

Patient Care Accountability in the Health Care System



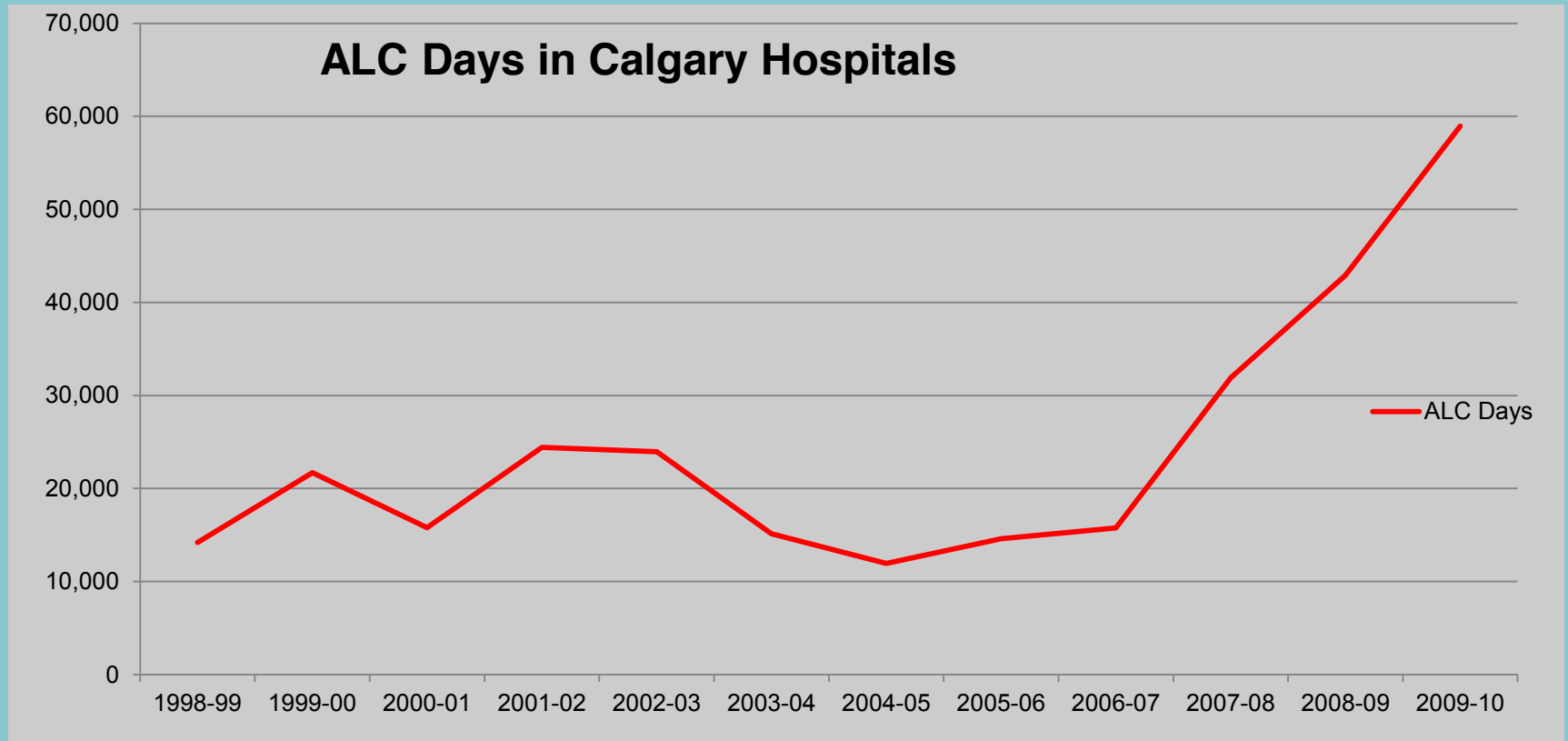
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Long Term Care Access Block

- An independent elderly woman fractures her pubic ramus and has difficulty weight bearing.
- After 2 days on a medical ward, she becomes confused and incontinent. A Foley catheter is placed, and she develops fever and delirium.
- When her urosepsis resolves, she is too weak to ambulate. Doctors decide she can't return home.
- A month later, wasting and wheelchair bound, she is still waiting for transfer to long-term care

Long Term Care Access Block - 2010

- 60,000 days ALC pts in acute care beds

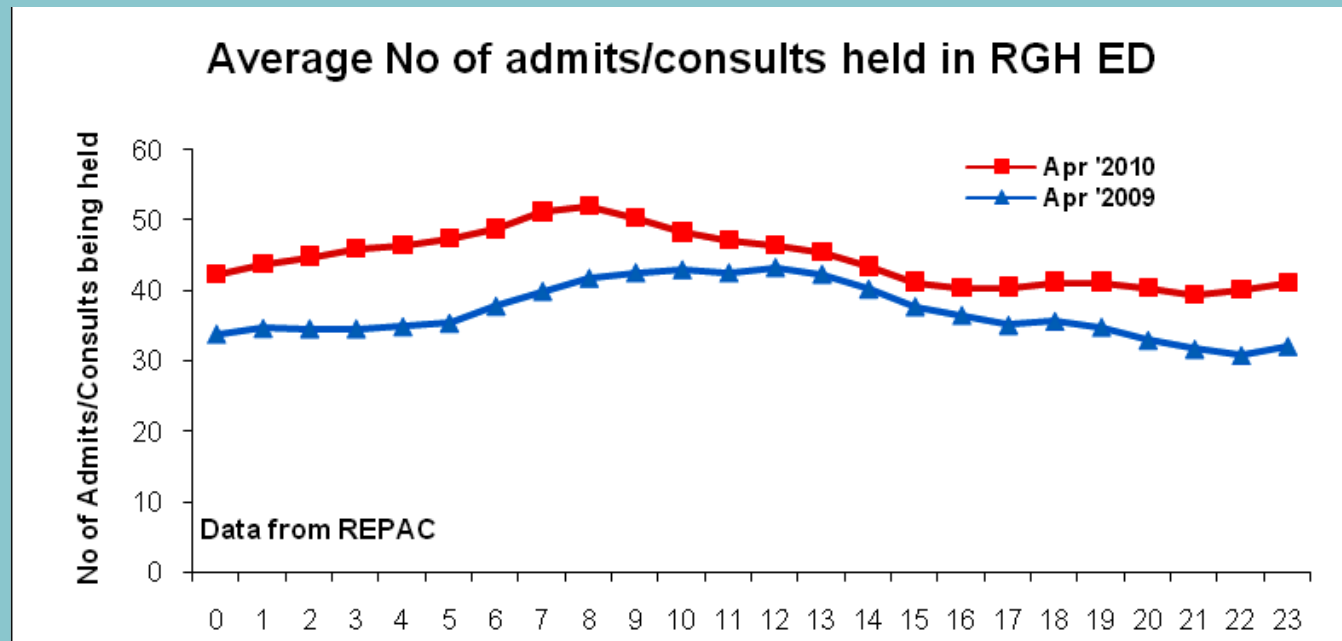


Hospital Access Block

- A 68 year-old with pneumonia is admitted by the hospitalist but no inpatient beds are available.
- After 20 hours in an ED stretcher, his daughter asks why he has not gone to a ward.
- *“The ED is noisy; the lights never go off; he can’t sleep, the stretcher is causing back pain.”*
- He wants to sign out AMA but can’t, because he is dyspneic on room air.
- The EP explains that the hospital is full. He suggests she write a complaint letter to the CEO

Hospital Access Block-Calgary 2010

- Avg ED LOS for admitted patients = 17 hrs
- Inpt care burden= 700,000 hrs (29,000 bed days)
- 40-100% of ED care capacity



Emergency Access Block

- A 70 yr old woman with post-op abdominal pain (CTAS 3) is diverted from another ED, and triaged to the waiting room because all ED care spaces are occupied—mostly by pts awaiting inpatient beds
- After 3 hours in the WR she collapses.
- Resuscitation is initiated in the ED. She is rushed to the OR, but dies in surgery
- Her husband and son ask, “Why did this happen?”

Patient Care Accountability?



Access Block . . .

Wrong patient in the wrong place

On a MASSIVE scale

Adverse outcomes ++++++

Causes of access block

Capacity?

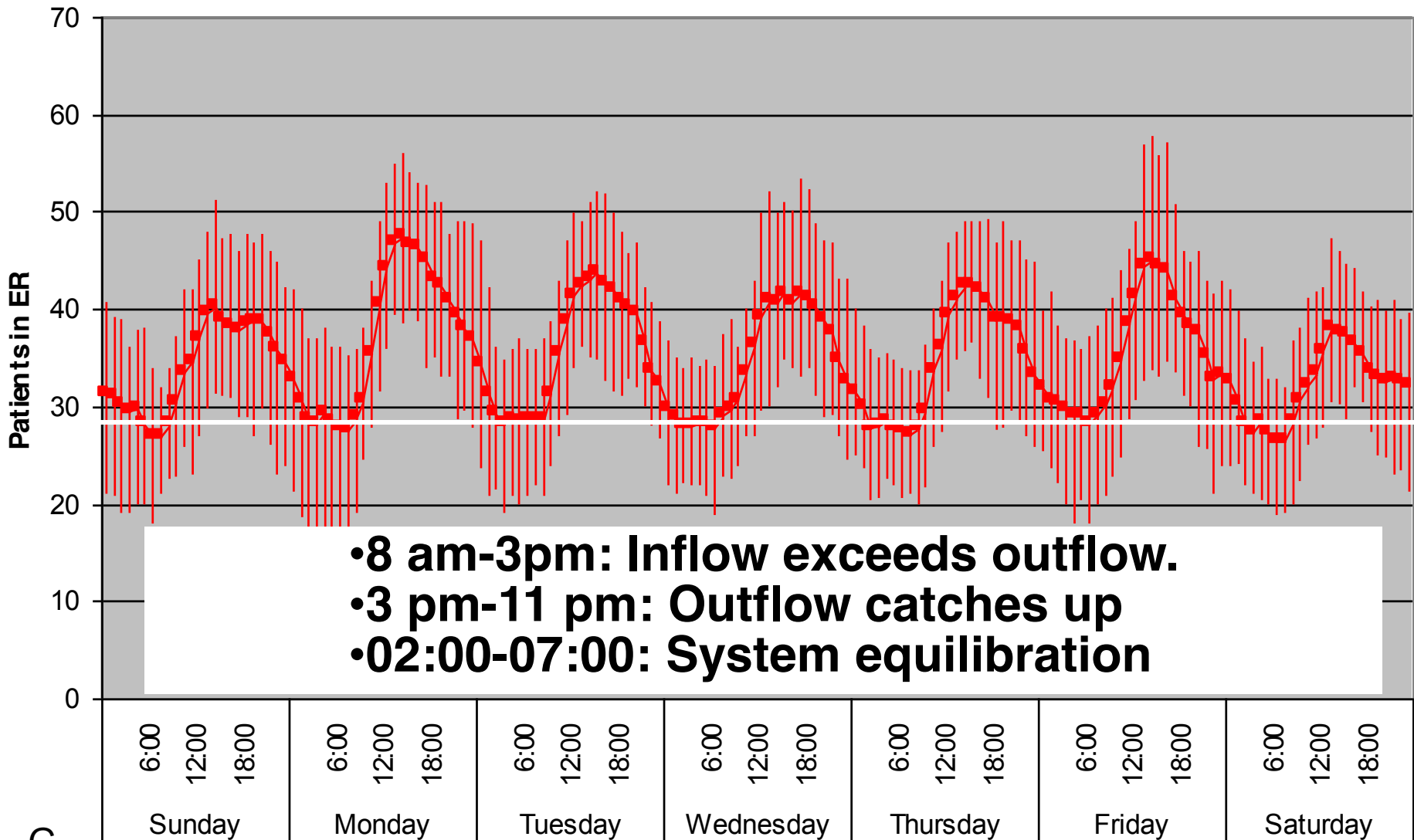
Efficiency (using more system resources than required to provide appropriate care)

Appropriateness:

- wrong care,
- care that could be provided elsewhere,
- care that is unnecessary or does not lead to a better health outcome (no/low value added)

Flow and care transitions

Flow!! A Critical Factor



Accountability is

Assuring access,
care quality
and value

for the population served

Facets of Accountability

Hippocratic paradigm:

- Provide patient care
- Advocate for the patient's interests above all else

Actually: *“placing the needs of individual patients above broader economic and corporate objectives”*

•We are accountable not just to individual pts, but to populations and our health care organizations

Accountable to the many—not just the one
Perfect is the enemy of good!

Accountable to pt needs? *or provider expectations?*

Patient needs: Timely care, even during busy periods

Provider expectations:

- Every pt undressed in a stretcher, on a monitor, for hours
- 4:1 nursing ratios, regardless of pt inflow and complexity
- Set MD schedule; no call-ins or stay-lates; no on-call
- no admissions/assessments outside M-F day hours,
- Inefficient trainee-driven processes,
- Morning teaching rounds instead of dischg rounds,
- Scheduled breaks; no new pts during breaks/shift change
- Redundant assessments

Who is accountable

Right provider, right place = best outcome

Accountability zones:

Who is responsible for service delivery planning

Where do we look for access solutions

ED: for referred, EMS, and walk-in patients

Inpatient: from referral to hospital discharge

Long-term care: from LTC referral

Figure 4. Accountability Zones and Flow Pathways

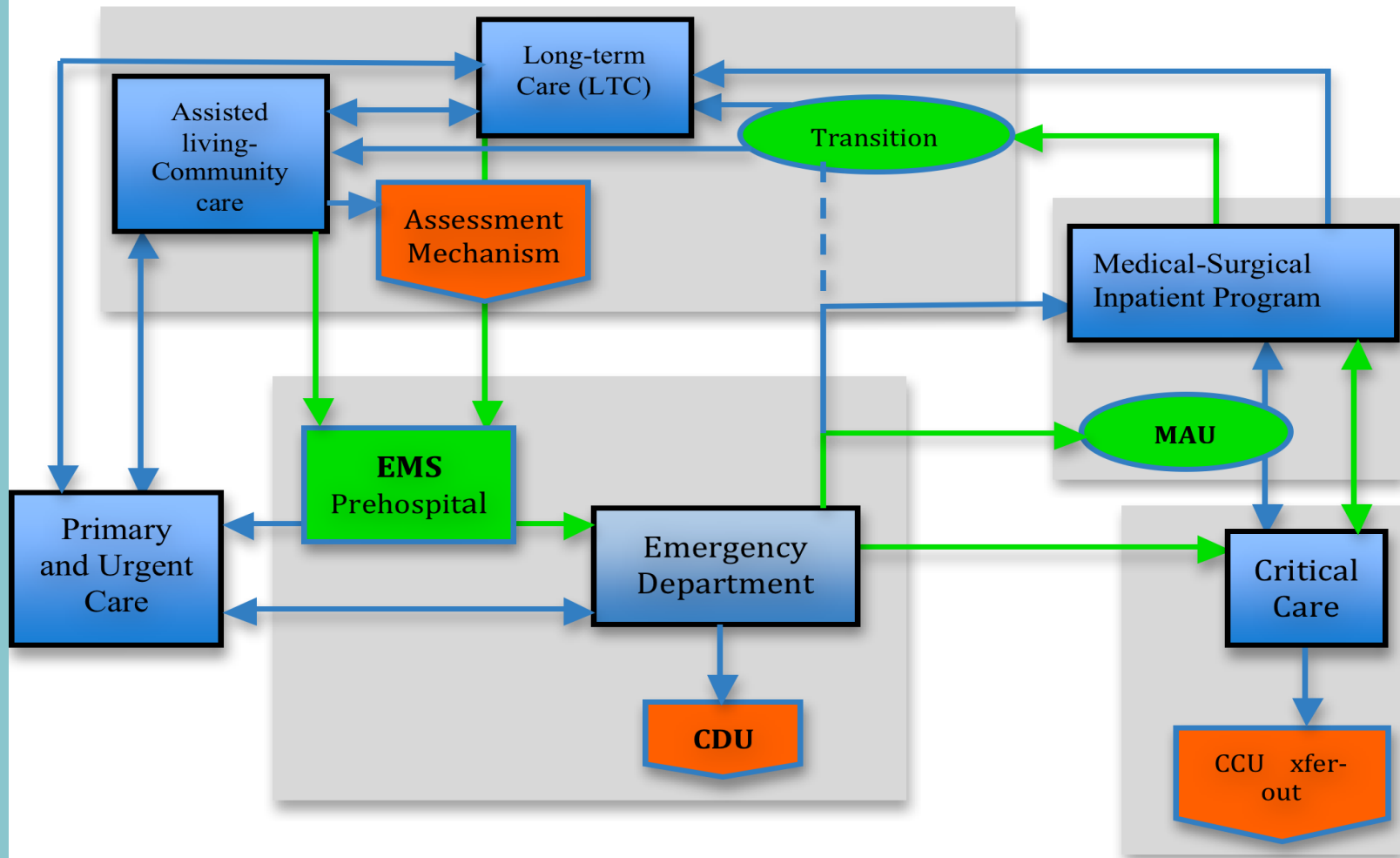


Figure: Blue boxes are programs. Green ovals are inflow areas to key programs. Grey

Who is accountable to care for:

- A delusional schizophrenic requiring admission
 - A woman in labour
 - A patient requiring ORIF of a tibial fracture
 - A septic patient
 - A patient with DKA
-
- Boundary issues should be resolved by people working at the boundary (one-way consultation)

Accountable for what?

- Timely assessment and disposition
- Budget, space, nursing care
- Queue management and surge plan



Accountability Failure*

- Homecare patients in LTC Facilities
- ALC patients in acute care beds
- Inpatients in ED stretchers and ICU beds
- Emergency patients in hallways

**Systematic downloading of patient care into more expensive and less effective locations*

Becoming Accountable

Improve efficiency

- Match capacity to demand
- Smooth elective demand
- Eliminate non-value added service
- Eliminate redundancy
- Eliminate needless queues
- Develop intake strategies
- contingency plans for supply-demand mismatch
- Discharge planning
- Day ahead demand capacity planning

Optimize appropriateness

- Alternate destinations for EMS
- NP filter before transfer from institutional care
- Don't put pts in stretchers
- Take patients out of stretchers
- Don't do unnecessary ED investigations
- Don't admit patients (CDU, O/P Rx)
- Sickest patients get priority for resources (focus on the front door)
- Medical needs trump social needs
- Rationalize care delivery: Is all care necessary?

Add Capacity

- If efficiency and appropriateness are optimized, access solutions may involve adding or redistributing program capacity
- Arguing for new capacity is tough

NOTE: New capacity has never been an answer for the ED



Coping S



**Management
by blocking
access**

Sorry—We're full!

- Access block: Not a problem--rather a *solution* to capacity-efficiency shortfalls.
- Long-term care patients left in hospital bed compromising acute care access;
- Inpatients left in ED and critical care spaces, compromising emergency and critical care;
- ED patients left in EMS gurneys and hallways, compromising prehospital care.
- Systematic downloading of care to more expensive, less effective locations compromises appropriateness, utilization and patient outcomes



The cost of failure



Management by blocking access

- When the consequences of failure in one “silo” are expressed primarily in a different silo, leaders capable of addressing the core problems are protected from having to do so
- Those in impacted areas who are highly motivated to solve the problems are not in a position to understand or address them
- A recipe for eternal system failure

The Accountability Solution

- Clarify patient care accountabilities and remove incentives for failure
- Establish an accountability framework is the first essential step in getting the right patient to the right provider and setting.
- Accountability is the evolutionary stressor required to drive necessary system change.
- Access blocks will not be solved until programs are accountable to solve



Accountability Framework: Set Targets

ED Access and Efficiency Targets:

- Time to MD (CTAS 3): 60 min
- ED LOS: 2 hrs and 4 hrs



Inpt Access and Efficiency Targets:

- Consult disposition time: 2 hr
- Admission order to Inpatient Transfer: 2 hrs
- Actual/Expected LOS for typical Cases:
96%

LTC Access Targets:

- ALC Threshold number (%)
- Time to ALC assessment/placement



Accountability Strategies

- Embedded opinion leaders as change agents (culture eats strategy for breakfast)
- Explicit accountabilities & targets; program agreements
- Measurement and feedback
- Performance management:
- Public reporting of performance (multi-level)
- Defined action on performance gaps
- Rewards (P4P, other) and penalties
- Eliminate rewards for failure
- Loss of job or contracts (e.g. NHS primary care trusts may end provider contracts if targets not met)

Real time accountability mechanisms

- Time rules
- Number limits (10 patient rule)
- Push systems (OCP)

MOH accountability

- strategic plan,
- accountability planning,
- Resources for measurement and reporting.
- clinical infrastructure and resources required to meet performance targets (assuming programs are operating efficiently and appropriately).
- legislative environment that makes it possible for leaders to be effective (e.g. union agreements).

No accountability without the ability to influence

Region and facility leaders

- Implement accountability structures and measurement systems in region and facilities.
- Track and report care and accountability gaps,
- Use data to determine how gaps are best addressed:
 - Fight for new capacity,
 - Lead efficiency improvements
 - Modify allocation of existing resources.
- Strategic control of funding
- resources for change management

Box 1. Levels of Accountability

1. Government/Ministry of Health accountability:

- a) Assure necessary infrastructure, budget and manpower, assuming high levels of appropriateness and efficient utilization by hospitals.
- b) Hold hospital boards and CEOs accountable for achieving performance levels

2. Hospital accountability:

- a) Assure necessary infrastructure, budget and support services are in place, assuming high levels of appropriateness and efficient utilization by programs
- b) Assure that care delivery planning is based on all-patient (population) need rather than historical limits
- c) Assure that effective patient-focused surge contingency plans are in place
- d) Assure program accountability along with common safety, nursing and infection control standards

3. Program Accountability:

- a) Provide budget, space and care for patients admitted to that program
- b) Provide timely access for patients requiring program-based care
- c) Assure timely admission and discharge decisions by physicians
- d) Assure high levels of appropriateness and efficient utilization (e.g. ALOS/ELOS)
- e) Match care provided (resource allocation) with patient need
- f) Implement effective contingency plans to address variable patient need
- g) Implement effective contingency plans for periods of capacity shortfall

Five Philosophical Tenets of an effective overcapacity plan

- OCP is not a plan to “share the pain.” It is an overcapacity contingency, an accountability mechanism and a flow strategy
- The same care standards, applied throughout the hospital begin at the time of patient arrival and extend to discharge
- Overcrowding must be addressed by the entire system
- Best outcomes and efficiencies occur when patients are matched to the right program and provider ASAP
- All programs have important care missions and require reasonable access to their resources in order to meet targets
- Hallways are undesirable locations for patient care

Demand-driven (patient-focused) Overcapacity Protocol

- Arriving CTAS 1-3 pts are moved rapidly (<15 min) into an ED acute care space.
- If necessary they will move to an ED overcapacity space.
- When the ED is overcapacity by 2 patients, the most stable supernumerary admitted patients are distributed, on a no-refusal basis, one at a time, to overcapacity care spaces on the most appropriate ward:

Level 1 OCP: to optimal unit (e.g. renal to renal)

Level 2 OCP: to similar unit (any “medical” to any “medical”)

Level 3 OCP: any patient to any unit

Summary

System access problems will not be solved until someone is accountable to solve them

QUESTIONS?