Shifting from performance to improvement:
Creating safer and calmer hospitals in Victoria

Department of Health, Victoria
The Institute for Healthcare Improvement

VICTORIA State Government

Institute *for* Healthcare Improvement

Presenters

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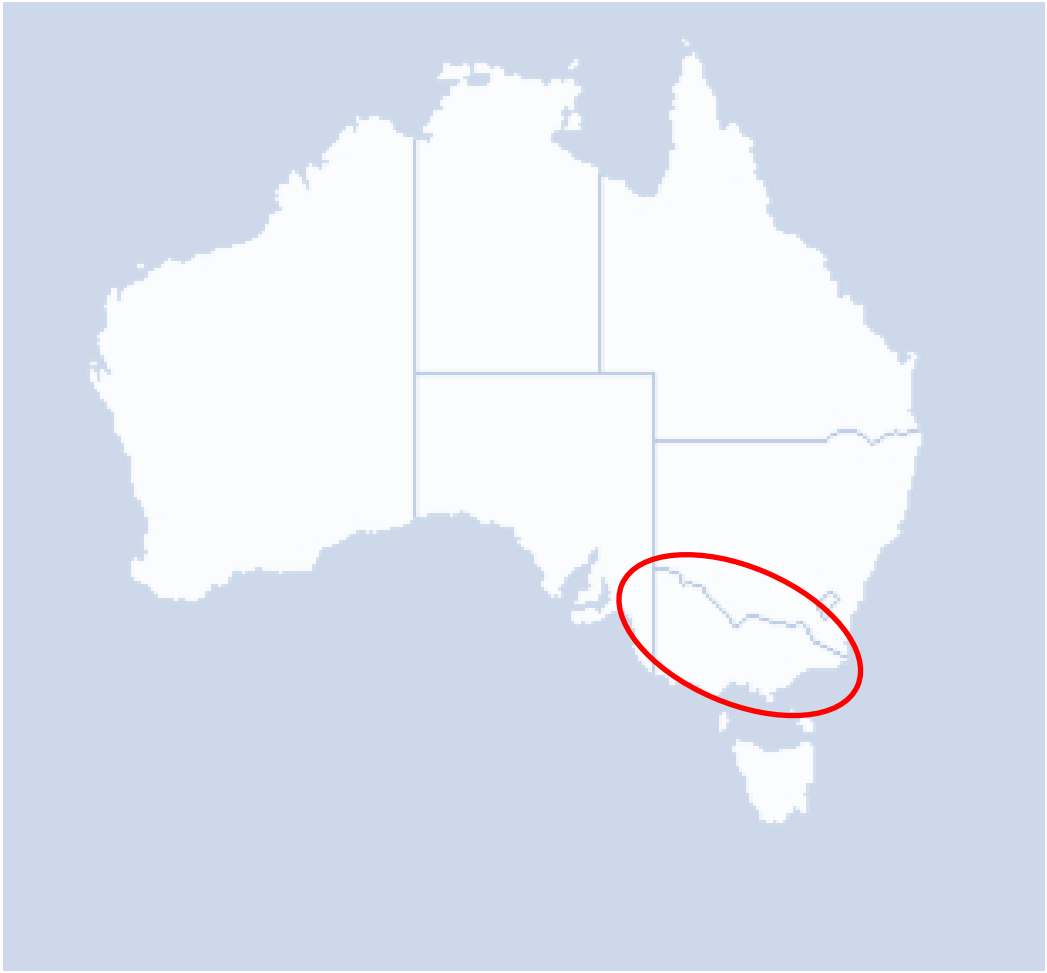
Stephanie Easthope is a Senior Director for the Institute for Healthcare Improvement and has no conflicts to declare.

Victorian Department of Health and IHI partnership

- Working together to improve the timeliness of emergency care in Victoria
- Using improvement science and collaboration to test, share and spread ideas
- Targeted projects to innovate and solve complex challenges

Phase 1: Aug 2022 – June 2024

Phase 2: July 2024 – June 2027



The situation

- Rising hospital demand
- High workforce turnover following Covid-19
- Difficulties accessing timely primary care / GP
- Low staff morale
- Growing financial pressure
- Expectation that the system would bounce back after the pandemic

The Age

‘The worst I have seen’: Hospital ramping costs paramedics 120 years worth of shifts

Key points ... Paramedics have spent a cumulative 120 years waiting for sick or injured patients to be admitted to overcrowded hospitals in the...

1 month ago

Herald Sun

Ambulance Victoria fails to meet targets as health system woes continue

Ambulance Victoria is failing to meet its key target of getting to priority code-one callouts within its 15-minute benchmark, as ramping...

4 Aug 2023

The Age

These paramedics are itching to work. The worst part of their job is sitting around

New data has exposed the severity of Victoria's ambulance crisis as hospital ramping costs paramedics 120 years of shifts. Read the full story...

1 month ago

3AW

Ambulance Victoria facing 'challenging' ramping issue

Ambulance Victoria facing 'challenging' ramping issue ... Ambulance transfer times are double what they should be, with the average patient...

1 month ago

We asked the sector – “What would help?”

Don’t just focus on ambulance and ED … think about flow

“I just feel like you could throw another $500 million at ambulances, and it wouldn’t do anything”

Bring us together to share what’s working

“While we get some intelligence about other health services, the cross-fertilisation of ideas has been harder in COVID…”

The goal

IF

...we improve hospital-wide patient flow

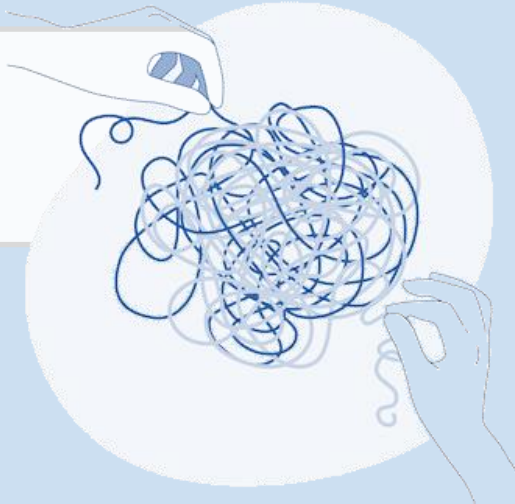
THEN

...we will reduce the capacity pressure on our emergency departments and delays for our ambulances

SO THAT

...staff will be able to work in a **calm** environment

...and patients will receive **safe** and timely emergency care.



Key challenges and questions we faced

Beginning

Emerging through the project and ongoing

Engagement

How do you engage (and motivate) a tired and skeptical workforce?

Pragmatism

How do you develop a simple but impactful change theory for a complex challenge?

Patience: It takes time.

How do you create space to create the conditions to sustain improvements?

Variation:

What differentiates organisations that are improving from those that aren't?

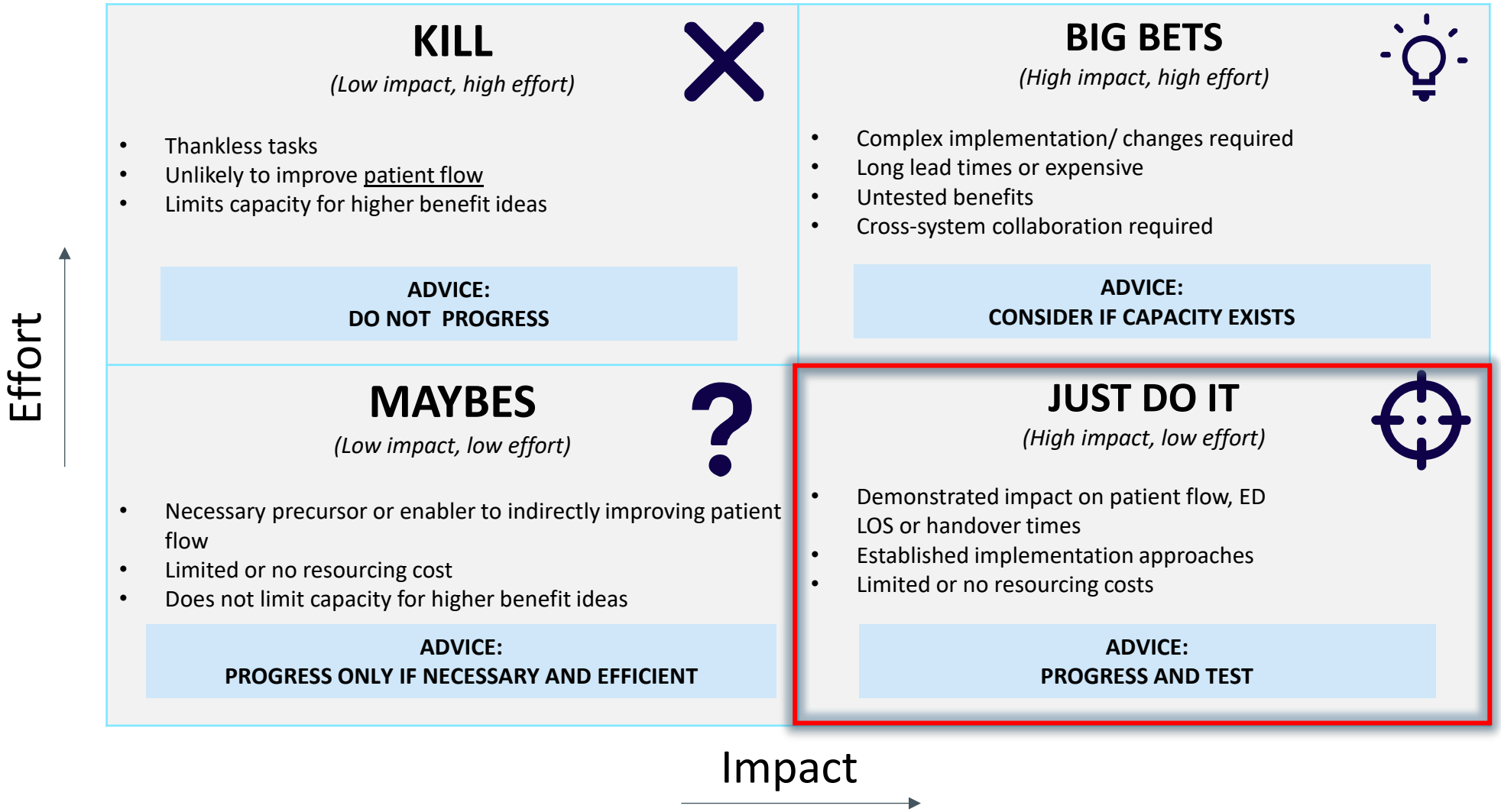
Spread

How do you recreate the conditions for success within and across services?

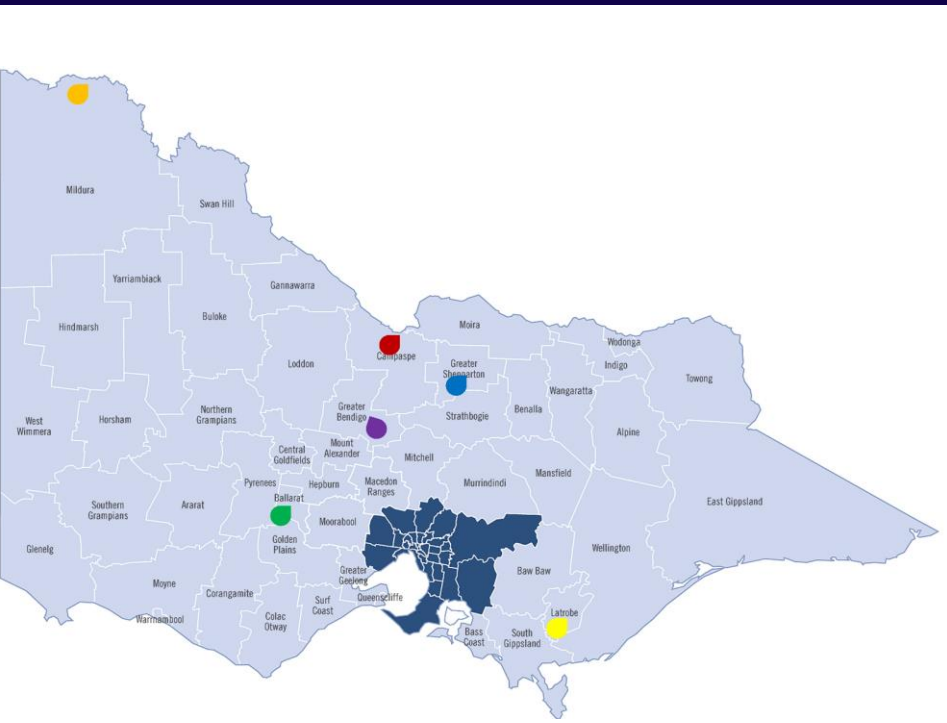
Sustainability

What are the service and system-level enablers that will promote continuous improvement?

Prioritising efforts within health service control



The Timely Emergency Care Collaborative



14 health services
9 metropolitan hospitals
6 regional hospitals

Learning Session 1
Dec 2022

- Establish governance
- Undertake diagnostics
- Improve daily operational meetings

Learning Session 2
Feb 2023

- Change theory established
- **Workstreams launched**

Learning Session 3
May 2023

Learning Session 4
Aug 2023

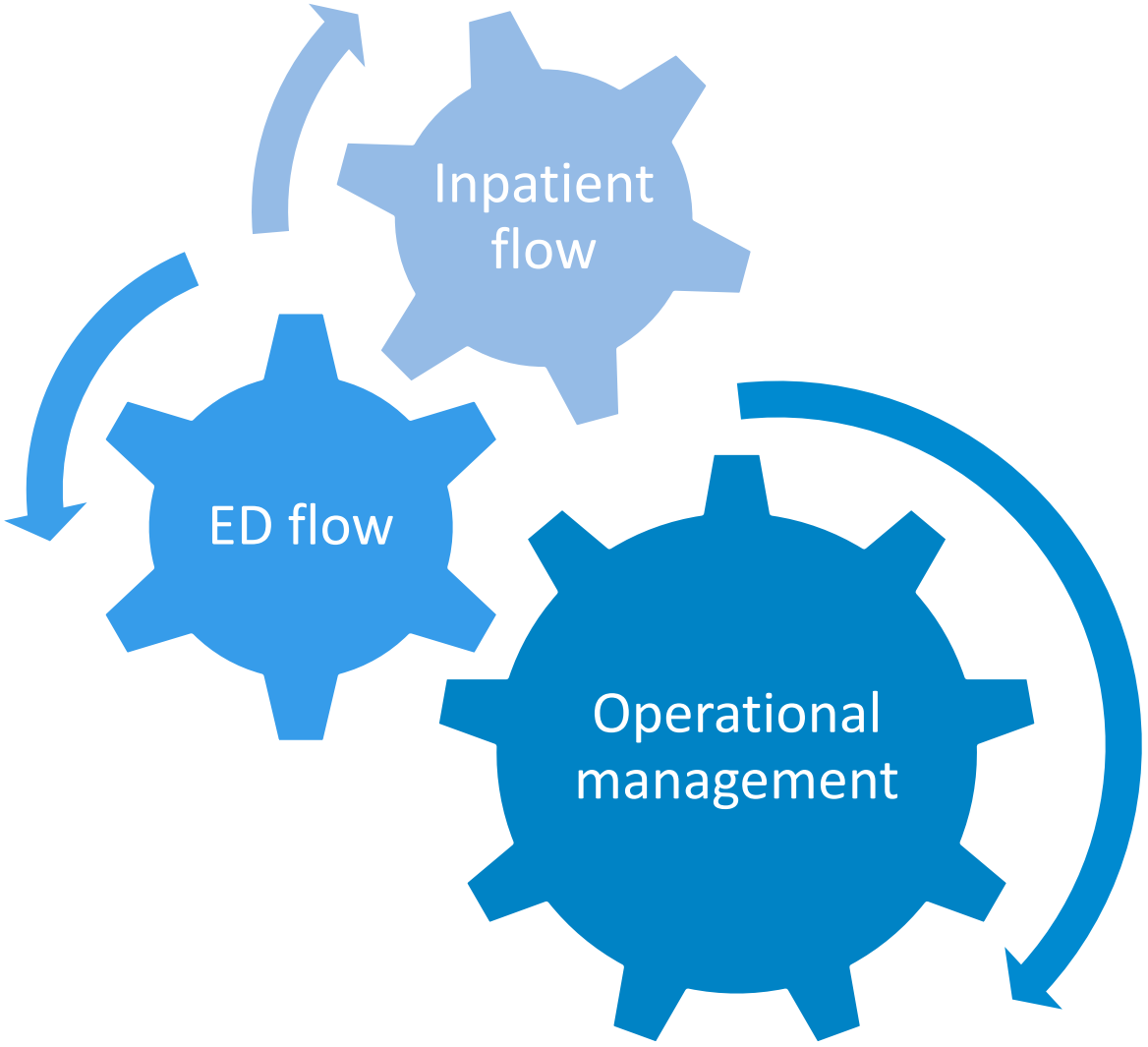
Learning Session 5
Nov 2023

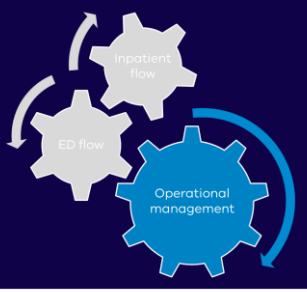
Learning Session 6
Mar 2024

- Share and learn from each other
- Reinforce change theory
- Improvement science learning

Wrap up event
June 2024

Three workstreams





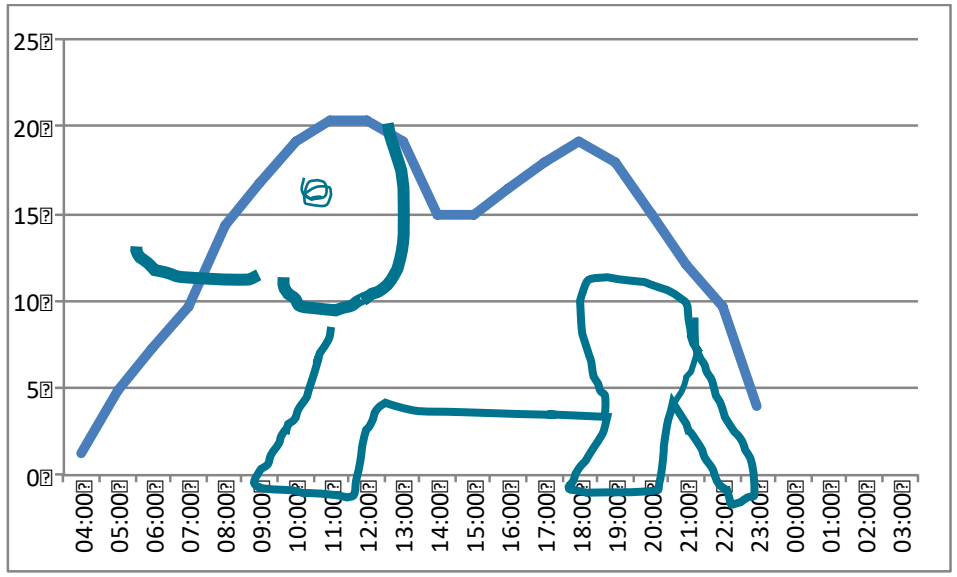
Improving hospital operational management

Daily flow management must focus on aligning to meet patient demand

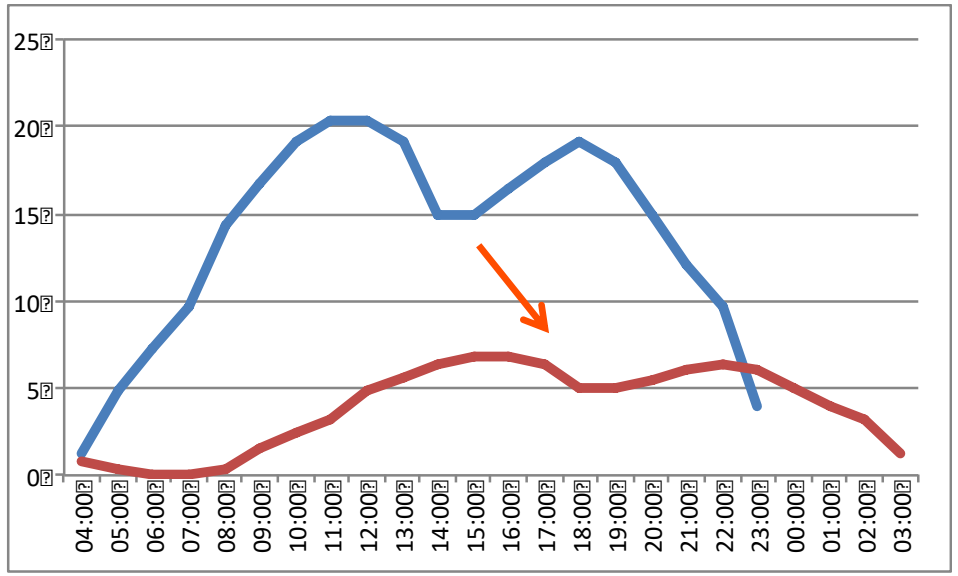
“The drumbeat of a hospital is set by patient demand”

Demand profile

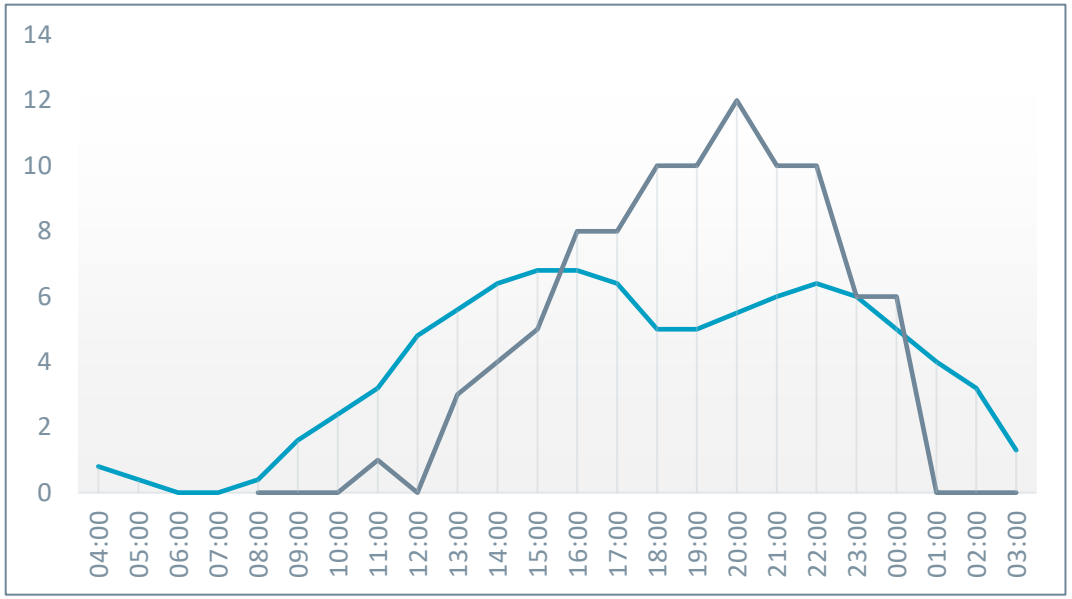
Typical ED attendance profile by hour



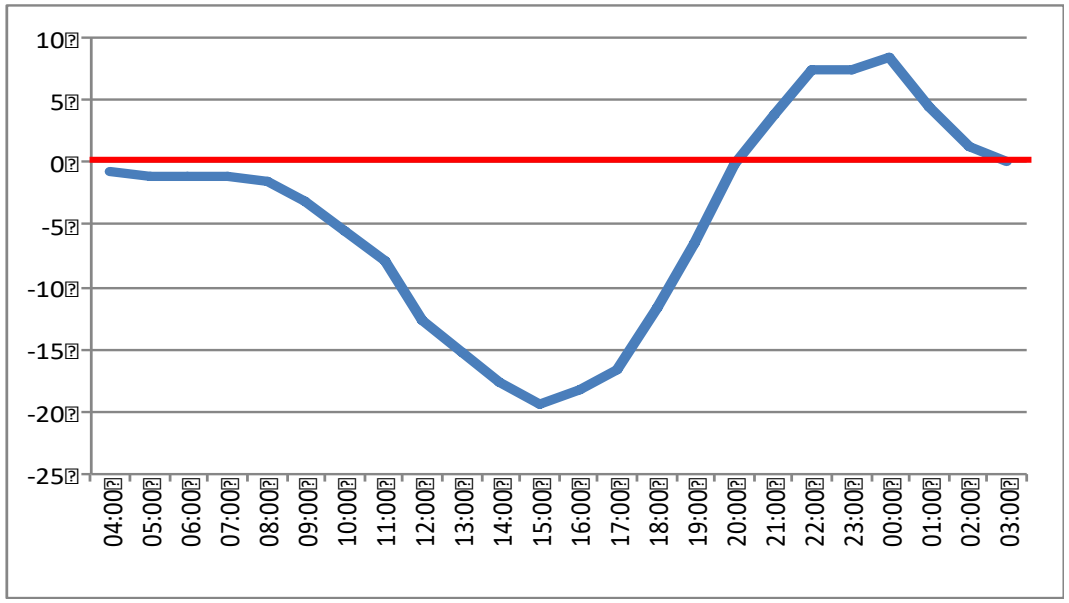
Admissions are typically 4 hours later and about 20-30% of admissions



Typical capacity profile

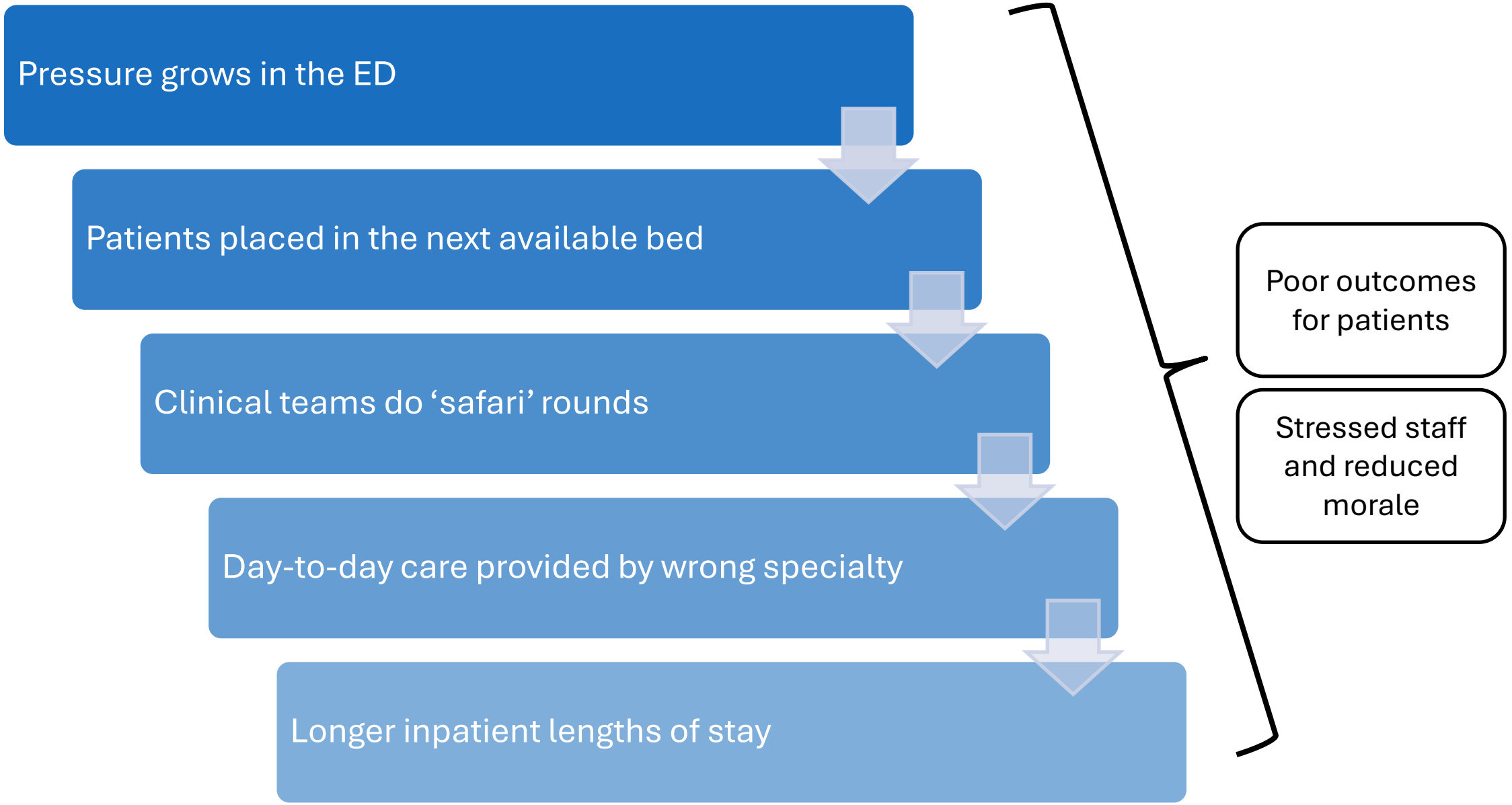


Discharges start after the first ward rounds are complete and peak in the evenings



Cumulative bed deficit plays out throughout the day

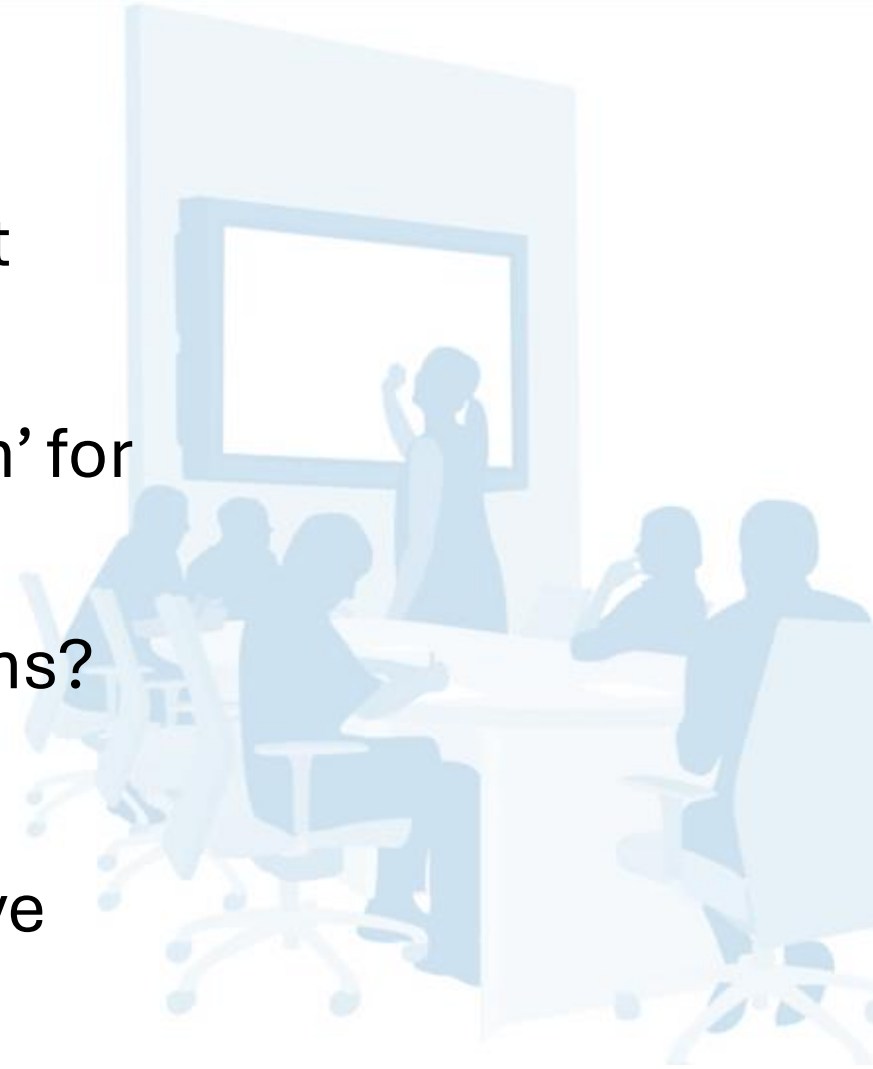
Consequences



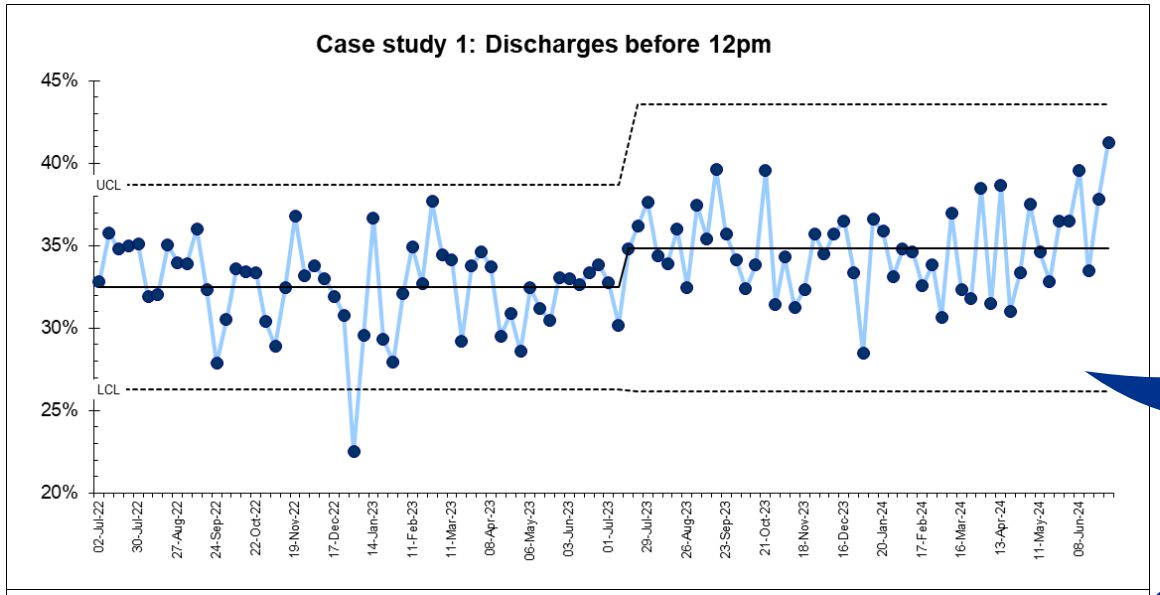
Data-informed daily operational ('bed') meetings

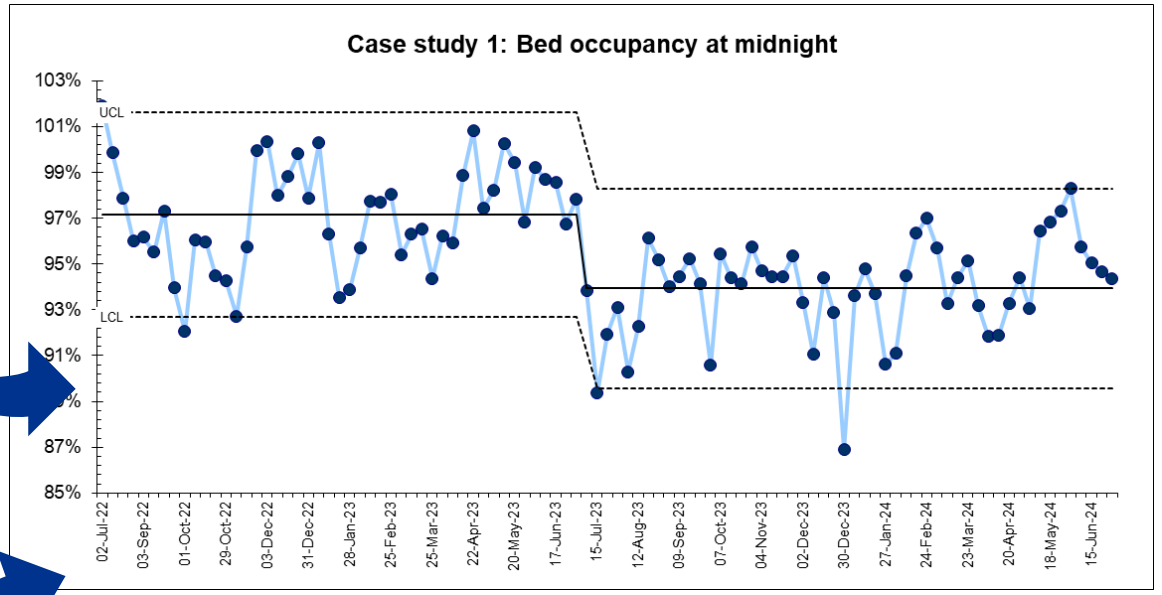
Should provide the organisation with a clear understanding of its **present bed capacity** against **expected demand**, and the **actions required** to ensure that patients can receive the **best possible care**.

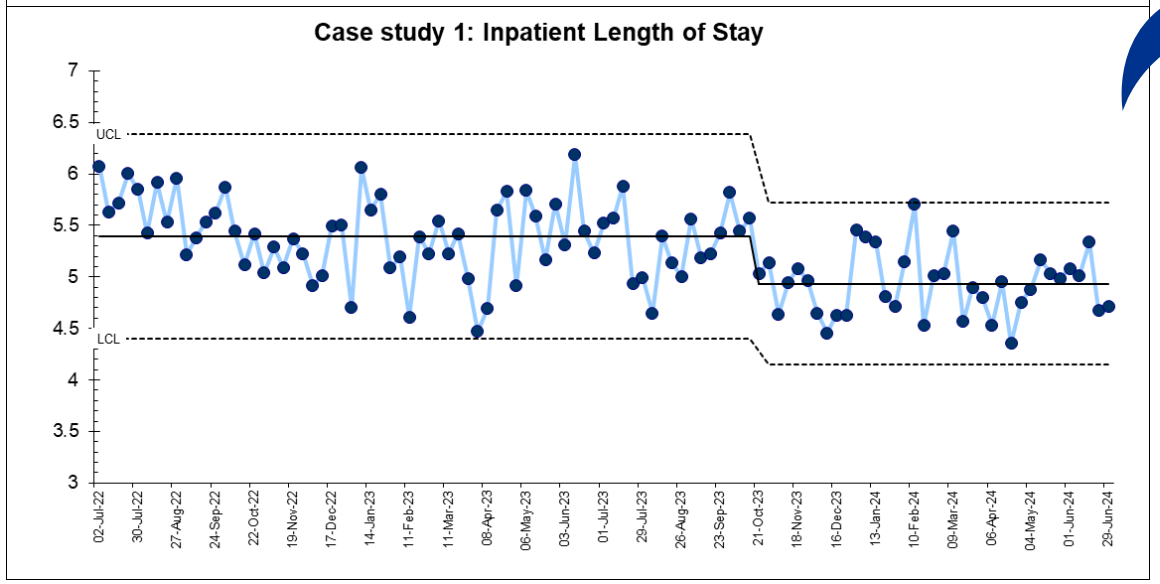
- Data driven
- Attended by the right people
- Focused on 'the plan' for today and tomorrow
- Result in clear actions?
- Focused (~15 mins)
- Structured / repetitive



Case study 1: Operational Management

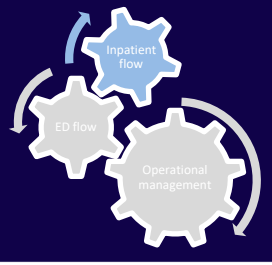






Improved daily operational management using centralised data to plan and co-ordinate patient flow led to:

- improved discharges
- reduce inpatient length of stay
- reduced occupancy



Inpatient workstream

Within the hospital, the greatest lever to improve patient flow is to have **patients discharged in a pattern that aligns to incoming admission demand**.

This typically means looking for opportunities to discharge patients earlier in the day.

Building engagement

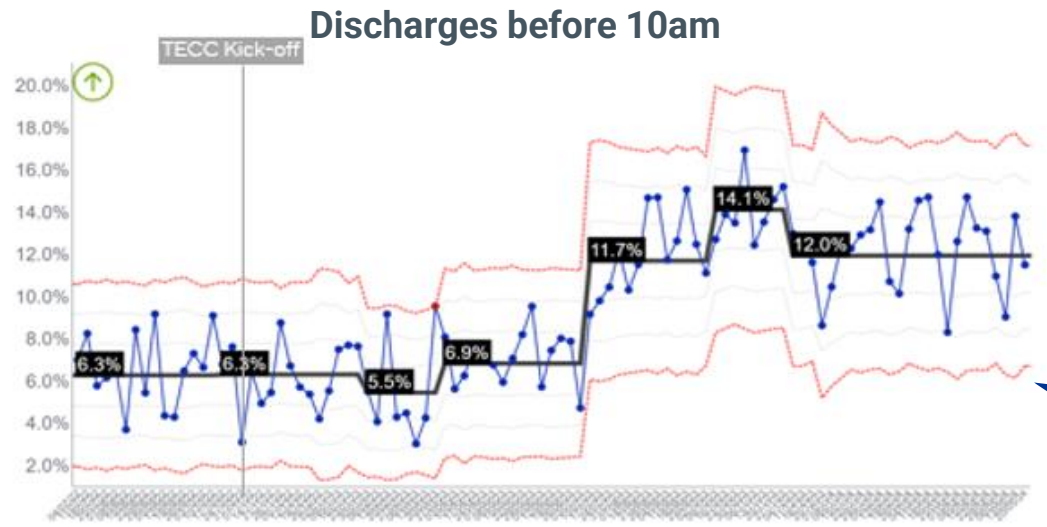
Explaining the ‘why’

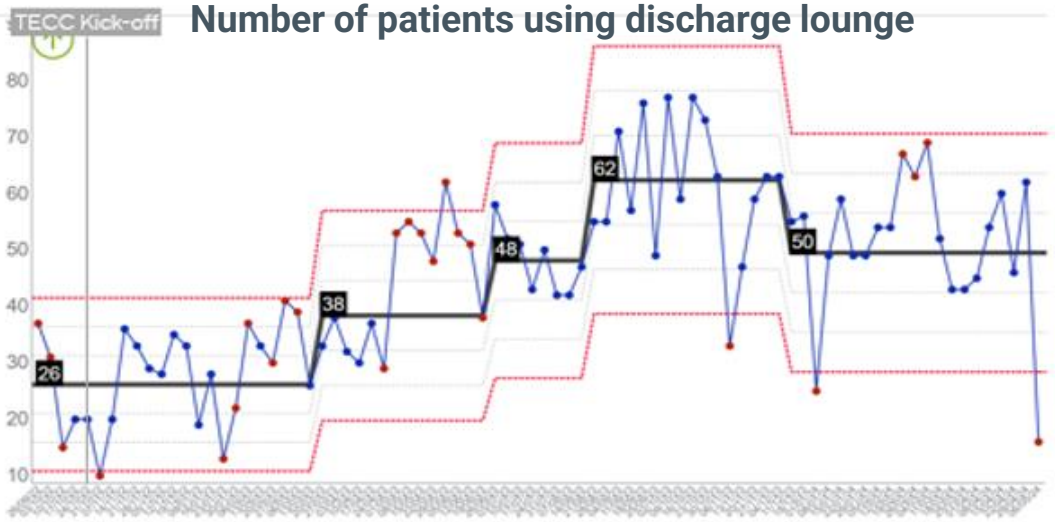
Inpatient workstream

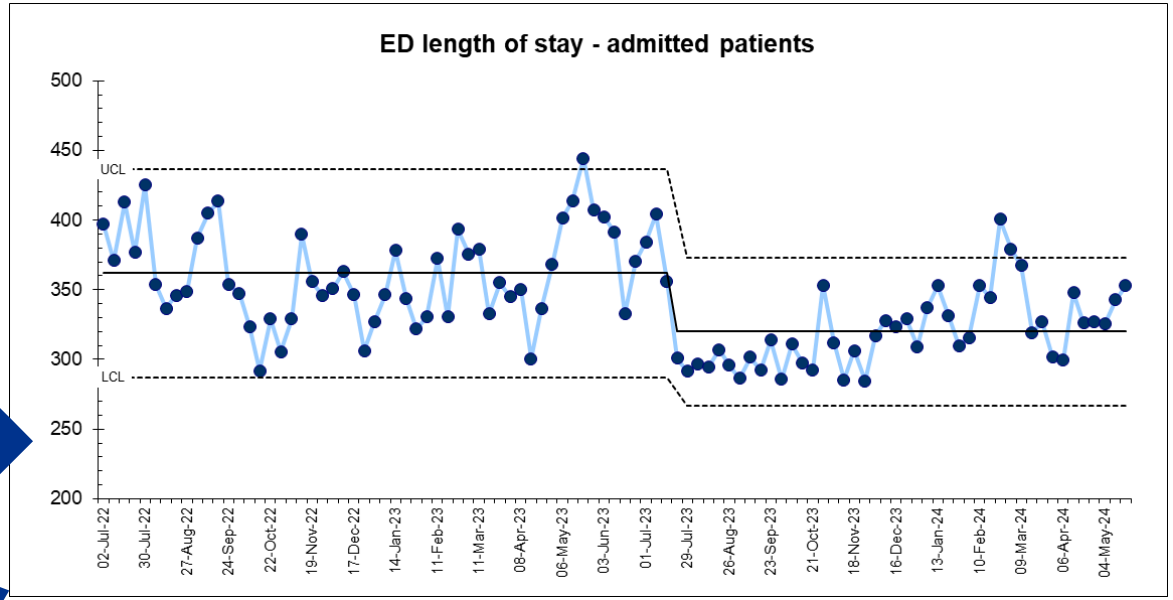
The three most impactful changes were:

1. Planning discharges the day before
2. Prioritising patients for discharge on ward rounds
3. Using a discharge lounge as the default for all patients

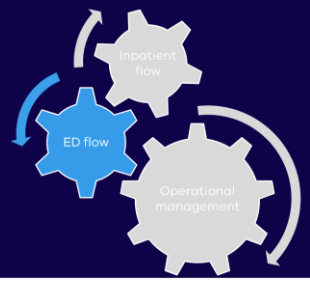
Case study 2: Inpatient workstream







Improved planning and prioritisation of patients for discharge as well as utilisation of the discharge lounge led to a **40-minute reduction** in the time patients waited for an inpatient bed



Improving ED Flow

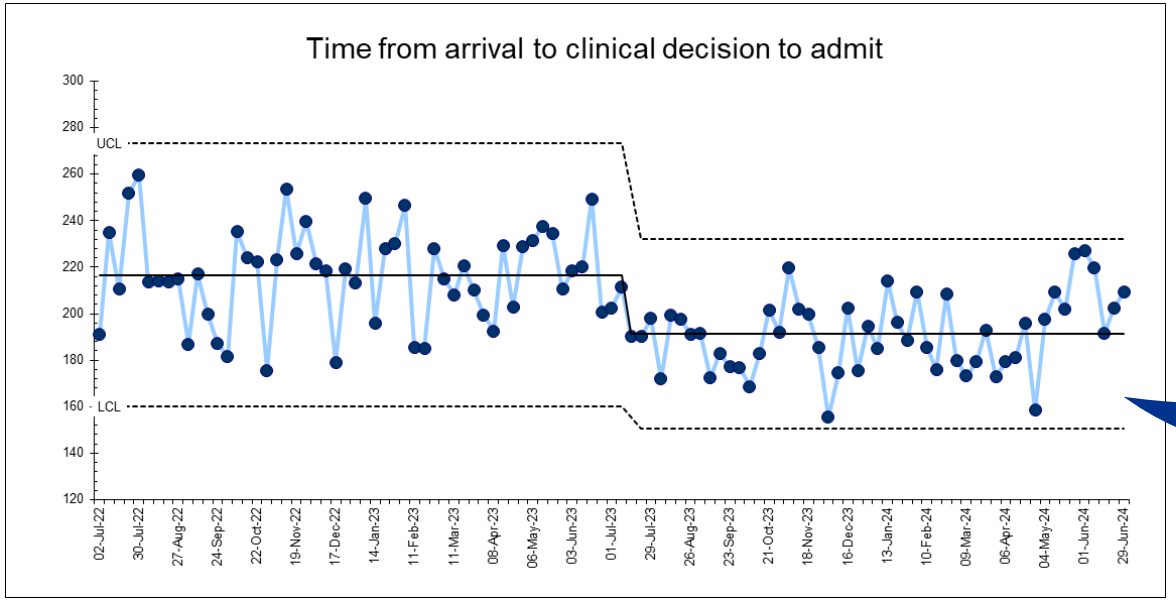
Three most impactful changes were:

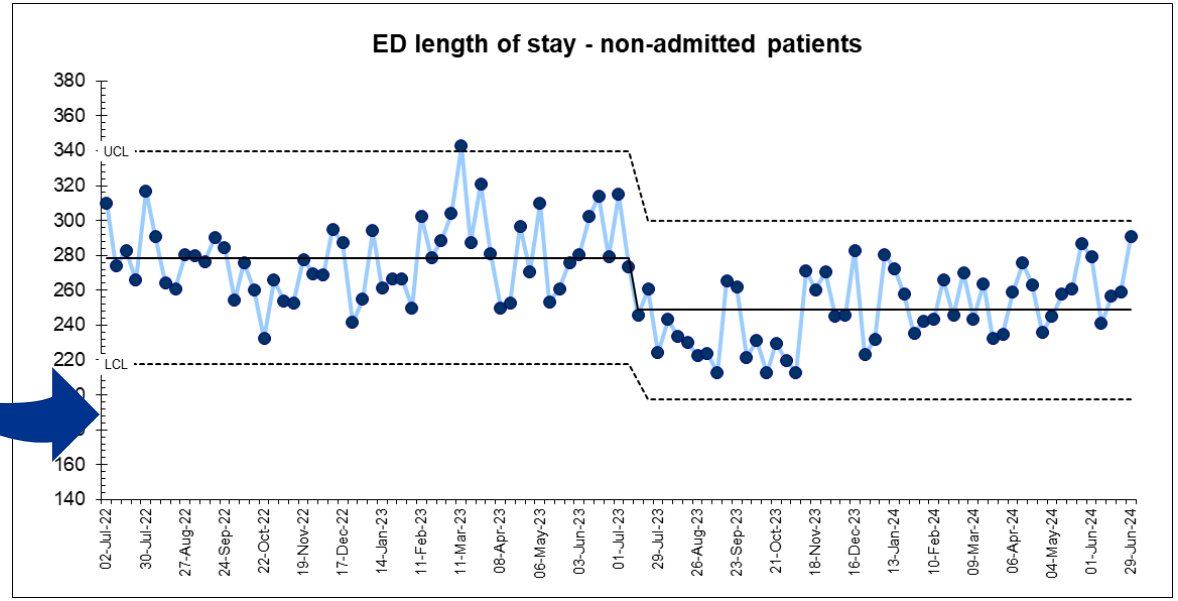
1. Early senior decision making in the ED
2. Implementing or optimising a ‘fast track’ non-admit patient stream in the ED
3. Optimising use of the ED Short Stay Unit to ensure right patient cohort and regular review and discharge

Case study 3: ED workstream

Implemented early senior decision maker leading to:

- **25-minute reduction** in time to decision to admit
- **30-minute reduction** in time to discharge (non-admitted patients)



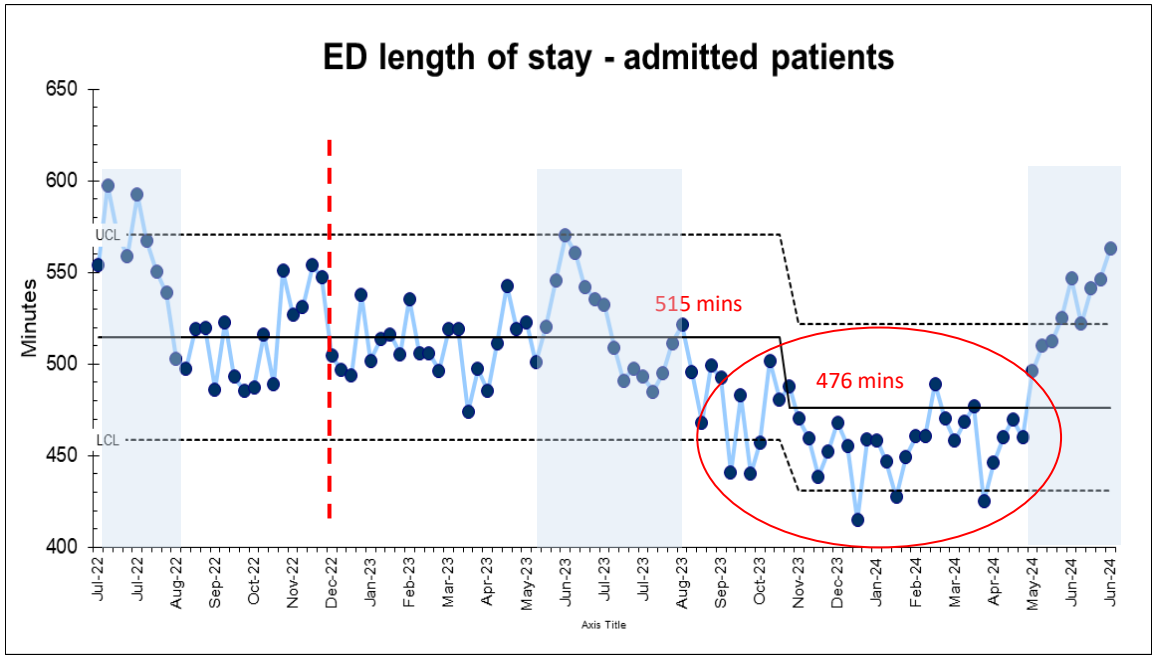


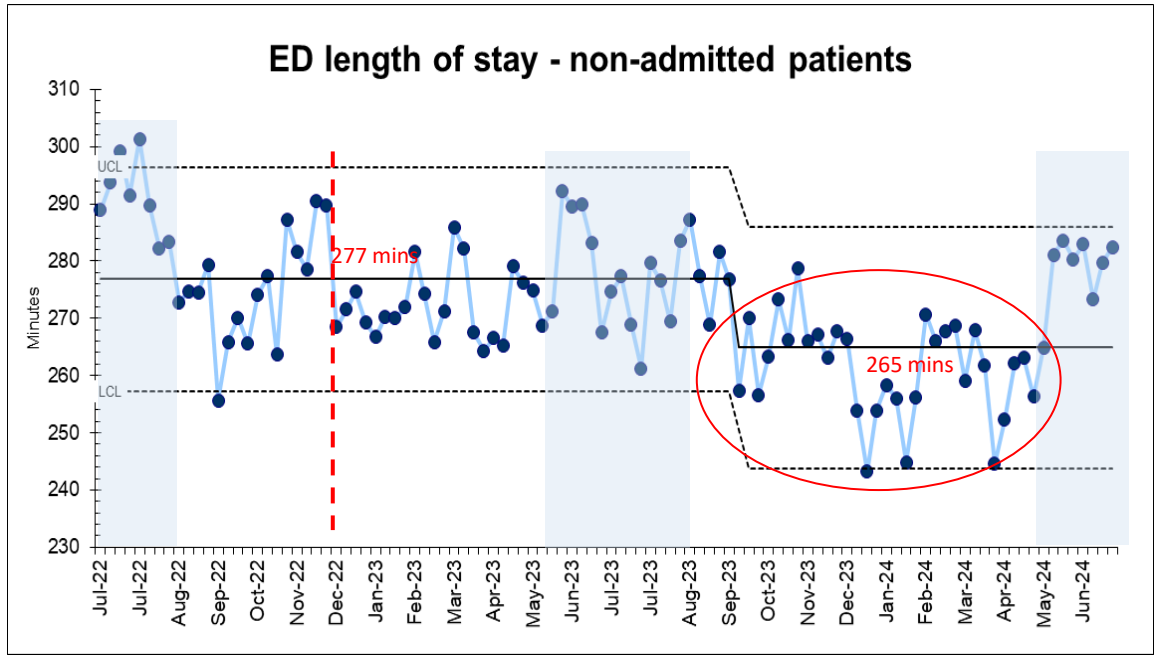
Results of the Timely Emergency Care Collaborative

Progress of all teams

- **100%** of teams improved ED or Inpatient process measures
- **93%** of teams significantly improved either ED admitted or non-admitted length of stay
- **71%** improved both ED admitted and non-admitted length of stay and sustained improvement in at least one of of them for >3 months
- **29%** of teams sustained improvements for >12 weeks in both outcome measures

Collaborative-wide aggregate results





Significant improvement was demonstrated in both ED admitted (**39 minutes**) and non-admitted (**12 minutes**) length of stay across all participating teams. But winter has seen a return to the performance of the prior year.

What happened?

Health services that had tested and implemented **a wide number of changes** and had **sustained them** for several months before winter were able to **hold the gains.**

Health services that had made **isolated improvements** for a short period were **not able to sustain the gains** when the pressure of 2024 winter hit.

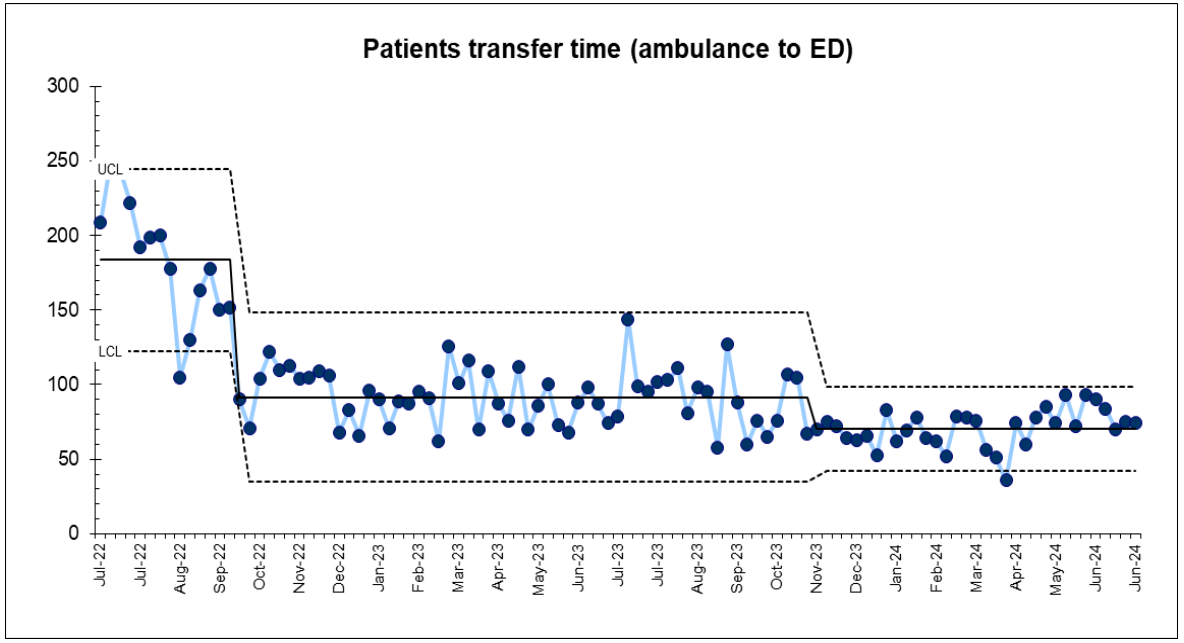
Case study 4: Sustained hospital-wide improvement

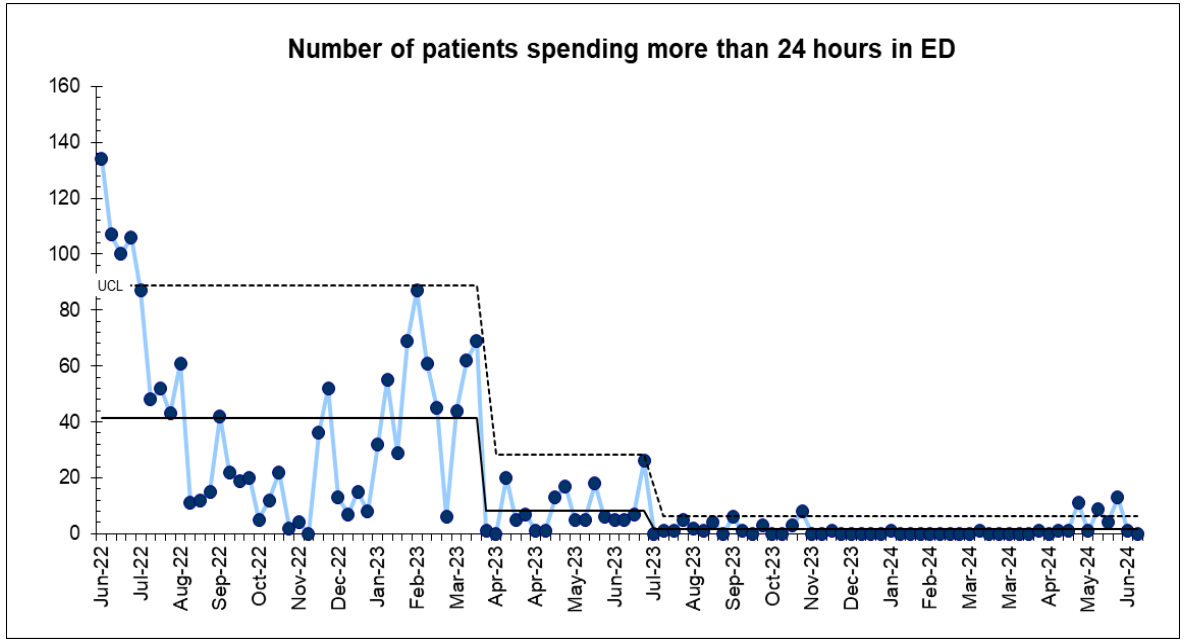
The situation in late 2022:

- “Covid tents” still up
- Average of >40 patients per week spending more than 24 hours in ED
- >90-minute patient transfer time from ambulance to ED

Results by 30 June 2024

Impact on key performance metrics





Time to transfer a patient from ambulance to ED has reduced by **more than 20 minutes** since the start of the collaborative

Fewer than 2 patients per week now wait in in ED >24 hours

What did they do?

Focused on discharge planning and discharge flow

Improved bed management and next day planning

- Structured their daily meetings to focus on plan for today and tomorrow
- Implemented afternoon discharge planning huddles on the wards

Expanded scope of Hospital In the Home

- Increased clinical hours
- Increased scope for eligibility for patients to access service

“Home for brunch”

- Engaged clinicians in why early discharges matter
- Set goal of 2 discharges before 10am
- Changed ward rounding to prioritise discharges

“Leave by lounge”

- Set expectation that all suitable patients will be discharged to the transit lounge
- Reviewed criteria and improved the transit lounge model

What did they do?

Improved streaming of care through the Emergency Department

Short stay - four by morning tea

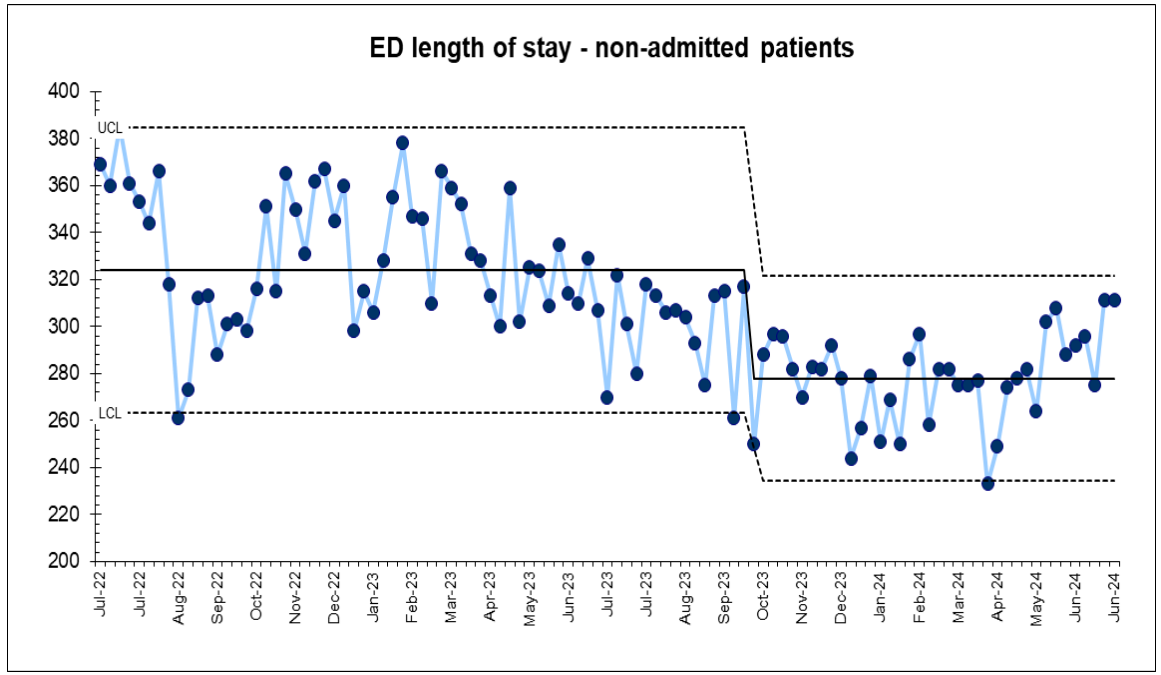
- Improved turnover of ED short stay
- Four patients admitted by 10am to ‘decant’ ED

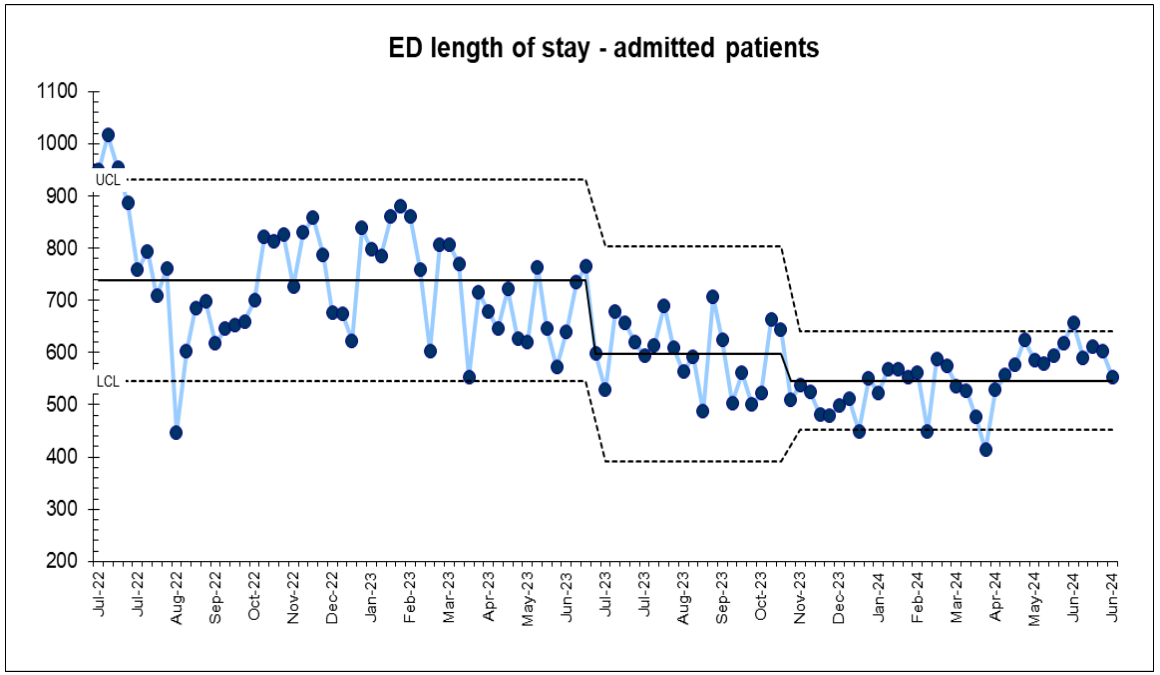
Fast track stream for non-admitted patients

- Refined non-admit / low complexity patient stream
- Protected this stream to avoid patients for admission blocking the non-admit flow

Results by 30 June 2024

The impact on ED length of stay

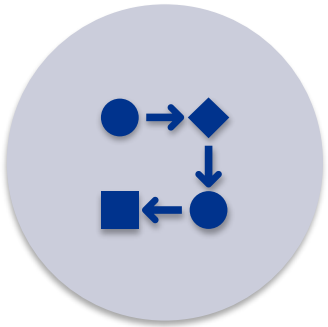




Reduction in ED admitted non-admitted length of stay of **>45 minutes.**

Reduction **in ED admitted length of stay** of **more than 3 hours!**

The learning they shared



Engage staff to see flow as a system (not just an ED problem)

Focus on high-impact changes that are co-designed and led by clinicians

Maintain communication about the improvement work at all levels of the organisation

Make sure new staff are oriented to organisational flow principles

So now what?

So now what?

1. **A 15-month collaborative to build on TECC**

   14 hospitals

2. **A collaborative focusing on acute care of older patients**

   14 hospitals

3. **Three innovation focus areas**
   i. 7-day patient flow (weekend discharges)
   ii. Innovating care at home
   iii. ED performance enhancements

4. **Enhanced state-wide patient flow performance insights**

The Timely Emergency Care Program (TEC2) is a single program with dual objectives to improve flow and optimise inpatient capacity

The best of TECC

- Collaborative learning
- Continue focus on inpatient and ED flow
- Opportunities to accelerate progress
- A single collaborative with options
- Opportunities for individualised coaching

What matters most

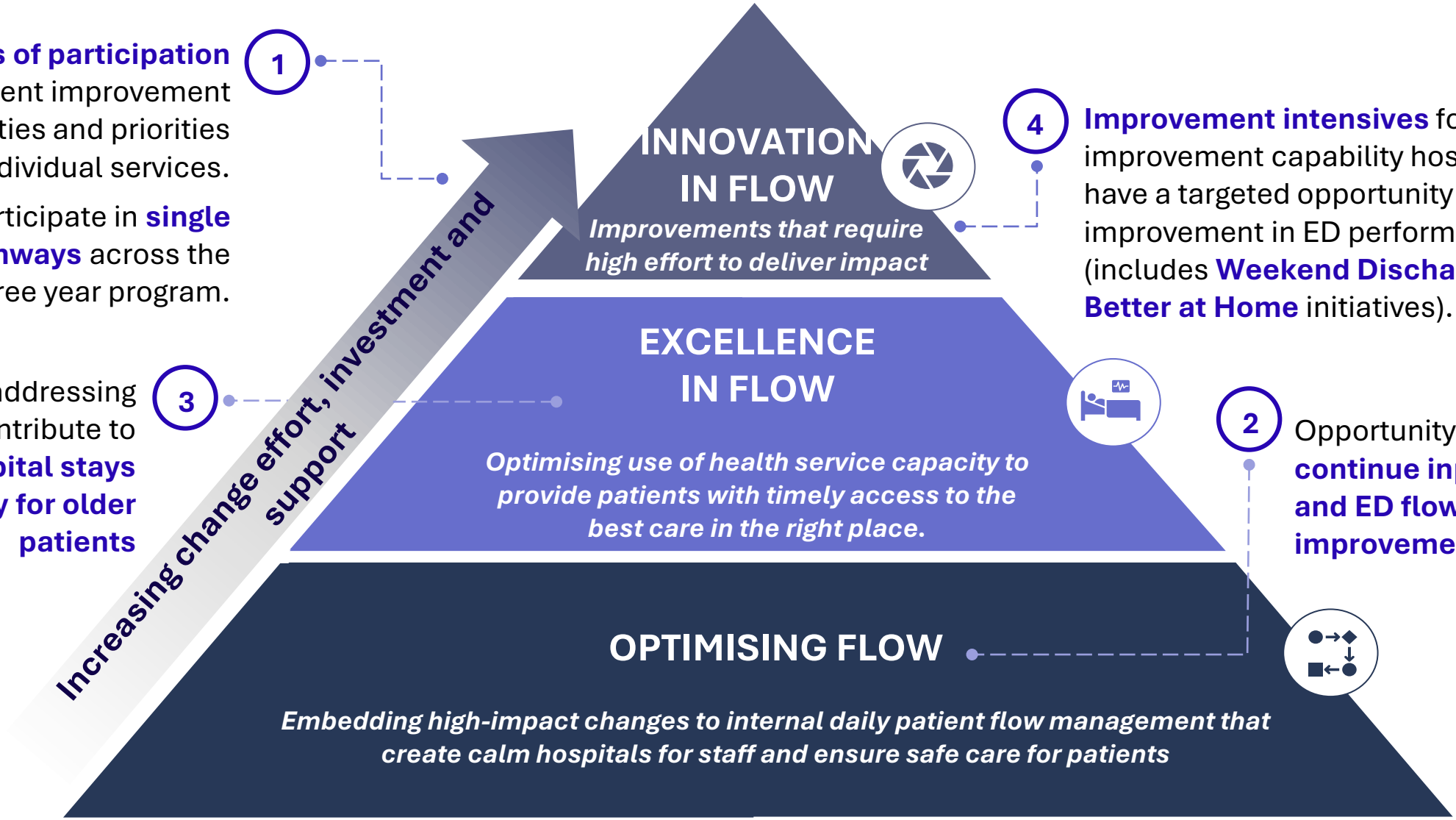
- Different types of support
- A focus on Care of the Older Person
- A simplified change theory
- Sustainability

Program features

Tiered levels of participation reflecting different improvement needs, capabilities and priorities of individual services.

Services can participate in **single or multiple pathways** across the course of the three year program.

Focus on addressing factors that contribute to **avoidable hospital stays – particularly for older patients**



Improvement intensives for high improvement capability hospitals that have a targeted opportunity for improvement in ED performance (includes **Weekend Discharge** and **Better at Home** initiatives).

Opportunity to **continue inpatient and ED flow improvements**

Shifting to improvement

New performance improvement *targets* have been adopted for emergency access and care measures

1. Measuring what matters
2. Success is improvement on individual performance
3. Reflect a whole-of-hospital approach to emergency department performance
4. Maintain a focus on quality and safety
5. Remove measures that do not support actionable insights

Questions?