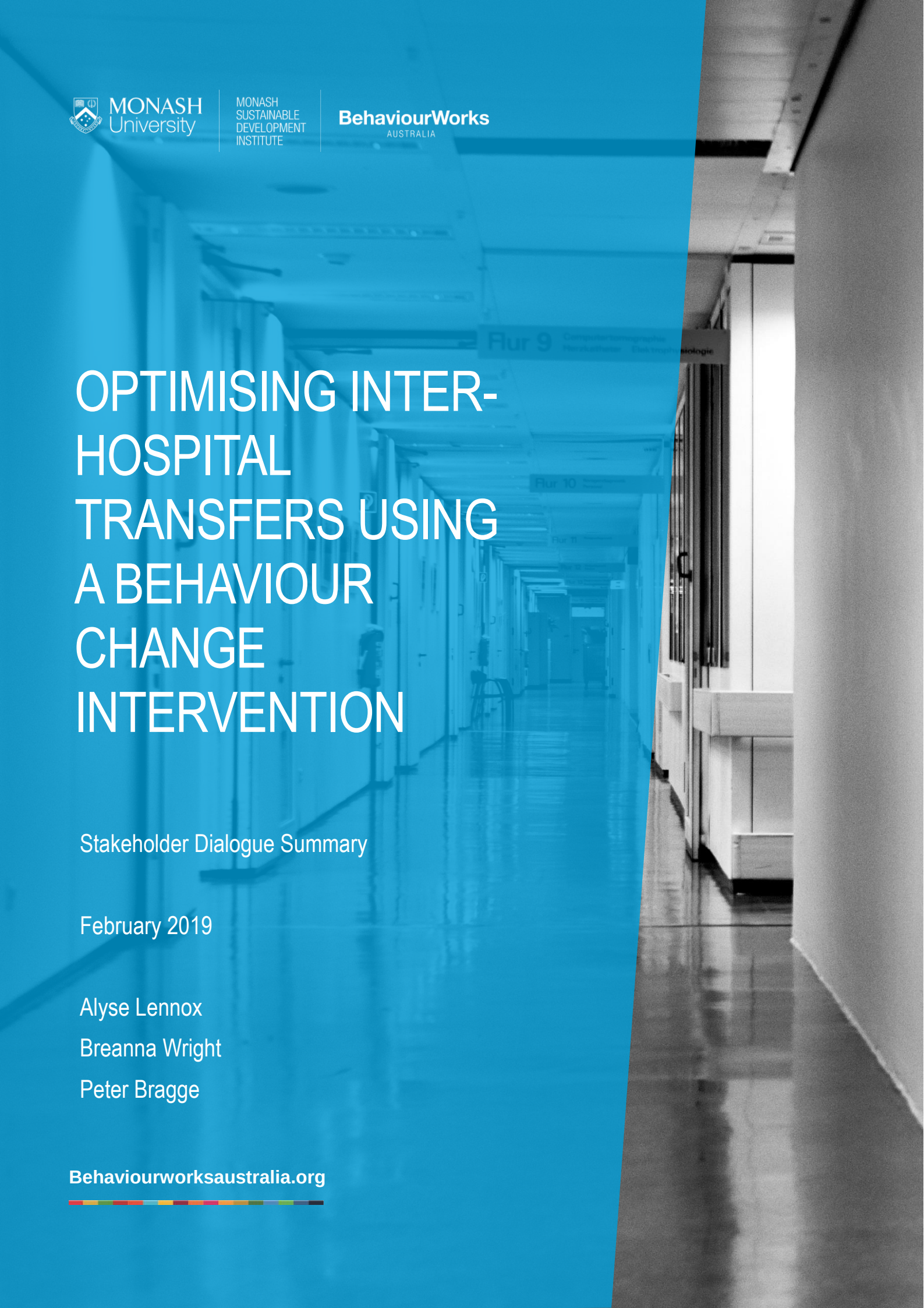

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OPTIMISING INTER-HOSPITAL TRANSFERS USING A BEHAVIOUR CHANGE INTERVENTION

Stakeholder Dialogue Summary

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Alyse Lennox
Breanna Wright
Peter Bragge

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OPTIMISING INTER-HOSPITAL TRANSFERS USING A BEHAVIOUR CHANGE INTERVENTION: STAKEHOLDER DIALOGUE SUMMARY

Authors

Alyse Lennox, BPsych(Hons), Research Assistant, BehaviourWorks Australia, Monash Sustainable Development Institute, Monash University; Melbourne, Australia

Dr Breanna Wright, PhD, Research Fellow, BehaviourWorks Australia, Monash Sustainable Development Institute, Monash University; Melbourne, Australia

Associate Professor Peter Bragge, PhD, BPhysio(Hons), BehaviourWorks Australia, Monash Sustainable Development Institute, Monash University; Melbourne Australia

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BehaviourWorks Australia
Monash Sustainability Institute
Monash University, Victoria 3800, Australia
+61 3 9905 9656
behaviourworksaustralia@monash.edu

EXECUTIVE SUMMARY

A day-long, structured stakeholder dialogue was convened on February 1, 2019 to address the issue of *"Improving the decision to transfer patients from a regional or rural hospital"*. This project was funded by the Victorian Managed Insurance Authority (VMIA). The dialogue was attended by 20 people representing government, policy, insurance, medicine, nursing, ambulance, operations and research. A briefing document summarising findings of a rapid review of academic evidence, practice interviews and citizen panel outcomes pertaining to this topic was sent out to all dialogue participants in advance of the day. The dialogue had three aims:

1. **Gain a shared understanding of evidence, practice and key issues relating to inter-hospital transfer.**

The biggest challenges to inter-hospital transfers from regional and rural hospitals include:

- Lack of awareness of existing guidelines and protocols, and the role of hospitals within a network of other hospitals; lack of protocols and guidelines in some areas
- Lack of awareness about when to use various transfer options
- Lack of awareness and trust surrounding lower acuity hospital capabilities by higher acuity hospital staff
- Balancing the risks of managing a potentially deteriorating patient against the risks of transfer to a higher acuity facility (including opportunity costs of having ambulances out of local areas)
- Attitudinal barriers from potential receiving hospitals – for example a culture of 'my beds' and a default of 'no' rather than 'what plan can we put in place?'
- Bed availability (out of scope for a behaviour change pilot trial)
- Transport availability (out of scope for a behaviour change pilot trial)

2. **Identify interventions to improve inter-hospital transfer from regional and rural hospitals that could be trialled and scaled across Victoria**

Issues with finding an available bed could be addressed through the introduction of a system that shows all available non-critical care beds and / or making existing systems more accessible (e.g., Retrieval and Critical Health- REACH). Guidelines and protocols could be developed about where to send people and when to reduce the need for these discussions and improve decision making. The discussion unpacked how larger hospitals in each region could adopt a 'buddy system' and take responsibility for patients from smaller hospitals within the region. Some regions reported doing this well and learnings could be drawn from these high-performing areas to improve behaviours in other regions. It was proposed that if larger hospitals could not take a patient, they should share ownership of finding another destination for the patient. An observational study could improve understanding of how well patient transfer networks are currently functioning.

3. **Prioritise an intervention and determine measures of success**

A range of suggested options to improve inter-hospital transfers from regional and rural areas arose in the discussion. The options with the most support were:

- Trialing an awareness campaign to increase knowledge of transport resources, hospital capabilities and protocols
- Trialing a communication strategy that reflects high-functioning systems to foster attitudinal change

INTERVENTION DEVELOPMENT

FOCUS AREA FOR AN INTERVENTION TO IMPROVE INTER-HOSPITAL TRANSFERS FROM REGIONAL AND RURAL HOSPITALS

Non-critical patients

Non-urgent patient transfers (i.e. patients that don't need lights and sirens but are still in need of an operation or surgical opinion) present more issues as they need to be organised by the referring hospital staff. Referrers need to call larger hospitals and find one who will accept the patient and has a bed available. This is resource intensive as it could involve calling multiple hospitals before finding an appropriate destination. Furthermore, making these calls takes away from clinical care of the patient. Transport is then organised through Ambulance Victoria (AV) or private transport providers. More issues were reported when transferring patients to metropolitan locations than when transferring within a region. There were significant concerns about the safety of non-critical patients while awaiting transfer, and they were deemed to be an appropriate focus area for an intervention.

Critical care patients

Urgent patient transfers are organised by Adult Retrieval Victoria (ARV). This was discussed as being a smooth process in which the referrer can continue to look after the patient while ARV identifies a bed and the appropriate skill set and transfer mode for the patient. Specialist opinion is also provided to manage patients while awaiting transfer. Therefore, critical care patients are not a target population for a behavioural intervention.

THE INTERVENTION

Intervention

To address the lack of awareness surrounding transport protocols by rural and regional hospitals and hospital capabilities by larger regional and metropolitan hospitals, as well as the negative attitudes experienced by referring hospital staff, an intervention that combines an awareness/attitudinal campaign and a trial of a communication strategy (e.g. including a communication script between hospitals) could be effective. The communication strategy could focus on fostering collegial attitudes and change the default 'no' response to 'how can we make the transfer happen?' It could also be embedded into VMIA's inter-agency risk profile. Learnings could also be drawn from high-performing regions to inform the trial.

It was also considered important to embed awareness within institutions as well as at the level of individuals and their existing networks and relationships, which are subject to change as staff turnover occurs.

Target audience

An intervention could be targeted at clinicians (junior and/or senior), bed managers, system coordinators and patient flow coordinators.

Target population

Suggested patient populations to target the intervention on included non-urgent:

- Orthopaedics
- Obstetrics
- Cardiac
- Neurological

- Gastro-med
- ‘Grey area’ patients (i.e. not sick enough for ARV but still not to be transferred)
- Non-STEMI
- Unstable angina
- Mental health

Target context

The intervention could be conducted at a specific time of day/night. Overnight was highlighted as a particularly difficult time for transfers and the preceding decisions.

POSSIBLE INTERVENTION OUTCOMES

- Increased system knowledge and awareness (including transport options, transfer protocols and hospital capabilities)
- Self-reported attitudes and beliefs

IMPLEMENTATION CONSIDERATIONS

It was acknowledged that we would need to consider how to get buy-in from Melbourne metropolitan hospitals to participate in the trial.

ADDITIONAL INTERVENTION OPTIONS

A number of additional intervention options were also discussed. These included:

- Observational study involving data collection to build a better picture of how well patient transfer networks are currently functioning
    - Characterise the maturity of rural and regional referral systems
    - Look for differences in outcomes between regions with established referral pathways and those without
    - Determine whether the same barriers to inter-hospital transfer are experienced in all regions
- The introduction of a system (similar to Bed Brokers) that shows available non-critical care beds in the state
- Consistent telehealth systems which can be used as a back-up to provide management advice when a hospital cannot take a patient
- A website for hospitals in which you specify the requirements for a particular patient and suitable hospitals are presented, similar to those that consolidate and compare information on hotels and flights for consumers
- Real-time access to hospital capabilities (acknowledging that these vary considerably especially at different times of the day and weekends/holidays)
- Development and awareness of guidelines and protocols to standardise inter-hospital transfer

OUT OF SCOPE

While increasing the number of beds, changing staffing numbers and shift times and developing protocols and information systems were discussed, they were determined to be out of scope for this project.

USEFUL RESOURCES

- Standardised inotrope and vasopressor guidelines developed by the Critical Care Network within Safer Care Victoria- https://bettersafercare.vic.gov.au/resources/tools/standardised-inotrope-and-vasopressor-guidelines
- Endovascular clot retrieval for acute stroke: statewide service protocol developed by Safer Care Victoria- https://bettersafercare.vic.gov.au/resources/clinical-guidance/stroke-clinical-network/endovascular-clot-retrieval-protocol
- Retrieval and Critical Health Information System (REACH)- https://reach.vic.gov.au
- Rural Acute Hospital Data Register (RAHDaR)- https://www.westernalliance.org.au/the-rural-acute-hospital-data-register-rahdar

KEY THEMES OF THE DISCUSSION

LACK OF AWARENESS

Capability

- There is currently a lack of awareness among receiving hospitals and transport providers about the capability of referring hospitals.
- While hospitals may have a 'base level' of capability, this can change from hour to hour (e.g. a regional hospital may only have one senior clinician who cannot be working 24/7).
- There needs to be a certain amount of trust at the receiving end that the referring hospital is being transparent about their capabilities.
- Knowing what resources are available at a particular hospital at any given time would be useful.
- Metropolitan registrars and those new to the system (e.g. from overseas countries and working in rural Victoria) often have no idea where the referring hospitals are, or the capabilities of the hospital.

Available resources

- There is lack of awareness around when it is appropriate to book a non-emergency ambulance and when hospitals should use their own private contractors.
- Those booking transfers are also unaware that contractors aren't rostered on 24/7.
- Many patients are put in a non-emergency ambulance because they can't afford public transport or taxi services.
- Non-emergency ambulance services could be freed up if they were used appropriately.
- Lack of awareness around available resources may be a reflection of high staff turnover and lack of time for education of new staff.
- There are peak times for transport (e.g. late afternoon on a Friday) where there is an increase for inter-hospital transfer requests however this puts pressure on the system as shifts are finishing and lighter night rosters are commencing.

FINANCIAL IMPLICATIONS

- Financial factors play into the decision to transfer.
- Hospitals have reported concerns about the cost of transfers.
- There is a lack of awareness around the cost of transfers and who sets the cost.
- There is a perception that using ARV is more expensive than using AV or private contractors.
- There is a financial incentive to use AV instead of private contractors, which can have flow on effects for ambulance availability.

PATIENT SAFETY

- Concerns were reported about the safety of patients awaiting transfer (due to bed availability, transport availability or time of day).
- There is a false sense of security for patients who are awaiting transfer in smaller hospitals, as they may deteriorate and there is often no plan for how they will be managed if this occurs given that the hospital is not capable of managing them.
- Considered decisions should be made about what will be done if a patient does deteriorate.
- Waiting in the corridor of a receiving hospital for a bed is often avoided, however it was stated that it is safer for them to be in a hospital that has the resources to deal with potential deterioration, even if they are waiting in a corridor.

- Patients are often awaiting transfers overnight which becomes even more unsafe due to reduced resources.
- Making decisions about inter-hospital transfers often involves choosing the 'least bad' option, that is, balancing the risk of staying in a regional or rural hospital and deteriorating against the risk of transfer, where the patient may deteriorate en route and/or the transfer takes a small region's only ambulance out of service, putting other people who experience health emergencies at risk.

TELEHEALTH

- Telehealth has the potential to reduce the need for transfer.
- Telehealth can give receiving hospitals a better idea what is going on with a patient, however it is still important that they have someone physically checking on them.
- While QLD use the same telehealth system statewide, Victoria have six different systems that are not integrated; some of these regions don't have an operational telehealth system at all.

ATTITUDES

- Acceptance of patients was reported to be dependent on the attitude of the receiver.
- Transfers were often perceived to be an imposition and thought to cause an increase in workload.
- Referrers often experience pushback from receiving hospitals e.g. 'Why don't you call somewhere else?' or 'Can you hang onto them?'
- Larger hospitals, which exist in a defined network designed to ensure patients ultimately receive the level of care they need, have an obligation to take in patients from regional or rural areas – however many regions are either unaware of their place within networks or do not feel a sufficient sense of personal obligation to assist.
- Language such as 'my hospital' and 'my beds' reinforces this negative attitude for the referrer. Shifting this default to 'our hospitals' and 'our patients' could promote more shared ownership for patients within the system and create a personal obligation to assist.
- Shifting of these defaults could help to balance the roles of regional and rural hospitals 'pushing' patients to larger hospitals, and larger 'buddy' hospitals 'pulling' patients from regional and rural hospitals
- Receivers should act as if the patient is part of their family.
- Examples of how to shift the existing 'no' default include starting calls with 'How can I help you?' and having a 'yes' attitude.

PATIENT FLOW ROLE

- A dedicated patient flow coordinator has been introduced in some health services to oversee the patient transfer process.
- The success of the role is very person-dependent. They need to be an effective communicator and be able to build relationships within the region.
- AV has seen a reduction in complaints for health services that have introduced this role, highlighting that engaging in conversations about transfer reduces complaints.
- However, this may not be scalable if funding is not available to staff a dedicated position.

TRANSFER PATHWAYS

- Regional partnerships exist in a formal way through the Department of Health and Human Services (DHHS) but they don't function as they are intended to.
    - Responsibility for catchment areas could be mandated by DHHS.

- Some transfer pathways work better than others due to their proximity to Melbourne (e.g. transfers from Colac Area Health to University Hospital Geelong are getting closer to Melbourne, whereas transferring to Latrobe Regional Hospital often involves moving further away from Melbourne).
- Tertiary hospitals should have a responsibility to make transfers happen.
- Transfers often occur through personal relationship pathways rather than using a systematic approach.
- Regional and rural hospitals also need to ensure that they are taking their patients back, when appropriate, to free up beds in larger hospitals.

DECISION TO TRANSFER PATIENTS

- In order to achieve the best outcomes for a patient, transfer decisions should not be delayed.
- Referring hospitals also need to determine whether patients should be transferred in the first place, particularly older patients and those nearing end of life.
- It is possible that some decision-making could be built into a 'transfer script' that is addressing underlying attitudes and awareness. Work in a related VMIA trial on escalation of deterioration within health services could inform this (recognising that some barriers to transfer between hospitals are different to those involved in escalating care within a hospital).

NEXT STEPS

- Assemble steering group
- Identify trial sites
- Fine tune the intervention based on individual site requirements

APPENDIX 1: BACKGROUND AND METHODS OF THE STAKEHOLDER DIALOGUE

The stakeholder dialogue was convened to enable a comprehensive discussion of relevant considerations (including research evidence) about a high priority clinical or system issue in order to inform action. The key features of the dialogue were:

1. It identified an issue that was considered a high priority;
2. It focused on different features of the problem, including (where possible) how this differed across settings and contexts;
3. It was informed by a pre-circulated briefing document that summarised contextual information on the current situation;
4. It brought together parties who would be involved in or affected by future decisions related to the issue;
5. It engaged a facilitator to assist with the deliberations;
6. It allowed for frank, off-the-record deliberations, by following the Chatham House rule:

   'Participants are free to use the information received during the meeting, but neither the identity not the affiliation of the speaker(s), nor that of any other participant, may be revealed'; and

7. It did not aim for consensus.

Participants' views and experiences and the tacit knowledge they brought to the issues at hand were key inputs to the dialogue. The dialogue aimed to connect the information from the briefing document with the people who can make change happen, and energise and inspire the participants by bringing them together to address a common challenge. This use of collective problem solving can create outcomes that are not otherwise possible, because it transforms each individual's knowledge into collective 'team knowledge' that can spark insights and generate action to address to issue. The dialogue summary was prepared based on notes of discussion taken independently by a BehaviourWorks Australia staff member (audio of stakeholder dialogues is not recorded). These notes were analysed to identify key themes and other information relevant to identifying priority areas.