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A Centralized System to Access Acute Healthcare Services: *The Pros and Cons*

by Susan Brown



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Abstract

Having a centralized access service results in a daily interconnectedness between hospital sites, which can create many benefits but also much controversy. Knowing the pros and cons of a centralized service and understanding the role and work environment of the access coordinator will assist you in deciding if this service would be of benefit to your health region. In this descriptive analysis of a centralized access model, a regional perspective is presented; however many of the strategies can be adapted to a single hospital service resulting in improved flow in clinical areas.

In 2001 the former 52 health regions in British Columbia were realigned to become six health authorities, one being Fraser Health (FH). FH is home to 1.4 million people or 33% of the population of British Columbia¹ and has 12 hospitals that provide around-the-clock emergency services. FH spreads geographically from Burnaby to Hope, and 28% of the population resides in a rural setting.¹ Since 2002, many of the services that each hospital offered have been reconfigured, resulting in the 12 hospital sites becoming co-dependent for specialty services.

Reconfiguration and the impact of high occupancy rates within acute facilities have spurred the need for a centralized access service to assist with patient movement throughout the region. FH experiences occupancy levels above 95% on a regular basis in most hospitals. The impact of having occupancy levels above 85% is that the response to emergency cases could be delayed due to a lack of flexibility.² Another factor that impacts access to acute services is the shortage of healthcare professionals and this international issue is forecast to become more severe over the next decade.³ Such daunting facts make the need for a centralized access service paramount.

Definition

The literature available on the topic of centralized access services is minimal, with no reference to a definition. The Canadian Council on Health Services Accreditation⁴ provides a definition of access which has helped shape the mission statement for the access team in FH.

"To collaboratively develop solutions to improve patient care by utilizing appropriate resources and to promote awareness of services available to FH and collect data to support and influence decision-making."

This mission is achieved by having access coordinators at each hospital who are regional employees but have the primary responsibility for one or two hospital sites. The purpose of having the access coordinators employed regionally allows for greater flexibility during times of crisis, and the advantage of this is outlined in the case report presented. At each hospital the access coordinators facilitate meetings each morning where they discuss daily bed utilization, which supports the plan for the day. The meetings are generally short, lasting about 15 minutes, and information from each unit is brought to the meeting by a charge nurse, coordinator or the manager. Information about discharges, complex cases, and expected admissions is pertinent, as the hospital liaison nurses from the community are also present. The bed meeting ensures that patients from the operating room are accommodated and movement of patients out of the emergency room and intensive care unit is achieved.

The access coordinators attend the ward interdisciplinary rounds and are aware of patients that present with complex needs for discharge. The relationships

with other healthcare professionals, especially the ward leader and hospital liaison nurses from the community, ensures that the patients are moved to the most appropriate setting and prevents acute bed days being lost. It is therefore important to have access coordinators who have good leadership skills and are able to lead others through complex issues to resolution.

Each access coordinator supports the needs of the hospital by managing transfers to a higher level of care and facilities repatriations back to the local community hospital for patients requiring ongoing care. Repatriations in FH are defined as bringing patients back to their home community after being at another hospital for care not offered locally. To assist with accounting for patient movement, the creation of a regional spreadsheet tracks patients waiting for service and those waiting to be repatriated. This spreadsheet has improved the access coordinators' awareness of patients waiting and the result has been improved throughput on a global- or health authority-wide basis. Improving the flow assists the tertiary care facility to meet its mandate of caring for those requiring specialty services unavailable at other sites.

The challenge to accepting repatriations at a facility that is currently busy is an immense but necessary function to maintain flow-through in the health authority. The role of the access coordinator can therefore be considered contentious and will test the communication and problem solving skills of your best employee.

Having a centralized access service has improved the interconnectivity between the 12 hospital sites as the access coordinators are in contact frequently. Each access coordinator brings a global perspective to situations, allowing resources to be allocated to those with the greatest need. Furthermore, the access coordinators are instrumental at identifying issues that impede the ability of the site to provide care. Such issues are discussed at the bi-weekly team meetings, which identifies trends

throughout the health authority. Identifying trends or issues appearing at several sites allows a more effective regional intervention to occur.

The access service in FH is comprised of one regional director and manager and nine access coordinators who manage the bed-booking clerks at each hospital. There is an executive sponsor of the access service who plays an important role in communicating regional issues to the executive team. Issues that are taken to the executive table often require intervention from other team members – for example, physician leaders to examine physician-on-call coverage. In addition to having executive support there have been several regional policies developed to further strengthen the outcomes achieved by the access service. The policies were developed with input from all hospitals in the health authority and include topics that relate to patient transfers and site/physician responsibility.

Role Comparison

Literature on centralized access services in healthcare is limited; therefore, reasonable comparison to the access coordinator role comes from Air Traffic Controllers (ATC). ATCs are responsible for the safety of others as they coordinate flights to prevent accidents and reduce delay⁵ and work under pressure due to the relentless volume of air traffic.⁶ The ATCs are expected to “visualize the whole traffic picture, establish priorities, and think clearly in emergencies.”⁵ In addition, ATCs are expected to manage large amounts of information at one time and communicate with many people frequently.^{5,6} These statements create a visual image that is extraordinarily similar to the work environment of the access coordinators.

Air traffic is managed centrally to enable controllers to understand what is happening in all air space versus only what is occurring in one small area. The purpose of this centralized function is to maximize efficiency and avoid overloads.⁷ This is exactly the purpose of the centralized function of access in healthcare. The access service attempts

to distribute the work to avoid overload in one area and ensures the patient gets to the most appropriate facility for service.

Case Report

To highlight the benefits of a centralized access service the following case report will outline the actions of the team in response to a Severe Acute Respiratory Syndrome (SARS) outbreak in April 2003. In 2003, three sites in FH were affected by SARS. SARS is a respiratory illness that can result in severe pneumonia or respiratory failure.⁸ At Royal Columbian Hospital, FH's tertiary care site, a patient who had recently traveled to China was experiencing symptoms that were consistent with SARS. The patient was on a large medical unit, which affected the site's ability to admit and discharge medical patients, leaving 18 unplaced medical patients in the emergency room.

A rapid response was required to assist the site with decongestion of the emergency room. The access director, manager and access coordinator worked from the Royal Columbian Hospital's emergency room, connecting with the access coordinators at other sites in FH to facilitate movement of the 18 medical patients. The access staff cleared the emergency department of all medical admissions within six hours by collaborating with physicians and other professionals external to the site. Having the access team onsite allowed local physicians and administration to focus on the issue at hand.

The patient identified as being suspect of having SARS became more acutely unwell, requiring intubation. Admitting this patient to the tertiary care intensive care unit (ICU) would have significantly compromised the care of other unstable critical care patients requiring tertiary services in the region. In response to the situation, a satellite ICU was opened in Surrey Memorial Hospital and the acutely ill patient and other patients suspected of having SARS were transferred to the alternate site. The transfer of these patients was coordinated by the access service in collaboration with the British Columbia Ambulance Service, again

allowing local physicians and staff to focus on patient care.

The outcome of this intervention enabled Royal Columbian Hospital to continue providing tertiary services by keeping the ICU and operating rooms free from contamination. In addition, the emergency room continued to provide service to local residents and tertiary trauma cases.

Focus Group Discussions

The benefits of the centralized team have been demonstrated in the case report. However in focus group discussions, senior leadership at individual hospital sites has identified other views of the service. The purposes of the focus group discussions were to evaluate the access services provided in FH, and, with the feedback, make improvements to the system. The group discussions were informal but facilitated by organizational development and are incorporated into the pros and cons of the access service.

The Pros and Cons of a Centralized Service

The pros and cons of having a centralized access service have been adopted from the feedback received during the focus group discussions and from personal experiences. In table 1 the pros and cons have been summarized with a more in-depth explanation following.

Table 1: The Pros and Cons of a Centralized Access Service

Pros	Cons
Global Picture	Not strategic in nature
Improved flow across health region	A sense of lacking control at the local level
Improved repatriation	System change
Faster mobilization of resources in a crisis	
Knowledge transfer between sites	

Global Picture

Having a global picture of FH ensures that the resources available are given to patients who are in most need. When

patients are waiting for the same service, a physician specialist will assist with prioritizing cases and providing time frames that cases have to be accommodated within.

Improved Flow across the Health Region

The philosophy of FH is *one hospital, 12 sites*. Patients within FH are frequently moved to the hospital that can provide the most appropriate care. Appropriate care could mean a higher level of care, or care that is unavailable due to a staffing or capacity issue at the hospital at that time. The centralized access service in FH has contributed greatly to the interconnectedness between the 12 hospital sites and provides creative solutions to managing patients within the health authority. Figures 1 and 2 demonstrate Intensive Care cases that were transferred from one hospital to another for a higher level of care or due to a capacity issue.

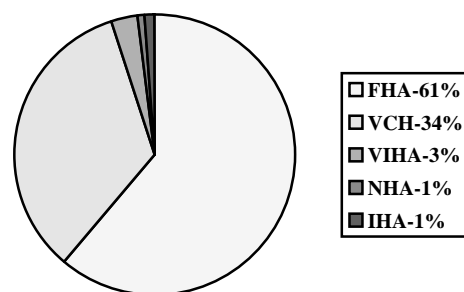
Historically, many patients requiring intensive care intervention received care in the downtown area of Vancouver, which is part of Vancouver Coastal Health Authority. The Ministry of Health now wants the health authorities to become self-sustainable and FH is working to increase the number of cases kept in the health region.

Figures 1 and 2 illustrate intensive care cases generated in FH and their final destination. The abbreviations in the graphs demonstrate the six health authorities in British Columbia: Vancouver Coastal Health Authority (VCHA), Provincial Health Services Authority (PHSA), Vancouver Island Health Authority (VIHA), Northern Health Authority (NHA), and Interior Health Authority (IHA). The figures compare the overall case volumes for similar time periods (September – February) in 2003 and 2004. In one year there was an increase in volume by 28% and FH increased their self-sufficiency by 10% - an overall increase of 44 cases, or 38%.

Improved Repatriation

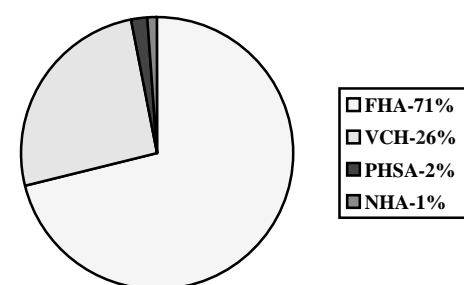
To support patient movement throughout the health authority the development of a repatriation policy has helped the

Figure 1



ICU Transfers from Fraser Health, by Receiving Health Regions[®] September 1, 2002 - February 28, 2003 (115 Total Transfers)

Figure 2



ICU Transfers from Fraser Health, by Receiving Health Regions[®] September 1, 2003 - February 29, 2004 (161 Total Transfers)

situation. The policy expects that patients will be repatriated to their local community, or to a community that can provide appropriate care when able. This policy assists the tertiary care facility to fulfill its mandate as well as getting patients closer to home.

The access coordinators drive the process of patients leaving the site for service elsewhere and the repatriation of patients coming back to the local community. Administration at the hospitals feels that decisions are not always being made in collaboration with the site management or in the best interests of the community. As a result of these feelings, the reporting structure of the access service has been brought into question. Some administrators feel that the access coordinator should not be reporting to an external individual - that it should be onsite management. To mitigate ongoing communication issues the Director of Access met with administration at each hospital site to establish who the access coordinator should collaborate with on a regular basis.

Faster Mobilization of Resources in a Crisis

During periods of crisis, mobilization of resources that are able to assist with limiting access to the site and transferring patients from the site can help considerably. Arguably, other healthcare professionals could perform this work; however, having individuals who manage this type of work on a daily basis ensures the process is more expedient. The communication pathway with external stakeholders is established and a level of trust and transparency is evident between the access coordinators.

Knowledge Transfer between Sites

The value of having employees across the health region who communicate frequently allows for transfer of knowledge to occur easily. Strategies that have been implemented or tested at one facility are often replicated across the health authority. The sharing of best practice or simply new ideas had assisted the coordinators in making improvements with, for example, dissemination or communication of information at the hospital, hiring practices and gathering statistics.

Not Strategic in Nature

A great amount of time is spent by the access service dealing with daily bed management problems, some days repeating the same events as the day prior.¹⁰ The issues can be repetitive as capacity challenges are often present in FH. The impact of dealing with bed capacity issues every day is that the access coordinators are unable to spend time looking at utilization practices in the hospitals. Examining the trends in utilization can be enlightening as improvement can be made to length-of-stay for certain patient populations. Furthermore, this type of self-critique can assist with the creation of new services to better meet the needs of the population. The situation is not ideal; however, as FH becomes more self-sustained it is anticipated that the access coordinators will participate in such activities.

A Sense of Lacking Control at the Local Level

Often the repatriation of a patient will create discussion and debate as this patient population is often considered a low priority by local administration when the hospital is busy. The repatriation function is essential to the overall flow of patients throughout the health authority and the access coordinators consider repatriations in their daily plan for patient movement at the site.

System Change

Moving to a centralized access service takes a considerable amount of effort. Depending on the size of the health region and number of hospitals, the work can seem relentless in the beginning. Having a high-energy person champion the project would be an asset, but the support of the executive is essential. Moving to a centralized access system can result in access coordinators who have a level of expertise around their local patient flow patterns which can assist with strategic planning and daily operations.

Conclusion

Centralized access service is a relatively new concept in healthcare and the work environment of the access coordinator can be challenging and stressful; however, the current employees find problem-solving can be rewarding and motivational. Many sites have their own access coordinator or bed management personnel however, connecting the hospitals in the region with employees who are familiar with the process for transfer can reduce acute bed days lost to delays. In addition to these benefits, this process results in patients receiving the service they need.

In Fraser Health's experience, a centralized access service has pros and cons and will not be the only answer to congestion or emergency overcrowding problems. The benefits of a centralized access service outweigh the negative aspects and contribute to an improved health authority flow of patients.

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