



OVERCAPACITY CARE AND THE OVERCAPACITY PROTOCOL

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Access Block: Brief History

1992: Health policy geniuses determine that it is better to prevent disease than treat it. With no acute illness, there will be little need for doctors or hospitals.

1992+: Hospitals closed. Med school and nursing cutbacks

1990-2010: The population continues to grow and age.

- Increasing obesity, diabetes, metabolic syndromes.
- More people surviving into their 8th and 9th decades—now having stroke, MI, renal failure and fractured hips.
- Demand on the acute care system has increased, not decreased

BUT: no hospital beds; nobody can get a family doc.

ED access block increasing yearly.



Q. WHY do we need an OCP?

A1. Because sometimes there are more patients than beds

A2. Because the alternative to an OCP is ignoring acutely ill patients

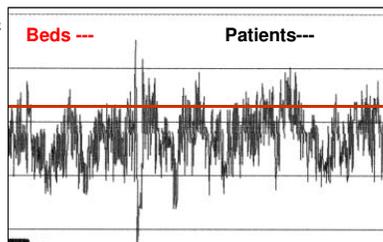
But why are there more patients than beds?

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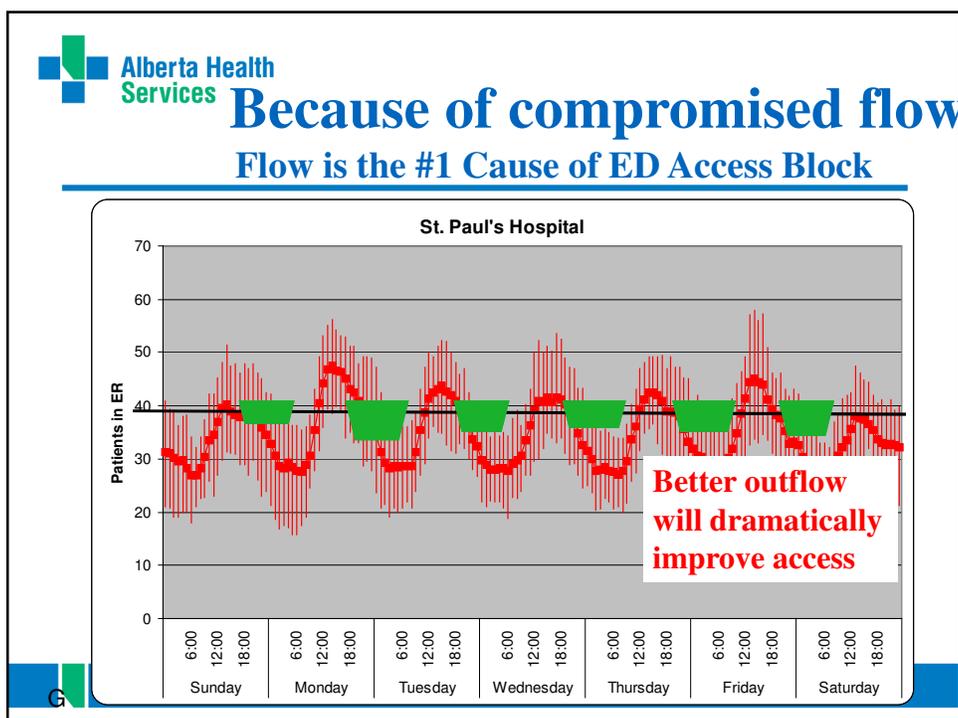


Variability makes overcapacity care inevitable

- Daily hospital bed demand is variable
- Overcapacity periods are inevitable
- 85% occupancy = 7% 'overcapacity'
- ↑ Demand variability = ↑ overcapacity
- Adding scheduled demand on top of natural demand aggravates overcapacity problems.
- Smoothing scheduled activity around natural demand will mitigate overcapacity periods and access block



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Appropriateness: Failure to modify resource allocation based on patient needs

Who's in?

- Stable patients awaiting diagnostic studies
- Convalescing patients being prepared for discharge (OT, education)
- Patients refusing Discharge to LTC facility
- Patients with mobility concerns
- Elderly with behavioural problems- unacceptable to LTC
- Apparently healthy patients smoking outside the hospital

Who cant get in?

- AMI-needs emergent revascularization
- Necrotizing fasciitis – needs rapid surgical debridement
- Massive PE – needs heparin/lytics
- SDH – needs CT and surgical evacuation

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Small inefficiencies cause big problems

At Foothills Medical Ctr:

- 1 extra hour ED LOS = 70,000 stretcher hrs/yr
- 2 hr consult delays = 60,000 stretcher hrs/yr
- 10 hour admission delay = 180,000 stretcher hrs
- 4 hr hospital DC delay = 150,000 stretcher hrs
- 10% reduction ALC days = 140,000 stretcher hr

We could solve the access block problem with
80,000 stretcher hours



Building an OCP



Five philosophical tenets of an effective OCP

1. The same care standards apply throughout the hospital, from patient arrival to discharge
2. Overcrowding (access block) must be addressed by the entire system
3. Best outcomes and efficiencies occur when patients are matched to the right program and provider ASAP
4. All programs have important care missions and require reasonable access to their resources in order to provide acceptable care and meet performance targets
5. Hallways are undesirable locations for patient care

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An OCP does more than 'share the pain'

- An overcapacity plan for high demand periods
- Forces flow!
- An evolutionary stressor to drive improvements in efficiency and appropriateness
- Pushes the sickest patients into care spaces, better matching patient needs to system capabilities
- Reduces risk: moves undiagnosed and unstabilized pts out of halls
- Right patient-right place = efficiency and outcomes
- Balances safety standards across the care spectrum

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Demand-driven OCP

Demand-driven OCP plans:

- address actual patient need
- Balance necessary overcapacity care across the institution, moving more pts to the “right” place.

Supply-driven OCP plans:

- often compromise flow
- limit patient care and exclude patients in need

Note: 5-6 emergent pts are given access for every 1 OCP patient generated

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Hospital to Community OCP

- To be effective the accountability framework for access and flow needs to be adopted across the system (Emergency, Inpatients, Community)
- To balance inevitable overcapacity care needs throughout the system and assure hospital programs remain functional, other overcapacity processes that expedite flow are necessary:
 - across the hospital-community interface and
 - across the critical care-inpatient interface

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The AHS Provincial Overcapacity Protocol

Access Block in AB: Recent History

2000-2010: Well-meaning politicians and leaders implement anti-
overcrowding solutions, based on:

- not addressing the actual problem OR rearranging deck chairs

2008: ED Integration team asked to improve ED access and quality

2009: EDIT recommendations disappear, having no apparent effect

2009-10: Waiting room care and ‘no patient left behind’ intake strategy
... 70,000 CTAS 2-3 pts in non-traditional care spaces.

2010: ED waits shorter but admitted pt delays become longer.

2010: OCP proposal, with supporting documents, and radical
recommendations for system change, gains some interest in AHS

Nov 2010: ED physicians release info to media re adverse pt outcomes

Nov 2010: OCP becomes AHS top priority; Mr Duckett loses his job

Dec 2010: OCP being implemented provincially

OCP Triggers

1. % of blocked ED care spaces (due to EIP or a patient waiting for consult) exceeds 35%.
2. Percentage ED occupancy exceeds 110%.
3. No ED space available to accommodate arriving CTAS 1-3 (emergent/urgent) patients.
4. More than 5 pts where the decision to admit was made > 8 hours previously
5. More than 5 patients who don't have an "owner"

OCP Actions:

ED – Charge Nurse and ED Physician in Charge

- Arriving emergent/urgent CTAS 2-3 pts will move within 15 min of arrival into an ED *acute care space*.
- If no ED space is available, pts will move to an ED overcapacity or intake space so care can be initiated.

ED / Inpatient Units

- Prioritize pts for overcapacity or intake spaces
- When the ED is overcapacity by 10% (based on funded stretcher capacity), the most stable admitted pts will be distributed one by one, on a no refusal basis, within 15 minutes to overcapacity or intake spaces on the most appropriate inpatient unit.



Patients not eligible for OCP

- Patients with airway impairment or requiring greater than 6L of oxygen via nasal cannula
- Imminent death
- Patients requiring ICU
- Ventilator dependent
- Continuous BiPaP or CPAP
- Inpatients requiring constant care
- Patients requiring negative pressure room (e.g. TB)

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OCP Levels

OCP Level 1; patients go to optimal units e.g. renal to renal.

- If no OCP Level 1 options available, proceed to OCP Level 2.

OCP Level 2; patients go to similar units e.g. medical to medical.

- If no OCP Level 2 options available, proceed to OCP Level 3.

OCP Level 3; patients go to any unit (not required to go more than 10% overcapacity with non-specialty specific patients).

- If no Level 3 options available proceed to OCP Level 4.

OCP Level 4 – Site VP and Facility Medical Director; hold facility senior team meeting to action next steps.

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ED – Diagnostic Imaging

Under OCP, DI will institute the following measures.

- ED pts will be deemed “next on the table” with consideration of urgency to ICU’s and other inpatient priorities
- Outpatient procedures will be delayed if necessary
- DI will call in additional staff and extend shifts as required.

To expedite ED flow, we can substitute some procedures:

- Immediate Coronary CT for Atypical Acute Chest Pain.
- CTA vs. delayed Doppler for suspected stroke.

DI managers will address the need for discharge of pts awaiting diagnostics and triage exams on pts awaiting diagnostics to assist in expediting discharge identified by hospital leads.

If further escalation is required, the DI Executive Director and DI Clinical Director will assist in approving the required studies.

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Directive from Provincial CMO

Physician Actions, roles and responsibilities:

Each department will assign an PIC to ensure:

- consults to ED are completed within 2 hrs,
- DC rounds are completed before 9am, 7 d/wk,
- DC plan printed on each patient chart within 24hrs of admission,
- DC SWAT teams are implemented during Surge times
- an intake process is established so units can rapidly receive OCP pts

The ED PIC will work with their operational managers to ensure the surge plan is followed

Escalation:

- Issues should be elevated first through the Site chief or Division chief, then to the Facility Medical Director.
- The Zone Medical Director call system will be accessed as required during evening/night hrs and during weekends.

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ED Response to the OCP

Proposed Internal Operations Plan to reduce ED Entropy

Eliminating ED bottlenecks

Triage: Move all CTAS 2-3 pts to care spaces (not WR)

MD Assessment: Reduce delay to MD (EP surge plan)

- Baseline staffing adjustment vs.
- Flex capability: in early; stay late; surge; on-call

EP Decision time: Discharge optimization (ED LOS)

Other services: imaging and consult delays

Actions:

- Clarify quarterback duties for CRN and PIC
- Track (% blocked and EDOC): activate OCP transfers



ED RN Actions

- Remove MD name if not assessed 10 min after REDIS sign on: (TTMD)
- Place patient reassesses as per current practice: (LOS)
- Page EP if reassess not done in 20 min: (LOS)
- Notify PIC if reassess not done in 30 min: (LOS)
- Notify EP and clerk if ED pt with LOS >2.5 hr and no plan (i.e. cons, DC or pathway): (LOS)
- Notify EP if patient with consult > 120 min: (other)
- Notify EP and clerk if pt with DI >120 min: (other)

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Clerk Actions

- Provide RN Clinician and PIC with data: #CTAS 2-3 pts waiting and #consults >2h
- Notify PIC if 6 ED pts with LOS >2.5 hrs
- Re-page consult service at 2h if no ADM order: Link attending EP with consultant
- Notify PIC about pts >4 hrs post consult
- Page attending MD from any service with >3 referrals waiting >2 hours. Link to PIC
- Tally # pts with DI >120 min (info from RN)

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ED Physician Actions

- Reassess and discharge expediently
- Outpatient imaging/consults wherever possible
- Offload stable (waiting) pts to waiting areas
- Follow up on DI and consults if 2 hr delay

Overhead Page: ED Overcapacity Warning:

Trigger (for discussion):

- <3 care spaces (stretcher/RAZ) available

Action: CRN initiates overhead page:

- RNs identify all ® and pts safe to download to WR (ie. Stable with no complex treatment)
- EPs do reassesses & DC. Move stable pts to WR
- Shift to outpatient imaging where possible



PIC Actions: Overseeing the “plan”

- Speak with attending consultant if no admit order 4 hrs after referral. Discuss:
 - a) coming in, or
 - b) admit-hold orders
- Speak with attending MD from any service with >3 referrals waiting >2 hours
- Speak to DI if >6 pts waiting 2h for imaging
- Speak to problem EPs (see above)
- Call in additional EP as below

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OCP Implementation Tips

- Collect your data: EDLOS, blocked stretchers
- Clean up your own back yard before you tell others
- Develop an OCP plan (no one else will)
- Credible champion: This will take time!
- Talk to people
- Work from the ground up and from the top down
- Use stories and data to make your point
- Pick your time: You need an (internal or public) crisis
- Avoid the political solution if possible (too hard to control)
- Communication plan: presentns, tutorials, brochures, FAQs

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Questions?