

Clinical Care Coordination Rounds: Facilitating Early & Safe Discharge

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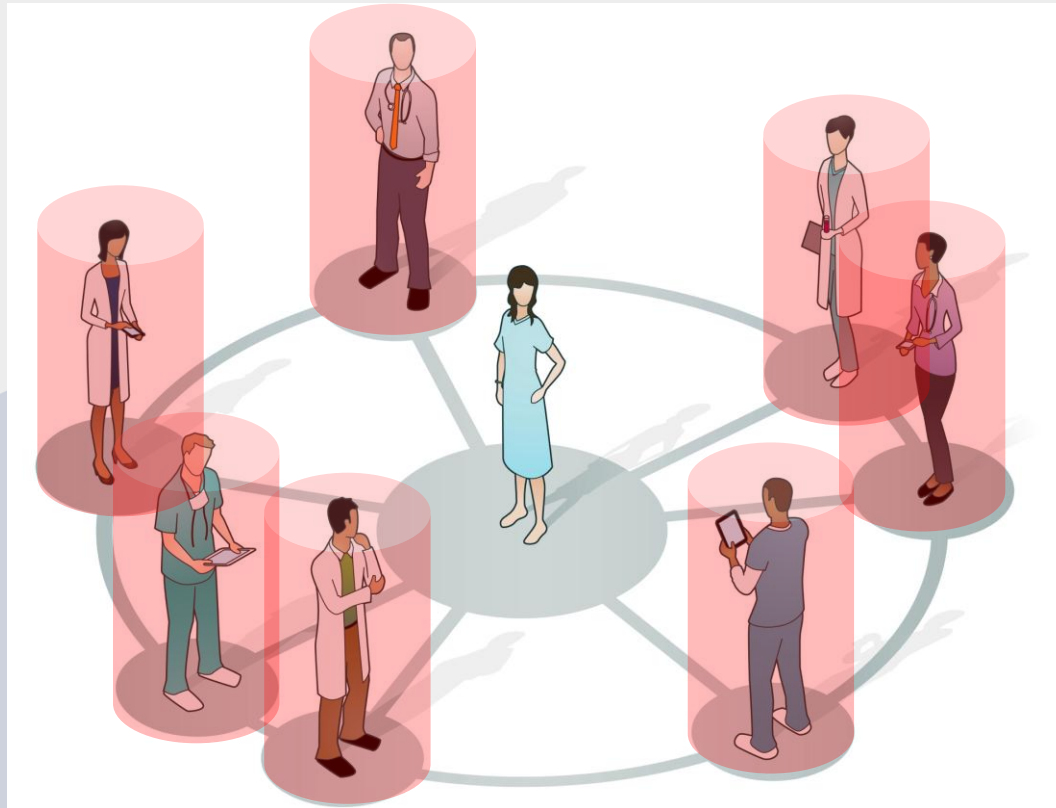
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Nature of the problem

- Increased hospital activity (compounding NEAT efforts)
- Increased length of stay (compounding NEAT efforts)
- Late discharge on the day (compounding NEAT efforts)



The Silos of Silence



[Modified from quotesgram.com/patient-centered-care-quotes/]

Aim

- To optimize discharge timing and length of stay without compromising patient care
- To improve ward communication between staff members and discharge planning for inpatients
- To understand what factors result in late discharge



Implementing solutions: Care Coordination Meeting

- Daily at 9:30am on home ward
- Led by staff specialist + NUM
- Attendees (mandatory):
 - All GE Advanced trainees, basic physician trainees, JMOs
 - Team leader, Clinical Nurse Educator
- Attendees (if available):
 - Patient flow manager
 - Pharmacist
 - Social worker, Dietitian, Physiotherapist, Occupational Therapist
 - Ward nurses



Implementing solutions: CCCM Agenda

For **each** patient **everyday**:

- To establish/review estimated date of discharge
- To assess ICU/HDU/telemetry needs
- To assess barriers to discharge
- To assess need for allied health intervention from day 1
- To discuss doctor/nurse/allied health concerns

Other discussion points:

- Patients with prolonged LOS to assess requirements for safe discharge.
- To consolidate outliers to home ward.
- Other business items (teams, GuidanceMS etc)



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Performance Indicators

- Discharge time
- Reasons for after 12 pm discharges
- Length of stay
- Peer hospital comparison
- Safety – readmission rate



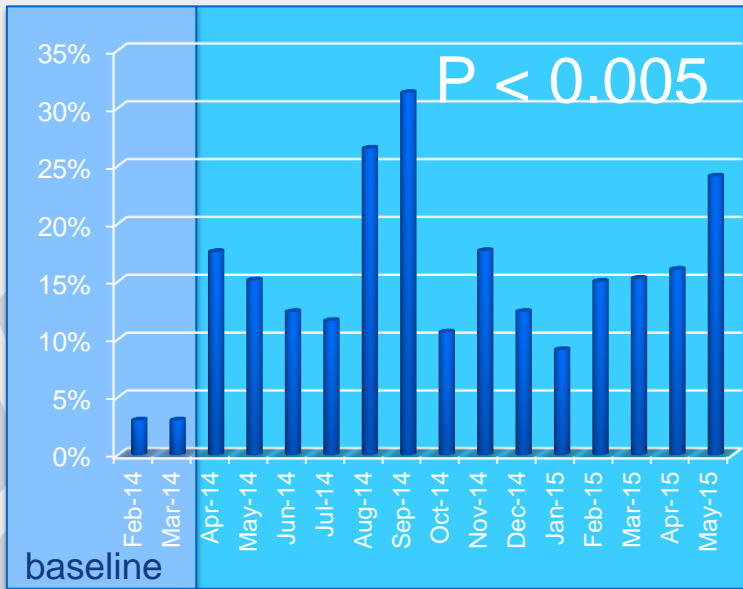
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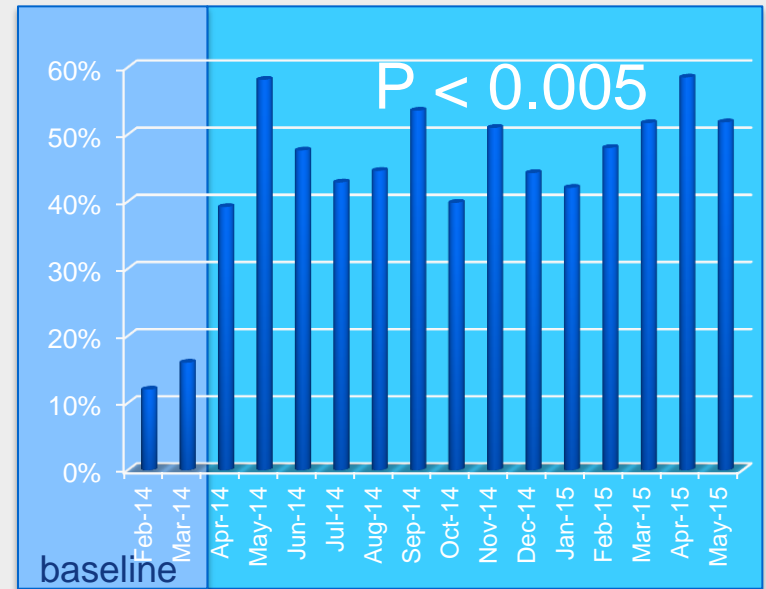


Discharge time improvement - Significant & Sustainable

Discharges before 10am



Discharges before 12pm

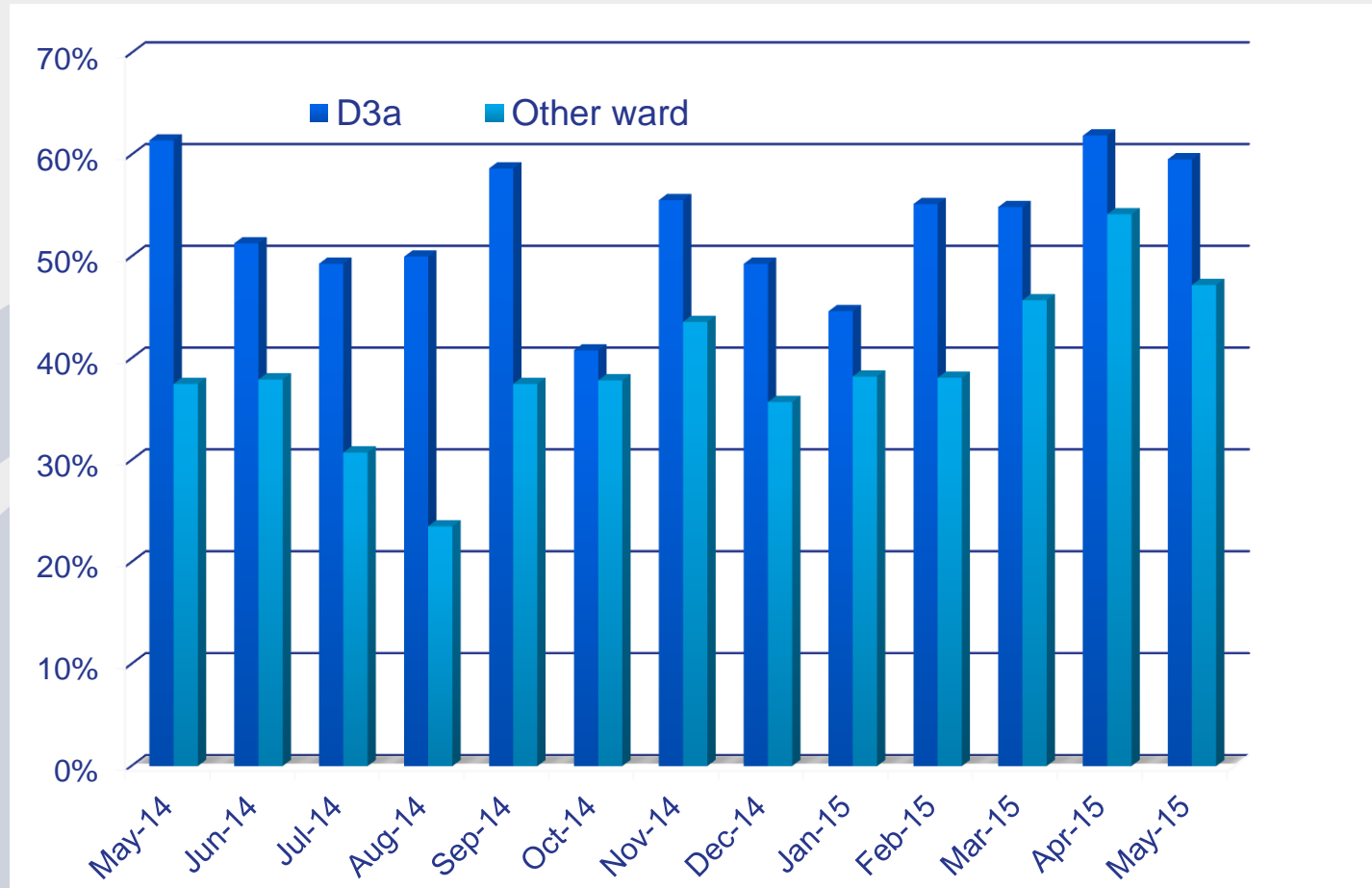


[Includes 5 new rotations of JMOs; Excludes deaths and weekends]



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Addressing negative impact of outlier status on discharge time



Performance Indicators

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Are discharges after 12pm late?

Reasons for DC after 12pm (April 2014):

- Upgrading diet (N=8; 28%)
- Consult from other specialty (N=8; 28%),
- Same-day endoscopic procedure (N=6; 21%)
- Awaiting imaging (N=6; 21%)
- Delay by Gastro team (N=2; 5%)

Higher complexity in DC after 12pm:

<12pm: NWAU 1.5 vs >12pm: NWAU 2.3 (p<0.05)

Savings through DC after 12pm:

LOS: 19.7 h/patient or Costs \$1030/patient

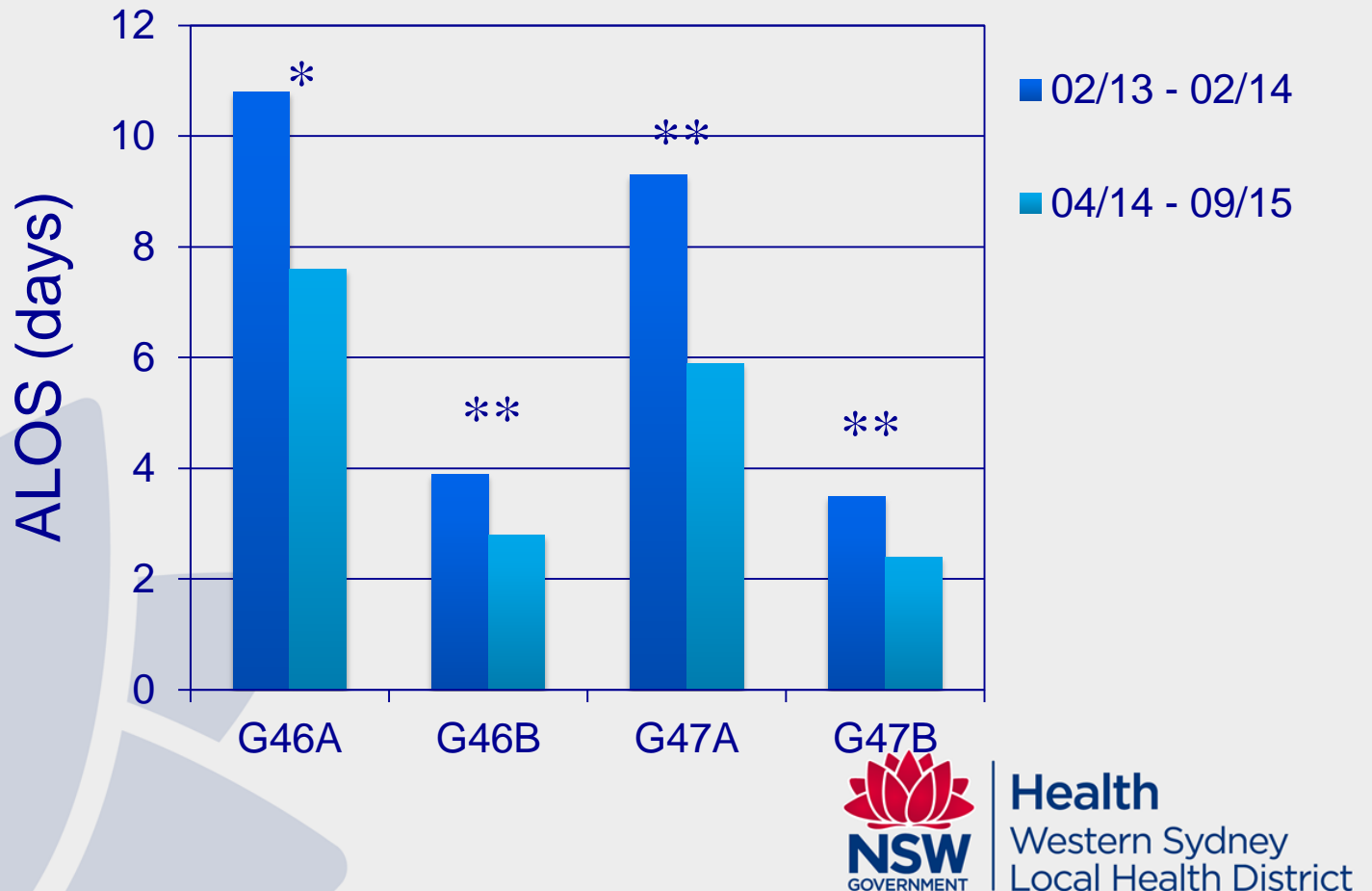


Performance Indicators

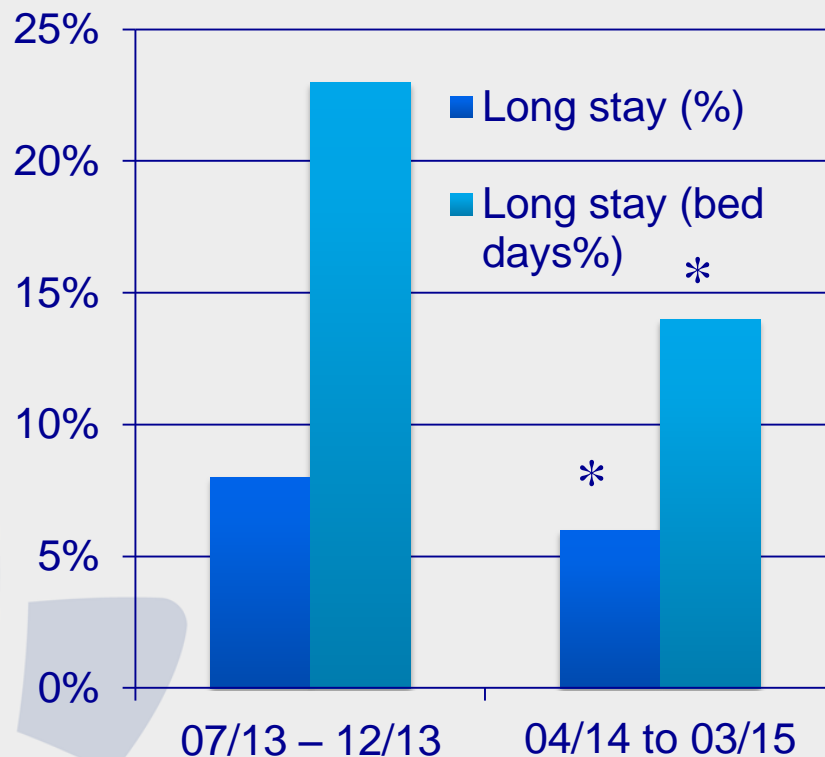
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Decreased LOS within specific DRGs



Long stay proportion improved



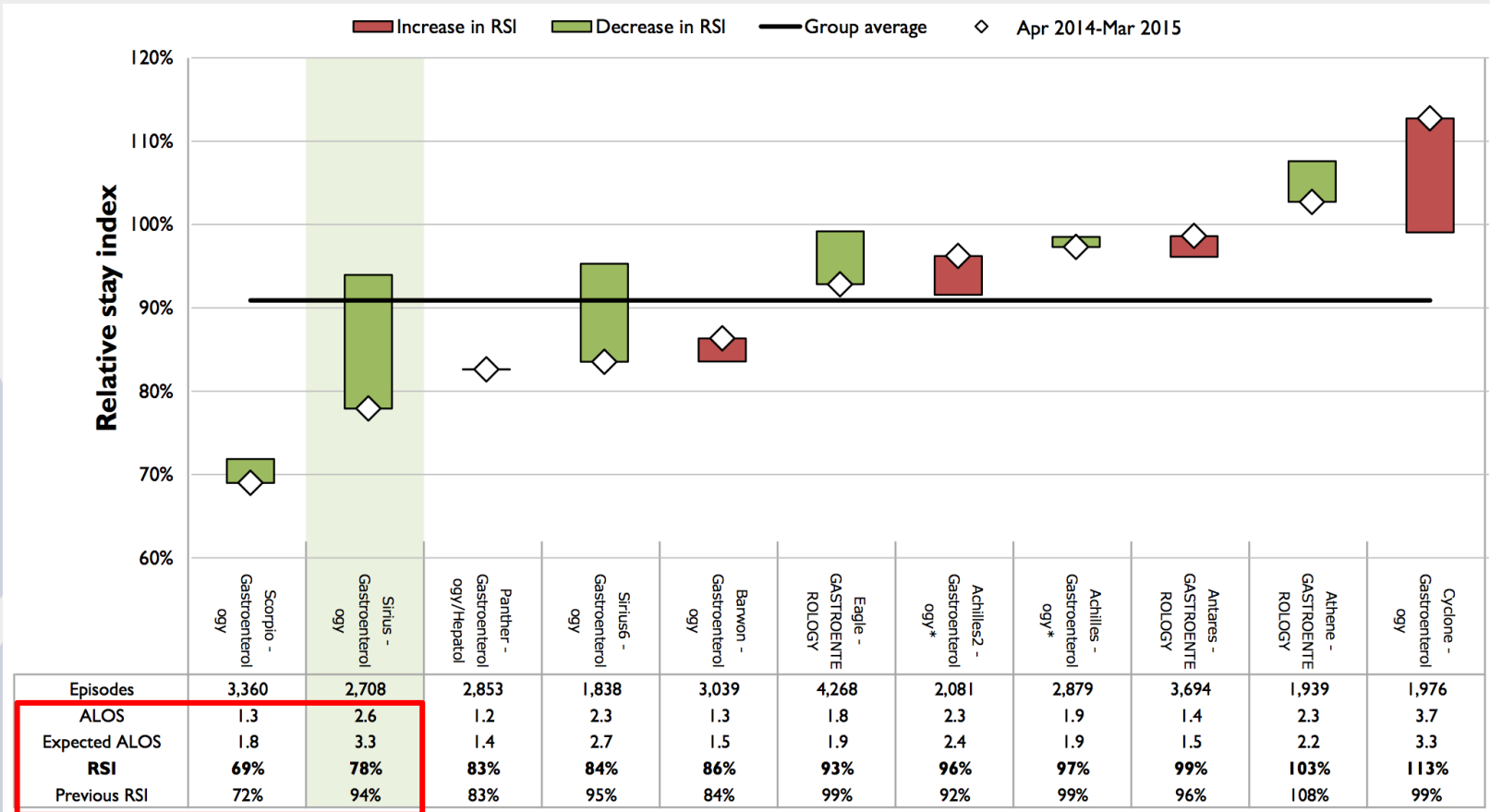
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Relative Stay Index

[RSI = \sum (Actual LOS) \div \sum (Expected LOS);
i.e. RSI < 1 indicates LOS less than expected]



Comparison of episodes by DRGs

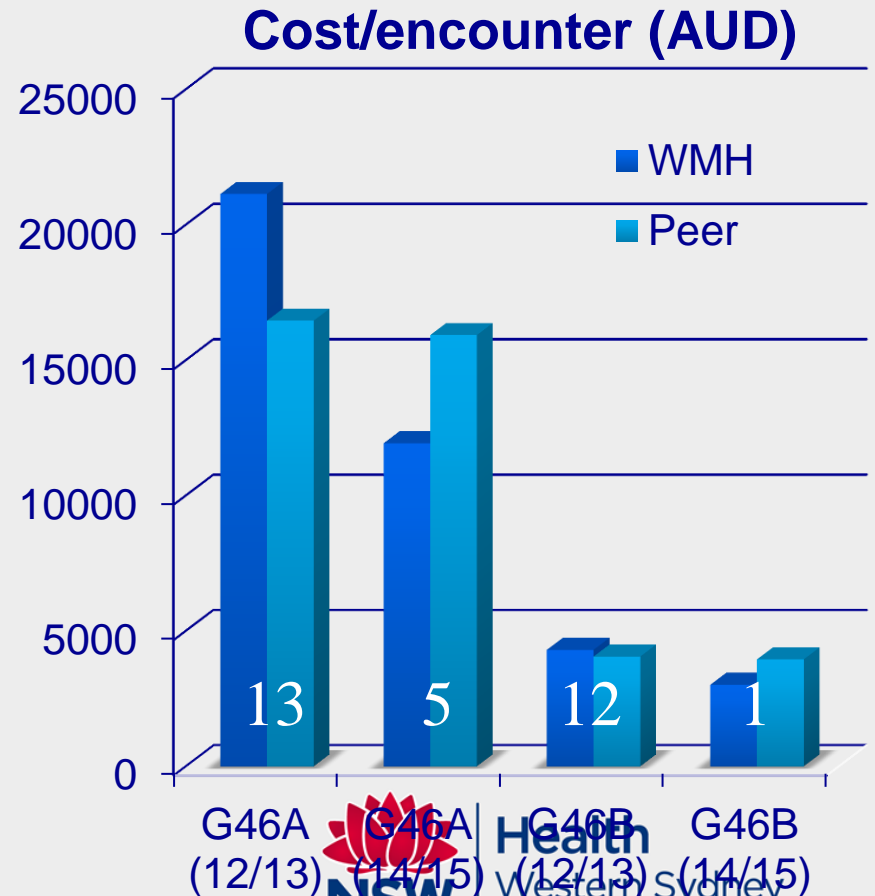
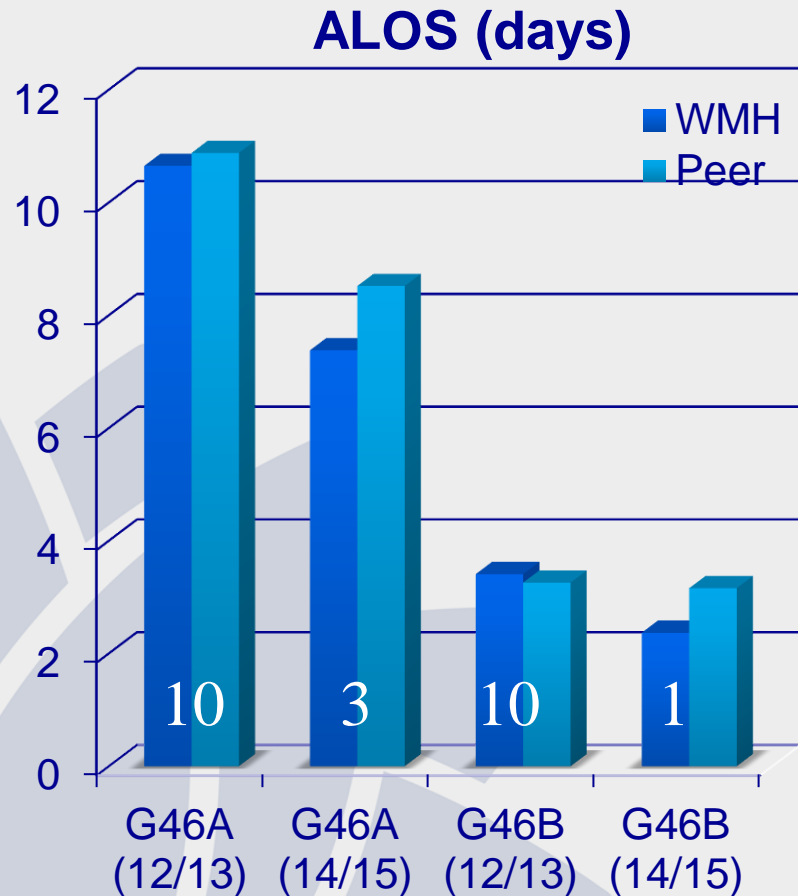
Apr 2014-Mar 2015

| DRG Family for department episodes | Episodes | Occupied bed days | ALOS | Relative stay index | Emergency episode % | Discharged home % | Same day % | Emergency readmit % | Peer RSI range† | RSI trend‡ |
|--------------------------------------|----------|-------------------|------|---------------------|---------------------|-------------------|------------|---------------------|-----------------|------------|
| G46 - COMPLEX GASTROSCOPY | 315 | 731 | 2.3 | 70% | 30% | 95% | 55% | 6% | 62% | 119% |
| G47 - OTHER GASTROSCOPY | 414 | 720 | 1.7 | 62% | 44% | 95% | 57% | 7% | 53% | 106% |
| H43 - ERCP PROCEDURES | 232 | 663 | 2.9 | 92% | 28% | 90% | 59% | 10% | 70% | 116% |
| G48 - COLONOSCOPY | 377 | 540 | 1.4 | 79% | 20% | 96% | 75% | 5% | 77% | 122% |
| H63 - DSRD LVR-MAL,CIRR,ALC HEP | 124 | 492 | 4.0 | 77% | 71% | 85% | 27% | 14% | 67% | 140% |
| G70 - OTHER DIGESTIVE SYSTEM DIAG | 148 | 492 | 3.3 | 110% | 68% | 90% | 21% | 20% | 80% | 177% |
| H60 - CIRRHOSIS & ALC HEPATITIS | 59 | 373 | 6.3 | 80% | 90% | 75% | 14% | 22% | 71% | 130% |
| G67 - OESOPHAGITIS & GASTROENTERITIS | 117 | 372 | 3.2 | 95% | 99% | 91% | 3% | 12% | 89% | 131% |
| H62 - DISORDERS PANCREAS-MALIG | 90 | 312 | 3.5 | 87% | 76% | 96% | 26% | 20% | 47% | 119% |
| G61 - GI HAEMORRHAGE | 92 | 251 | 2.7 | 74% | 97% | 84% | 5% | 9% | 55% | 146% |

†The boundaries of the coloured bands denote quartiles of the distribution of peer RSIs; The black line is the median.

‡RSI trend points are 6 month intervals

Peer Comparison: LOS and Costs



[ABM Portal; numbers in white indicate rank of 13 peer hospitals]



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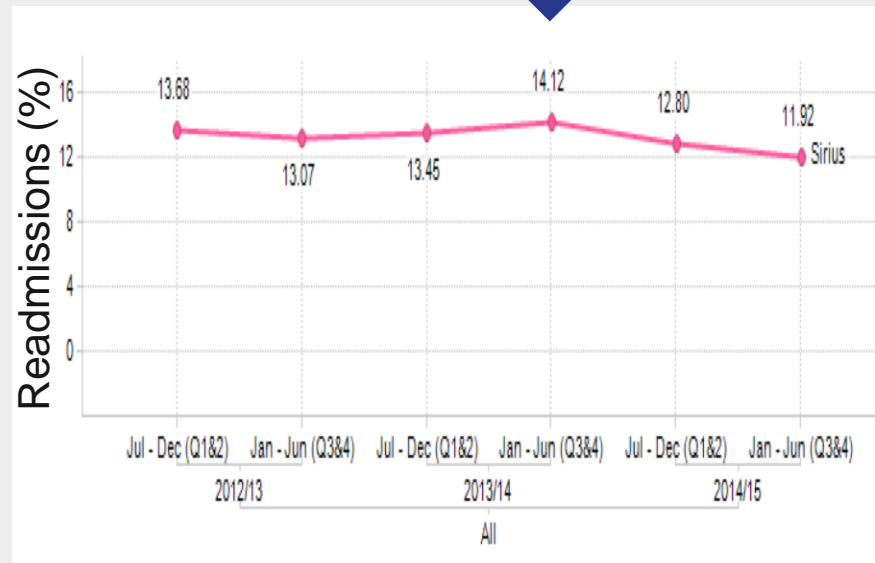
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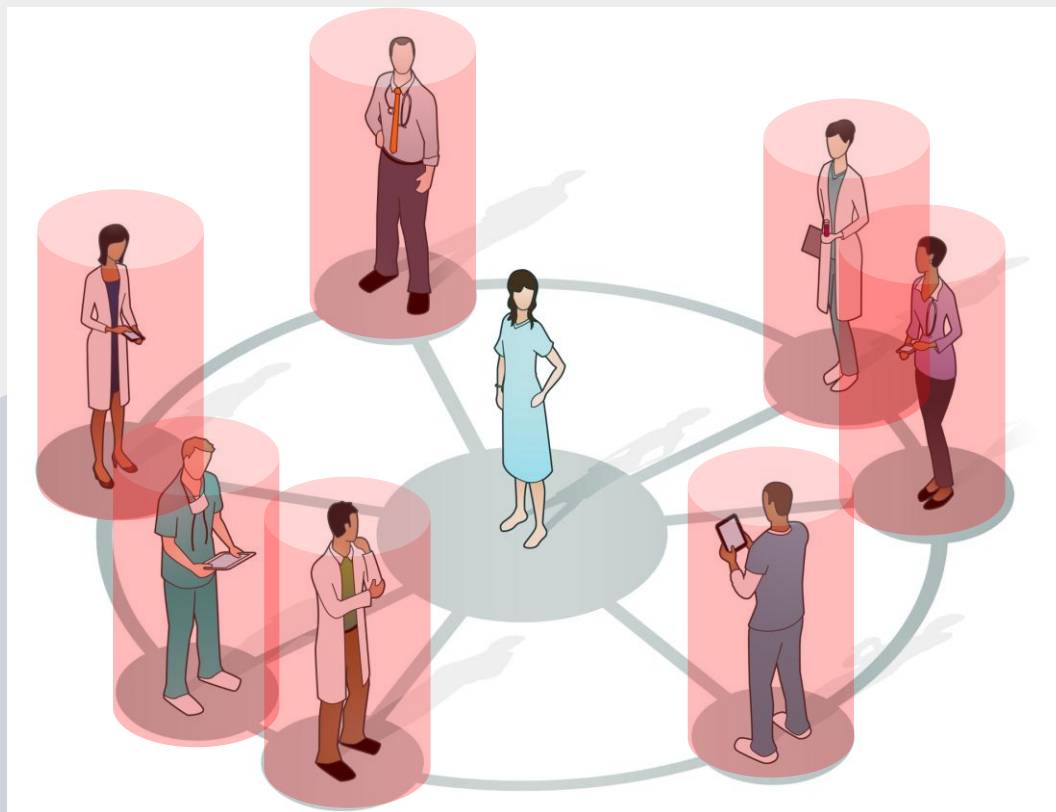


Safety:

Readmissions not increased



Communication is the key



[Modified from quotesgram.com/patient-centered-care-quotes/]

Summary - Outcomes

- **Efficiency**

Discharge times improved

RSI improved

ALOS for common DRGs improved

Cost/encounter optimized

Discharges after 12pm appropriate and save beds and costs

- **Sustainability** maintained for > 15 months

- **Safety** readmissions not increased



Transferability

- The general challenges of meeting targets for performance and safety are similar all across specialties and LHDs
- While developed for the needs of the Gastroenterology Department at WMH, the employed solutions are readily transferable.
- Close communication between all staff members involved in patient care is effective and sustainable.



Acknowledgements

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Guidance performance

