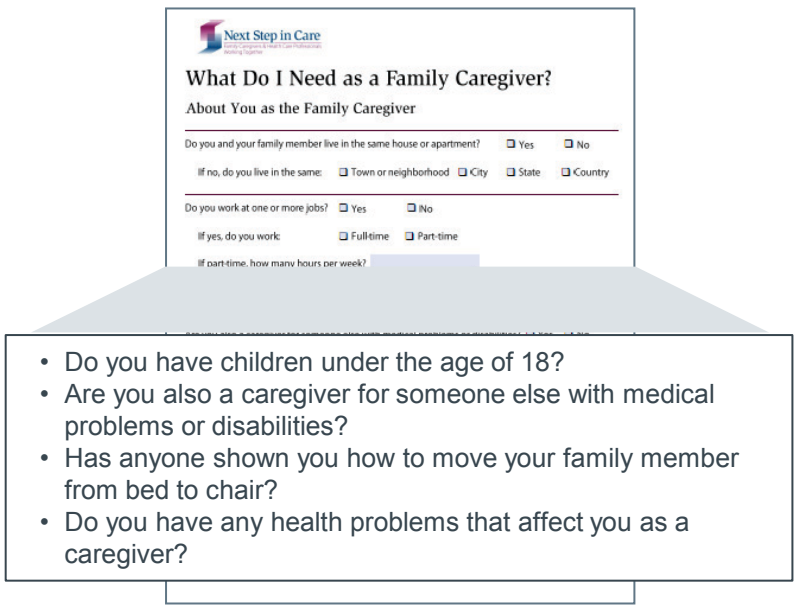
Caregivers Often Overlooked During Post-Discharge Care Planning Process

Critical Elements in Caregiver Assessment

- Level of patient care needs
- Caregiver's proximity, availability to care for patient
- Caregiver's health limitations
- Evaluation of available services at home and in community
- Caregiver concerns about patient
- Available places and people to call or go for assistance

Case in Brief: Lutheran Medical Center

- 395-bed hospital located in Brooklyn, New York, US
- Created admission form that is loaded into hospital's EMR[1]
- Form includes general patient assessment, as well as specific questions targeted to patient's family or caregiver


Next Step in Care

What Do I Need as a Family Caregiver?

About You as the Family Caregiver

Do you and your family member live in the same house or apartment? ❑ Yes ❑ No

If no, do you live in the same: ❑ Town or neighborhood ❑ City ❑ State ❑ Country

Do you work at one or more jobs? ❑ Yes ❑ No

If yes, do you work: ❑ Full-time ❑ Part-time

If part-time, how many hours per week?

- Do you have children under the age of 18?
- Are you also a caregiver for someone else with medical problems or disabilities?
- Has anyone shown you how to move your family member from bed to chair?
- Do you have any health problems that affect you as a caregiver?

For full version of **Lutheran Medical Center's Family Caregiver Assessment**, please see appendix, p.153

1) Electronic Medical Record.

Source: Lutheran Medical Center, Brooklyn, New York, US; Next Step in Care, "What Do I Need as a Family Caregiver?;" Advisory Board interviews and analysis.

Encouraging Discharge Plan Use

Even when all the right information is collected, organisations can struggle to coordinate the input from all disciplines to make a decision about a patient's post-acute care needs.

Discharge planning is a commonly used tool for care team members to identify and avoid delays. However, they are rarely implemented without flaws. Many plans are not utilised by the whole multidisciplinary care team, fail to identify key barriers to discharge, or simply do not correctly identify patient needs.

Discharge Plans Not Used by All Staff

- Only case managers and social workers used discharge plan
- Doctors complained plan was too time consuming to complete
- Discharge plan lacked multidisciplinary perspective

Plans Not Capturing Barriers to Discharge

- Barriers to discharge not identified early
- Discharge planning occurred too late in stay
- Experienced avoidable delays in discharge

Plans Not Meeting Patient Needs

- Clinicians fail to create comprehensive plans for high complexity patients
- Plans provide inadequate post-discharge support to chronically ill patients
- Patients not matched to most-appropriate post-acute care services, risking readmission

Source: Advisory Board interviews and analysis.

Redesigning Plans to Capture Multidisciplinary Input

Recognising that their discharge plans often failed to capture key information, Chevington Hospital[1] decided to completely redesign their discharge planning templates.

After incorporating doctor and clinician feedback into the design process, the new template was significantly shorter, clearly focused on barriers to discharge, and action-oriented.

In addition, Chevington required all members of a patient's care team to contribute to the discharge plan, including the medical staff; accountability was enforced by clinical leaders.

The plan's redesign was accompanied by a rebranding effort: instead of the "discharge plan", the new template is called the "multidisciplinary transition plan." This helped to underscore the need for clinicians, and especially doctors, to participate.

Doctor Input Solicited

Doctors commented that existing form was inefficient; unnecessarily complicated and time-consuming

Plan Redesigned

- Additional field added to specifically identify barriers to discharge and assign tasks
- Unnecessary fields removed; form simplified to reduce time required to complete
- Plan name changed from "discharge plan" to "multidisciplinary transitional plan" to better reflect intention

Improving Care Team Communication

"We are absolutely getting better input from the entire care team. I think any time you can involve the team and use their input, and allow them to communicate their opinion on post-acute care, it's positive."

Chief Nursing Officer, Chevington Hospital[1]

For complete version of **Chevington Hospital's[1] Transition Plan,** please see appendix, p.153

Case in Brief: Chevington[1] Hospital

- 450-bed hospital in midwestern US
- Found discharge planning process was failing to capture all barriers to discharge; observed that doctors were not providing input into discharge plans
- Sought hospitalist input in redesigning discharge plan, refocusing on barriers to discharge; plan simplified to encourage clinician use

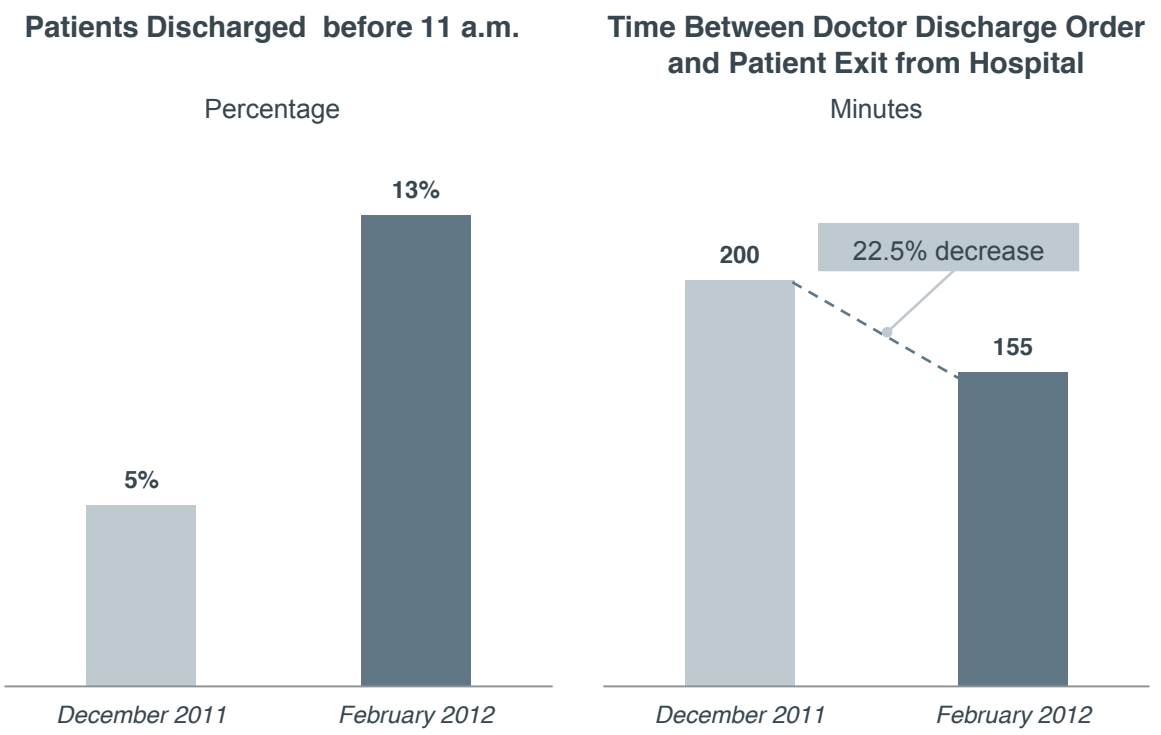
1) Pseudonym.

Source: Advisory Board interviews and analysis.

Redesigned Plan Speeds Up Transitions

Since the redesign of the discharge planning process, Chevington has enjoyed a significantly improved patient discharge. In particular, the patient experience on the day of discharge is much smoother and more efficient.

Redesign Leads to Length of Stay Improvement



Source: Advisory Board interviews and analysis.

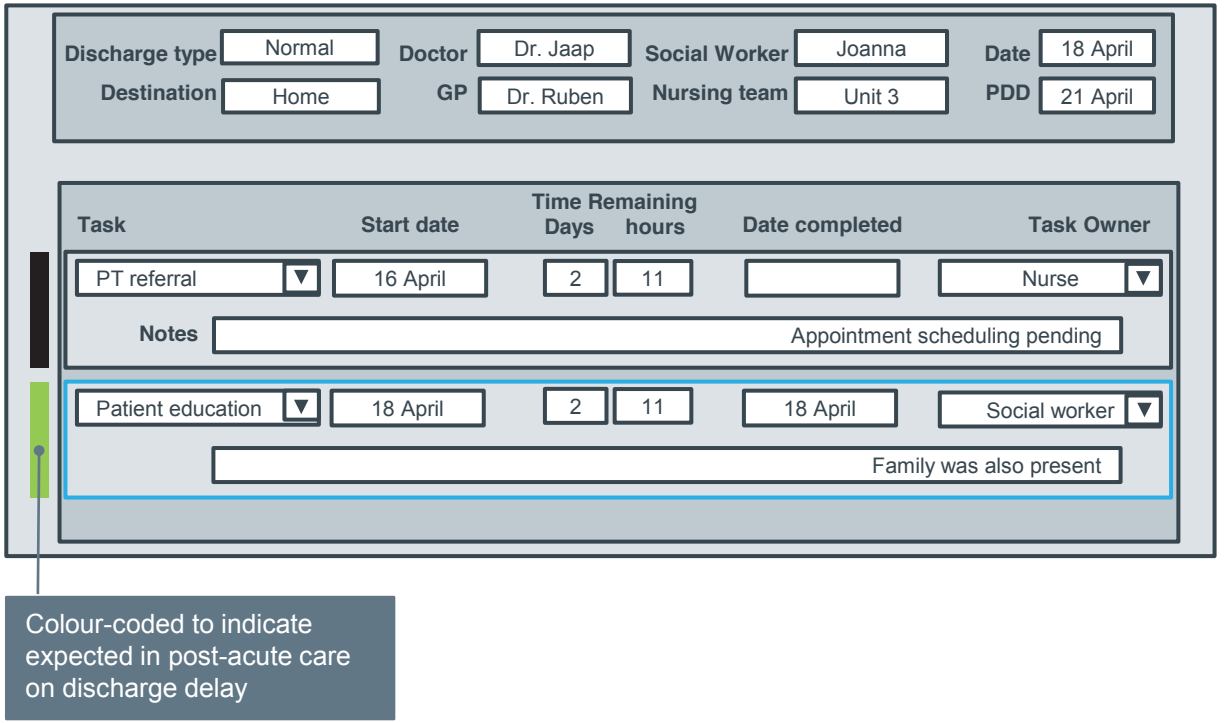
Embedding Discharge Planning into IT System

Maasstad Ziekenhuis faced similarly low levels of multidisciplinary input into the discharge planning process, and used their electronic medical record to create a proactive solution.

The EMR automatically links each patient's record with their care team, at the top of the page. The plan only includes pertinent information: it identifies the type of discharge expected for the patient, as well as their probable destination, and indicates down to the hour how much time remains before discharge.

Most importantly, each task required before discharge is listed out along with assigned owners and deadlines, leaving no confusion over task responsibility. Finally, automatic colour-coding helps staff to priortise tasks based on relative risk that any particular task will cause discharge to be delayed.

Maasstad Discharge Planning IT Platform



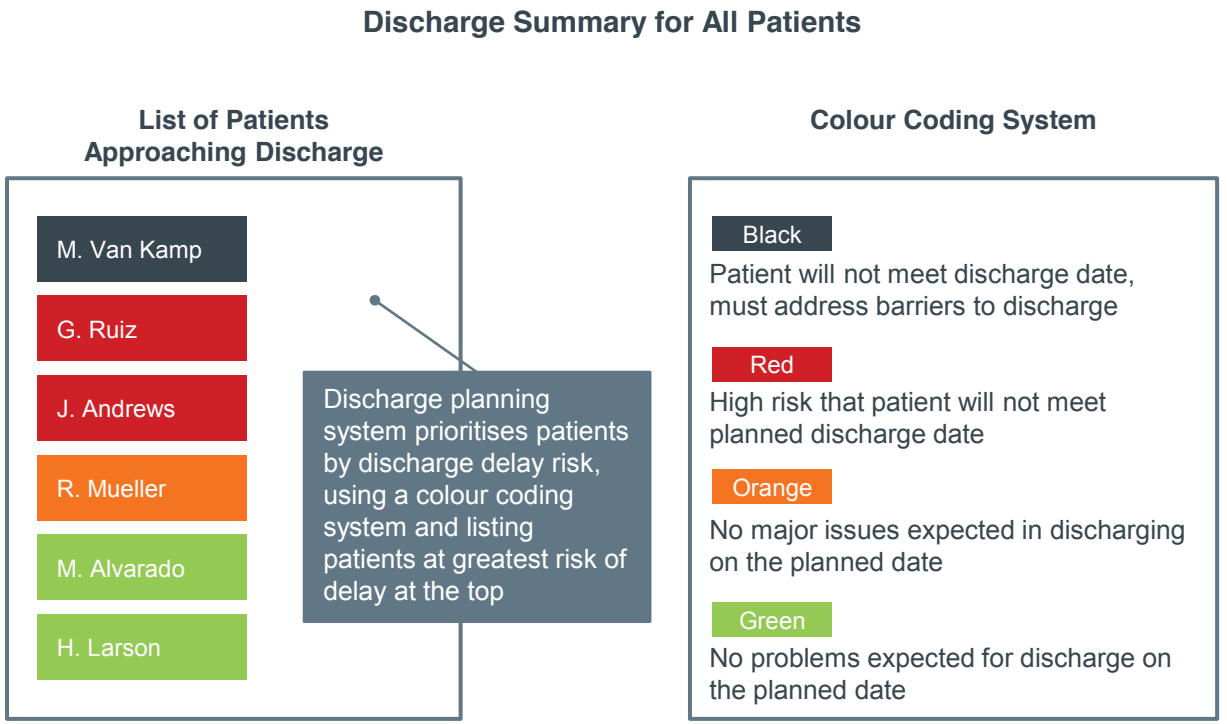
Case in Brief: Maasstad Ziekenhuis

- 600-bed hospital in the Netherlands
- Developed IT system to identify barriers to discharge for each patient
- Completion of tasks necessary to overcome discharge barriers assigned to specific members of care team
- Observed steady decrease in discharges delayed by non-medical barriers

Source: Maasstad Ziekenhuis, Rotterdam, Netherlands; Advisory Board interviews and analysis.

Capturing a Hospital-Wide Snapshot

The system also offers staff a high-level view of discharge task status. Hospital staff are able to see an overview of all patients, colour-coded according to their likelihood of discharge delay, as well as an overview of tasks assigned to them personally. The system automatically tracks and prioritises tasks to ensure that the most urgent steps are promptly completed.

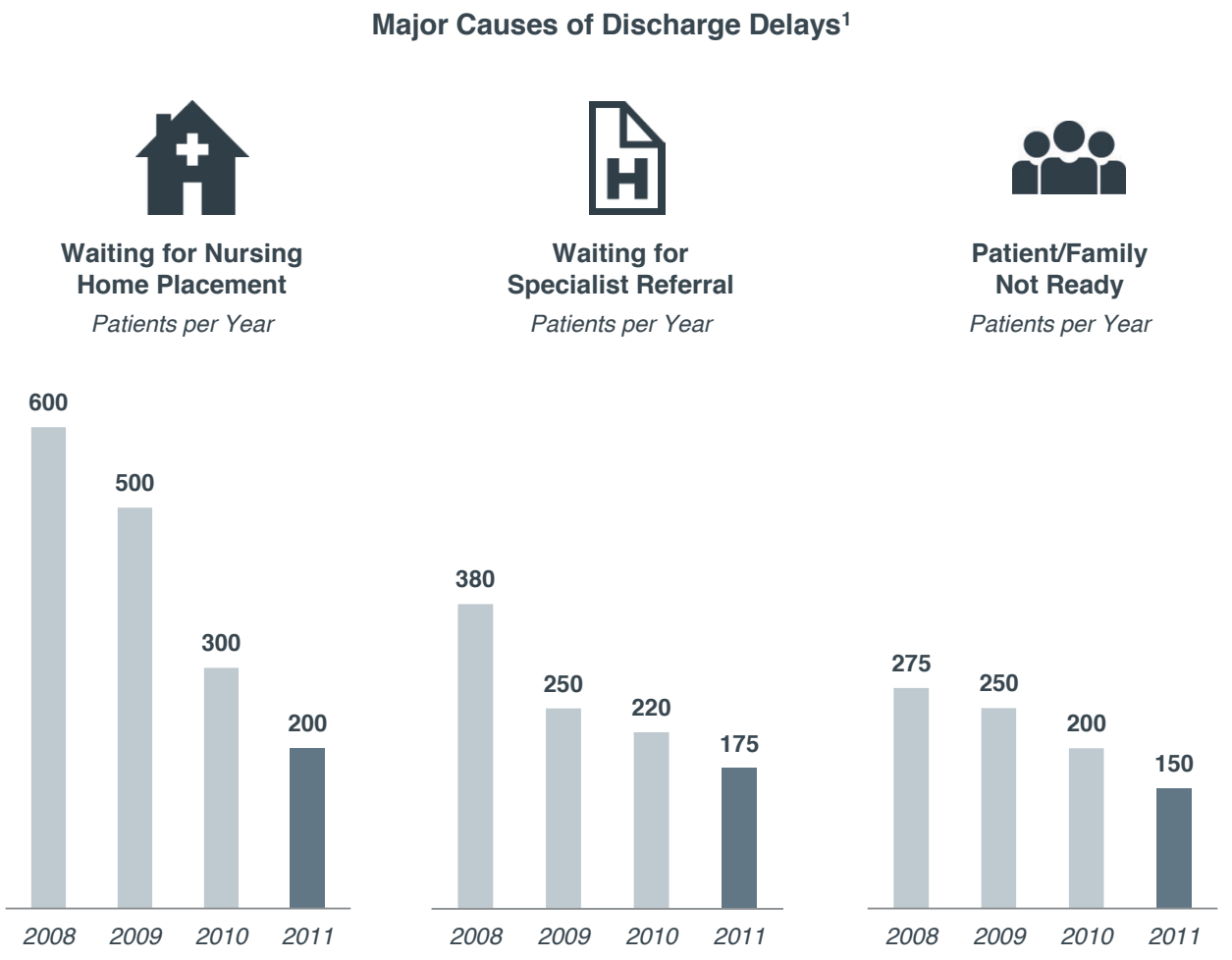


Source: Maasstad Ziekenhuis, Rotterdam, Netherlands; Advisory Board interviews and analysis.

Successfully Avoiding Discharge Barriers

In the four years since discharge planning was embedded into their EMR, Maasstad has seen a substantial reduction in the number of discharge delays occurring for any reason.

Improving Performance Regarding Common Discharge Delays



1) Discharge efficiency interventions introduced in 2009.

Source: Advisory Board interviews and analysis.

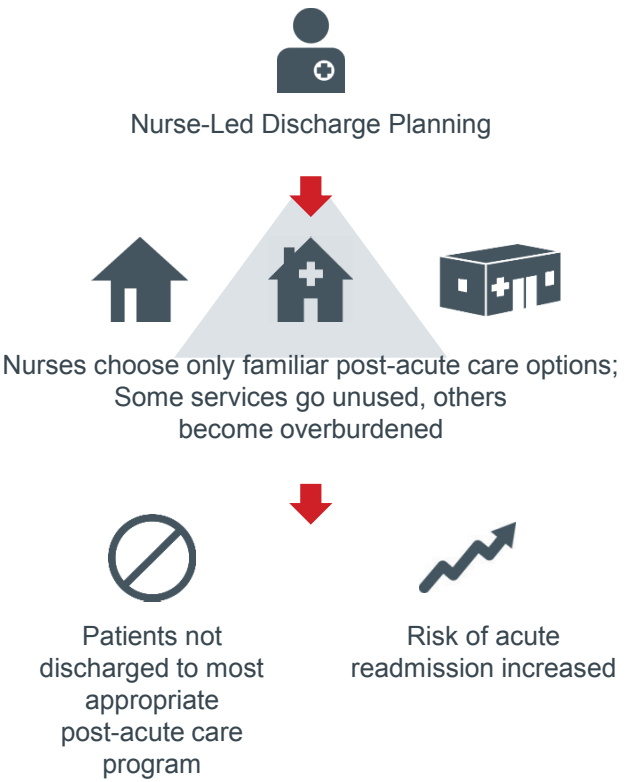
Overwhelmed by Complexity

The final challenge is one of complexity. Whereas in the past discharge was typically a straightforward process easily managed by nursing staff, today's patients often have significant ongoing care needs after discharge. Adding to the complexity, post-acute care options have expanded as well.

In spite of these changes, frontline nurses continue to lead discharge planning for complex patients at many organisations. Without time to research the best option for each individual, nurses often refer patients to familiar services which may not be the most appropriate for the patient.

Clinicians Lack Time, Knowledge for Necessary Coordination

Discharge Process Typically Overlooks Post-Acute Care Options



Too Many Moving Parts

"They [complex patients] often have chronic illness and the presence of comorbidities. Clinical need can become overwhelming for doctors and nursing staff, which means discharge planning is not carried out."

"Fast-forward to quicker discharge"
Health Service Journal

Source: Health Service Journal, "Fast-forward to faster discharge," hsj.co.uk, 21 December 2012; Advisory Board interviews and analysis.

Division of Labor Key

City Hospitals Sunderland NHS Foundation Trust recognised its nursing staff lacked the time and specialised knowledge to efficiently place complex patients in the most appropriate post-acute setting. In cooperation with local primary and post-acute care providers, the trust held a series of rapid process improvement workshops involving care leaders from all levels of the organisations, from frontline clinicians to executives.

Together, they analysed sources of delay and inefficiency and developed realistic solutions. This effort resulted in the Sunderland Intermediate Care Hub, which is managed by staff sourced from primary, acute and post-acute service providers.

New Model Leads to Improved Outcomes for Patients and Hospital

New Post-Acute Care Referral Model at Sunderland

Nurse completes Discharge Request form; sends to Hub

Within 12 hours, Hub staff create post-acute care proposal based on patient needs

Nurse, patient (or family) signs off on post-acute care plan; Hub staff arrange post-acute care placement

Patient discharged to most appropriate setting with minimal delay

Case in Brief: City Hospitals Sunderland NHS Foundation Trust

- 1,000-bed trust located in ‘Sunderland, England
- Frontline clinicians tasked with post-acute care placement lacked time, specialised knowledge to make correct referrals
- Created specialised office, the Hub, to be responsible for planning complex discharge and reablement packages; admission avoidance
- Nurse workload was reduced and quality and timeliness of discharge increased

Sunderland Intermediate Care Hub

- Developed by multi-agency Intermediate Care and Reablement Strategy Group; funded by Reablement and Readmission funds
- Staffed by multi-agency team from PCT, Local Council and City Hospitals Sunderland
- Responsible for determining appropriate next step of care for all patients needing post-discharge care; staff co-location enables rapid decision making
- Able to refer to all area post-acute care programs and services; designed to reduce referrals to long-term residential care

Source: City Hospitals Sunderland NHS Foundation Trust; Advisory Board interviews and analysis.

Specialisation and Accountability Central to Improvement

Sunderland's Intermediate Care Hub's only function is finding the best possible post-acute care destination or service for complex patients. This narrow focus has allowed Hub staff to develop specialised, detailed knowledge of the many post-acute options available to patients.

The effectiveness of this specialisation is enforced by a strict mandate that all planning requests be responded to within 12 hours, with exceptions only made for rare, highly complex cases requiring consultation with doctors and the patient's care team. For less complicated cases, responses are typically received in 30 minutes or less. The mandate is enforced by regular contact between Trust and Hub staff, as well as targeted performance metrics.

Specialisation

- Staffed by multi-agency discharge specialists with clinical knowledge
- Dedicated to planning patient discharge and arranging post-acute care services
- Hub staff familiar with all available post-acute care options
- Hub staff develop personal relationships with post-acute care providers through frequent contact
- Multidisciplinary composition of Hub staff ensures complete knowledge of available services

Accountability

- Hub staff required to create post-discharge care plans within 12 hours of receiving referral; two-hour response "optimum" goal
- Trust discharge team, nurses and social workers follow up daily with Hub to monitor progress of discharge planning
- Trust Discharge Team leader meets in person with Hub staff weekly
- Hub performance targets monitored by Trust and Intermediate Care and Reablement Strategy Group

For complete version of the Hub's referral form, please see appendix, p.153

Source: City Hospitals Sunderland NHS Foundation Trust; Advisory Board interviews and analysis.

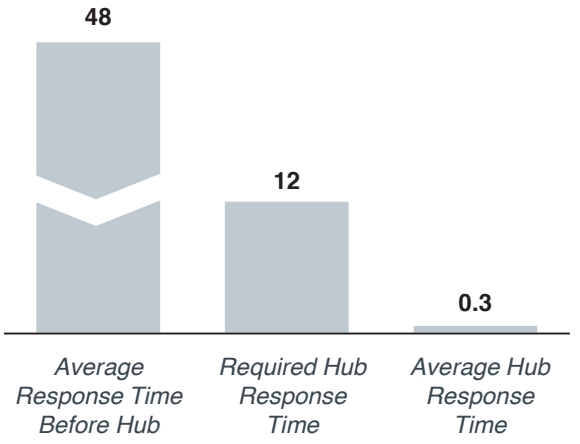
Specialised Planning Keeps Complex Cases on Track

The creation of Sunderland's Intermediate Care Hub has led to significant improvements that have benefited patients, as well as primary, acute and post-acute providers. In the hospital this has resulted in faster discharge planning, more appropriate placement, and reduced wait times for patient transfer.

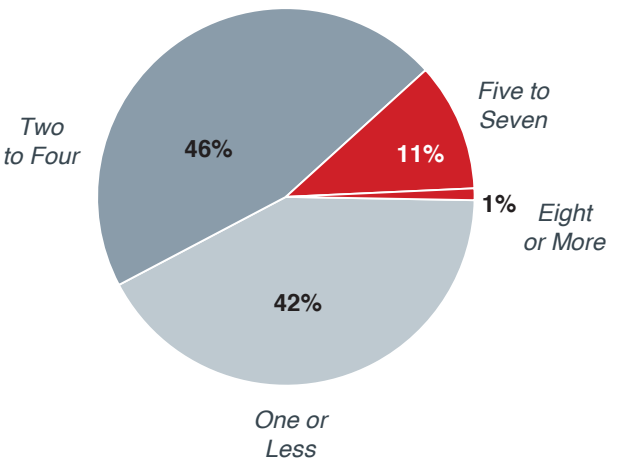
Based on this success the Hub has expanded its services to the emergency department and primary care settings to prevent patients from occupying acute beds unnecessarily.

Improved Outcomes for Patients and Hospital

Time to Respond to Post-Acute Care Referral
Working Hours



Time from Referral to Start of Service
Days



Improvement on All Fronts

"It used to be, whatever bed came up first, that's where the patient ended up, so that they didn't stay in hospital any extra time. It was not necessarily the right place for the person with access to the services they needed, so their recovery once they left hospital wasn't necessarily very fast … The Hub has improved communications, we are getting quicker answers to our questions and we are getting a quicker turnaround on finding the right care for patients when they leave hospital."

Sue Martin, City Hospitals Sunderland NHS Foundation Trust

Source: City Hospitals Sunderland NHS Foundation Trust; Advisory Board interviews and analysis.

Recognising an Unmet Need

A second, alternative to integrate this specialised discharge planning function into a multidisciplinary team. Fundación Santa Fe is a 200-bed hospital in Bogotá, Colombia. Realising that discharge delays for complex patients were the greatest opportunity to reduce length of stay, the medical director proposed the creation of a new resource, a Dedicated Discharge Team to manage discharge for this patient population.

The compelling proposition of improving finances and care quality convinced the board to invest in the team, and stakeholders across the organisation were engaged in the team design and launch.

The team was designed as a dedicated resource to ensure that they had the time and expertise to focus on complex discharge. Critically, a highly respected internist was recruited to lead the team. Having worked at the hospital since his medical student days, the new team leader was well known by other doctors and nurses throughout the organisation.

Dedicated Discharge Team Champions Appropriate Utilisation

Rolling Out a Dedicated Resource

1 Dedicated discharge resource deemed most appropriate response to capacity pressures; request for funding for discharge team presented to board

2 Discharge Team proposal makes dual argument for funding

3 Respected internist recruited to lead discharge team; Executive Board gives full authority to team to make proposed changes

4 Four-person dedicated discharge team launched in February 2013; 80+ meetings held to educate staff

Financial Benefit
Record analysis revealed significant capacity waste and revenue opportunity

Moral Imperative
Hospital mission includes providing highest quality care to as many patients as possible

Fundación Santa Fe's Dedicated Discharge Team

- 1 Senior Doctor
- 1 Registered Nurse
- 1 Social Worker
- 1 Auxiliary Nurse

Discharge Team Focus

- Complex Patients
- Complicated Financing Cases
- Transport Logistics
- Oxygen and Equipment Approval and Installation
- Optimising Discharge Process

Source: Fundación Santa Fe de Bogota, Bogota, Colombia; Advisory Board interviews and analysis.

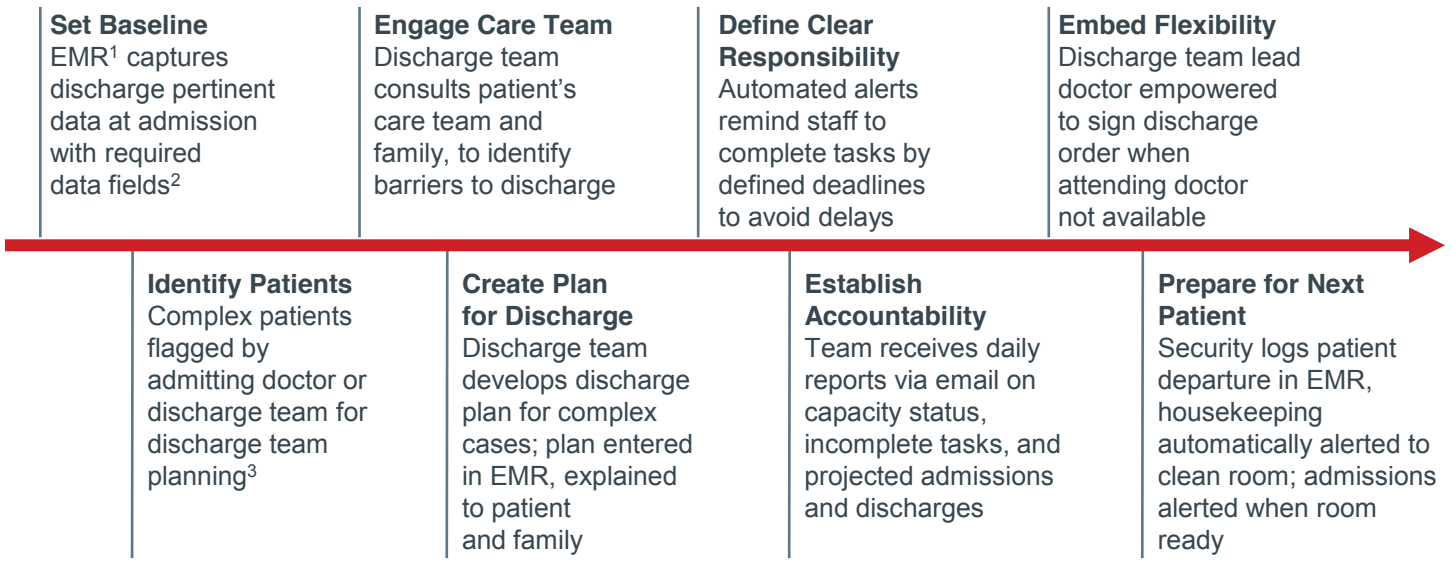
Managing Every Part of the Process

The newly-established team worked to streamline the discharge process for complex patients, creating an efficient and largely automated system for identifying and managing patients likely to require complex discharge planning.

For every barrier and necessary discharge task, clear responsibility is individually assigned. Task assignments are added to the electronic medical record, which provides automated reminders for staff, and also sends daily discharge status email reports to the discharge team.

A critical principle is that the discharge team creates no extra work for attending staff, but rather reduces demands on clinician time. Additionally, the discharge team lead doctor has the authority to discharge patients independently, without waiting for attending doctor approval. This prevents delays when busy doctors are unable to promptly attend to discharge-ready patients.

Addressing Complex Discharges Early and Often



Case in Brief: Fundación Santa Fe

- 200-bed hospital in Bogotá, Colombia
- With hospital consistently at or near 100% capacity, medical director suspects opportunity to reduce patient LOS[4]
- Analysis reveals significant delays present in patient discharge process, but hospital's independent doctors reluctant to change practice
- Dedicated discharge team identified and implemented solution for hospital; embraced by staff

1) Electronic Medical Record.
2) Data includes EDD, age, living situation, doctor generated discharge plan, etc.
3) Admitting doctor required to either create patient discharge plan or flag patient for Discharge Team planning.
4) Length of Stay.

Source: Fundación Santa Fe de Bogotá, Bogotá, Colombia; Advisory Board interviews and analysis.

Supporting the Investment

This practice was not embraced by clinicians overnight. The hospital framed the creation of a dedicated discharge team as a supplementary resource to ease the workload of busy doctors and nurses, not as a threat to medical staff authority.

It had long been policy at Fundación Santa Fe that all patients must receive discharge plans at admission, but in the past this policy had never been enforced. With the discharge team creation, the hospital's independent doctors were given two options: create timely discharge plans for patients or cede responsibility to the discharge team. No doctor is forced to cede control as long as they create and execute discharge plans for patients.

Discharge Team Empowered to Succeed

Three Keys to Discharge Team Effectiveness

Engaged Stakeholders

- Medical Director and discharge team present new initiative at 80+ different staff forums
- Clear executive support signals importance to all staff
- Piloted Discharge Team with two progressive wards to prove success to rest of hospital
- Leadership of respected colleague mitigates distrust
- Initiative designed to accommodate specific needs of wards; flexibility reduces opposition

Elevated Authority

- Discharge team led by respected, well-connected internist and career Fundación Santa Fe doctor; able to persuade peers of new process benefits
- Lead doctor granted authority to sign discharge orders for all patients if necessary
- Team allowed to take over discharge planning without doctor consent if doctor fails to create and execute discharge plan
- Collectively possesses full knowledge of discharge process

Strong Accountability

- EMR[1] redesign ensures inclusion of all discharge necessary patient data
- EMR sends daily reports on delayed discharges, long-stay patient status and projected bed need
- Alerts signal staff to complete specific tasks
- Measured response times create data to evaluate staff performance

1) Electronic Medical Record.

Source: Fundación Santa Fe de Bogota, Bogota, Colombia; Advisory Board interviews and analysis.

A Worthwhile Pursuit

Staff have embraced the new discharge planning process, and as a result of these changes, patients needing discharge planning are identified earlier, planning is actively managed, and patient transitions and satisfaction have improved.

Dedicated Discharge Team Breaks Discharge Bottleneck

Lightening the Clinical Load

"Physicians love [the Discharge Team]. They're happy, they have a load taken off their shoulders; we haven't had a single problem. I really thought that there were going to be objections. And really they were so happy to get our help! I'm still not over my surprise."

Medical Director, Fundación Santa Fe de Bogotá

Clarifying the Process

"We try to help patients throughout the whole process. We explain our procedures when they arrive, talk with their families, and when they receive the bill, we walk them through it to answer any questions. We help them all along the way. When it is time to leave, they are prepared."

Discharge Team Director, Fundación Santa Fe de Bogotá

Source: Fundación Santa Fe de Bogotá, Bogotá, Colombia; Advisory Board interviews and analysis.

Embedding an Infrastructure to Execute Discharge Plans

With limited time and an extensive list of tasks to complete each day, clinicians, understandably, have a tendency to prioritise essential tasks over those such as discharge planning, which are less urgent in the moment. As a result, clinicians compromise, putting acute care first and deferring non-essential tasks, sometimes repeatedly. Unclear responsibility adds to the problem, as clinicians assume other members of the care team will complete discharge tasks. A strong infrastructure is required to ensure that discharge tasks are embedded into clinical workflow.

Typical Care Team Daily Task List

Essential Care Tasks

- ☑ Diagnostic tests
- ☑ Bathing and toileting assistance
- ☑ Medication administration
- ☑ Daily evaluation of clinical status
- ☑ Meal delivery
- ☑ Surgery
- ☑ Occupational/Physical therapy
- ☑ Referral to specialists
- ☑ Post surgical functional rehab
- ☑ Specialist consultation
- ☑ Final radiology scan

Discharge Planning Tasks

- ✖ Patient and caregiver education
- ☑ Social worker assessment
- ✖ Follow-up appointment(s) made
- ☑ Final radiology results received
- ☑ Medication reconciliation
- ✖ Discharge transportation arranged
- ☑ Doctor orders discharge

Chapter 3: Install Proactive Preparation for Discharge, p. 75

Chapter 4: Coordinate End-of-Stay Processes, p. 105

Source: Advisory Board interviews and analysis.

Chapter 3

Install Proactive Preparation for Discharge

Embedding an Infrastructure to Execute Discharge Plans

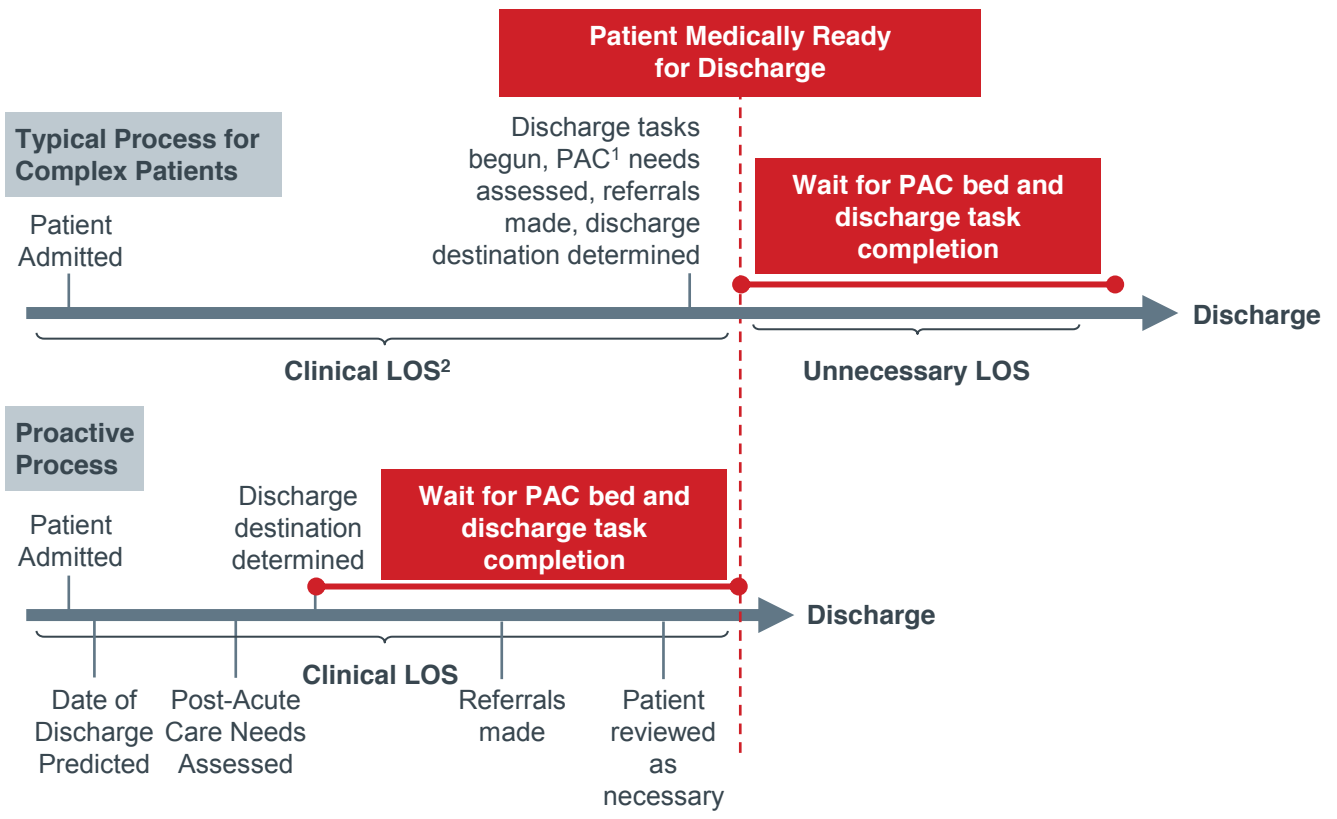
- Practice #7: Workflow-Centred Journey Boards
- Practice #8: Staff-Designed Multidisciplinary Rounds
- Practice #9: Specialised Case Management Staffing
- Practice #10: Patient-Centred Discharge Scripting
- Practice #11: Patient-Centred Staff Education

Proactive Preparation Essential to Avoid Delays

When discharge preparation begins at the end of acute treatment, patients spend unnecessary days in the hospital waiting for discharge tasks to be completed and post-acute care service availability. But when discharge tasks are completed earlier in the stay, patients are more likely to leave as soon as they are medically ready to do so.

Hospitals that effectively reduce discharge delays implement systems to ensure tasks are proactively completed before the patient is medically fit for discharge.

Two Models of Patient Discharge Preparation



1) Post-Acute Care.
2) Length of Stay.

Source: Advisory Board interviews and analysis.

Not Part of the Routine

A successful, proactive discharge preparation system must overcome four primary obstacles: poor management of relevant data, inadequate daily processes and routines to manage discharge tasks, and poor lack of staff and patient engagement in timely discharge.

Proactive Preparation Inconsistent Without Infrastructure, Culture

Obstacles to Proactive Discharge Preparation

Patient Data Dispersed, Inaccurate, Out of Date

- Patient information repeatedly collected by different care givers; storage decentralised
- Poor visibility of patient status and discharge tasks; ward staff often not aware of task status, urgency

Systems for Early Task Completion Not Reliable

- Difficult for ward staff to fulfill clinical duties and manage patient pathway
- Lack of clarity regarding who is responsible for managing patient discharge

Low Patient Engagement in Timely Discharge

- Patient confused about post-discharge care options, care plan
- Patient and family do not understand importance of timely discharge

Staff Do Not Understand Importance of On Time Discharge

- Staff do not understand discharge best practice
- Staff fail to connect discharge delays with ability to meet personal, departmental and organisational goals

Source: Advisory Board interviews and analysis.

Journey Boards Failing To Realise Communication Goals

Ensuring staff have easy access to accurate, up-to-date, and comprehensive patient data pertinent to discharge planning can be difficult for many organisations. This challenge is amplified with complex patients, where input from diverse parties are required for planning.

A commonly employed solution to this problem is the use of patient journey boards (also known as status boards, ward boards, or rounding boards). These boards are meant to solve an array of common communication problems, but often fall short of their goals.

Patient Journey Boards Frequently Falling Short

Common Discharge Communication Challenges

- Patient assessments and data collection repeated unnecessarily
- Limited overview of ward case load and patient status
- Patient data storage not centralised
- Data on discharge status often not readily accessible, unreliable, outdated or inaccurate

Journey Boards Commonly Attempted Solution

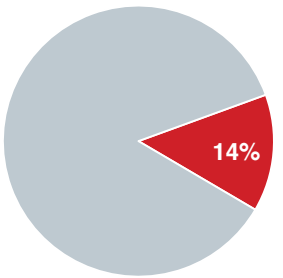
A Common Concept

- Patient Journey Boards centralise patient information into a single, easily visible point in ward
- Most hospitals have employed journey boards as solution to communication challenges
- Boards often fail to achieve wide-spread or lasting improvement

Fail to Meet Expectations

Journey Board Users Reporting "Very Effective" Use[2]

n = 127 global hospital executives and clinicians



Patient Journey Board

Patient Journey Boards are display boards centrally located in wards that concisely display essential patient data for all ward patients, to facilitate treatment, planning and communication. They are most commonly used in either electronic or dry-erase format.

50%

Surveyed hospitals using Journey Boards[1]

1) Percentage answering "Yes, very effective," or "Yes, but could be more effective," to the question, "Please indicate whether the following discharge efficiency strategies are utilised at your organisation". n=98 UK hospital executives and clinicians.
2) Percentage of journey board users answering "Yes, very effective," to the question, "Please indicate whether the following discharge efficiency strategies are utilised at your organisation?"

Source: Clinical Operations Board 2012 Survey on Transitions; Advisory Board interviews and analysis.

Common Pitfalls Undermine Efforts

There are four main reasons why patient journey boards often fail to deliver results: inadequate content, inconsistent formatting, low utilisation and limited accountability.

Many Hospitals Failing to Address Key Journey Board Challenges

Four Common Sources of Patient Journey Board Ineffectiveness

Inadequate Content

- Key patient data not included on Patient Journey Board
- Unnecessary data fields clutter and distract

Lack of Consistency

- Format and style must be consistent across Journey Board
- Wards, clinical staff and allied health employ different definitions, terms and abbreviations

Poor Participation

- Clinical staff fail to update Journey Board regularly
- Lack of participation from small hold-out group undermines efforts of majority

No Accountability

- Responsibility for updating patient info unassigned or not enforced
- Expectation to utilise Journey Boards not established

Confidence in Journey Board accuracy and utility undermined	Confusion and errors attributed to Journey Board ineffectiveness	Better communication and coordination not achieved	Accuracy and impact of Journey Board suboptimal

Source: Advisory Board interviews and analysis.

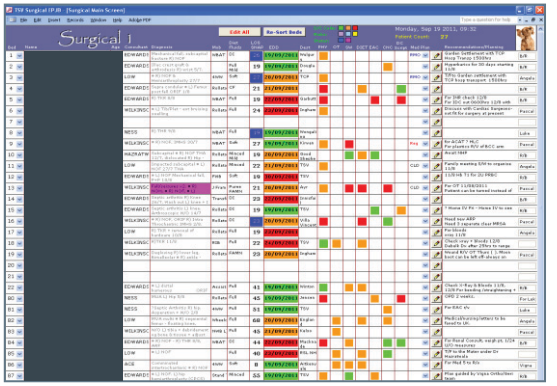
Custom Designed Journey Boards Enhance Care

Queensland Health, the state health department in Queensland, Australia, had experimented with whiteboards in hospitals across the state, but found limited value in their use.

To improve interdisciplinary communication and ensure up-to-date data, they funded a pilot program to develop an electronic patient journey board that was more sophisticated but easier to use. The pilot program also implemented accountability structures to ensure consistent use of the boards, and addresses all other key barriers to success.

Importantly, the board's end-users—ward clinicians—were involved in all aspects of development and design to ensure the boards were useful and that staff were engaged in their use.

Queensland Health Workflow-Centred Journey Board Template



Case in Brief: Queensland Health

- Workflow Centred Patient Journey Board program started as single site pilot at the Prince Charles Hospital
- Queensland Health initiative implemented in more than 60 wards throughout the state

For an additional method to embed reliable early task completion, please see **Workflow-Centred Journey Boards** in appendix, p.153

Addressing Key Barriers

- **Standardised Core Content, Unit-Specific Additions**
  Mix of mandatory and customisable fields and format to ensure essential information always captured and still allow for ward-specific needs
- **Common Language Established Hospital-Wide**
  Universal terms and abbreviations established to ensure clear communication between different care providers and those working in multiple areas of the hospital
- **Local Ownership Drives Participation**
  Clinician input into board design and intuitive system encourages initial participation; steadfast project leadership at ward level develops sense of ownership and investment in journey board use
- **Clear Delineation of Responsibility**
  Responsibility for board updating tasks clearly assigned to each staff member; expectation for staff to update and react to board clearly established by clinical leaders; expectations reinforced by peers

Source: Queensland Health, Queensland, Australia; Advisory Board interviews and analysis.

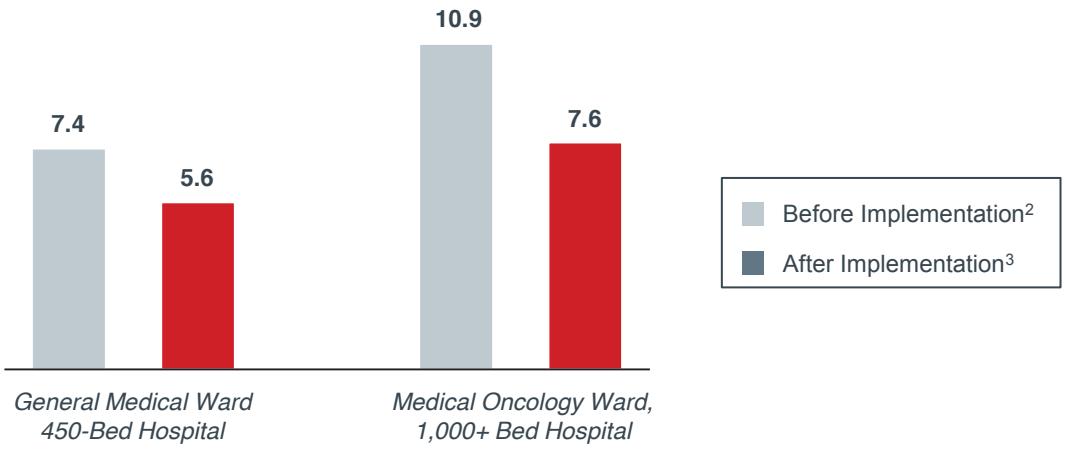
Consistency and Commitment Optimise Results

Since the initial pilot, the journey boards have been installed in more than 60 wards across the state. Hospitals achieving improvements by using the Workflow-Centred Journey Boards range from small rural hospitals to large specialty hospitals.

Workflow-Centred Journey Board Yields Significant LOS Reduction

Workflow-Centred Patient Journey Boards Reduce LOS[1]

Length of Stay



Improved Communication Becomes Automatic, Drives Efficiencies

"Because all of the information is visible to all of the care givers, allied health, they could all see the estimated discharge date, post-acute care planning, home meds, home visits. This means they can all be better coordinated with far less reliance on team leaders making sure that every member of the team has received every piece of information, several times a day."

Susan Moller, Lead Project Officer
Workflow-Centred Journey Board Initiative, Queensland Health

1) Average inpatient length of stay measured in days.
2) 28-day period prior to Journey Board implementation.
3) Most recent 28-day period since implementation.

Source: Advisory Board interviews and analysis.

Many Rounds Failing to Reach Potential

With reliable, easy-to-access patient information in place, hospitals must ensure that reliable systems for proactively completing discharge tasks are in place.

Multidisciplinary rounding is one of the most common tactics used to achieve prioritisation and accountability for discharge tasks. Yet, many hospitals struggle to leverage their multidisciplinary rounds to achieve lasting improvements in discharge efficiency.

Common Pitfalls of Multidisciplinary Rounds

Intermittent Attendance

Not all potential barriers to discharge are captured without input from full care team

Limiting Effectiveness

"One of the challenges of interdisciplinary rounds when you don't have a physician or mid-level provider present is that you're creating more to-do lists people have to keep track of versus creating a sense of closure around specific items."

The Hospitalist, 2008

No Clear Focus

Rounds are time consuming and may not elicit essential information about discharge barriers

Lacking Objective

"With rounding, some wards do quite well gathering and analysing the patients' needs. But in many, rounding is very much limited to addressing acute conditions."

Hospital Executive
NHS Acute Trust, UK

Poor Documentation

Staff unsure which tasks they are assigned to complete after rounds end; no accountability for task completion

Missing Follow-Up

"One of the issues that we have is that there often is not one person who is identified as the accountable person for completing a task required to discharge a patient. The team knows they need to be done, but no one considers it their responsibility."

Throughput Manager
General hospital, Canada

Source: Dillard B, "Round Up Staff For Better Rounds," *The Hospitalist*, September 2008; Advisory Board interviews and analysis.

Opportunities to Refresh Rounding

There are three major opportunities to improve multidisciplinary rounding effectiveness that must be addressed.

Essential Elements for Productive Multidisciplinary Rounds

Clear Staff Roles and Expectations

- Engage all essential staff in round design to generate ownership, buy-in and ensure attendance
- Assign clear roles and accountability

Structured Format

- Provide structure regarding time, place and leaders of rounds
- Establish guidelines on time commitment
- Discuss barriers to discharge from the perspective of each discipline

Documentation of Discussion

- Designate a note taker to document the discussion
- If electronic documentation possible, record in real time during rounds

Source: Advisory Board interviews and analysis.

Setting the Stage for Success

Leaders at Northwestern Memorial Hospital in Chicago recognised that round attendance and staff buy-in would suffer if the process felt imposed by management. So they created a structured template which allows wards to design their own rounding process while still ensuring that the critical elements are covered.

The template aims to achieve two outcomes: ensuring that the planned structure takes into account the unique needs of the ward, and building a sense of ownership among clinicians and a commitment to maximise rounding effectiveness.

In this way, Northwestern leaders have been able to make sure that staff members have a clear understanding of their individual roles and responsibilities, and also that all essential elements of an effective rounding process are in place.

Structured, Ward-Led Start Boosts Impact of Multidisciplinary Rounds

Questions to Answer Prior to Implementing Multidisciplinary Rounds

1. When should we meet?
2. How long should we meet for?
3. Where should we meet?
4. Who should we include in the conferences?
5. Should we stagger attendance of any care team members?
6. What items should we cover in the conferences?

Checklist Ensures Key Items Covered

INTERACT Communication Tool

- **Room Number**
- **Patient Last Name**
- **Overall Plan of Care**
  - ❑ Diagnosis
  - ❑ Patient Chief Concern
  - ❑ Tests/Procedures for the day
  - ❑ Medication
  - ❑ Diet
- **Discharge Plan**
  - ❑ Patient education needs
  - ❑ Anticipated discharge date
  - ❑ Discharge needs (placement, home health, transportation?)
- **Patient Safety**
  - ❑ GP contact
  - ❑ On VTE prophylaxis
  - ❑ Mobility assessment
  - ❑ Can catheter or central line be discontinued?
  - ❑ Can we reduce pressure ulcer risk?
  - ❑ Goals of care and code status

For an additional example of **Staff-Designed Scripted Multidisciplinary Rounds**, please see appendix, p.153

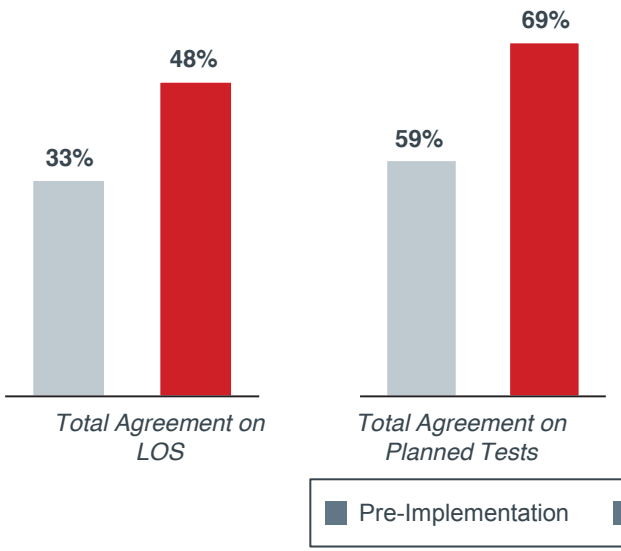
Source: Northwestern Memorial Hospital, Chicago, US; O'Leary, K, et al, "Impact of Localizing Physicians to Hospital Units on Nurse Physician Communication and Agreement on the Plan of Care," *Journal of General Internal Medicine*, 2009, 24(11), 1223-7; Advisory Board interviews and analysis.

Rounds Improve Communication, Safety

Northwestern's staff-owned, scripted multidisciplinary rounds have created meaningful improvements in care coordination at the organisation: notably, agreement between care team members has increased and adverse events have significantly decreased.

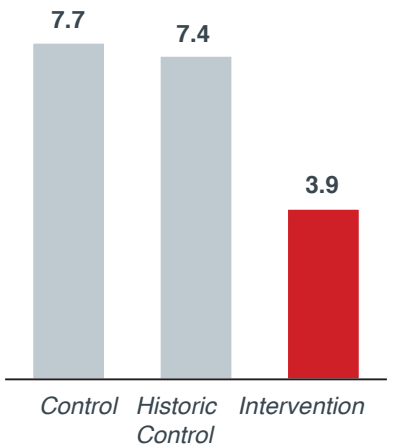
Agreement Between Nurse and Doctor on Aspects of the Plan of Care

n=280 to 286[1] Clinicians



Effect of Multidisciplinary Rounds on Adverse Events

Per 100 Patient Days



Case in Brief: Northwestern Memorial Hospital

- 897-bed teaching hospital in Chicago, US
- In 2008, implemented ward-specific planning for multidisciplinary rounds
- Six-month rollout included cohorting 73% of doctors on floors with their patients, and team training
- Nurse and doctor leader on ward jointly conduct multidisciplinary rounds

1) The number of surveyed doctors and nurses ranged from 280 to 286 between pre and post-implementation, due to missing data elements. Implementation included localisation of doctors and patients.

Source: Northwestern Memorial Hospital, Chicago, US; O'Leary, K, et al, "Impact of Localizing Physicians to Hospital Units on Nurse Physician Communication and Agreement on the Plan of Care," *Journal of General Internal Medicine,* 2009, 24(11), 1223-7; O'Leary, K, et al, "Structured Interdisciplinary Rounds in a Medical Teaching Unit," *Archives of Internal Medicine,* 2011, 17(17), 678-684; Advisory Board interviews and analysis.

Complex Patients Dominate Rounding Discussions

Complex patients represent another obstacle to efficient and effective rounding. Rounding processes can be derailed by a small group of highly complex patients. These patients take considerable time to discuss, and appear in rounds day after day, wasting time for staff members not involved in their care. Over time this discourages participation, slowly undermining rounding quality and effectiveness.

Fraser Health Authority faced this situation: each round lasted for two hours on average, and complex patients represented the majority of that time. Over time, frustrated staff stopped attending rounds.

Inefficiency of Rounds Leads to Poor Attendance

Single Patient Rounding Process → **Complex Patients Dominate Discussion** → **Staff Frustrated by Wasted Time**

- All patients in ward assessed in single, daily rounding process
- Two hours average duration
- Lacked consistent discharge focus, escalation of discharge barriers

- Small number of patients with highly complex needs occupy majority of care team time

- Many staff attendees not involved in care for complex patients
- Attendance decreases due to perception of inefficiency

Single-Stream Rounds Unproductive

"Doctors didn't attend rounds because the rounds lacked focus and were too long; Allied Health begrudged their time in rounds because few of the patients discussed had discharge needs that they could contribute to, hence it wasn't good use of their time."

Senior Executive, Health system, Canada

Source: Fraser Health Authority, British Columbia, Canada; Advisory Board interviews and analysis.

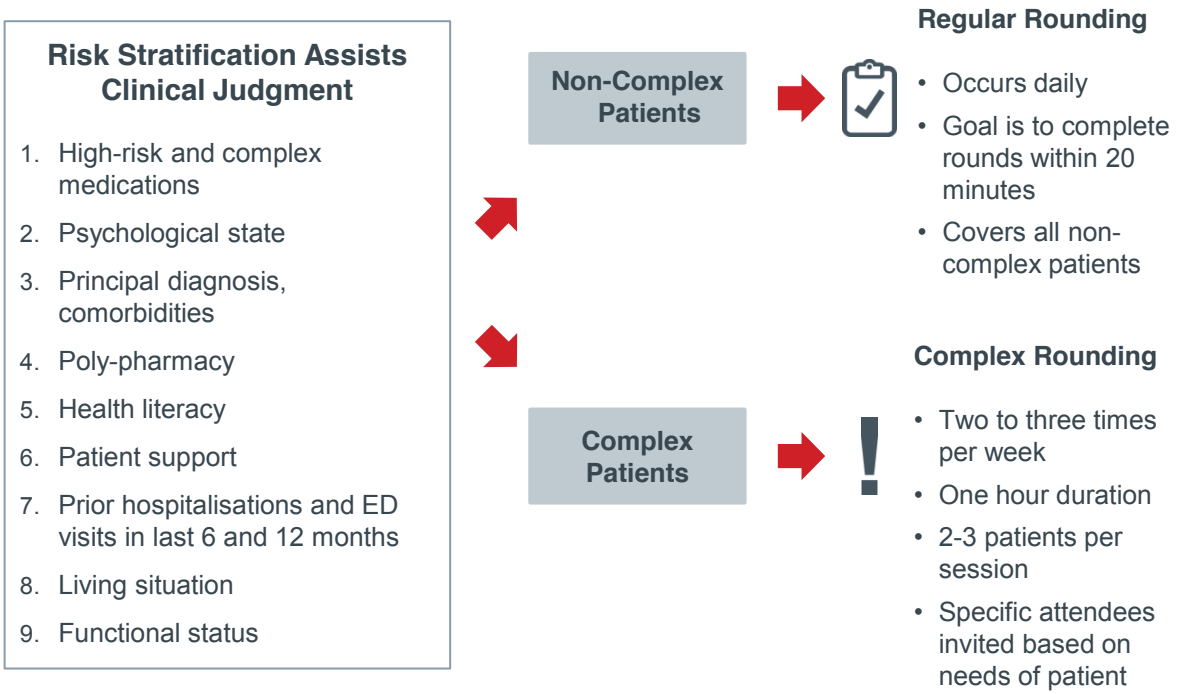
Create Dedicated Time for Most Complex Patients

Fraser recognised that rounding would not be effective until this problem was resolved. Their solution was a dual rounding process that separates complex and noncomplex patients into separate rounding groups.

Fraser employs a risk assessment screen alongside clinical judgment to classify patients as “complex” or “non-complex.”

Daily rounding on noncomplex patients continues as originally envisioned: each round now lasts only 20 minutes. Meanwhile, complex patients are discussed two to three times per week in one-hour sessions dedicated to managing difficult cases. A predetermined meeting agenda keeps discussion on track and ensures that only appropriate care team members are invited.

Stratified Rounding Efficiently Manages Time-Intensive Patients



Case in Brief: Fraser Health Authority

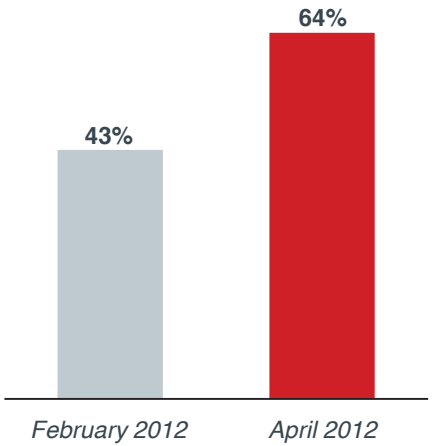
- Integrated health care service in British Columbia, Canada
- Staff dissatisfied with time-consuming multidisciplinary rounds
- In September 2011, implemented two-tiered rounding practice to round separately on complex patients, reducing regular rounding time by over 80%
- Rounds focus on risk assessment for new admissions, patient status changes impacting discharge, and planned discharges in next 24–72 hours

Source: Fraser Health Authority, British Columbia, Canada; Advisory Board interviews and analysis.

Achieving a Higher Standard

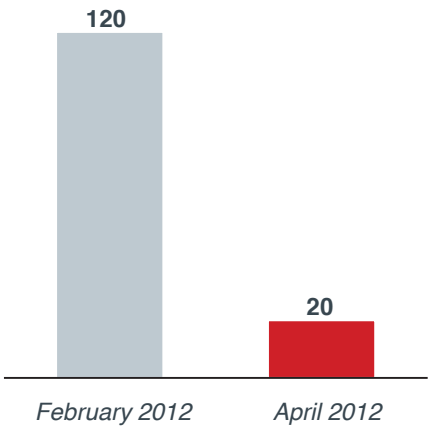
The new process was introduced in September 2011. By February 2012 Fraser had already achieved greater staff participation in rounds as well as a 20% increase in patients discharged within the hospital's target length of stay.

Percentage of Patients Discharged Within Target LOS[1]



Duration of Daily Rounds

Minutes



1) 8.6 day target length of stay set based on 30% decrease in length of stay from previous year.

Source: Fraser Health Authority, British Columbia, Canada; Advisory Board interviews and analysis.

Case Management Common Practice

Case management can serve as a second option to ensure reliable completion of discharge tasks.

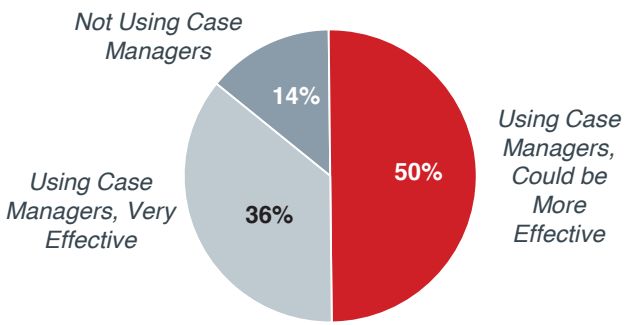
Case managers manage discharge planning, scheduling and coordination with patients, clinicians and external providers. They typically manage between 10 and 50 patients at a time, depending on patient complexity. Where multidisciplinary rounding spreads tasks across multiple people, case management centralises responsibility with a single person: a case manager.

However, case management also requires careful implementation to avoid common obstacles and ensure effective use.

High Return on Investment Eludes Many

Effectiveness of Complex Case Managers[2]

n = 252 international hospital executives and clinicians



Obstacles to High-Value Case Management

Lack of authority and accountability
Case managers lack authority to make decisions regarding their patients; efficiency of patient transitions not measured or managed

Overwhelming administrative demands
Substantial time spent by case manager specialists on administrative tasks misallocates high-value staff time

Inadequate qualifications, personal characteristics to manage complex cases
Hiring practices not oriented towards identifying key qualifications and characteristics necessary to effectively manage caseloads

Insufficient time to address complex cases
Large case loads prevent comprehensive management of patients with multiple medical conditions, as well as mental health, social and legal issues

1) Responses to 2012 Clinical Operations Board Survey on Transitions Question: "What kinds of services are typically provided for complex patients? Please check all that apply." "Yes" identifies those selecting "Case Manager Led Treatment Plan."
2) Responses to 2012 Clinical Operations Board Survey on Transitions Question: "Please indicate with a tick or check mark whether the following discharge efficiency strategies are utilised at your organisation?" For the strategy, "Complex case managers," options included: "Yes, very effective," "Yes, but could be more effective," "No, not utilised," and "I don't know."

Source: 2012 Clinical Operations Board Survey on Transitions; Advisory Board interviews and analysis.

Key Attributes of Successful Case Manager Programs

Here, we lay out common problems experienced by case managers, along with potential solutions and diagnostic questions for surfacing areas where your organisation may need to focus attention.

Case Manager Assessment Diagnostic

	Common Problems	Suggested Actions	Diagnostic Questions
Ensure Appropriate Authority and Accountability	• Staff not empowered to make necessary decisions about patient transition needs • Not held accountable for patient discharge delays and quality of patient transitions	• Track LOS[1], rate of timely discharge and patient satisfaction measures • Endow position with authority necessary to meet performance criteria	• Does your hospital track case manager performance (e.g. individual, department or unit-based metrics)? • Do case managers have leadership support and clear avenues to elevate challenges?
Ease Administrative Burden	• Burdened by administrative tasks that limit bedside discharge planning time with patient and caregiver	• Offload administrative tasks, e.g., transportation arrangements and completing paperwork to non-licensed staff • Reduce repetition; centralise patient data for ease of access	• How much time does a case manager have for discharge planning at bedside? • How much time is occupied by tasks that can be offloaded to non-licensed staff?
Hire for Fit	• Limited clinical knowledge prevents effective coordination with clinical and allied health staff • May lack personal skill-set necessary for success	• Determine characteristics necessary for success in role, make hiring decisions accordingly • Consider staffing case managers to specialties instead of individual wards to enhance team work	• Do doctors and clinicians recognise value of the case manager role? • Are case managers hired based on characteristics relevant to role and organisational culture?
Provide Resources for Complex Patients	• Difficult to allocate workloads based on patient acuity • May not be well-equipped to manage complex cases	• Consider dedicating complex case manager with special expertise and resources to highest risk patients • Limit complex case manager caseload to 15 patients	• How many complex patients does each case manager oversee? • Do case managers have the ability to escalate complex cases when necessary?

1) Length of stay.

Source: Advisory Board interviews and analysis.

Redefining Relationships

Austin Health in Victoria, Australia, found their ward-based case managers were often distracted by requests to perform ward-level tasks unrelated to their discharge responsibilities, leaving them unable to focus their full attention on achieving the best discharge outcomes for patients.

A simple solution overcame this issue. Austin Health created a separate reporting structure for case managers, removing them from the ward hierarchy. They now report through the system's access and demand manager, allowing a broader perspective on patient flow throughout the hospital.

Case managers continue to collaborate with ward staff, but have the independence to work across departments and the authority and executive backing to provide different perspectives from ward staff.

Discharge-centred performance metrics further ensure that case managers efforts remain firmly focused on efficient patient discharge.

Clear Authority and Accountability Empowers Case Managers

Selected Care Coordinator Performance Evaluation Criteria

Post-Acute Referrals

- Number of referrals managed without post-acute care admission
- Assessments completed within four hours of referral

Complex Case Management

- Patients with LOS 1 >14 days
- Coordination with clinicians, allied health to progress appropriate discharge plan

Post-Acute Referrals

- Post-acute care referrals per ward per month

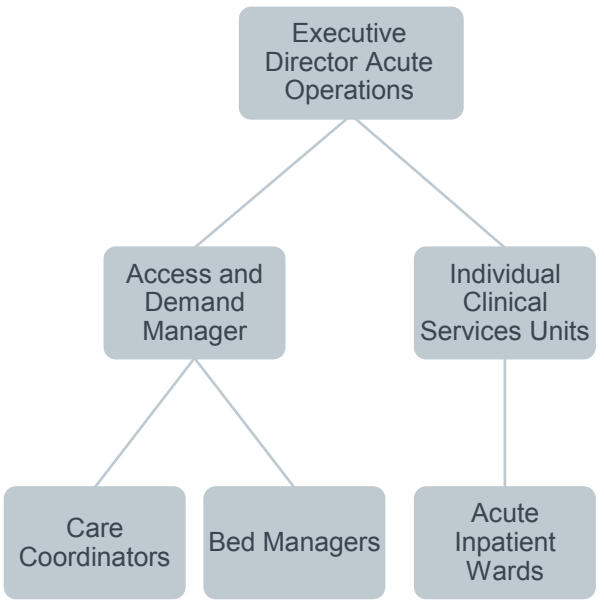
Coordinated Discharge Planning

- Effectiveness avoiding delays for all other patients

Case in Brief: Austin Health

- Three-facility health system in Melbourne, Victoria, Australia
- Operates dynamic case management program: case managers report outside ward-level structure; clear expectations and accountability for performance

Separate Reporting Structure Key to Success



1) Length of stay.

Source: Austin Health, Melbourne, Victoria, Australia; Advisory Board interviews and analysis.

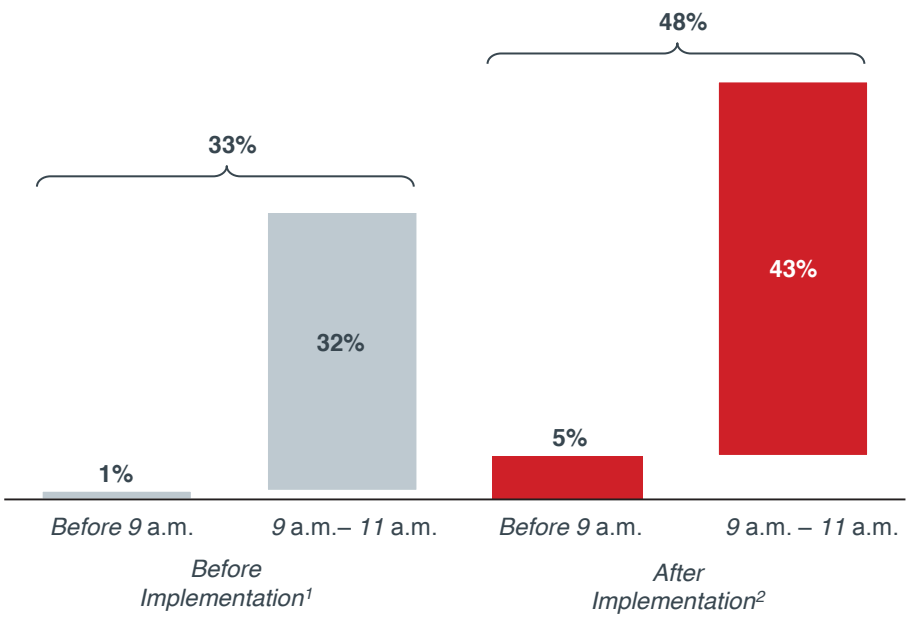
Smoothing Patient Flow

The results speak for themselves: Austin Health has seen significant gains in discharge efficiency across the system. Perhaps most impressively, the number of discharges occurring before 9 a.m. has significantly increased.

Empowered Staff, Clear Goals Enable Morning Discharges

Discharges Occurring Before 9 a.m. and 11 a.m.

Percentage of Total Discharges



1) 28-day period prior to implementation, *n = 2271.*
2) Most recent 28-day period after implementation, *n =2 091.*

Source: Austin Health, Melbourne, Victoria, Australia; Advisory Board interviews and analysis.

Redistributing Administrative Tasks

The University of Wisconsin identified the burden of administrative tasks as the primary obstacle for their case managers. To address this, they created a "Transition Resource Centre" staffed by six non-clinical staff with specialisations in sub-acute options and care funding.

The Centre effectively liberated case managers to focus solely on aspects of discharge planning that require a clinical background. This process allows all staff to function at "top of license" and the hospital reports that the transition process has become smoother and patient satisfaction with their discharge has increased.

Separating Low-Skill Tasks to Better Leverage Case Manager Time

Clinician Case Manager

Resource Centre Benefits

- Clinical background fully utilised; engaged in top of license tasks
- Increased time at patient bedside
- More face-to-face conversations with family
- Ability to attend inpatient team meetings
- Majority of time focused on transition planning tasks

Resource Centre

Referral Specialists

- No clinical background, university educated
- Gather information on discharge options and community resources
- Arrange transportation

Payer Specialists

- No clinical background, university educated
- Serve as contact for insurance companies, government and other payers
- Facilitate information flow

Case in Brief: University of Wisconsin Hospitals and Clinics

- 483-bed hospital located in Madison, Wisconsin, US
- Established off-site Resource Centre staffed by three referral specialists and three payer specialists
- Centre serves case management functions such as researching discharge options, arranging patient transportation, contacting payers, and assisting with data and outcomes analysis
- Allows case managers more time at bedside and ability to focus on transition planning tasks

Source: Liegel B, "How to Make the Care Management Model Work: A Case Study," *The Case Manager,* vol. 17 (4), 2006; University of Wisconsin Hospital and Clinics, Madison, Wisconsin, US; Advisory Board interviews and analysis.

Migrating to a Specialised Resource

Some organisations may find, however, that coordinating a smooth discharge process for their patient population requires a specialised team of case management staff.

Counties Manukau District Health Board is responsible for the care of an ethnically diverse and socio-economically disadvantaged population of half a million in Auckland, New Zealand. Facing numerous "frequent presenter" patients in their emergency department, they implemented a "Very High Intensive User Program" in 2009 to target these patients.

The program is a case management team dedicated to managing the Board's most difficult cases. They work with patients throughout their acute stay and continue to manage them after discharge to prevent future admissions. The model includes patient assessments, home visits, interdisciplinary case reviews, and shared care planning with patients. The main focus is to re-engage patients with their primary care teams and support them to self-manage their conditions.

A Comprehensive Approach for Frequent Presenters

Team Members Carefully Selected for Roles

- Demonstrated top performer in area of specialisation
- Experience working in the community and patient homes
- Excellent communication and interpersonal skills with ability to develop patient rapport and trust
- Competence in motivational interviewing and engaging and empowering patient in self-management of health care needs

Case in Brief: Counties Manukau District Health Board

- Serves primary, acute, and post-acute health needs of population of 490,000 in Auckland, New Zealand
- Cost of care and population growth exert increasing pressure on acute capacity
- Focused on "Very High Intensive Users" to curb growth in acute presentations

Very High Intensive User Program

- Created in 2009 to better meet healthcare needs of patients with complicated social situations, health literacy issues, and complex medical conditions
- Patients with more than 5 presentations in 12 months included in the program; identified on ED presentation
- Strict admission criteria limits case load, ensures each patient receives necessary attention
- Multidisciplinary team includes staff dedicated to VHIU[1] patient group
- VHIU team conducts home visits, assessments, case review and care planning; works with primary and post-acute care providers to engage patients in their own care

Source: Counties Manukau District Health Board, Auckland, New Zealand; Advisory Board interviews and analysis.

Proactive Approach Pays Dividends

The team comprises members with a variety of complementary clinical and nonclinical backgrounds; however all members are carefully chosen for their strong communication skills. Team members are also held accountable for their performance on a variety of efficiency and quality metrics.

Strong Accountability Motivates Diverse Team

VHIU[1] Team Members

- Doctor
- Nurses
- Occupational Therapist
- Physiotherapist
- Cultural Support Worker
- Pharmacist
- Social Workers
- Locality Coordinators
- Team Administrator
- VHIU manager

Performance Measurements

- Time from triage to patient intervention (first home visit)
- Total reduction in hospital impact, including ED[2] presentations, admissions, and LOS[3]
- Patient engagement in primary care
- Total face-to-face time spent with patients
- Improvement in patient quality of life
- Patient and family experience

50%

Average reduction in bed days achieved for VHIU program participants

50%

Average reduction in ED presentations achieved for VHIU program participants

1) Very High Intensive User.
2) Emergency department.
3) Length of stay.

Source: Counties Manukau District Health Board, Auckland, New Zealand; Advisory Board interviews and analysis.

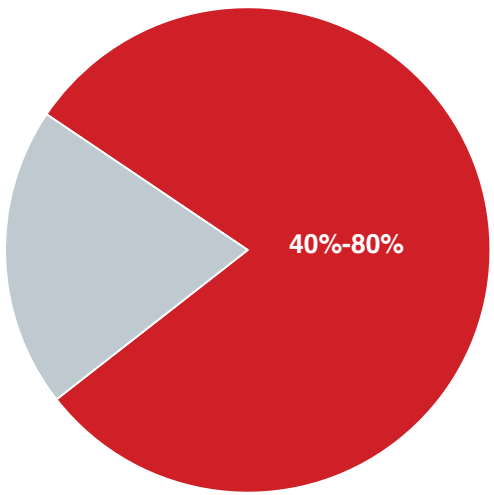
Hospitals Struggle to Communicate Effectively with Patients

One of the most important factors in achieving a timely discharge can also be the most elusive: engaging the patient. Most hospitals fail to communicate discharge information to patients until the end of their patient stay. This is made more difficult by the fact that between 40% and 80% of information provided by clinicians is immediately forgotten by patients. However, as informed patients are critical for smooth discharges, as well as high-quality care, hospitals must find ways to ensure that communication is connecting with patients.

Most Patients Do Not Understand Urgency of Timely Acute Discharge

Patient Communication a Difficult Task

Medical Information Provided by Health Care Practitioners Forgotten Immediately



Many Hospitals Not Rising to the Challenge

Patients Leaving Confused

61% Australian patients experiencing at least one discharge communication gap

28% New Zealand patients not receiving clear instructions about symptoms to watch for

32% UK patients leaving hospital without written post-discharge instructions

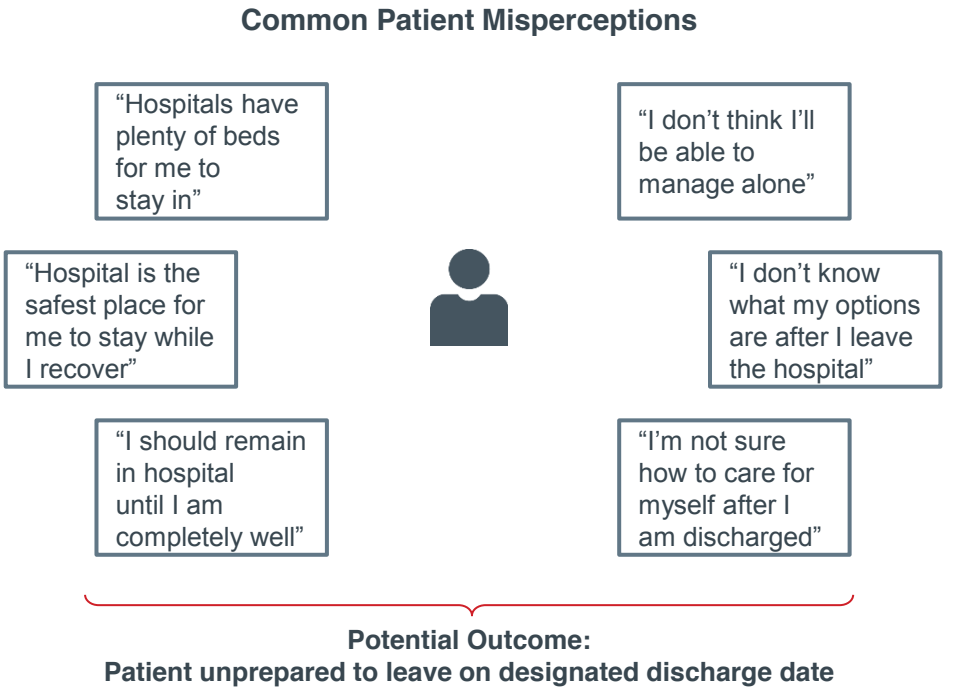
Sources: MaGuire LC, "Remembering what the doctor said: organization and older adults' memory" *Experimental Aging Research*, 1996: 22:403-28; Schoen C, et al., "In Chronic Condition: Experiences of Patients with Chronic Health Care Needs, In Eight Countries, 2008," *Health Affairs*, 2009:28(1):w1-w16; Advisory Board interviews and analysis.

Not On the Same Page

Many patients experience fears or misperceptions that make them reluctant to leave the hospital when they are medically fit for discharge.

Failure to set patient expectations early and address these concerns can contribute to avoidable delays.

Patient Misperceptions, Confusion May Cause Delays



Source: Advisory Board interviews and analysis.

Communicating Early, Often

Trillium Health Partners in Ontario, Canada, recognised that one of their chief barriers to effective dialogue was the lack of a clear process for staff to communicate with patients. Staff sometimes provided conflicting information, or failed to set patient expectations appropriately.

Trillium's approach to improvement was simple: they created scripts for staff to use, along with guidelines on the essential points to cover. To embed these into workflow, the scripts were accompanied by simple timelines on when staff should communicate information, and when they should follow up.

Ensuring Patient Awareness of Post-Discharge Options

Trillium's Discharge-Focused Patient Scripting

Scripting

"After your acute care needs are finished, you will be ready to be discharged from the hospital. We're here to work with you to help you return home. There are several options, but staying in hospital is not one of them."

Points to cover

- Options for discharge home include: CCAC[1] in-home supports, friends, family, neighbours, community agencies including day programs…
- Alternatives also to be considered are retirement homes, assisted living, group homes, etc.

For complete version of **Trillium's Discharge-Focused Patient Scripting**, please see appendix, p.153

Case in Brief: Trillium Health Partners

- 793-bed hospital, part of newly merged health system including Trillium Health Centre and Credit Valley Hospital, located in Mississauga, Ontario, Canada
- Experienced an unsustainable increase in number of patients clinically ready for discharge waiting in acute beds for post-acute care placement
- Organised an education program for staff to address patient concerns and encourage patient transition out of hospital
- Together with other interventions, reduced number of discharge-ready patients waiting in hospital by 69%

1) Community Access Care Centre.

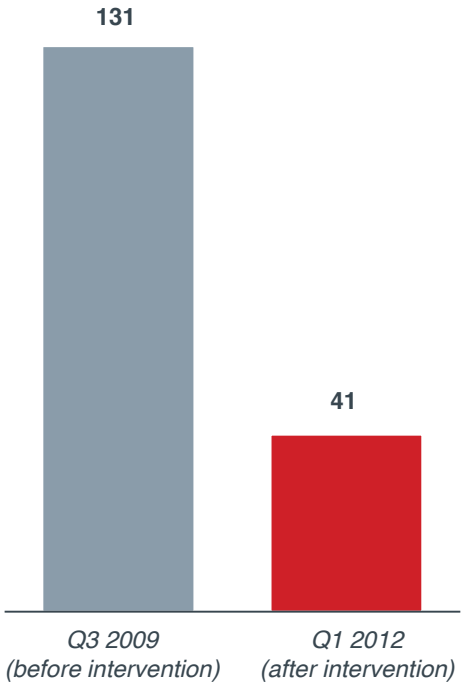
Source: Trillium Health Centre, Mississauga, Ontario, Canada; Advisory Board interviews and analysis.

Informed Patients Better Prepared for Discharge

At Trillium, realigning patients' expectations was critical to reducing delays. These communication efforts were accompanied by other work to avoid delays due to lack of post-acute care capacity as well, but leaders in the organisation feel that the improvement would not have been possible without patients' engagement and cooperation.

Number of Discharge-Ready Patients in Acute Inpatient Beds

Patients Waiting in Hospital for Post-Acute Care Placement



A Shift in Mentality

"A lot of people felt that the hospital was a great place to stay and wait and wait and wait. We really changed the conversation and the language to say that we'll work with you, we'll get you safely transitioned, and move you to the most appropriate location if you need post-acute care."

Susan Bisaillon
Executive Director of Clinical Operations, Trillium Health Partners

For additional patient education resources see best practices in our study *Seamless Care Transitions at* **advisory.com/cob/patienteducation**

Source: Advisory Board interviews and analysis.

Derailing the Train

Doctors, nurses and other staff play a central role in proactive discharge preparation.

Each of these individual stakeholder groups can obstruct discharge, and may also have incentives to do so.

Eliminating Delays Impossible without Staff Support

Potential Sources of Delay

Low stakeholder engagement creates unnecessary obstacles to achieving timely patient discharge

Nursing Staff

"I'm too busy to discharge this patient now and a new patient means even more work"

Medical Staff

"A shorter length of stay reduces my income for this patient"

Administrative Staff

"It's fine if I send these invoices tomorrow"

Source: Advisory Board interviews and analysis.

Differences Deeply Entrenched

There are two major sources of stakeholder misalignment. Some delays are caused by staff simply unaware of the impact their actions have on achieving timely discharge. Other delays are caused by incentives that conflict with achieving timely discharge.

Stakeholder Misalignment

Lack of Awareness

- Staff not aware of specific discharge responsibilities
- Do not understand patient risks associated with discharge delay
- Do not understand how discharge delays impact organisation and other patients

Lack of Incentives

- **Doctors** financially incented towards long stays for patients
- **Nurses** incented to continue caring for healthy patients over taking on new, acutely ill patients

Hard to Change Mindsets?

"In general in Brazil we have a sense of dependence on doctors. They are the kings. We need to change this, everybody needs to be involved in the discharge of the patient."

General director, Brazilian private hospital

Source: Advisory Board interviews and analysis.

Creating an Engaging Education Process for Staff

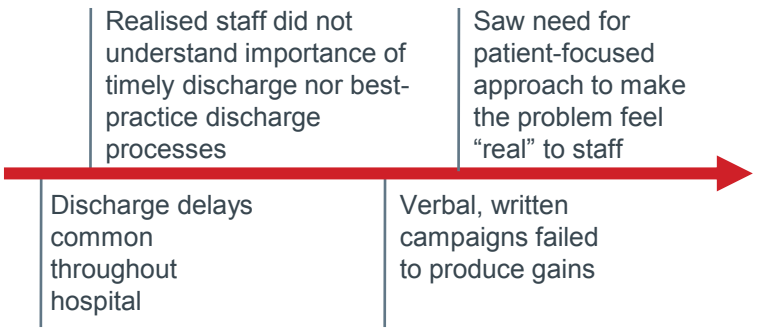
Education is critical to staff engagement, yet many hospital efforts fail to produce the desired effect.

One Latin American hospital, Clinica Salud, recognised that their past discharge education campaigns with newsletters, posters and emails had failed to produce lasting results. Leaders realised that these efforts had not helped staff understand the impact of discharge delays on patients, or their own roles in improvement.

The hospital developed a series of educational sessions centred around two custom-made “best” and “worst” practice discharge videos to clearly demonstrate staff responsibilities for discharge efficiency.

Passive Education About Discharge Fails to Raise Performance

Development of Staff Education Processes at Clinica Salud[1]



Created Best and Worst Practice Discharge Videos
Illustrate specific responsibilities and expectations to all staff demonstrates how principles of past campaigns translate into daily action

Case in Brief: Clinica Salud[1]

- Large acute hospital in major Latin American city
- Recognised low staff awareness of effective discharge processes and negative impact of poor processes on hospital and patient
- Professionally produced two 10 minute videos documenting the patient journey: one best practice journey and one with inadequate or delayed staff-patient interactions
- Presented videos to all relevant staff to explain hospital expectations for discharge process; alongside other interventions, resulted in substantial improvements in discharge efficiency

1) Pseudonym.

Source: Advisory Board interviews and analysis.

Delivery as Important as Content

To ensure the new curriculum achieved its desired impact, they developed a 2.5 hour interactive program designed around the best and worst practice videos.

Staff hospital-wide were expected to participate, and numerous sessions were held to accommodate all schedules. The length of the sessions also served as a signal from hospital leadership that improving discharge was a top hospital priority.

As a result, the hospital was able to substantially reduce delays on the day of discharge as well as the number of very long stay patients.

Educational Videos Bring Best Practice Discharge into Focus

Evolution of the Discharge Education Program at Clinica Salud[1]

Determined need for more effective staff education about discharge processes

↓

Produced Discharge Education Agenda materials, including "how to" and "how not to" discharge patients

↓

Began education program with nurses, technicians, physiotherapists, new hires and cleaning staff

↓

Currently rolling out education sessions to target medical staff role in discharge planning

Discharge Education Program at Clinica Salud[1]

Staff Discharge Education Agenda	
14:10 – 14:30	The Importance of Discharge Planning
14:30 – 14:50	Scenario 1
14:50 – 15:10	Discussion
15:10 – 15:30	Scenario 2
15:30 – 15:50	Discussion
15:50 – 16:10	Guide to Discharge Planning
16:10 – 16:30	Scenario 3
16:30 – 16:50	Closing Discussion

Education Contributes to Major Improvements

24%

Reduction in delay between signed discharge order and patient leaving the hospital

23%

Reduction in percentage of patients staying longer than 100 days

1) Pseudonym.

Source: Advisory Board interviews and analysis.

Chapter 4

Coordinate End-of-Stay Processes

Embedding an Infrastructure to Execute Discharge Plans

- Practice #12: Night Shift Task Organiser
- Practice #13: Localised Nurse-Led Discharge Rollout

Right Timing Critical

Proactive discharge preparation is essential to avoid delays, but not all discharge tasks can be completed in advance. Furthermore, delays in the last 24 hours of a patient stay can have a disproportionate effect on hospital throughput.

A study analysing discharge in 23 hospitals in Queensland, Australia found a direct correlation between the time of day that discharges occur and the mean peak occupancy rate of hospitals.

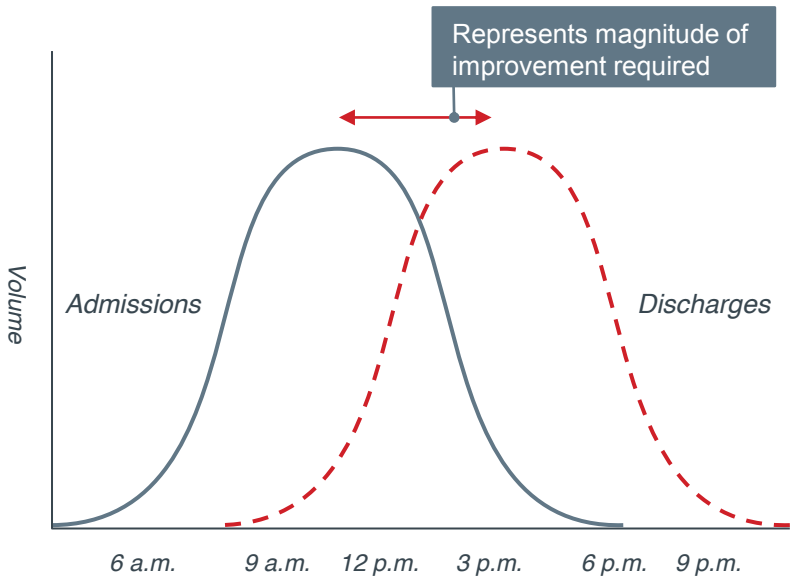
When the majority of discharges occur before the majority of admissions, the average peak occupancy rate was found to be 91%. However, when the majority of admissions occur before the majority of discharges, this figure is 10% higher.

Therefore, there is a substantial benefit to avoiding delays in the final 24 hours of a patient's stay; in particular, focusing on discharging as many patients as possible in the morning.

Morning Discharges Have Outsized Impact on Patient Flow

Admissions Demand Versus Bed Supply

By Time of Day



Clear Correlation Between Discharge Time and Overcrowding

91% Mean peak occupancy when peak discharge time was before peak admission time[1]

101% Mean peak occupancy when peak discharge time lagged behind peak admission time[1]

1) Analysis of relative timing of daily admission and discharge curves at 23 Queensland, Australia n public hospitals.

Source: Khanna S et al., "Impact of Admission and Discharge Peak Times on Hospital Overcrowding," *Health Informatics: The Transformative Power of Innovation,* ed. Hansen, D. et al, 2011; Advisory Board interviews and analysis.

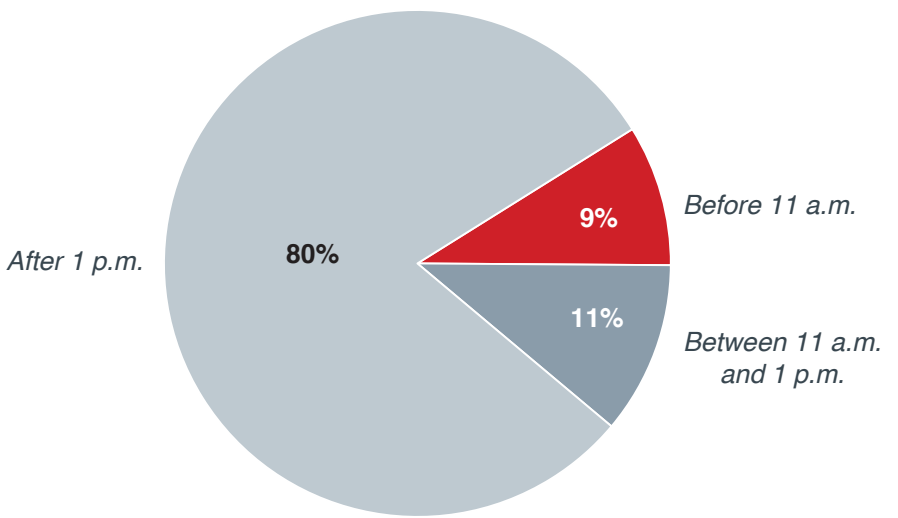
Final Day of Stay Prone to Delays

Although the importance of consistently achieving morning discharges is well known, most hospitals continue to struggle in this area. The UK is representative of this challenge.

Reactive Approach Makes Morning Discharges a Rarity

When Discharges are Most Likely to Occur in UK Hospitals[1]

n = 79 UK hospital executives and clinicians



1) Responses to 2012 Clinical Operations Board Survey on Transitions Question: "Please rank the times when discharges most frequently occur in your organisation (1 = most likely)?" Options included: "Before 9AM" "Between 9AM and 11AM" "Between 11AM and 1PM" and "After 1PM."

Source: 2012 Clinical Operations Board Survey on Transitions; Advisory Board interviews and analysis.

Common Barriers Regularly Derail Discharge

The risk of delay in the last 24 hours of the patient stay is attributable to two key problems.

To avoid last-minute delays, hospitals need to address both of these challenges.

Two Challenges to Overcome at End of Stay

1

Poor Prioritisation of Day-of-Discharge Tasks

Myriad Tasks on Staff's To-Do Lists

End-of-stay tasks with potential to delay discharge compete for attention with numerous other clinical and operational tasks

Lacking Mechanisms to Prioritise Tasks

Staff unable to identify and prioritise tasks critical to preventing discharge delays

2

Doctors Have Potential to Derail Discharge Process

Schedules Not Arranged with Discharge Efficiency in Mind

Rounding times may not consistently coincide with efficient discharge times, or doctors may round on sickest patients first; doctors not present to sign off on discharge orders

Source: Advisory Board interviews and analysis.

Using Downtime to Prioritise Next Day's Workload

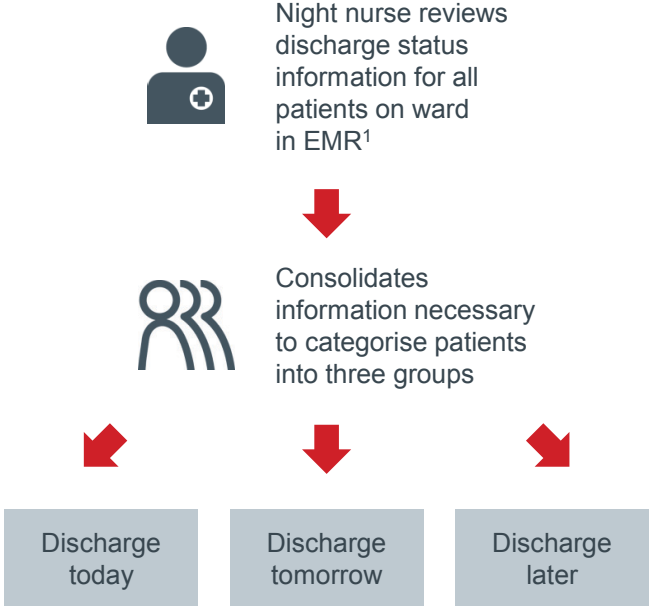
With clinicians' busy schedules, it can be hard to establish which nonclinical tasks are important to complete first, before they can cause delays.

To address this issue, Wellmont Holston Valley Medical Center, in Kingsport, Tennessee, asked night-shift nurses to use the quieter hours in the middle of the night to help plan the next day's discharges.

Nurses pull together all patient information relevant to discharge readiness, and use it to proactively assign each patient to one of three categories: discharge today, discharge tomorrow, or discharge later. For each patient a loose care plan is developed, outlining the steps necessary to prepare for discharge.

This information is then used to quickly set priorities for the day shift, with efforts initially focusing on patients designated for discharge that day.

Night Nurse Assesses Discharge Readiness



Case in Brief: Wellmont Holston Valley Medical Center

- 504-bed hospital in Kingsport, Tennessee, US
- Experienced disorganised discharge execution, causing capacity challenges and doctor frustration
- Leveraged night nurses to proactively assess discharge readiness and consolidate information for clinical leaders to classify patients into three categories: potential discharge today, tomorrow and later
- Practice permanently embedded into night-shift role; all new nurse staff receive training
- Saw a 52% increase in patient satisfaction with discharge process

1) Electronic medical record.

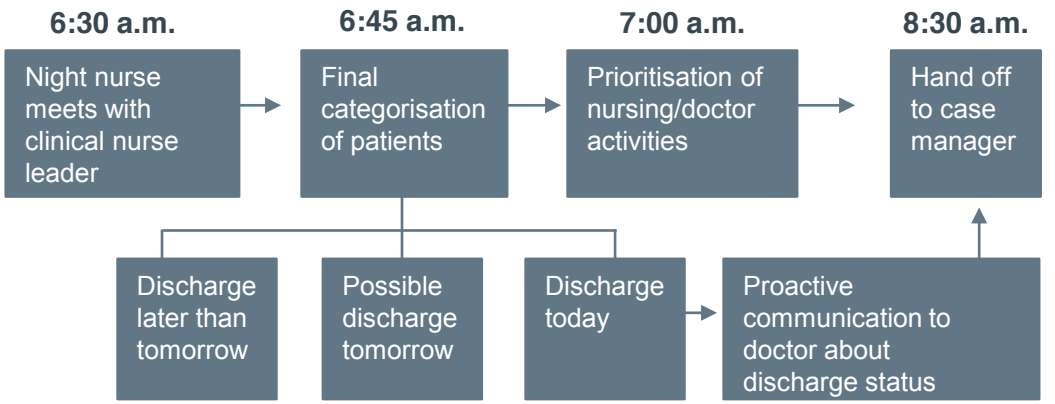
Source: Wellmont Holston Valley Medical Center, Kingsport, Tennessee, US; Advisory Board interviews and analysis.

Mapping a Clear Process

At 6:30 AM, a night-shift nurse gives a report to each unit's clinical nurse leader. The conversation finalises the categorisation of patients, which is the guiding principle for workflow prioritisation throughout the day.

Patient status is shared with nurses, case managers, and doctors, all of whom rely on it to structure their activities. This provides a structure for principled clinical rounding strategies, with doctors first rounding on their most acute patients, and then turning next to their discharge-ready patients.

Transition Between Night Shift and Day Shift



Logistics of Doctor Communication

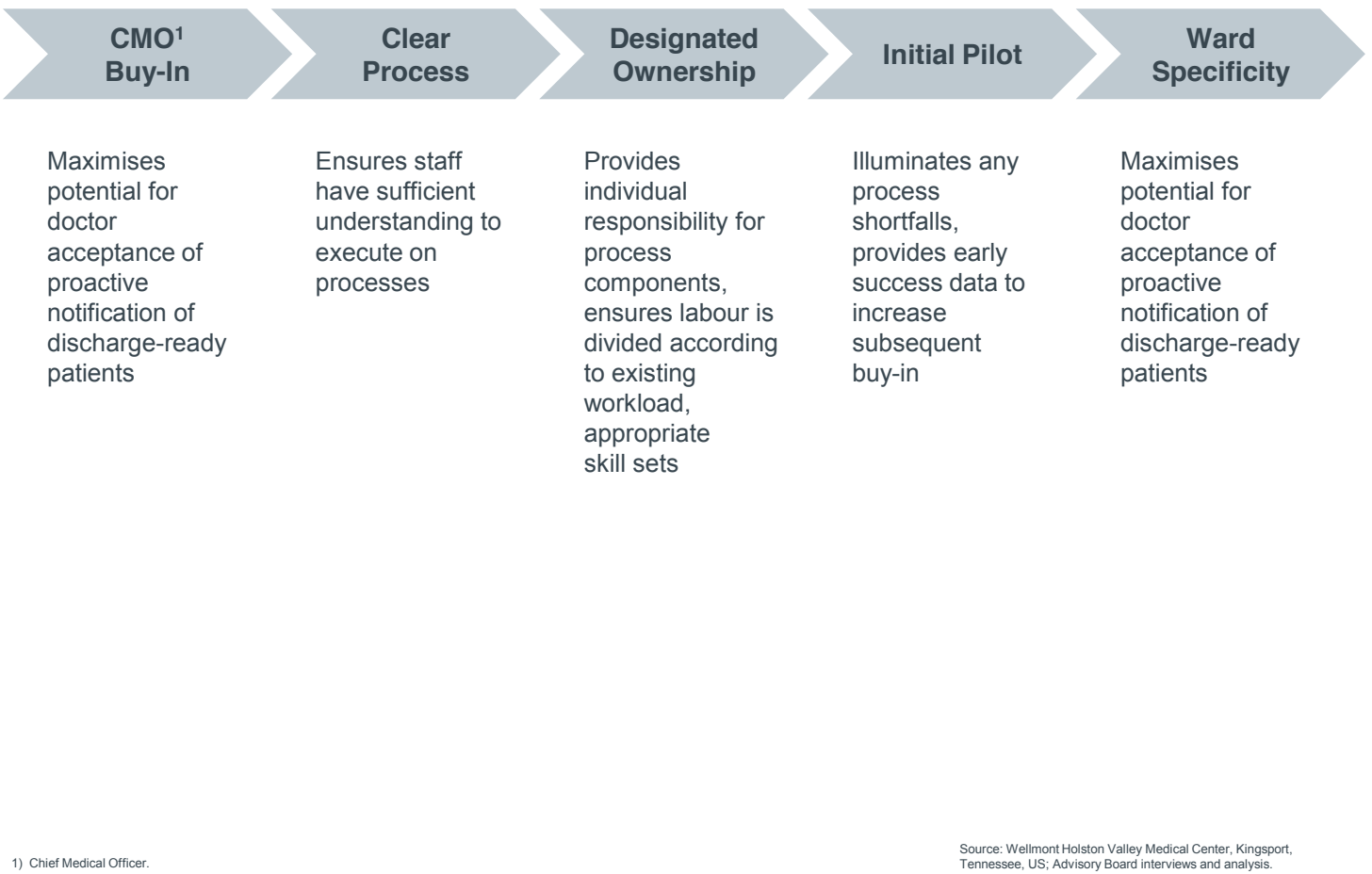
- Each morning doctors receive copies of summary with discharge-ready patients circled, as determined by nursing assessment in conjunction with Clinical Nurse Leader
- Telephone communication to doctors based outside the hospital follows short script, confirming:
  - Discharge-ready status
  - Bed availability/reservation at local facility
  - Completion of discharge paperwork, pending doctor signature

Source: Wellmont Holston Valley Medical Center, Kingsport, Tennessee, US; Advisory Board interviews and analysis.

Setting the Stage for Success

To ensure a smooth implementation of the new process, Wellmont Holston Valley Medical Center addressed several critical steps.

Key Elements of Successful Implementation



1) Chief Medical Officer.

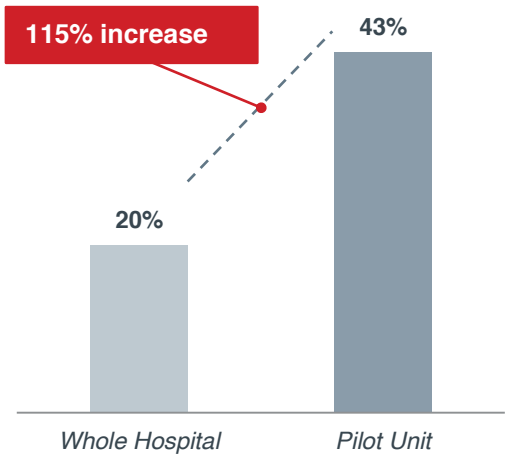
Source: Wellmont Holston Valley Medical Center, Kingsport, Tennessee, US; Advisory Board interviews and analysis.

Providing Tangible Efficiency Benefits

Wellmont Holston has seen excellent results, more than doubling their rate of discharges before 1 p.m., while also increasing patient satisfaction with the discharge process.

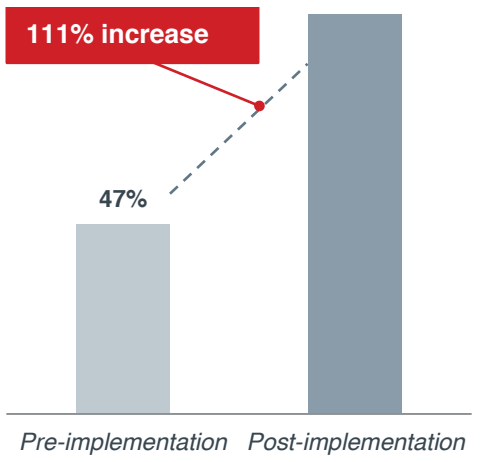
Discharges Before 1:00PM

Percentage



Patient Satisfaction with Discharge Process

Percentage



Reaping the Benefits of Early Discharge Planning

"Everything is much more organised now; you don't have the real surprises that come up, because everything is checked off, or taken care of, before the discharge ... It's more or less making sure that all your 'i's are dotted and 't's are crossed."

Rhonda McGhee
Director of Medical/Surgery
Wellmont Holston Valley Medical Center

Source: Wellmont Holston Valley Medical Center, Kingsport, Tennessee, US; Advisory Board interviews and analysis.

Often Tried, Seldom Successful

In some cases, doctors may be unwilling to alter their schedules to round in the morning, or to prioritise discharge-ready patients in their daily rounds.

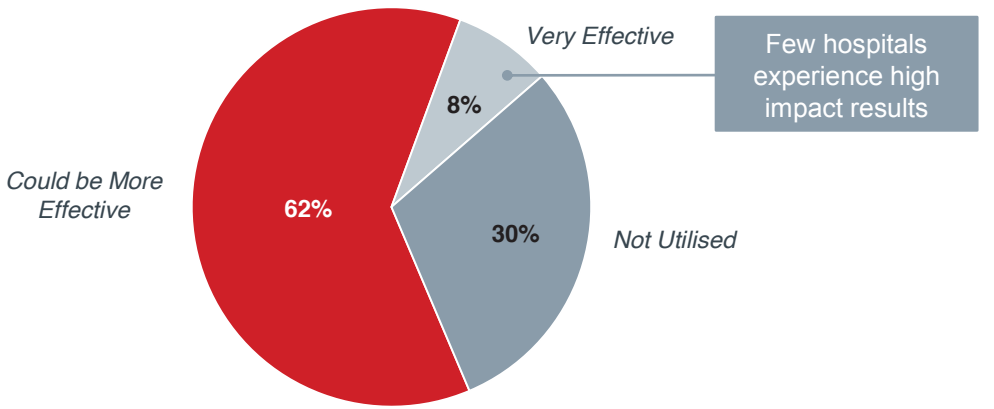
Criteria-led discharge, also known as nurse-facilitated discharge, is often attempted as a solution: the attending doctor establishes criteria during his or her rounds the day before the patient's planned discharge. If, on the day of discharge, the bedside nurse determines that the patient meets those criteria, they are authorised to discharge the patient without the doctor being present.

However, three challenges have prevented many organisations from seeing the full benefit of this tactic.

Sustaining Nurse-Led Discharge Requires Leadership Investment

Reported Use of Nurse-Led Discharge in Acute Hospitals

n = 252 international hospital executives and staff



Three Key Challenges to Sustaining Nurse-Led Discharge

Poor Communication
Limited dialogue about patient needs and readiness for discharge between clinicians

Lack of Ward Leadership
Few champions of nurse-led discharge actively involved in project implementation

Lack of Trust
Doctors lack confidence in nurses' ability to make appropriate decision about patient readiness

1) Percent answering "Yes, very effective" or "Yes, but could be more effective" to the question, "Please indicate whether the following discharge efficiency strategies are utilised at your organisation" n = 98 UK hospital executives and clinicians.

Source: Advisory Board interviews and analysis.

Making Nurse-Led Discharge Routine

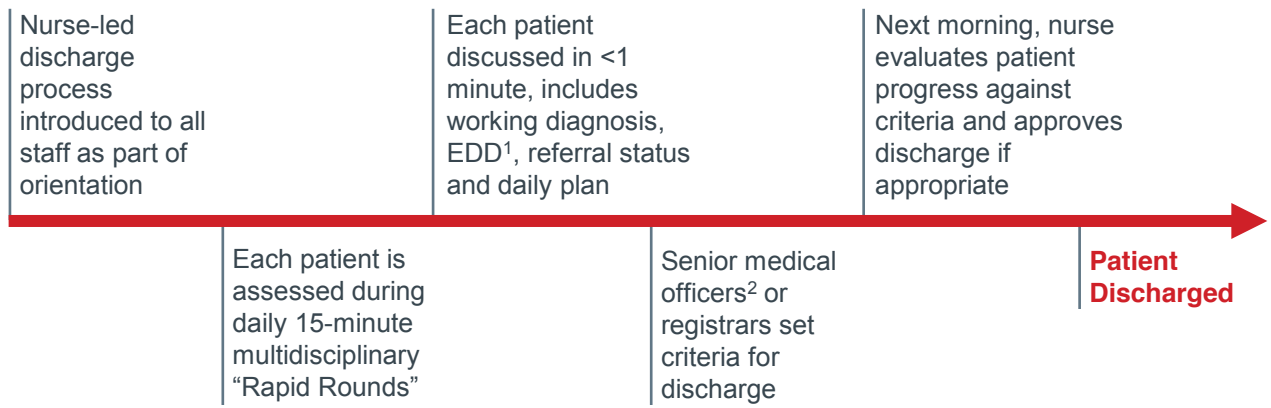
Auckland District Health Board experience these frustrations when they tried to implement nurse-led discharge in 2006. Derailed by these challenges, the initiative never left the pilot phase.

However, in 2010, under pressure to improve, they revisited the idea and learned from past mistakes.

The basic process that they follow is laid in the graphic. Critically, the process is embedded as part of an already-established multidisciplinary communication method: daily 15-minute "Rapid Rounds." During their discussion of each patient, medical staff and nurses consider patient suitability for nurse-led discharge.

They use a simple, standardised form for eligible patients to ensure that all elements required for a safe nurse-led discharge are always covered.

Nurse-Led Discharge at Auckland District Health Board



Case in Brief: Auckland District Health Board

- Healthcare system serving population of 460,000 in and around Auckland, New Zealand
- Initially trialed nurse-led discharge in 2006, program failed due to problems with communication and staff buy-in
- Relaunched nurse-led discharge in April 2010 on general medicine wards, beginning with long-standing medical-nursing partnerships
- Combination of daily multidisciplinary "Rapid Rounds," staged implementation process and strong senior and ward-level leadership overcame implementation barriers

For **Auckland District Health Board's Nurse Facilitated Discharge Checklist** please see appendix, p.153

1) Estimated Discharge Date.
2) Consultant-level medical staff.

Source: Auckland District Health Board, Auckland, New Zealand; Advisory Board interviews and analysis.

Leadership Crucial for Success

The difference between the failed attempt in 2006 and successful implementation in 2010 was strong ward-based leadership. This leadership has enabled the organisation to overcome other objections and demonstrate the safety and effectiveness of nurse-led discharge.

In addition to supporting the program day-to-day, ward leaders regularly communicate data on avoided bed days, demonstrating the program's value.

Importantly, the program was launched in a staged fashion, beginning with a few doctor/nurse teams with long-standing relationships and a high degree of trust and mutual respect for clinical competency. The successful nurse-led discharges facilitated by these teams helped to convince skeptics.

Over time, demonstrable improvements in discharge efficiency with no negative effect on patient care has developed trust in the program, further increasing participation.

Strong Ward-Based Leadership Overcomes Cultural Obstacles

- Ward leaders assume responsibility for championing nurse-led discharge and generating support amongst ward staff
- Medical and nursing staff considered equal partners in care delivery and patient flow responsibility

Prioritising Active Communication

- Established daily 15-minute multidisciplinary "Rapid Rounds" to prompt proactive planning of discharges between ward rounds
- Reinforcement from senior medical staff ensures doctor attendance and participation
- Rounds structured to ingrain assessment of patient candidacy for nurse-led discharge in the daily tasks of each ward; charge nurses and medical staff both able to propose candidates for nurse-led discharge
- Following rapid rounds, medical teams consider all proposed nurse-led discharges and document discharge criteria on simple one-page form

Building a Culture of Trust

- Program introduced in general medicine ward
- Following an assessment of previous failed implementation, hospital leadership sponsored revised program focused on ward-level leadership
- Initial launch worked with long-standing doctor-nurse partnerships; success of pilot nurse-led discharges crucial to build trust in program safety among other clinicians, enables broader program expansion
- Frequent publication of results, competition between medical teams supports confidence in program and sustains focus

Source: Auckland District Health Board, Auckland, New Zealand; Advisory Board interviews and analysis.

Tangible Improvements

Auckland has calculated nearly 8,000 fewer wasted patient hours, and about $160,000 NZD saved since nurse-led discharges began. The program has also contributed to a half-day decrease in average length of stay, primarily through hours saved in the morning and on the weekend.

Patients and Hospital Benefit from Ward-Led Policy

Moving Patients Out of Hospital Faster

7,995

Fewer hours patients spent waiting for medical staff discharge approval from April 2010[1]

Increasing Available Bed Capacity

326

Number of bed days saved under nurse facilitated discharge since introduction in April 2010

Proposed Nurse-Led Discharges Successful

81%

Percentage of successful nurse-facilitated discharges; 366 successful out of 450 proposed

Cost Savings Associated with Nurse-Led Discharge

$163,000[2]

Savings accrued by hospital from April 2010 through July 2012

1) Also due to increases in nurse facilitated discharges on the weekend. From 47 in December 2010 to 72 in December 2011.
2) New Zealand dollars.

Source: Auckland District Health Board, Auckland, New Zealand; Advisory Board interviews and analysis.

Chapter 5

Leveraging Post-Acute Capacity to Avoid Delays

- Practice #14: Financially Accountable Transfer Agreement
- Practice #15: Hospital – Hotel Care Partnership
- Practice #16: Hospital Driven Outreach and Collaboration
- Practice #17: Co-Located Decision Making
- Practice #18: Integrated Acute / Post-Acute Management
- Practice #19: Home-Centred Demand Management

Full is Full

Even after making the most of in-hospital opportunities to improve discharge efficiency, organisations may still face delays placing patients into post-acute care.

Although these bottlenecks are not directly under the hospital's control, there are still substantive opportunities to find better ways of working with post-acute care facilities. There are also a few realities that any solution must manage.

First, in some cases post-acute care capacity in the community is simply insufficient to meet demand.

Genuine Post-Acute Care Shortage Contributes to Many Delays

Demand Outstripping Supply Around the World

"When you ask most hospital staff, they will say, 'Yeah, we just can't get a bed at a rehab facility, or we just can't get a bed at a nursing home,' so that patient ends up stuck."

Chief Operating Officer
Public hospital, Australia

"We don't have enough beds in our nursing homes, so patients stay longer in the hospital than necessary."

Chief Operating Officer
General hospital, Netherlands

85%

English health budgets restricting publicly funded post-acute care to only individuals with substantial and/or critical needs.

Ham C, et. al., *Transforming the Delivery of Health and Social Care, available at www.kingsfund.co.uk,*; Advisory Board interviews and analysis.

Too Many Cooks…

Placing patients appropriately in post-acute care is often complicated by the numerous rules or guidelines in place, and the different providers available, many serving niche patient populations. In England's National Health Service, for example, discharge staff must ensure compliance with numerous regulations.

England Representative of Network of Rules that Complicate Post-Acute Care Placement Around the World

Selected Recent English Reforms Impacting Discharge Practices

2003 - 2012

2012 *2012* *2005* *2003* *2005* *2003* *2008*

Growing Case Complexity

"Since 2000 there has been a massive growth in statutes, guidance, statutory directions, laws, new initiatives, you name it, adding layer after layer after layer of legislation: ***NHS Continuing Healthcare Framework, Deprivation of Liberty Safeguards, National Service Framework for Older People, Fair Access for Care***, and so on. All these rules and regulations have layered on top of each other and made it very difficult, unless you are en expert, to make sense of things. So people put it in the 'too difficult' box and don't solve the problem."

Hospital Executive
NHS Acute Trust, UK

Source: Advisory Board interviews and analysis.

Playing the Blame Game

In many regions, the myriad obstacles to a smooth discharge process have created a perception among both hospital and post-acute providers that delays are due to lack of cooperation from the other party. This exacerbates the challenge of improving cooperation and transitions between providers.

Most hospital staff count post-acute care capacity shortages and delays in securing funding among their top three causes of delayed transfers.

Post-Acute Care Providers Often Seen as Adversaries

Two Sides to Every Story

Hospital Perspective

"Nursing homes are picking the "good" patients [who can go home within six weeks], and the other ones remain in the hospital, and they will stay there longer because they're the more complex population."

Researcher
University of Amsterdam

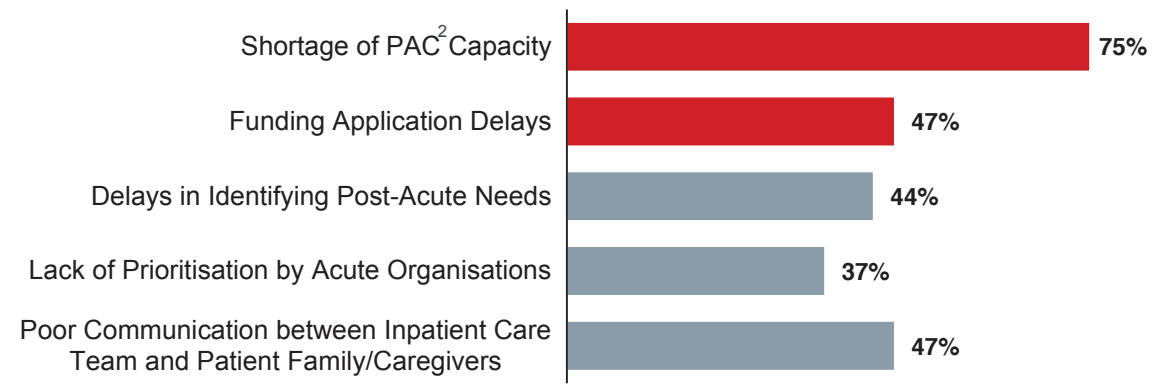
Post-Acute Provider Perspective

"You [Hospitals] can talk about integrated care but you cannot even get us a discharge summary. The problem is clearly that it is not treated as top of the list by hospital staff"

"NHS Discharge Planning: Lost for Words"
Health Service Journal

Primary Causes Transfer Delays from Acute to Post-Acute Care

n = 533 international hospital executives and clinicians[1]



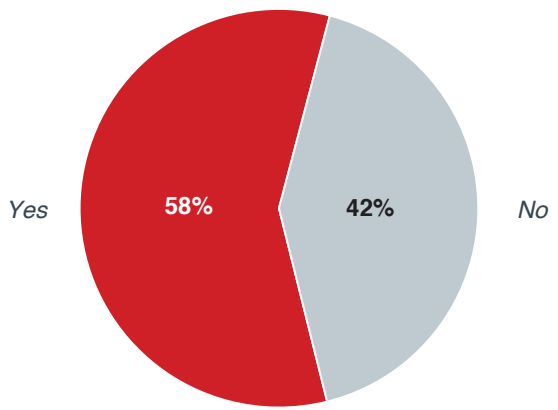
Source: Carlisle D, *NHS Discharge planning: lost for words*, www.hsj.co.uk.; Advisory Board interviews and analysis.

Degree of Integration Varies Widely

In our survey of hospitals around the world, we found wide variance in the degree of integration between hospitals and post-acute providers—from stand-alone hospitals to health care organisations responsible for primary, sub-acute and acute care.

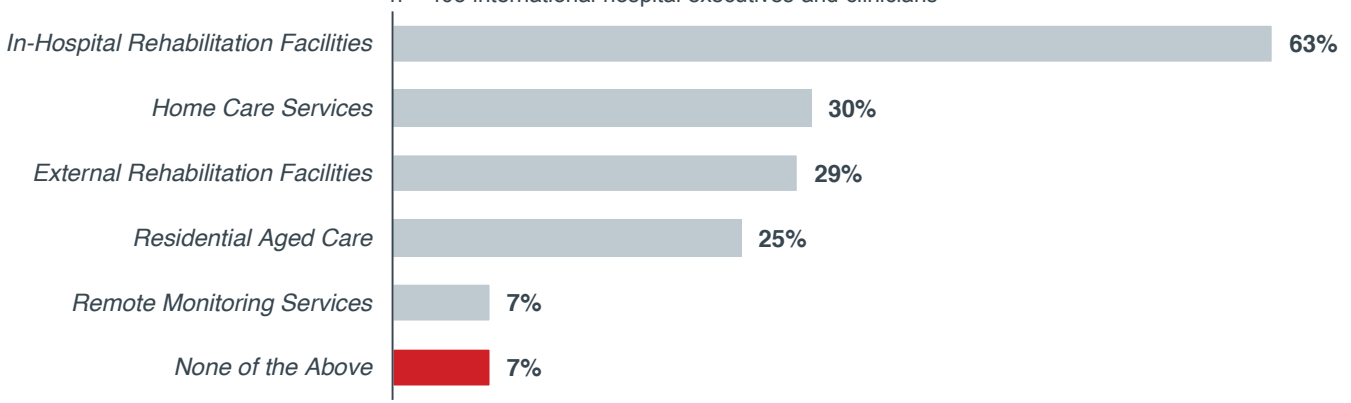
Hospitals with Formal Agreements with Post-Acute Care Providers

n = 210 international hospital executives and clinicians[2]



Hospitals Owning or Managing Various Post-Acute Services[1]

n = 405 international hospital executives and clinicians



1) Survey question: "What types of sub-acute care services does your organisation own or manage?" Please check all that apply.
2) Answers in response to the question, "Does your organisation have a formal agreement or contract with regional post-acute care facilities (eg., nursing homes, rehabilitation, or care at home)?"

Source: 2012 Clinical Operations Board Survey on Transitions; Advisory Board interviews and analysis.

Integration Not a Cure-All

While each organisation will need to consider their unique situation and level of integration to determine first steps to improvement, all should recognise that integration alone is not a cure-all for post-acute-related discharge delays.

At every level of integration, organisations face challenges to smooth patient flow—and some organisations have found best practice tactics to resolve those challenges.

Hospitals Face Challenges Despite Cross-Continuum Management

Challenges Faced by Hospital at Each Integration Level

Degree of Care Continuum Integration

Standalone Hospital → Fully integrated organisation

Key Challenges	Limited accountability in PAC[1] agreements	Lack of short-term PAC capacity in the community	Lack of trust prevents cross-continuum cooperation	Inter-organisational barriers delay discharge	Siloed management practices in integrated organisation	Poor management of acute demand
Advanced Solution	Financially accountable transfer agreement	Hospital-Hotel care partnership	Hospital-driven outreach and collaboration	Colocated Integrated Discharge	Integrated acute-post-acute management	Home-centred demand management
Case Study	**Chesdale Hospital**	**Tria Orthopaedic Center**	**Central Manchester University NHS Foundation Trust**		**Alfred Health**	**Canterbury District Health Board**

1) Post-Acute Care.

Source: Advisory Board interviews and analysis.

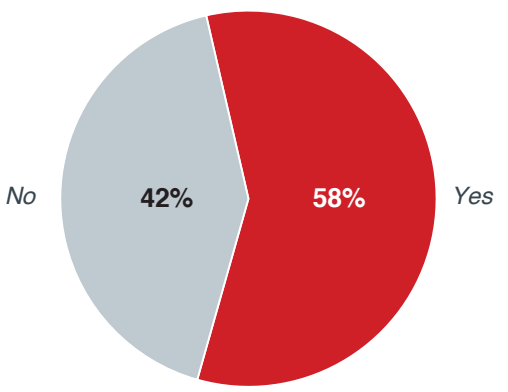
Widely Practiced, but Seldom Effective

At the most limited level of integration, many standalone hospitals have entered into agreements with post-acute care providers. These agreements aim to improve cooperation and reduce instances of delayed transfers, commonly including elements such as prioritising placement of the hospitals' patients, speeding information transfer and notifying the hospital of post-acute bed availability. However, due to a lack of enforceability and accountability, many hospitals report that these agreements have failed to realise their intended effect.

Hospitals Lack Mechanism to Enforce Agreements

Hospitals Partnering with Post-Acute Care Facilities

n = 595 international hospital executives and clinicians



A Constant Struggle

"We used to tell them, we know we deliver about six COPD patients a month, so we want six places per month available. For hip replacements, we are sure we are going to send you two a week, so you should have a place for us. Yet in the end it turned out that they didn't really fulfill those agreements, there was no way to try to force them."

Capacity Manager
General hospital, Netherlands

1) Survey question: "Does your organisation have a formal agreement or contract with regional post-acute care facilities?"

Source: 2012 Clinical Operations Board Survey on Transitions; Advisory Board interviews and analysis.

Ensuring Effective Agreements

There are six key elements to consider when developing a collaborative agreement with post-acute care providers. Articulating the value and benefit for post-acute care providers is particularly important and a common stumbling block for many organisations.

Key Considerations for Forging Affiliations Between Hospital and Post-Acute Care Providers

1. **Approach Post-Acute Care Providers with Defined Value Proposition**
   Clearly delineate value proposition for developing affiliation, e.g., providing consistent, predictable stream of transfers; improving accuracy of referrals; offering clinical support to PAC clinicians
2. **Identify Mutual Improvement Areas and Track Outcomes**
   Consider improvement metrics to track, outline expectations for data sharing in agreement, e.g., referral turnaround time and availability; rehospitalisation rates; LOS; meeting attendance
3. **Recognise Importance of Clinical Workgroup Participation**
   Clinical workgroup meetings serve as trust-building mechanism, enables hospital and PAC[1] to address issues, e.g., inefficient patient transfers, accuracy of referrals, and information exchange
4. **Appoint Facility-Based Point of Contact to Manage Relationship**
   Central point of contact at post-acute care facility and hospital manages relationship on day-to-day basis and serves as reliable communication mechanism
5. **Tailor Affiliation Approach to Hospital's Long-Term Strategy**
   Regularly evaluate affiliation from strategic standpoint; consider organisational long-term strategy and how clinical affiliation serves as lever in addressing future demographic changes
6. **Consider Tightening Relationship with Patient-Centred Services**
   Consider establishing cross-continuum care pathways and evaluating cross-continuum patient satisfaction, particularly under payment systems which value patient satisfaction scores

For a copy of *Strategies for Implementing and Managing a Hospital-PAC Affiliation Agreement White Paper*, please go to advisory.com/cob

1) Post acute care.

Source: Advisory Board interviews and analysis.

Inefficiencies Catalyst for Improvement

Chesdale Hospital, a pseudonym for a Swiss Hospital, struggled to transfer patients into local rehabilitation and nursing homes after acute treatment was complete.

Frustrated by these delays, and alarmed by the substantial impact they had on the hospitals' length of stay, Chesdale's new chief executive sought out local providers willing to negotiate a transfer agreement that would facilitate smoother, more timely patient discharge.

New Hospital Chief Executive Dissatisfied with Delayed Transfers to PAC[1] Facilities

Current, ineffective arrangements with post-acute care facilities prompts chief executive to look for formal partnership opportunities with local facilities

Problems Prior to Change

- Constant shortage of beds for discharge-ready patients in post-acute care facilities
- Patient flow to post-acute care facilities highly erratic; not incentivised to improve
- Hospital unable to establish reliable partnerships with post-acute care facilities

Case in Brief: Chesdale[2] Hospital

- 200-bed private hospital in Switzerland
- Established legal agreement with neighbouring post-acute care facility to ensure timely patient transfers, including bidirectional financial penalties if either organisation causes the transfer to occur after agreed-upon date
- Transfer planning initiated prior to obtaining payer approval to avoid administrative delays
- Since beginning of contract, hospital has not paid any fines to rehab facility; staff report fewer patients waiting for transfer to post-acute rehabilitation
- Observed decrease in LOS[3] after contract implemented

1) Post-Acute Care.
2) Pseudonym.
3) Length of Stay.

Source: Advisory Board interviews and analysis.

Creating Bidirectional Accountability

Chesdale Hospital was able to reach a transfer agreement with a local rehabilitation facility seeking more predictable patient flow.

However, wary of a "cooperation" agreement that did not include provisions for accountability, the chief executive negotiated financial penalties for both parties, should one fail to adhere to the terms of the agreement.

As well as defining accountability mechanisms, the agreement focuses on mutual benefits. It lays out logistical steps that are designed to help each party meet the terms. For example, transfers must be planned a minimum of four days in advance, allowing the rehabilitation facility time to prepare a bed.

Meaningful Consequence for Non Compliance Ensures Action

Initiating a Partnership

- Hospital Chief Executive visited director of rehabilitation facility to explore potential partnership
- Hospital and post-acute care facility agree to mutually enforce timely transfers with financial penalties

Establishing Financial Accountability

- Hospital to pay rehab facility 700 CHF[1] per day of delay if patient not ready for transfer on transfer appointment day
- Rehab facility to pay hospital 1,300 CHF per day if unable to admit patient on appointed day[2]

Key Contract Elements

- Transfer appointment date for each patient set through consent of both parties
- Transfer appointments made prior to obtaining insurance approval; hospital to reimburse rehabilitation facility if insurance denies transfer
- Both parties penalised for up to four days of delayed transfers

1) Swiss Francs.
2) More than covers the cost of an additional inpatient day in hospital and empty bed in rehabilitation facility.

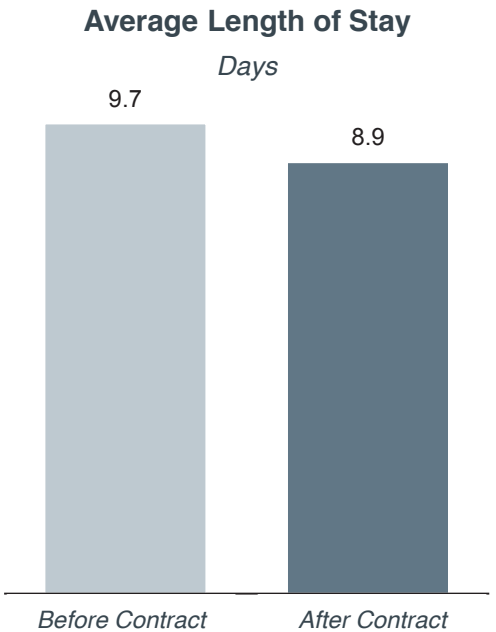
Source: Advisory Board interviews and analysis.

Reducing LOS and Wasted Bed Days

One year after the introduction of the agreement, Chesdale has seen an average length of stay reduction of nearly a full day and staff report that fewer medically fit for discharge patients occupying beds while awaiting transfer for rehabilitation.

The hospital has also successfully avoided any delayed transfer penalties; the high potential cost has motivated staff to organise discharges more efficiently.

Accountability Leads to Lower Average Length of Stay



A Win-Win Situation

"The good thing is that the rehab facility wants the bed occupied as soon as possible, so they have an incentive to call us because we can usually send them patients on the same day or the next day. If they call today they have a better chance of filling their beds by tomorrow."

Chief Executive
Chesdale Hospital[1]

1) Pseudonym.

Source: Advisory Board interviews and analysis.

Options Outside of Medical Institutions

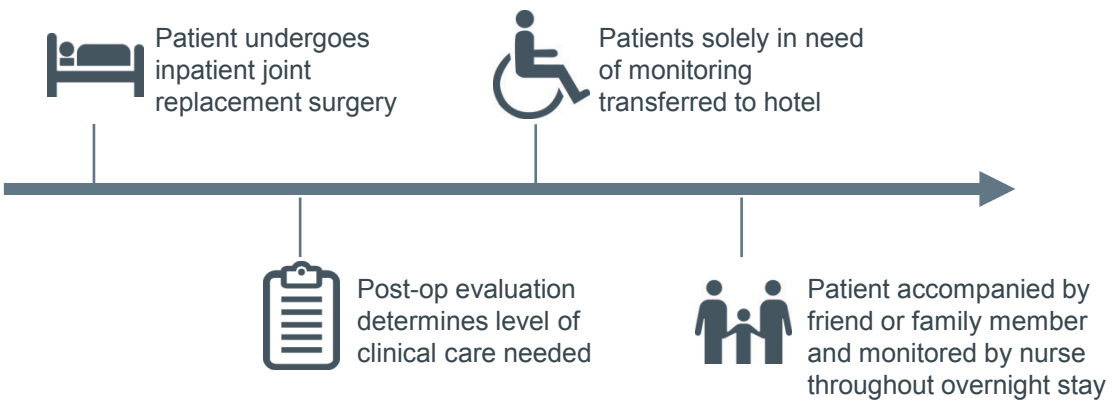
Care hotels, facilities where patients and their families can stay close to a hospital while receiving lower-acuity treatments outside of an acute setting, are not a new concept.

However, Tria Orthopaedic Center in Minnesota took an innovative approach to the care hotel concept. Instead of building their own facility, Tria partnered with a Hilton Hotel located across from the hospital to house patients during their recovery period. Surgical recovery takes place in a private room with personal nursing care and family or caregivers are able to stay with the patient. In the days following the surgery, the patients are able to easily access follow-up and physical therapy appointments, without occupying a hospital bed. The program is for healthy elective surgery patients who do not have complex issues such as heart disease, diabetes, sleep apnea or a BMI
over 42.

As a result, they were able to capture the benefits of providing non-acute treatments, such as antibiotic injections and physiotherapy, outside of the hospital, without the considerable time and cost involved with building a hotel.

Hospital Collaboration Major Hotel Chain

Tria Orthopaedic Center Joint Replacement Patient Pathway



Case in Brief: Tria Orthopaedic Center

- Orthopaedic specialty practice formed through partnership between Park Nicollet Health Services, The Orthopaedic Center and University of Minnesota Physicians, US
- Initiated pilot program with Hilton Hotels and payer to transfer joint replacement surgery patients to hotel following surgery for observation
- Insurance reimburses episode through bundled payment[1] on a case-by-case basis
- Early transfer reduced costs by 15% to 20% in comparison to typical hospital stay

1) Reimbursement based on expected cost.

Source: "Tria Orthopaedic Center in Bloomington Offers Surgery Recovery at Hilton," *Minneapolis Star Tribune*, 27 April 2010; Advisory Board interviews and analysis.

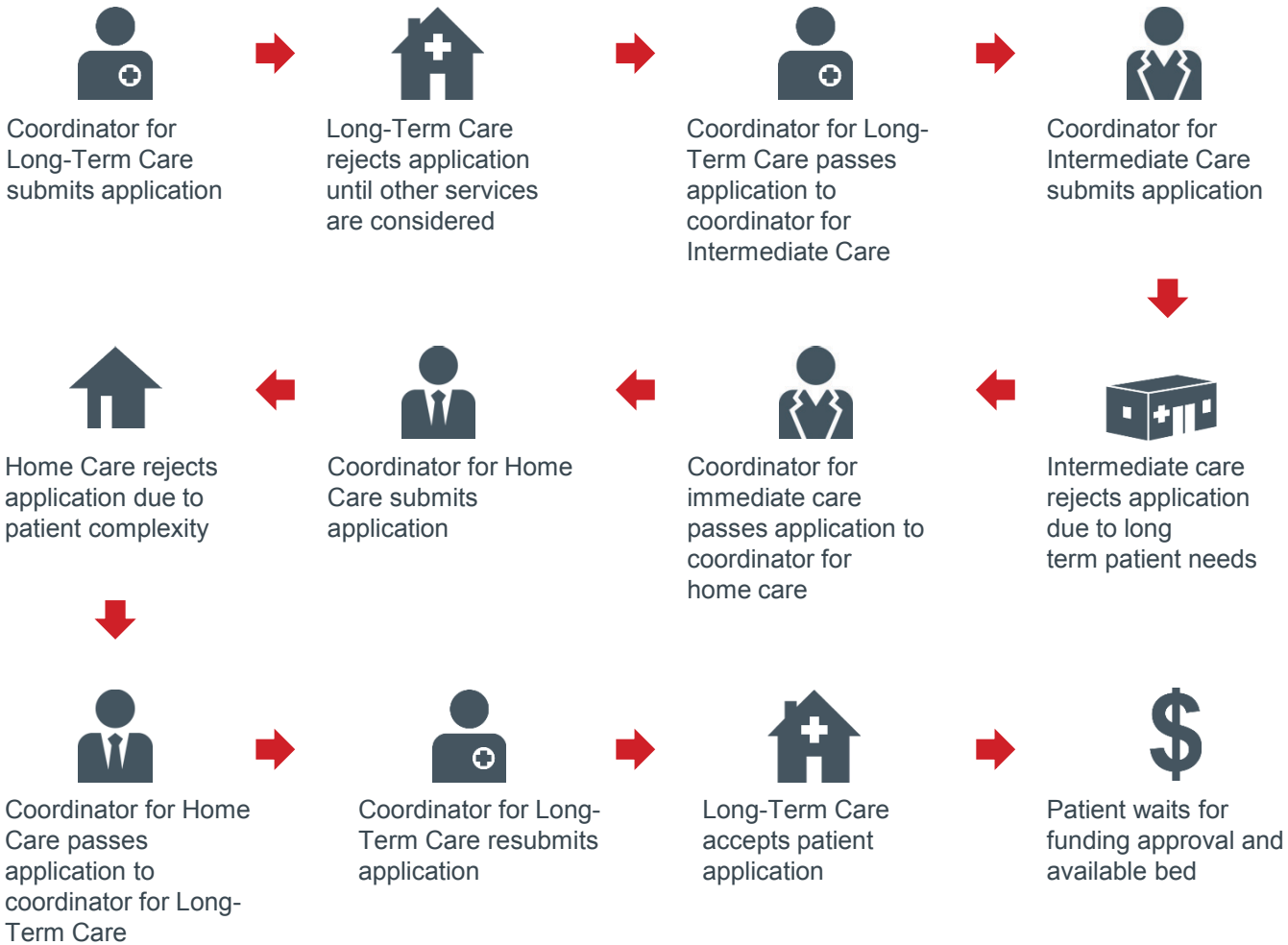
Artificial Barriers

Post-acute services are usually not a single entity: just as they are siloed from the hospital, they are siloed from each other. As a result, hospital discharge services may be split in a similar manner, with each staff member taking responsibility for discharging patients destined for a different service.

However, these divisions can often amplify delays to patient transfer: a typical process is laid out on this slide.

Common Post-Acute Care Placement Practices Rife with Inefficiency

Common Post-Acute Care Referral Process



Source: Advisory Board interviews and analysis.

Establishing New Ways of Working

In 2008, leaders at Central Manchester NHS Foundation Trust in England were concerned about their discharge process. In particular, they had noticed increasing numbers of wasted bed days due to patients waiting for transfer to post-acute care, with 20% of patients who required some form of post-acute care waiting at least 11 days on average for referral paperwork to be completed, with additional wait time for transfer after a referral.

As a result, leaders at Central Manchester realised they would need to work more closely with local post-acute care providers to avoid delays, but felt that before they could ask post-acute providers to make changes they would first need to eliminate internal inefficiencies.

Making the Case for Closer Hospital-Post-Acute Care Partnership

Case in Brief: Central Manchester University Hospitals NHS Foundation Trust

- 1,200-bed, five-hospital acute trust in Manchester, England
- Recognised poor relationship with external Post-Acute Care providers limited trust's ability to improve discharge process
- In 2008, began actively working to engage PAC[1] providers and change dynamic of relationships
- In new system, trust discharge staff and PAC provider logistical staff co-located for enhanced cooperation and efficiency

Trust Minimises Post-Acute Care Delays with Three Major Initiatives

Set Stage for Engagement:

1

Maximise Internal Efficiency

Practice #12: Hospital-driven Outreach and Collaboration

2

Establish Trust and Common Ground

Practice #13: Co-located Integrated Discharge

3

Challenge All Barriers to Discharge

1) Post-acute care.

Source: Central Manchester University Hospitals NHS Foundation Trust; Advisory Board interviews and analysis.

From Adversary to Ally

After improving their internal discharge processes, Central Manchester began to work on their relationship with local post-acute care providers.

First, the leadership team worked to identify and resolve sources of tension: notably, they decided to eliminate the use of Delayed Transfer of Care fines levied by the Trust on local post-acute care providers. These fines had proved a point of contention in the past, which leaders felt would hinder future cooperation.

This allowed Central Manchester to forge a closer relationship with post-acute care services, based on mutual concern with the wellbeing of patients.

At Central Manchester, delayed transfer of care fines was the greatest obstacle to collaboration. Though every organisation will face different obstacles, improvement requires identifying these obstacles and resolving them.

Essential Steps in Developing Cooperative Relationship

Identify and Eliminate Sources of Tension

Contentious relationship between Trust and Social Services developed in large part due to delayed transfer fines

Trust agreed to **cease use of Delayed Transfer of Care fines**[1]; shifted focus with social services to discuss collaborative approach to resolving shared challenges

Acted on social services' requests for internal practice changes

Focus on Common Goals
Example: Worked with commissioners and post-acute care providers to reduce Community Care Act patients to 10% of referrals

Highlight Impact of Transfer Delays
Example: Demonstrated access impact caused by assessment delays; post-acute providers agreed to accept patients *before* assessment and approval

Changing the Dynamic

"In Manchester we said, 'We aren't going to fine you, so let's stop arguing about the code for the delay and use this time as a problem solving session to help each other.' So we stopped being adversaries and started to work together. That was the key to beginning to build trust."

Adrian Crook, Head of Service
Central Manchester University Foundation Trust

1) English NHS regulations allow acute care providers to impose fines on post-acute providers for unnecessary discharge delays caused by PAC in under certain circumstances.

Source: Central Manchester University Hospitals NHS Foundation Trust; Advisory Board interviews and analysis.

Set the Stage for Engagement

In 2009 Central Manchester's discharge practices were as siloed as the services they referred to. Three different categories of discharge specialists independently referred patients to post-acute services. The result was considerable unnecessary delay as patient cases were passed from one specialist to the next.

Their response was to remove all siloes and create a single discharge specialist role empowered to refer patients to all post-acute care services. This eliminated many of the internal artificial barriers at the Trust without adding additional staff. Each staff member trained their peers on the particulars of the service line in which they had previously specialised.

Address Internal Obstacles First

Change in Internal Organisation Necessary First Step

Siloed positions added unnecessary days to patient stays

Before Integration

Discharge Nurse Coordinator → Responsible for general discharge processes, patient communication

Intermediate Care Assessors → Organised intermediate care bed placement and home services

District Nursing Liaison → Carried out district nursing referrals, nursing home assessments, end of life care

After Integration

Integrated Discharge Coordinator

Existing discharge staff transitioned into new Integrated Discharge Coordinator (IDC) role to retain institutional knowledge

Integrated Discharge Coordinator able to refer patients to all post-acute care provider services

New hires partnered with senior Integrated Discharge Coordinator; mentorship focuses on specialised knowledge only learnt in role

Source: Central Manchester University Hospitals NHS Foundation Trust; Advisory Board interviews and analysis.

Investing for the Long Term

As the relationship between the Trust and post-acute care services improved, they agreed on steps to reduce transfer delays. They created the Central Manchester Integrated Discharge Service, a discharge facilitation office cooperatively run by Integrated Discharge Coordinators and staff from key post-acute services.

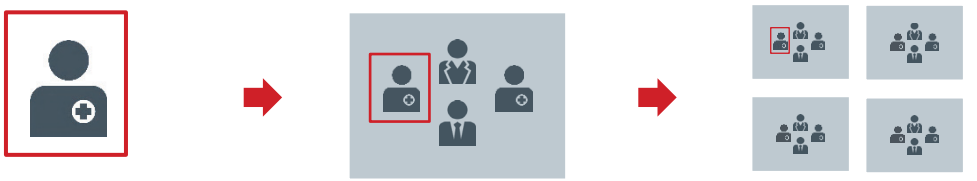
The Integrated Discharge Service handles the most complex patients - those with three or four chronic conditions, orsocial and mental health issues which make finding a viable next destination challenging.

The service discharges about 550 cases a month. Each Integrated Discharge Coordinator meets with patients, families and clinical teams to create customised discharge plans.

At inception, no additional staff were required. Now, the service has become so successful that it comprises four hubs. Three cover ten wards each, together serving all of Central Manchester's acute wards. The fourth Hub is dedicated solely to identifying inappropriate emergency department admissions and diverting them directly into post-acute care

Relationship-Building Enables Meaningful Collaboration

Components of Central Manchester Integrated Discharge Service



Integrated Discharge Coordinator

- Single point of contact for patient and clinicians
- Collaborates with patient and clinicians to develop discharge plan
- Organises post-acute care placement, responsible for ensuring timely discharge
- Standardised PAC[1] provider forms minimise duplication of actions

Integrated Discharge Hub

- Three to four Intermediate Discharge Coordinators (IDC) per hub
- One to two social workers per hub
- Each hub manages discharge for 10 wards
- One hub dedicated exclusively to triaging A&E presentations directly to post-acute care

Integrated Discharge Service

- Acute and post-acute staff colocated in single office
- Able to refer to all PAC[1] services
- **No additional staff at inception; existing discharge staff roles redefined**
- Now expanded to four colocated hubs, servicing all acute wards and A&E[2]

1) Post-acute care.
2) Accident and Emergency (Emergency Department).

Source: Central Manchester University Hospitals NHS Foundation Trust; Advisory Board interviews and analysis.

Post-Acute Collaboration an Incremental Process

This successful process has evolved over time and required substantial focus by Trust leadership on building good relationships with other providers.

Evolution of Provider Collaboration

Current Discharge Process at Central Manchester

1	2	3	4	5
Nurse submits brief electronic discharge request form	Hub IDC assigned case based on case load, required specialisation	IDC visits patient, treating clinicians to determine need, preferences	IDC recommends most appropriate PAC[3] service, patient approves	IDC organises care, responsible for ensuring timely discharge

1) Integrated Discharge Coordinator. IDCs are able to refer patients to all PAC services available to Central Manchester patients.
2) Central Manchester Integrated Discharge Service.
3) Post-acute care.

Source: Central Manchester University Hospitals NHS Foundation Trust; Advisory Board interviews and analysis.

Collaboration Bears Fruit

While the benefits of collaboration have been widespread and shared equally between acute and post-acute providers, the real winner has been the patient. Now, patients spend less time in hospital, receive more personalised care planning, and are more likely to be transferred to the post-discharge service best suited to their needs.

Fewer Delayed Discharges and More Appropriate Post-Acute Care Placement

Capacity

9500

Excess acute bed days avoided annually

Cost Avoidance

£2.3M

Excess bed day costs avoided by PCT[1] in one year

Care Quality

.06%

Percentage of discharges managed by Integrated Discharge Service resulting in patient complaints

Enabling Personalised Attention to Patient Needs

"I would say our model is old fashioned, really. Our model aims to put one person back in front of the patient, talking to them and their relatives, saying, 'Because I have spent some time getting to know you I think this is what you need, do you agree? I can tell you this is what you will get because I will be arranging it and if it doesn't work or happen in time, it will be my fault.'"

Adrian Crook
Head of Service, Intermediate Care
Central Manchester University Hospitals NHS Foundation Trust

1) Primary Care Trust.

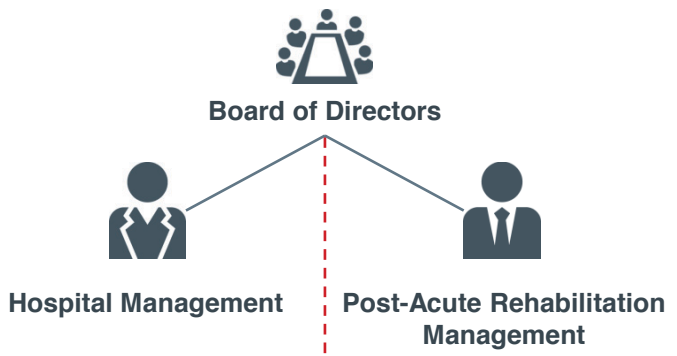
Source: Central Manchester University Hospitals NHS Foundation Trust; Advisory Board interviews and analysis.

Integration Not Living Up to the Promise?

Many organisation with nominally greater levels of integration have found that different services can still be siloed, working towards different goals and with different incentives.

Cross-Continuum Ownership Not Always Connected to Efficiency

Typical "Integrated" System Management



Not Operating as a System

"We have a sub-acute facility that is part of the organisation...Our CEO is also CEO of the sub-acute facility, but their management is different. It is very difficult to resolve issues of access to our own sub-acute facility because they've got their own financial and activity targets, and they don't really buy in to the idea that our issues are their issues. If we miss the ED wait targets that's not their problem."

Executive, Public hospital, Australia

Source: Advisory Board nterviews and analysis.

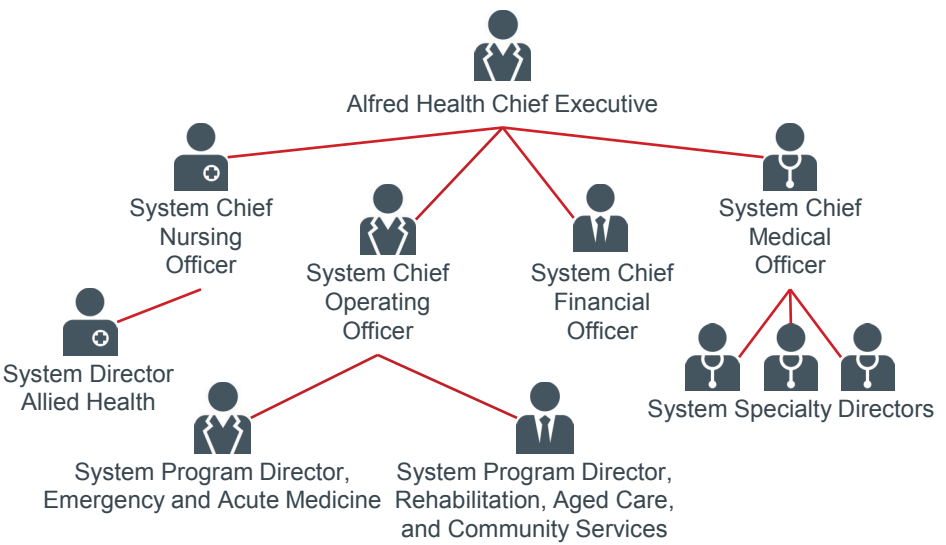
Integrating the Management Model

Alfred Health is a health care system in Melbourne, Victoria, made up of one acute hospital, one rehabilitation hospital, and one community hospital.

In 2008, a new chief executive at Alfred Health led a reorganisation of their system. Under his direction, the organisation transitioned from a system in which each hospital had its own general manager to one in which all senior leaders have responsibilities across all three organisations. This has helped to create a mindset at the management level that encourages and incentivises cooperation between the different types of care that the organisation as a whole provides: a more holistic approach to caring for patients.

Managers Working Across Acute and Post-Acute Services

Partial Organisation Chart



Case in Brief: Alfred Health

- Three-hospital health system in Victoria, Australia, providing acute, post-acute and community care
- All sites managed under a single, system-wide leadership structure
- Structure creates system-wide accountability for patient flow, drives cross-continuum cooperation

Source: Alfred Health, Victoria, Australia; Advisory Board interviews and analysis.

Collaboration Deeper Than Organisation Chart

As well as structural reform, Alfred Health introduced three key elements to foster a "single system" mindset among their staff.

Three Key Factors Institutionalise Cooperation

> **A System Mentality**
>
> "When you look at where we are now [what is critical] is the work that preceded that, which was about getting people's head around flow of the system. Understanding that what happens from Caulfield hospital's capacity to discharge someone…is directly related to our capacity to admit a patient from the waiting room to a cubicle."
>
> *Andrew Stripp, Chief Operating Officer, Alfred Health*

1 Strong Management Vision for Integrated Health Service

- Management promotes common goals and vision for system provider sites
- Focus on ensuring right level of care is accessible to all patients, transitions between settings are seamless, and acute admissions are avoided wherever possible

2 Sense of Responsibility for System Flow at Every Level

- Service managers evaluated based on patient flow performance, regardless of external financial incentives
- Staff educated to understand personal role in seamless patient care and avoiding flow bottlenecks

3 Consistent Measurement and Management of Whole-System Flow

- Weekly flow scorecard established for system level, each hospital, and unit-level metrics
- Monitors performance against best practice post-acute LOS[1], number of weekly discharges, and discharges by ward
- Blockages and slowdowns in patient flow met by immediate leadership response

1) Length of Stay.

Source: Alfred Health, Victoria, Australia; Advisory Board interviews and analysis.

“System” Mentality Enhances Integration

The shift to a system mentality has manifested tangible benefits. As a result, the organisation as a whole is able to treat patients more effectively.

Key Changes Result from Unified Management Goals

Post-Acute Care Operating at Top of License

- Significant resources dedicated to enabling care of complex post-acute patients allows earlier transition from acute hospital
- Higher weekend staffing levels, medical and nursing staff with acute care skills enables care of patients with IV antibiotic needs, tracheal tubes

Acute-Led Rehabilitation Admission

- Multidisciplinary rehabilitation team located in acute hospital enables assessment of candidates for transfer to post-acute service on the same day as referral is completed
- Transfer to appropriate post-acute ward within 24 hours for 85% of referred patients once wait-listed

Reciprocal Admission Arrangements

- Acute hospital offers straightforward path for admission or readmission from post-acute facility of patients requiring critical care, surgical interventions
- Post-acute doctors able to transfer patients back to acute hospital when required without difficulty

Source: Alfred Health, Advisory Board interviews and analysis.

Recognising the Need for Redesign

To realise the benefits of integration, organisations must overcome a final obstacle - poor management of acute demand.

Canterbury District Health Board, based in Christchurch, New Zealand, recognised that their rising acute demand would be unsustainable in the future. The change was further galvanised by a significant earthquake that reduced bed capacity.

The organisation has worked to shift their focus away from acute care towards the prevention of acute episodes.

Case in Brief: Canterbury District Health Board

- Second largest DHB[1] in New Zealand with over 700 beds, serving population of 505,000
- Funded on capitation model to manage all primary, acute, post- and post-acute care for population
- Focused on eliminating traditional primary, acute, and post-acute care silos

Two Triggers for Change

Leaders Determine Current Care Model Is Unsustainable

- Leadership recognised that growth in acute demand would be unsustainable under capitated budget
- In 2008, leaders began system redesign to provide care closer to patients' homes

Earthquake Galvanises System Redesign

- Canterbury region struck by magnitude 6.3 earthquake in February 2011
- Canterbury DHB experienced disruption of services, and long-term loss of acute and post-acute capacity

The Key Trade-Off of Acute-Focused Systems

"If you burn the money on hospital care, then you squeeze primary care services, and therefore they send more people to hospital. That's the wrong cycle."

Nigel Millar, Chief Medical Officer, Canterbury District Health Board

1) District Health Board.

Source: Canterbury District Health Board, Christchurch, New Zealand; Advisory Board interviews and analysis.

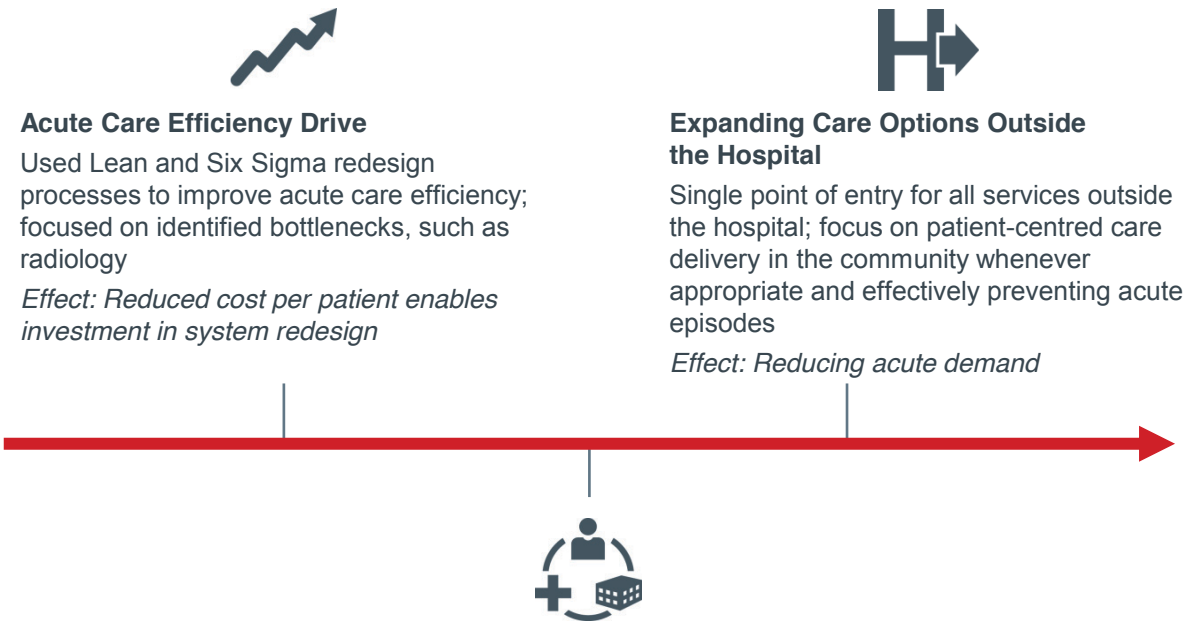
Shifting System Emphasis Away from Acute Care

As a first step, Canterbury DHB focused on efficiency improvement in their acute care services. Because the organisation had limited resources, these improvements were essential to allow funds to be redirected to primary and sub-acute care services.

Next, the organistion began to develop care pathways for major disease groups that span primary, sub-acute and acute care services. Importantly, this step has improved the accuracy of referrals from primary to acute care, leading to more appropriate utilisation.

Finally, Canterbury has created more out-of-hospital care options for patients.

An Evolving Process



Acute Care Efficiency Drive

Used Lean and Six Sigma redesign processes to improve acute care efficiency; focused on identified bottlenecks, such as radiology

Effect: Reduced cost per patient enables investment in system redesign

Expanding Care Options Outside the Hospital

Single point of entry for all services outside the hospital; focus on patient-centred care delivery in the community whenever appropriate and effectively preventing acute episodes

Effect: Reducing acute demand

Designed Cross-Continuum Clinical Pathways

Conducted complete overhaul of care provision throughout patient journey; clinician-led redesign creates system-wide consensus on processes, emphasis on delivering care in most appropriate setting for the patient

Effect: Better coordination between providers; improved accuracy of referrals, seamless cross-continuum care

Source: Canterbury District Health Board, Christchurch, New Zealand; Advisory Board interviews and analysis.

Supporting the New System

Canterbury DHB began this work in 2008, and consider their improvement efforts to be ongoing. Leaders at the organisation attribute their success so far to three elements.

Commitment at All Levels Key to Change

Factors Underpinning Transformation

Critical Baseline Initiatives

Broad, Intensive Education Programs

Numerous staff education programs permanently established to upskill staff, introduce redesign principles, and change mindset

Visible and Constant Leadership Commitment

Committed leadership focused on creating patient-centered care model; frequent staff engagement communicates importance of initiatives

Advanced Strategy

Improving Information Access and Integration

IT investments enable increasing system-wide access to patient health information, amplifies impact of care pathways, cultural and educational initiatives

Source: Canterbury District Health Board, Christchurch, New Zealand; Advisory Board interviews and analysis.

Innovating to Keep Patients in the Community

Here, we profile just two examples of services that Canterbury has put in place to care for patients in the community and avoid acute admissions where appropriate.

Whole-System Approach to Care Delivery Redesign

Two Components of Cross-Continuum Care

Avoiding Admissions

Acute Demand Management Service

- Program designed to identify and assist patients suitable to receive care at home in place of ED attendance or acute admission
- Condition-specific algorithms guide acute admission/home care decisions
- Rapid Response Team replaces need for ED visits with home visits
- Program funds home visits by GPs and nurses, home help, rehabilitation and support services
- Established home care support system allows earlier patient discharge for patients otherwise lacking support system
- Operating cost lower than equivalent hospital visits

Returning Patients to the Community

Community Rehabilitation Enablement Support Team (CREST)

- 25+ FTE[2] team of clinical and allied health professionals tasked with expediting acute discharge by creating and providing viable post-acute recovery environments at home or in short-term care
- Implemented in wake of acute and post-capacity shortages following earthquake
- Conduct patient assessments to determine readiness for discharge, arrange transfer to post-acute care, conduct home visits, work to minimise readmissions

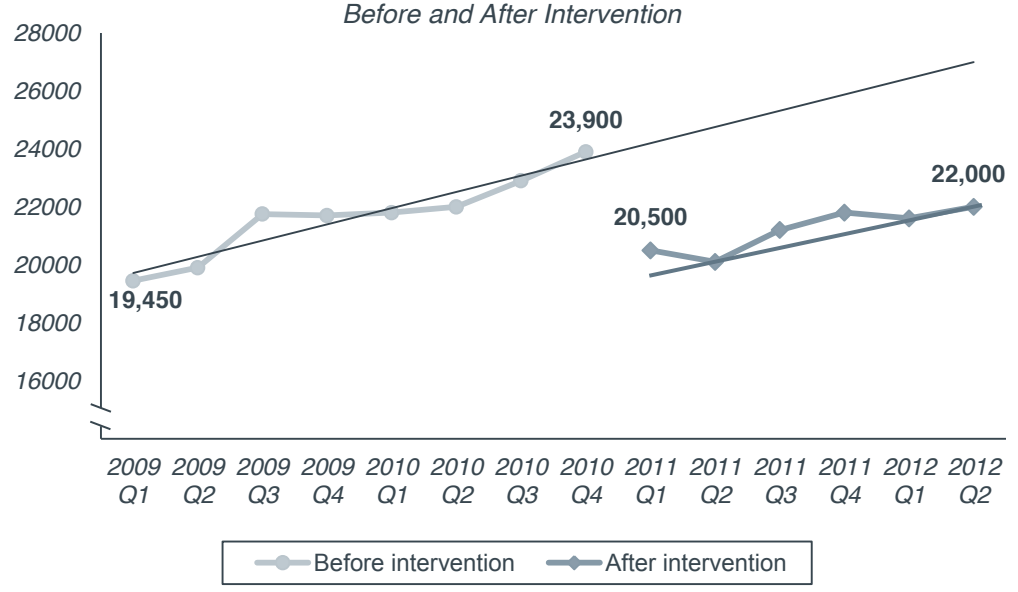
Source: Advisory Board interviews and analysis.

Efforts Lead to Decline in Acute Demand

The change in acute demand at Canterbury has been substantial. Previously unsustainable demand trends have been reset and a substantial number acute admissions have been avoided.

Trend in Quarterly ED Presentations

Before and After Intervention



Whole-System Approach Curbs Admissions and Readmissions

31% Admissions avoided compared with projections based on national benchmarks

67 Additional beds required in DHB[1] if operating at national average admission rates and LOS[2]

13% Fewer readmissions compared to the national average

1) District Health Board.
2) Length of Stay.

Source: Canterbury District Health Board, Christchurch, New Zealand; Advisory Board interviews and analysis.

Leading Sustained Improvement

Leading the Organisation to Clockwork Efficiency

Though hospital leaders do not have hands on responsibility for discharge, they have a key role to play in eliminating discharge delays and enhancing collaboration with post-acute care providers.

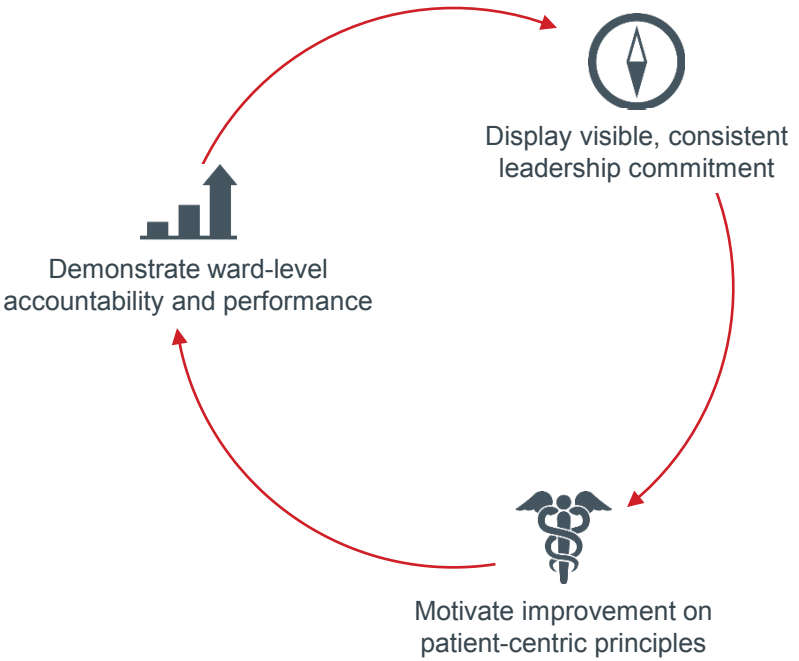
At the organisations that were most successful in driving improvements, leaders followed three behaviours.

First, they displayed visible and consistent commitment to improving discharge efficiency, leaving no doubt that a timely discharge was a high priority for them personally and for the organisation as a whole.

Second, leaders motivated improvement on patient-centric principles with both clinical and non-clinical staff. They emphasised the negative impact on care quality, both for the patient spending unnecessary days in hospital, and the new patient waiting for an inpatient bed.

Third, leaders demanded performance accountability at the ward level, to ensure that each staff member understands their responsibility for a timely discharge, and where they need to improve.

Common Factors in Successful Efficiency Leadership



Source: Advisory Board interviews and analysis.

Laying the Groundwork for Collaboration

Hospital leaders also have a critical part to play in building the relationships with other providers that are necessary to avoid delays.

Leaders must personally develop relationships with leaders from post-acute care providers. Without top-level contact, lower-level collaboration is unlikely to occur.

As relationships develop, they must be leveraged into opportunities for front-line and mid-level staff to interact, build relationships and brainstorm solutions to shared challenges and frustrations.

This executive time and commitment is a vital facilitator of better-coordinated, higher-quality, more cost-effective care.

External Relationship Building

Engage Post-Acute Care Organisation Executives

- Develop familiarity and rapport with post-acute care counterparts
- Emphasise opportunities for cooperation and mutual benefit

Facilitate Multi-Level Engagement

- Create space for lower-level acute and post-acute engagement
- Encourage dialogue and create forums for cooperation between acute discharge staff and post-acute care "receiving" staff

Source: Advisory Board interviews and analysis.

Appendix

Cardiff and Vale's Ticket Home

TICKET HOME

Name		
Consultant		
Physio	Discharged	Yes/No
OT	Discharged	Yes/No
Other Info		
Planned Date for Going Home	Date Going Home	Yes/No
	TTO Written	Yes/No
	X-ray Done	Yes/No
	Transport Required	Yes/No

Source: Advisory Board interviews and analysis.

Mayo Clinic's Risk Scoring Algorithm

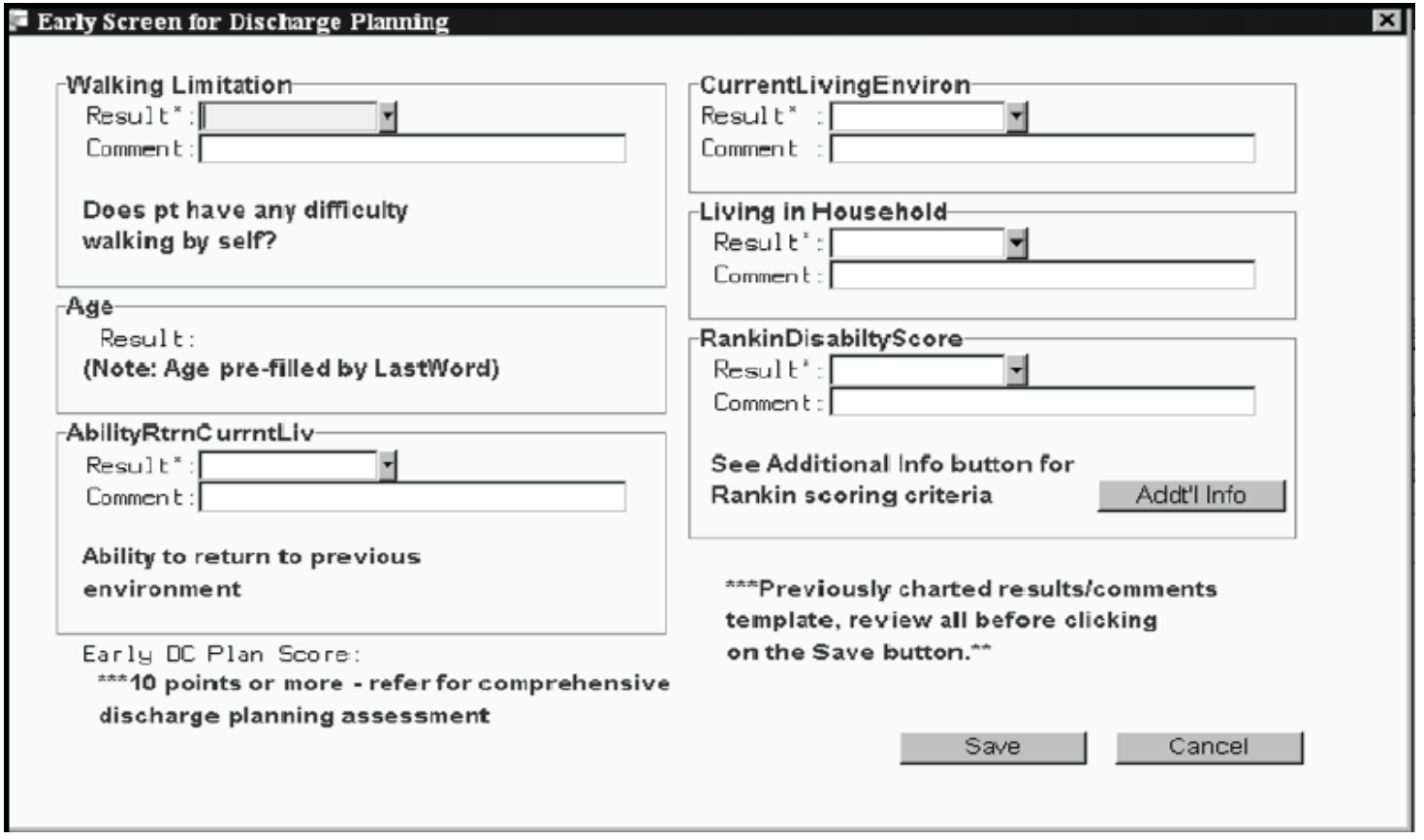
	Scoring		Multivariate Statistics	
Variable	**Coefficient**	**Algorithm Points**	**Odds Ratio (95% Confidence Interval)**	**p**
Constant	-4.59			<0.001
Age (years)				
18-44	0	0	1.0 (reference)	-
45-64	1.02	4	2.8 (1.0, 7.7)	0.051
65-79	1.58	6	4.9 (1.8, 12.9)	0.002
80+	1.98	8	7.3 (2.6, 20.6)	<0.001
Disability				
No significant disability	0	0	1.0 (reference)	-
Slight disability	0.81	3	2.3 (1.2, 4.2)	0.012
Moderate or greater disability	2.26	9	9.6 (4.9, 18.7)	<0.001
Prior living status				
With others	0	0	1.0 (reference)	-
Lived alone	0.75	3	2.1 (1.3, 3.5)	0.003
Lived in facility	0.09	0	1.1 (0.4, 2.9)	0.823
Self-rated walking limitation				
No	0	0	1.0 (reference)	-
Yes	0.84	3	2.3 (1.5, 3.7)	<0.001

MAYO CLINIC

Source: Mayo Clinic, Rochester, Minnesota US; Holland, D. et. al., "Development and Validation of a Screen for Specialized Discharge Planning Services," *Nursing Research*, January/February 2006, vol 55(1), pp 62-71.

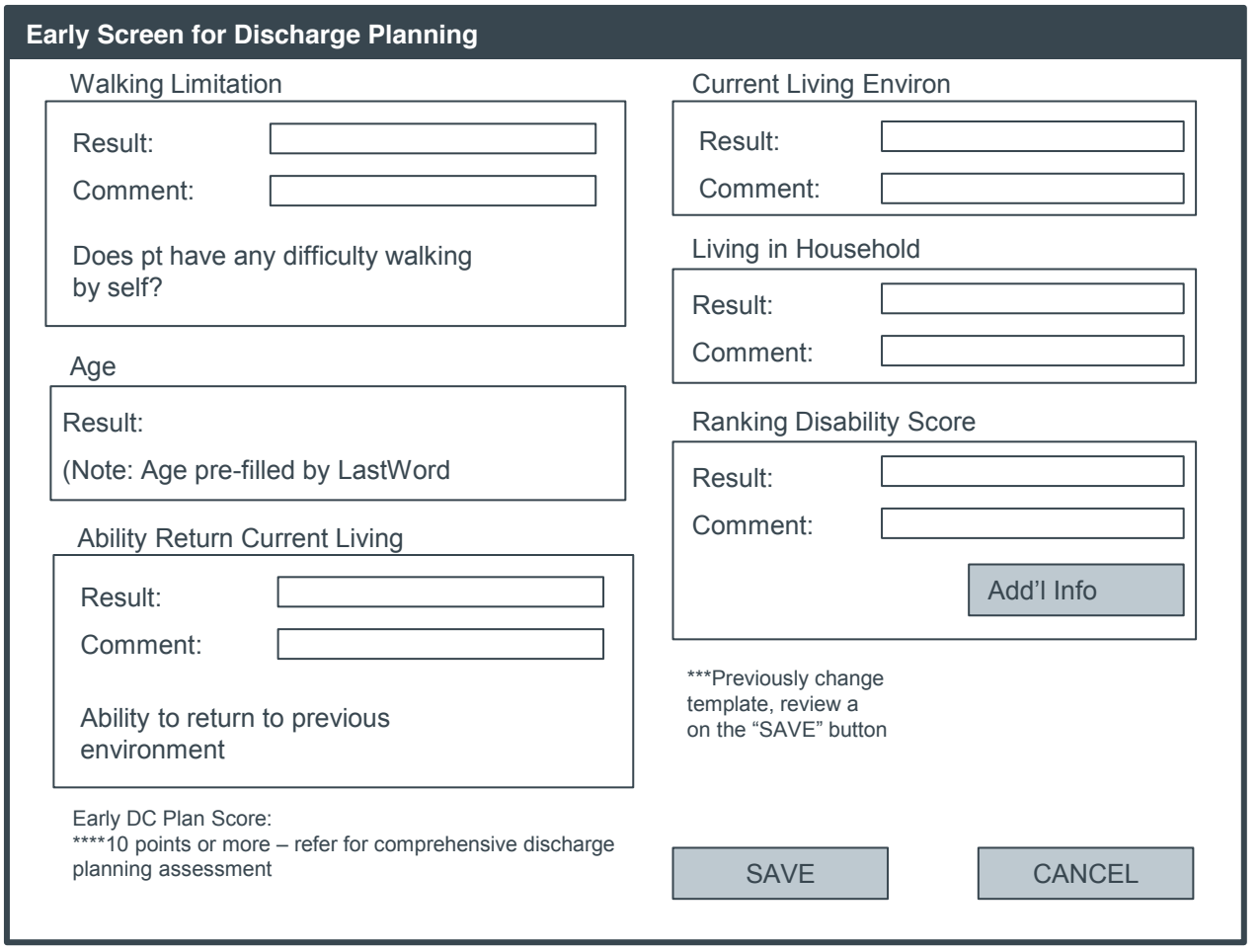
Mayo Clinic's Early Screen for Discharge Planning Tool

MAYO CLINIC



Source: Mayo Clinic, Rochester, Minnesota, US; Bowles K, et. al, "A Research and Clinical Partnership to Improve the Identification of Hospitalized Patients in Need of Post Acute Care," Presentation, 2010 National Association for Home Care & Hospice, October 2-6, 2010.

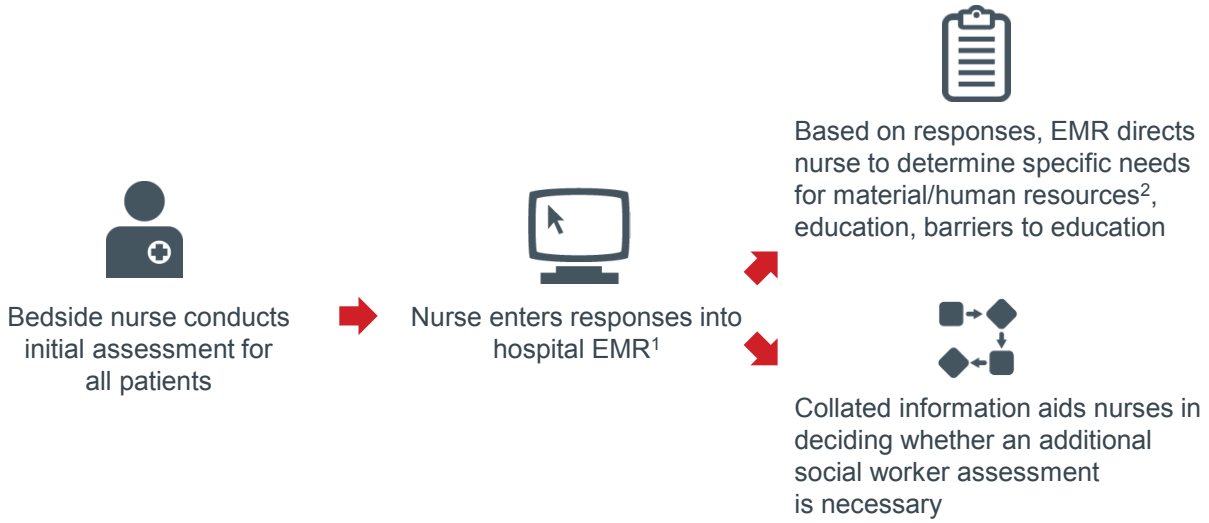
Rankin Disability Score



Source: Mayo Clinic, Rochester, Minnesota, US; Bowles K, et. al, "A Research and Clinical Partnership to Improve the Identification of Hospitalized Patients in Need of Post Acute Care," Presentation, 2010 National Association for Home Care & Hospice, October 2-6, 2010.

Clinica Universidad de Navarra's Assessment Program (Page 1 of 4)

Comprehensive Complex Patient Assessment



Case in Brief: Clinica Universidad de Navarra

- 300-bed university hospital located in Pamplona, Spain
- Introduced EMR-based patient assessment in 2004
- Icon in EMR flashes red until patient assessment is complete; responses used to develop discharge plan, helps medical staff decide when more in-depth social assessment is necessary
- Discharge plan reassessment prompted every three days by automatic reminder embedded into EMR

Systematically Identifying Potential Barriers

"There were unexpected discharge delays that would come up in the past that we couldn´t plan for, but with the patient assessment we've been able to avoid them."

Cristina Gordo,
Quality Management Nurse
Clinica Universidad de Navarra

1) Electronic Medical Record.
2) Includes assistive devices at home or home health nurses.

Source: Clinica Universidad de Navarra, Pamplona, Spain; Advisory Board interviews and analysis.

Clinica Universidad de Navarra's Assessment Program (Page 2 of 4)

Nursing Department Assessment Part 1

Name _____ Room Number _____ Department _____
Consultant _____ Tel. Number _____ Medical Diagnosis_____
Reason for admission _____ Weight _____ Height _____ Blood Pressure _____ Heart rate _____ SatO2 _____ VAS_____
Allergies: Yes/No_____ Specify: _____

MEDICAL
Condition: Good/Regular/Critical
Does patient know their medications (name, dosage, indication, side effects): Yes/No
Does the patient know how to manage their illness: Yes/No Patient following instructions: Yes/No
Tobacco: Yes/No Alcohol: Yes/No Stress: Yes/No Sedentary: Yes/No

EDUCATION
Needs Education: Yes/No
Education related to:
☐ Pathology ☐ Medication ☐ Post acute care needs ☐ Hygiene and Diet habits ☐ Harmful habits
☐ Interventions ☐ Medical Equipment ☐ Pain Management ☐ Rehabilitation ☐ Other
Educate: ☐ Patient ☐ Family ☐ Caregiver ☐ Both

Barriers to Education:
☐ None ☐ Physical ☐ Cognitive ☐ Psychological ☐ Sensory
☐ Sociocultural ☐ Language ☐ Religion ☐ No motivation
Education Methods:
☐ Written ☐ Verbal ☐ Audiovisual ☐ Demonstration

Discharge planning /Anticipation of necessary resources: None/Material/Human

NUTRITIONAL/METABOLIC
Method of diet administration:
☐ Oral ☐ Gastric tube ☐ Duodenal tube ☐ Jejuna tube
☐ Gastrostomy ☐ Jejunostomy ☐ IV
Appetite:
☐ Normal ☐ No appetite ☐ Little ☐ Large
☐ Bulimic ☐ Nauseated
Physical condition:
☐ Normal ☐ Obese ☐ Morbidly Obese
☐ Thin ☐ Cachexia
Food tolerance: Good/Regular/Bad

Digestive symptoms: Absence/Dysphagia

Changes to weight in last 6 months:
☐ None ☐ Voluntary weight loss
☐ Involuntary weight loss ☐ Weight gain

Has patient gone without eating more than 5 days? Yes/No
Is it likely that the patient will go 5 days without eating? Yes/No
Skin colour: Normal____
Temperature: Normal/Cold/Hot Hydration: Normal/Dry
Pruritus: Yes/No Oral cavity: Normal/Abnormal
Prosthesis: Yes/No

Source: Clinica Universidad de Navarra, Pamplona, Spain; Advisory Board interviews and analysis.

Clinica Universidad de Navarra's Assessment Program (Page 3 of 4)

Nursing Department Assessment Part 2

Name _____ Room Number _____ Department _____
Consultant _____ Tel. Number _____ Medical Diagnosis_____
Reason for admission _____ Weight _____ Height _____ Blood Pressure _____ Heart rate _____ SatO2 _____ VAS_____
Allergies: Yes/No_____ Specify: _____

URINARY
- Track: Normal/Catheter/Nephrostomy, Rhythm: Normal/Low/Polyluria
- Urine: Normal/Coloured/Concentrated/Blood, Sphincter Control: Yes/No

FECAL
- Rectal/Ostomy, Rhythm: Specify_____
- Consistency: Normal/Liquid/Hard_____ Characteristics: Normal/Discoloured/Green

EXERCISE ACTIVITY:
- Frequency: ☐ Normal ☐ Tachypnea ☐ Bradypnea,
- Dyspnoea: ☐ No ☐ Small ☐ Medium ☐ Large effort
- Cough: ☐ No ☐ Productive ☐ Morning ☐ Dry ☐ Irritating
- Mobility: ☐ Normal ☐ Limited ☐ Hemiplegia ☐ Paraplegia ☐ Tetraplegia_____

SLEEP PATTERNS
- Night time: Sleeps well/Rests without sleeping/Sleeps in small intervals/Doesn't sleep
- If doesn't sleep, specify type of insomnia: _____Sleep Apnoea: Yes/No

COGNITIVE PERCEPTION
- Level of consciousness: Conscious/Confused/ Drowsy/Agitated/Irritable
- Awareness: Yes/No, Himself/Place/Time
- Can follow directions:

SENSORY
- Hearing: No/Yes_____
- Smell: No/Yes_____
- Sight: No/Yes_____
- Touch: No/Yes_____
- Taste: No/Yes_____
- Vertigo: No/Yes_____

- Any pain: Specify Location and VAS _____ Duration: Constant ☐ Intermittent ☐ Occasional ☐

SELF PERCEPTION
- Emotional State: Normal ☐ Anxious ☐ Sad ☐ Depressed ☐
- Cooperation: Good ☐ Little ☐ None ☐
- Behaviour: Normal/Dependent ☐ Negative ☐ Passive ☐
- Risk: Suicide ☐ Escape ☐ Self-injury ☐ Aggression ☐

FINANCIAL
- Work status: Not working ☐ Sick leave ☐ Retired ☐
- Abuse: No ☐ Psychological ☐ Neglected ☐ Economic ☐ Physical ☐ Sexual ☐ Munchausen ☐
- Norton Scale (Risk of pressure ulcers) Downton Scale (Risk of falls)

Source: Clinica Universidad de Navarra, Pamplona, Spain; Advisory Board interviews and analysis.

Clinica Universidad de Navarra's Assessment Program (Page 4 of 4)

Social Worker Sample Questions

SOCIAL WORKER SAMPLE QUESTIONS

The Department of Social Work at CUN conducts interviews with patients/families/caregivers upon admission for all patients in the psychiatric ward and whenever necessary on other wards in the hospital.

In the interview, there are various themes that are explored, including:

- ☐ Does the patient live alone?
- ☐ Does the patient have a temporary or permanent caregiver?
- ☐ Is the patient socially isolated?
- ☐ Does the patient lack a network of support?
- ☐ Is the patient a primary caregiver for others?
- ☐ Does the patient understand his/her condition?
- ☐ Is the patient's socio/family environment inadequate?
- ☐ Does the patient present any behavioural disorders?
- ☐ Does the patient have any substance abuse issues?
- ☐ What are the patient's living conditions like? (Sanitary? Architecturally sound? Etc.)
- ☐ Has the patient experienced functional decline since they have been admitted in relation to the performance of everyday activities?
- ☐ Does the patient have any chronic illness? Is the patient a "frequent flyer"?
- ☐ Does the patient lack the economic resources to pay for basic cost of living?

Source: Clinica Universidad de Navarra, Pamplona, Spain; Advisory Board interviews and analysis.

Lutheran Medical Center's Family Caregiver Assessment (Page 1 of 5)

What Do I Need as a Family Caregiver?

About You as the Family Caregiver

Do you and your family member live in the same house or apartment?

☐ Yes ☐ No

If no, do you live in the same:

☐ Town or neighborhood ☐ City
☐ State ☐ Country

Do you work at one or more jobs?

☐ Yes ☐ No

If yes, do you work:

☐ Full-time ☐ Part-time

If part-time, how many hours per week? _____

Do you have children under the age of 18?

☐ Yes ☐ No

Are you also a caregiver for someone else with medical problems or disabilities?

☐ Yes ☐ No

If yes, are you a caregiver for:

☐ Children ☐ Other adults

Do you have any health problems that affect you as a caregiver?

☐ Yes ☐ No

If yes, are these problems due to:

☐ Arthritis ☐ Asthma ☐ Back problems
☐ Diabetes

Other:_____

Will other people (such as family members or friends) help care for your family member?

☐ Yes ☐ No

If yes, do they live in the same:

☐ Building, house, or apartment

☐ Town or neighborhood

☐ City ☐ State ☐ Country

Lutheran Medical Center's Family Caregiver Assessment (Page 2 of 5)

About Helping Your Family Member

As a family caregiver, you might be responsible for the help your family member needs at home. Here is a list of many of the things that may need to be done. For each item, check one of the following: **I am able to help *without* training, I would be able to help *with* training,** or **I am unable to help.** If your family member will not need help with one or more of the items, just skim them and go on to the rest of the list.

What Needs to be Done	I am able to help WITHOUT training	I am able to help WITH training	I am unable to help
Bathing (washing in the shower, bath, or sink)	❑	❑	❑
Dressing (getting dressed and undressed)	❑	❑	❑
Eating	❑	❑	❑
Personal hygiene (such as brushing teeth)	❑	❑	❑
Grooming (such as washing hair and cutting nails)	❑	❑	❑
Toileting (going to the bathroom or changing diapers)	❑	❑	❑
Transfer (such as moving from the bed to a chair)	❑	❑	❑
Mobility (includes walking)	❑	❑	❑
Medication (ordering medications, organizing them, and giving all medications as prescribed)	❑	❑	❑
Managing symptoms (such as pain or nausea)	❑	❑	❑
Equipment (such as oxygen, IV, or infusion)	❑	❑	❑
Coordinating the patient's care (includes talking with doctors, nurses, and other health care workers)	❑	❑	❑
Making and keeping appointments	❑	❑	❑
Driving or helping with transportation (such as a car, bus, or taxi)	❑	❑	❑
Household chores (such as shopping, cooking, and doing laundry)	❑	❑	❑
Taking care of finances (includes banking and paying bills)	❑	❑	❑

Lutheran Medical Center's Family Caregiver Assessment (Page 3 of 5)

About Worries

Being a family caregiver is a big responsibility. Sometimes I worry about (check all that apply):

- ❑My level of stress and how to cope with it
- ❑How to get time off (respite from being a family caregiver)
- ❑What my family member's condition means to me and others who care about him and her
- ❑How to manage medications and care for my family member
- ❑How to deal with my family member's behavior (such as refusing to eat or take a bath) and feelings (such as anger, resistance, and resentment)
- ❑Whether my family member is safe at home, or what to do if he or she wanders
- ❑Where my family member lives, and if this needs to change (such as moving to a nursing home or assisted living)
- ❑Making health care decisions on behalf of my family member (being the health care proxy)
- ❑How to talk about what is going on with family or friends
- ❑Legal issues (such as Living Will, Power of Attorney, and other paperwork)
- ❑How to pay for care
- ❑What to do if my family member needs end-of-life care

Notes and Questions

_____
_____
_____
_____
_____
_____
_____
_____

Lutheran Medical Center's Family Caregiver Assessment (Page 4 of 5)

Places and People I Can Call or Go To for Help

Ask the nurse, case manager, or social worker to suggest places and people you can talk with about your worries.

Place _____

Person to talk with _____

Telephone number _____

How this can help _____

Place _____

Person to talk with _____

Telephone number _____

How this can help _____

Lutheran Medical Center's Family Caregiver Assessment (Page 5 of 5)

About Services at Home/Community

If your family member has received home care or other services before, discuss these services with the nurse or case manager. You may also want to discuss some of the options under Other services mentioned below.

Check all the services your family member had before this admission:

❑Home care
If home care was provided, please indicate which agency provided the service; whether insurance covered it, and how much service was provided:

❑Medicaid
Name of agency_____ Hours per week_____

❑Medicare
Name of agency_____ Hours per week_____

❑Private insurance
Name of agency_____ Hours per week_____

❑Self pay
Name of agency_____ Hours per week_____

Please provide contact information for the agency that provided home care services:

_____

_____

Other Services

❑Home companion

❑Meals on Wheels

❑Personal emergency response system

❑Senior center

❑Transportation

❑Adult day care

❑Other: _____

City Hospitals Sunderland's Hub Referral Form (Page 1 of 2)

Intermediate Care Hub Referral Form

Name:	DOB:	Age:
Address:		
Patient Contact:		
Referrer (Inc. Role and Agency):		
GP:		
Patient Location:	Hospital and Ward:	
Home:	Other:	

Intermediate Care Hub Acceptance Criteria		
Sunderland GP:	☐ Yes	☐ No
Sunderland Resident:	☐ Yes	☐ No
Patient/Carer Agreement to Service:	☐ Yes	☐ No
Referrer's Preferred Option:	☐ Bed based	☐ Home based
Do you need to discuss referral with clinician:	☐ Yes	☐ No
Current presenting problem or reason for admission to hospital:		
Does patient need medical assessment:	☐ Yes	☐ No
Exit Route: ☐ Home	☐ Other, please state	
Current Social Care support:		
Medical History/Medication/Allergies:		
Mental Health Issues:		

Source: Sunderland Intermediate Care Hub; Advisory Board interviews and analysis.

City Hospitals Sunderland's Hub Referral Form (Page 2 of 2)

Intermediate Care Hub Referral Form

Functional Activity:			
Task	Independent (with or without equipment)	Require Assistance	Totally Dependent
Mobility	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
Transfers	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
Dressing	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
Washing	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
Bathing	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
Toileting	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
Eating / Drinking	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐

Has there been any deterioration from usual functions (Please describe)		
Are there concerns regarding:	Tick as appropriate	If yes, provide further information
Management of Continence	Yes ☐ No ☐	If yes, provide further information
Pain Management	Yes ☐ No ☐	If yes, provide further information
Medication Management	Yes ☐ No ☐	If yes, provide further information
Sleep Pattern	Yes ☐ No ☐	If yes, provide further information
Sensory Impairment	Yes ☐ No ☐	If yes, provide further information
Risk of Falls	Yes ☐ No ☐	If yes, provide further information
Rehabilitation and Reablement:		

Is Occupational Therapist intervention required for Intermediate Care Rehabilitation?

Yes ☐ No ☐

(If yes, explain reason/goal)

Is Physiotherapist intervention required for Intermediate Care Rehabilitation?

Yes ☐ No ☐

(If yes, explain reason/goal)

If none of the above please state reason for Reablement goals/reason for referral:

Safe and independent on stairs ☐

Bathing ☐ Food preparation ☐

Outdoor mobility ☐ Dressing ☐

Toileting ☐ Other ☐

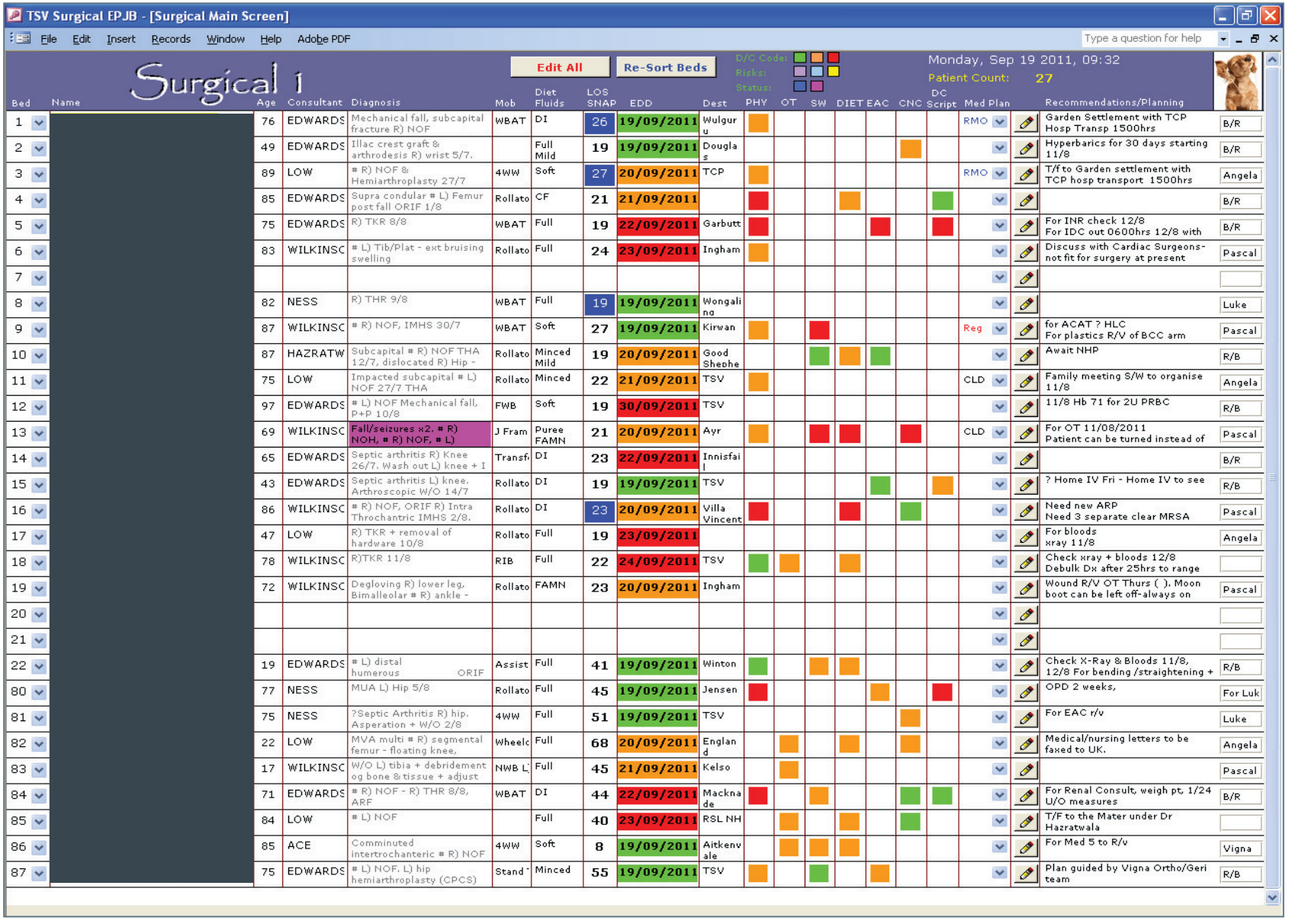
Special Dietary Requirements:

Outpatient Appointments:

Signed	Date:
Base:	Telephone:

Source: Sunderland Intermediate Care Hub; Advisory Board interviews and analysis.

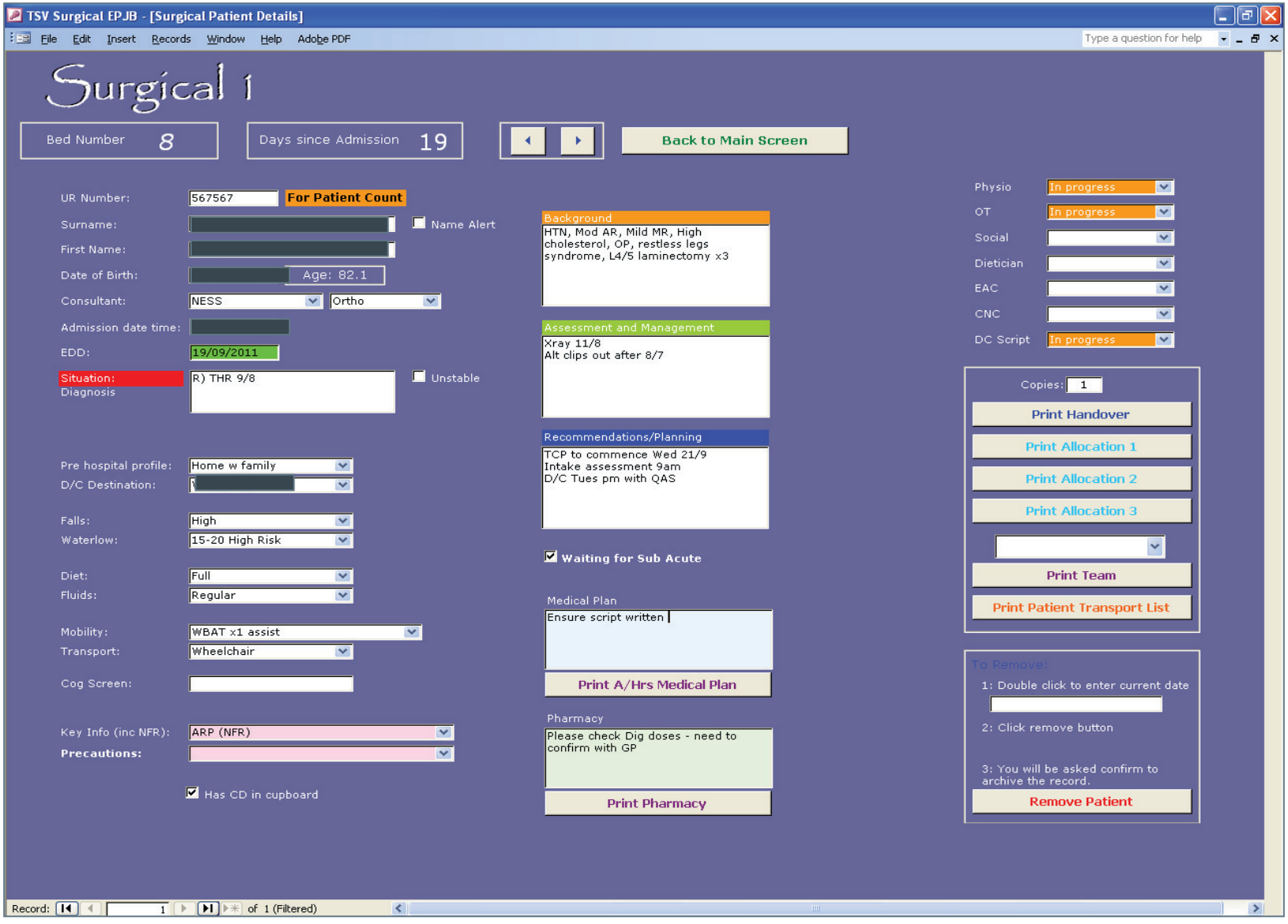
Workflow-Centred Journey Boards (Page 1 of 3)



Bed	Name	Age	Consultant	Diagnosis	Mob	Diet Fluids	LOS SNAP	EDD	Dest	PHY	OT	SW	DIET	EAC	CNC	DC Script	Med Plan		Recommendations/Planning	
1		76	EDWARDS	Mechanical fall, subcapital fracture R) NOF	WBAT	DI	26	19/09/2011	Wulguru								RMO		Garden Settlement with TCP Hosp Transp 1500hrs	B/R
2		49	EDWARDS	Illac crest graft & arthrodesis R) wrist 5/7.		Full Mild	19	19/09/2011	Douglas										Hyperbarics for 30 days starting 11/8	B/R
3		89	LOW	# R) NOF & Hemiarthroplasty 27/7	4WW	Soft	27	20/09/2011	TCP								RMO		T/f to Garden settlement with TCP hosp transport 1500hrs	Angela
4		85	EDWARDS	Supra condular # L) Femur post fall ORIF 1/8	Rollato	CF	21	21/09/2011												B/R
5		75	EDWARDS	R) TKR 8/8	WBAT	Full	19	22/09/2011	Garbutt										For INR check 12/8 For IDC out 0600hrs 12/8 with	B/R
6		83	WILKINSC	# L) Tib/Plat - ext bruising swelling	Rollato	Full	24	23/09/2011	Ingham										Discuss with Cardiac Surgeons- not fit for surgery at present	Pascal
7																				
8		82	NESS	R) THR 9/8	WBAT	Full	19	19/09/2011	Wongalin											Luke
9		87	WILKINSC	# R) NOF, IMHS 30/7	WBAT	Soft	27	19/09/2011	Kirwan								Reg		for ACAT ? HLC For plastics R/V of BCC arm	Pascal
10		87	HAZRATW	Subcapital # R) NOF THA 12/7, dislocated R) Hip -	Rollato	Minced Mild	19	20/09/2011	Good Shephe										Await NHP	R/B
11		75	LOW	Impacted subcapital # L) NOF 27/7 THA	Rollato	Minced	22	21/09/2011	TSV								CLD		Family meeting S/W to organise 11/8	Angela
12		97	EDWARDS	# L) NOF Mechanical fall, P+P 10/8	FWB	Soft	19	30/09/2011	TSV										11/8 Hb 71 for 2U PRBC	R/B
13		69	WILKINSC	Fall/seizures x2. # R) NOH, # R) NOF, # L)	J Fram	Puree FAMN	21	20/09/2011	Ayr								CLD		For OT 11/08/2011 Patient can be turned instead of	Pascal
14		65	EDWARDS	Septic arthritis R) Knee 26/7. Wash out L) knee + I	Transf	DI	23	22/09/2011	Innisfail											B/R
15		43	EDWARDS	Septic arthritis L) knee. Arthroscopic W/O 14/7	Rollato	DI	19	19/09/2011	TSV										? Home IV Fri - Home IV to see	R/B
16		86	WILKINSC	# R) NOF, ORIF R) Intra Throchantric IMHS 2/8.	Rollato	DI	23	20/09/2011	Villa Vincent										Need new ARP Need 3 separate clear MRSA	Pascal
17		47	LOW	R) TKR + removal of hardware 10/8	Rollato	Full	19	23/09/2011											For bloods xray 11/8	Angela
18		78	WILKINSC	R)TKR 11/8	RIB	Full	22	24/09/2011	TSV										Check xray + bloods 12/8 Debulk Dx after 25hrs to range	
19		72	WILKINSC	Degloving R) lower leg, Bimalleolar # R) ankle -	Rollato	FAMN	23	20/09/2011	Ingham										Wound R/V OT Thurs ( ). Moon boot can be left off-always on	Pascal
20																				
21																				
22		19	EDWARDS	# L) distal humerous ORIF	Assist	Full	41	19/09/2011	Winton										Check X-Ray & Bloods 11/8, 12/8 For bending /straightening +	R/B
80		77	NESS	MUA L) Hip 5/8	Rollato	Full	45	19/09/2011	Jensen										OPD 2 weeks,	For Luk
81		75	NESS	?Septic Arthritis R) hip. Asperation + W/O 2/8	4WW	Full	51	19/09/2011	TSV										For EAC r/v	Luke
82		22	LOW	MVA multi # R) segmental femur - floating knee,	Wheelc	Full	68	20/09/2011	England										Medical/nursing letters to be faxed to UK.	Angela
83		17	WILKINSC	W/O L) tibia + debridement og bone & tissue + adjust	NWB L	Full	45	21/09/2011	Kelso											Pascal
84		71	EDWARDS	# R) NOF - R) THR 8/8, ARF	WBAT	DI	44	22/09/2011	Macknade										For Renal Consult, weigh pt, 1/24 U/O measures	B/R
85		84	LOW	# L) NOF		Full	40	23/09/2011	RSL NH										T/F to the Mater under Dr Hazratwala	
86		85	ACE	Comminuted intertrochanteric # R) NOF	4WW	Soft	8	19/09/2011	Aitkenvale										For Med 5 to R/v	Vigna
87		75	EDWARDS	# L) NOF. L) hip hemiarthroplasty (CPCS)	Stand	Minced	55	19/09/2011	TSV										Plan guided by Vigna Ortho/Geri team	R/B

Source: Queensland Health, Brisbane, Queensland, Australia.

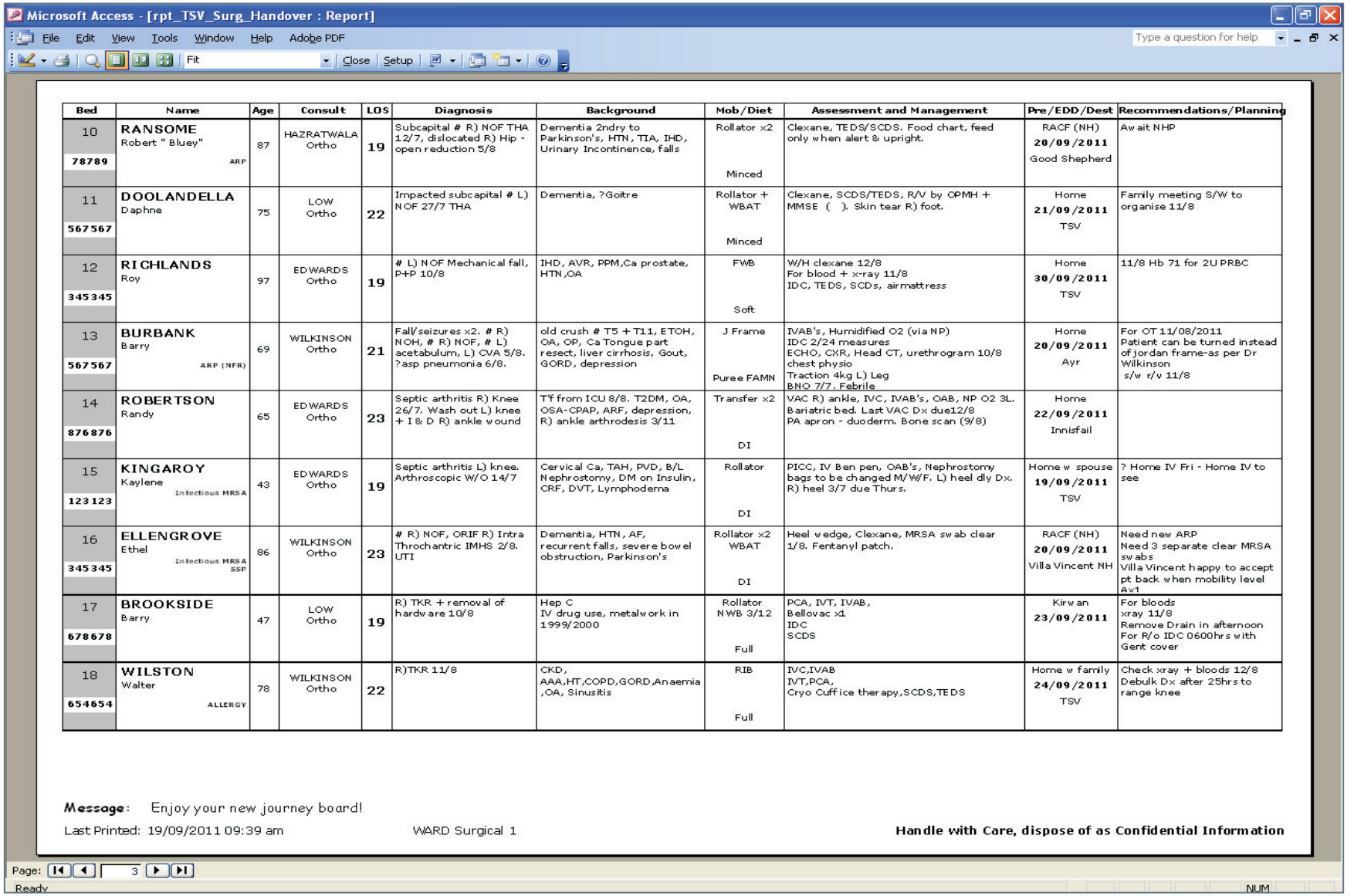
Workflow-Centred Journey Boards (Page 2 of 3)



1) Community Care Access Centre: Canadian organisation that coordinates home and community care.
2) Long-term care.

Source: Queensland Health, Brisbane, Queensland, Australia.

Workflow-Centred Journey Boards (Page 3 of 3)



Microsoft Access - [rpt_TSV_Surg_Handover : Report]

File Edit View Tools Window Help Adobe PDF — Type a question for help

Fit | Close | Setup

Bed	Name	Age	Consult	LOS	Diagnosis	Background	Mob/Diet	Assessment and Management	Pre/EDD/Dest	Recommendations/Planning
10 78789	RANSOME Robert " Bluey" ARP	87	HAZRATWALA Ortho	19	Subcapital # R) NOF THA 12/7, dislocated R) Hip - open reduction 5/8	Dementia 2ndry to Parkinson's, HTN, TIA, IHD, Urinary Incontinence, falls	Rollator x2 Minced	Clexane, TEDS/SCDS. Food chart, feed only when alert & upright.	RACF (NH) 20/09/2011 Good Shepherd	Await NHP
11 567567	DOOLANDELLA Daphne	75	LOW Ortho	22	Impacted subcapital # L) NOF 27/7 THA	Dementia, ?Goitre	Rollator + WBAT Minced	Clexane, SCDS/TEDS, R/V by OPMH + MMSE ( ). Skin tear R) foot.	Home 21/09/2011 TSV	Family meeting S/W to organise 11/8
12 345345	RICHLANDS Roy	97	EDWARDS Ortho	19	# L) NOF Mechanical fall, P+P 10/8	IHD, AVR, PPM,Ca prostate, HTN,OA	FWB Soft	W/H clexane 12/8 For blood + x-ray 11/8 IDC, TEDS, SCDs, airmattress	Home 30/09/2011 TSV	11/8 Hb 71 for 2U PRBC
13 567567	BURBANK Barry ARP (NFR)	69	WILKINSON Ortho	21	Fall/seizures x2. # R) NOH, # R) NOF, # L) acetabulum, L) CVA 5/8. ?asp pneumonia 6/8.	old crush # T5 + T11, ETOH, OA, OP, Ca Tongue part resect, liver cirrhosis, Gout, GORD, depression	J Frame Puree FAMN	IVAB's, Humidified O2 (via NP) IDC 2/24 measures ECHO, CXR, Head CT, urethrogram 10/8 chest physio Traction 4kg L) Leg BNO 7/7. Febrile	Home 20/09/2011 Ayr	For OT 11/08/2011 Patient can be turned instead of jordan frame-as per Dr Wilkinson s/w r/v 11/8
14 876876	ROBERTSON Randy	65	EDWARDS Ortho	23	Septic arthritis R) Knee 26/7. Wash out L) knee + I & D R) ankle wound	T/f from ICU 8/8. T2DM, OA, OSA-CPAP, ARF, depression, R) ankle arthrodesis 3/11	Transfer x2 DI	VAC R) ankle, IVC, IVAB's, OAB, NP O2 3L. Bariatric bed. Last VAC Dx due12/8 PA apron - duoderm. Bone scan (9/8)	Home 22/09/2011 Innisfail	
15 123123	KINGAROY Kaylene Infectious MRSA	43	EDWARDS Ortho	19	Septic arthritis L) knee. Arthroscopic W/O 14/7	Cervical Ca, TAH, PVD, B/L Nephrostomy, DM on Insulin, CRF, DVT, Lymphodema	Rollator DI	PICC, IV Ben pen, OAB's, Nephrostomy bags to be changed M/W/F. L) heel dly Dx. R) heel 3/7 due Thurs.	Home w spouse 19/09/2011 TSV	? Home IV Fri - Home IV to see
16 345345	ELLENGROVE Ethel Infectious MRSA SSP	86	WILKINSON Ortho	23	# R) NOF, ORIF R) Intra Throchantric IMHS 2/8. UTI	Dementia, HTN, AF, recurrent falls, severe bowel obstruction, Parkinson's	Rollator x2 WBAT DI	Heel wedge, Clexane, MRSA swab clear 1/8. Fentanyl patch.	RACF (NH) 20/09/2011 Villa Vincent NH	Need new ARP Need 3 separate clear MRSA swabs Villa Vincent happy to accept pt back when mobility level Ax1
17 678678	BROOKSIDE Barry	47	LOW Ortho	19	R) TKR + removal of hardware 10/8	Hep C IV drug use, metalwork in 1999/2000	Rollator NWB 3/12 Full	PCA, IVT, IVAB, Bellovac x1 IDC SCDS	Kirwan 23/09/2011	For bloods xray 11/8 Remove Drain in afternoon For R/o IDC 0600hrs with Gent cover
18 654654	WILSTON Walter ALLERGY	78	WILKINSON Ortho	22	R)TKR 11/8	CKD, AAA,HT,COPD,GORD,Anaemia ,OA, Sinusitis	RIB Full	IVC,IVAB IVT,PCA, Cryo Cuffice therapy,SCDS,TEDS	Home w family 24/09/2011 TSV	Check xray + bloods 12/8 Debulk Dx after 25hrs to range knee

Message: Enjoy your new journey board!

Last Printed: 19/09/2011 09:39 am WARD Surgical 1

Handle with Care, dispose of as Confidential Information

Page: 3

Ready NUM

1) Community Care Access Centre: Canadian organisation that coordinates home and community care.
2) Long-term care.

Source: Queensland Health, Brisbane, Queensland, Australia.

Chevington[1] Hospital's Transition Plan (page 1 of 2)

Transition Plan

Case Mgmt Associate _____ Pager #_____ Probability Readmission Rate _____

Anticipated Discharge Date _____ Care Conference Date _____

This Transition Plan was completed after review of admission assessment, provider documentation, interdisciplinary documentation and/or his/her family/significant other.

Primary Contact: ☐ Patient ☐ Other: _____

(H) _____ (W)_____(C)_____

Location of patient prior to hospital

☐ Home with services: _____

☐ Skilled Nursing Facility _____ Bed hold: ☐ No ☐ Yes (☐ MA ☐ Private pay)

☐ Other: _____

Comments: _____

_____

_____

_____

Current Agency Phone Fax Notified of hospitalization

Patient and/or Family goal for discharge (Check all that apply)

☐ Assisted Living ☐ Family Assistance ☐ Home ☐ Home Health ☐ Independent

☐ Outpatient Therapy ☐ Rehab ☐ Skilled Nursing Facility ☐ Other: _____

(Possible needs/barriers identified on back of form)

Date/Time/Initial	Patient needs for successful discharge	
		❑ No barriers identified
		❑ No barriers identified
		❑ No barriers identified

Initiated By: _____ Date: _____ Time: _____

Transition Plan Continued

☐ Verbal discharge choices offered patient/family preference: _____

☐ A list of Medicare-certified home health agencies, Skilled Nursing facilities and/or Hospice serving the geographic area in which the patient resides and/or requests was provided to the patient and his/her family and/or caregiver

☐ Continuity of Care Plan in centricity

Anticipated Discharge Plan:

Agency_____

Phone: _____ Fax: _____

Accepting Provider _____

Discharge Date _____ Discharge Time _____

Transportation _____

DischargeInstructions_____

_____

_____

_____

_____

_____

_____

Transition Plan reviewed with patient/family

Date/Time/Initial____/____/_____ ROI Contacted

Alterations in above Transition Plan_____

1) Pseudonym.

Source: Advisory Board interviews and analysis.

Chevington[1] Hospital's Transition Plan (page 2 of 2)

Date/Time/Initial	Patient needs for successful discharge	
		❑ No barriers identified
		❑ No barriers identified
		❑ No barriers identified
		❑ No barriers identified
		❑ No barriers identified
		❑ No barriers identified

Additional Notes:

1) Pseudonym.

Supplementary Practice: Hawthorne Medical Center's Staff-Designed Scripted Multidisciplinary Rounds

Strict Scheduling Ensures Doctor Attendance

Multidisciplinary Rounds Operate Like Clockwork

Timetabled Rounding

Each team comprises two doctors and their care teams who share one time slot; if one member is late, team waits for all other teams to round first

Team	Time
Smith & Jacobs	10:00
Garcia & DuPont	10:15

Key Elements

Attendance Enforced
Charge nurse has attendance list to ensure late penalty is enforced

Strictly Timed
Rounds are officially timed to last one to two minutes per patient for a maximum of 15 minutes per team

Scripted
Hospitalist leading rounds uses a script to keep rounds on track

Case in Brief: Hawthorne[1] Medical Center

- 650-bed university hospital located in western US
- Piloted hospitalist-led multidisciplinary rounds with two floors of medical patients
- Rounds are timed and held in a separate room; hospitalists lead using a script and charge nurse uses a timer to adhere to 15-minute time limit
- Hospital observed increased patient satisfaction with discharge

1) Pseudonym.

Source: Advisory Board interviews and analysis.

Trillium's Care Team and Home Health Patient Scripting (Page 1 of 3)

Trillium Care Team Scripting for Home First Pathway

1. **"After your acute needs are finished, you will be ready to be discharged from hospital. We're here to work with you to help you return home. There are several options, but staying in hospital is not one of them. It's best to make long term decisions in the community because your condition may improve. We're committed to helping you make an appropriate plan for your safe discharge home."**

Points to cover:

- Options for discharge home include: CCAC[1] in-home supports, friends, family, neighbours, community agencies including day programs, Supports for Daily Living, nursing support provided by insurance coverage, fee for service nursing support and fee for service home support.

Alternatives also to be considered are retirement homes/assisted living, group homes, etc.

2. **Reinforce and review Point #1, with the addition of discussion of Wait at Home for LTC[2]/Wait at Home Enhanced for those patients requiring support beyond what can be provided with the services mentioned in the first visit.**

   Information on LTC facilities can be provided at this time, and family encouraged to visit, but the understanding remains that the plan is still working towards discharge home to await LTC.

3. **"Our goal is to help you return home. Your care needs may be too high at the moment, but we may be able to look at this again in future if your condition improves. In the meantime, while you wait in hospital for transfer to LTC[2], you are asked to choose 2 LTCH[3] that have beds available, where you can wait for your preferred choice. We will work with you to help you select available beds in the community, as remaining in hospital is not an option. You may also be asked to consider a transfer to a LTCH not included in your choices, if a suitable bed becomes available. You may choose to decline selecting homes with available beds, in which case the team will work with you towards a discharge home."**

Points to cover:

- While awaiting placement in hospital, the patient must agree to apply to idle beds.
- The patient will be required to apply for placement at an appropriate facility with immediate availability while awaiting placement in one of his or her preferred choices.
- While Trillium works to incorporate patient choice and preferences, it is recognized that this is not always possible given the limited availability of resources for patients outside the hospital setting.
- Recommend that patients who request a private room may wish to consider also applying to a bed at a semi-private level and patients who request a semi-private room may wish to consider a bed at the basic level to increase their options.
- When a bed is offered, you will be transferred to that facility. Should you choose not to accept the bed offer, the team will work with you towards an immediate discharge home.
- Where a patient accepts a bed that is not their preferred choice, they may choose to remain on the waiting list for his or her preferred facility.

1) Community Care Access Centre: Canadian organisation that coordinates home and community care.
2) Long term care.
3) Long term care hospital.

Source: Trillium Health Centre, Mississauga, Ontario; Advisory Board interviews and analysis.

Trillium's Care Team and Home Health Patient Scripting (Page 2 of 3)

Trillium Care Team Scripting for Home First Pathway (cont.)

4. "There is a copayment fee as mandated by the Ministry of Health."

Points to cover:

- Patients must agree to pay the copayment fee as mandated by the Ministry of Health while awaiting LTC[1]. A financial assessment will be scheduled to determine if the patient is eligible for a reduction. If the patient/SDM do not present the necessary information for this assessment, the patient will be billed the full amount.

5. Reinforcement of hospital policy regarding idle bed choices: "While you wait in hospital for transfer to LTC, you are asked to choose 2 LTCH[2] that have beds available, where you can wait for your preferred choice. We will work with you to help you select available beds in the community, as remaining in hospital is not an option. You may also be asked to consider a transfer to a LTCH not included in your choices, if a suitable bed becomes available. You may choose to decline selecting homes with available beds, in which case the team will work with you towards a discharge home."

Points to cover:

- While awaiting placement in hospital, the patient must agree to apply to idle beds.
- The patient will be required to apply for placement at an appropriate facility with immediate availability while awaiting placement in one of his or her preferred choices.
- While Trillium works to incorporate patient choice and preferences, it is recognized that this is not always possible given the limited availability of resources for patients outside the hospital setting.

6. Reinforcement of hospital policy regarding accepting a bed offer: "When a bed is offered, you will be transferred to that facility. Should you choose not to accept the bed offer, the team will work with you towards an immediate discharge home."

Points to cover:

- Where a patient accepts a bed that is not their preferred choice, they may choose to remain on the waiting list for his or her preferred facility.
- Services will be coordinated to assist patient in returning home should they choose to decline the bed offer.

1) Long-term care.
2) Long-term care hospital.

Source: Trillium Health Centre, Mississauga, Ontario; Advisory Board interviews and analysis.

Trillium's Care Team and Home Health Patient Scripting (Page 3 of 3)

CCAC[1] Scripting for Home First Pathway

1. Meeting when Completing Assessment/Application and Facility Choice List:

    - Hello. My name is _____ and I am a Case Manager with the MH CCAC. I am here to ask you some questions to determine your eligibility for relocation to a Long-Term Care Facility. The process will take approximately _____ minutes. Do you consent to my assessment and application on your behalf to the long term care homes of your choice? Have you had a discussion with your physician or discharge planner (PN or SW) regarding your care needs and long term care? The Ministry of Health asks that CCAC help you to complete a few application forms and I would like to go through them with you. (list all the forms, explain and give copies of any that they sign)
    - Included in our long term care information package is a list of Long-Term Care facilities within the Mississauga Halton area (show client the page and the corresponding facility choice sheet). You are allowed to select up to 5 Long-Term Care facilities as your preferred choice(s) and you may also consider other long term care homes out of the region that you currently reside.
    - Some Long-Term Care Homes have lengthy waitlists, some well over a year. The benefit of moving to a long term care facility allows you to receive physiotherapy to maintain your current physical wellbeing, removes you from the risk of hospital acquired infections (expand if necessary) and allows you to participate in recreations activity in a more social/restful environment. Some of our homes have a shorter waiting periods and we are able to advise you of these home.
    - We ask that you and your family (etc) visit some of the facilities listed to determine which is the better fit(s) for (client name)_____ and return your completed list of up to 5 choices directly to MH CCAC, not the hospital within the next 5 working days so that we may facilitate your transfer as soon as possible.(set the end date for return here, how to fax and provide the fax number, who to return to if off hours and indicate they will get a copy of the signed form)
    - Thank you for your cooperation.

2. Script for CCAC Case Manager After 5 Days With No LTC[2] Facility Choices

    - Last week on (date) _____ the assessment portion of the LTC application for admission into a Long-Term Care Home was completed. That day we talked about the need to select up to 5 LTC Homes, indicating your preference. I am following up today as it has been five days since we met and MH-CCAC has not received the Facility Choice Sheet from you.
    - Have you had an opportunity to tour any homes since our last meeting? Do you have any further questions? (If they have some choices, ask them to send the form in with any homes so that you can start the application process). It would be preferable if you could submit your completed list to MH-CCAC within the next couple days. (identify a specific date)
    - Some LTC facilities have lengthy waitlists. I can give you the names of homes that may have a shorter time-frame to assist with admission to a long-term care home that can better meet your/or (client name)_____ needs, provide an opportunity to participate in recreational/physical and social activities and facilitate (client name)_____ to settle into a home.
    - (Provide method for submission of FCS to CCAC via fax, providing name of HCM and option to drop off FCS to CCAC Office.)
    - I will touch base with you on (date that is 2 days after this conversation)_____to see how you are doing.

1) Community Care Access Centre: Canadian organisation for coordinating sub-acute care services that coordinates home and community care.
2) Long term care.

Source: Trillium Health Centre, Mississauga, Ontario; Advisory Board interviews and analysis.

Auckland District Health Board Nurse Facilitated Discharge

Nurse Facilitated Discharge (NFD) General Medicine Instructions

Doctors

1. Identify and Inform Patient if intended NFD
2. Document discharge criteria on Nurse Facilitated Discharge form (CR4743). Note: A *Registrar or Consultant must set the criteria for NFD*
3. Complete Electronic Discharge Summary (EDS)
   Write: *"This discharge summary is subject to nurse facilitated discharge which may result in an updated discharge summary"* in clinical management section of EDS (EDS does not need to be pre-printed).
4. Sign prescription
5. Place NFD Form and prescription in clinical notes
6. Inform Charge Nurse or Coordinator of planned NFD

Charge Nurse or Coordinator

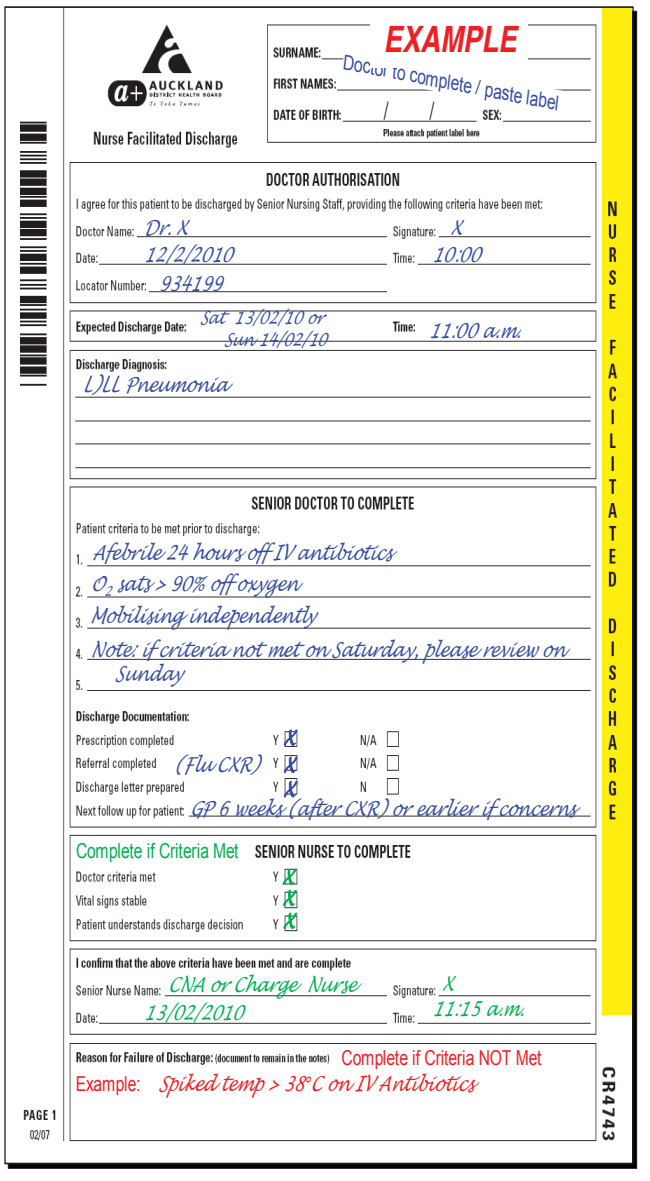
8. Update CHIPS whiteboard:
   - Go to "pathway" column on CHIPS whiteboard
   - Click on pathway box for patient specified to be a NFD
   - Select date/time of intended NFD.

Charge Nurse or CNA (after hours)

10. Review Patient indicated by "NFD" on CHIPS whiteboard column

Criteria Met	Criteria NOT Met
11a ▪Complete NFD form ▪Print EDS ▪Discharge patient	11b Consider contacting On-Call House Officer for review and /or set additional EDD – OR – Complete "Reason for Failure" on NFD Form

12. Place completed NFD Form in clinical notes



Auckland District Health Board

Nurse Facilitated Discharge

EXAMPLE

SURNAME: Doctor to complete / paste label

FIRST NAMES:

DATE OF BIRTH: / / SEX:

Please attach patient label here

NURSE FACILITATED DISCHARGE

DOCTOR AUTHORISATION

I agree for this patient to be discharged by Senior Nursing Staff, providing the following criteria have been met:

Doctor Name: Dr. X Signature: X

Date: 12/2/2010 Time: 10:00

Locator Number: 934199

Expected Discharge Date: Sat 13/02/10 or Sun 14/02/10 Time: 11:00 a.m.

Discharge Diagnosis: L/LL Pneumonia

SENIOR DOCTOR TO COMPLETE

Patient criteria to be met prior to discharge:

1. Afebrile 24 hours off IV antibiotics
2. O_2 sats > 90% off oxygen
3. Mobilising independently
4. Note: if criteria not met on Saturday, please review on Sunday
5.

Discharge Documentation:

Prescription completed Y ☒ N/A ☐

Referral completed (Flu CXR) Y ☒ N/A ☐

Discharge letter prepared Y ☒ N ☐

Next follow up for patient: GP 6 weeks (after CXR) or earlier if concerns

Complete if Criteria Met **SENIOR NURSE TO COMPLETE**

Doctor criteria met Y ☒

Vital signs stable Y ☒

Patient understands discharge decision Y ☒

I confirm that the above criteria have been met and are complete

Senior Nurse Name: CNA or Charge Nurse Signature: X

Date: 13/02/2010 Time: 11:15 a.m.

Reason for Failure of Discharge: (document to remain in the notes) Complete if Criteria NOT Met

Example: Spiked temp > 38°C on IV Antibiotics

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CR4743

Source: Auckland District Health Board

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