

Acute Medical Unit

Panel Discussion

Dr John Henley

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INTRODUCTION

1. Increasing admissions – extent and cause
2. Terminology – Acute v Emergency
3. Problems in the past
4. Hospital Strategies
5. Barriers to acceptance of new ways of doing things

INCREASING ADMISSIONS

1. Mostly seen in medicine
2. Increasing age of patients
3. Multisystem Disease

POPULATION DEMOGRAPHICS

Australia:

At present >65 2.59 m i.e. 12.9% population
2025 >65 4.46 m i.e. 19.4% population

New Zealand:

At present >65 473,000 i.e. 11.7% population
2025 >65 723,000 i.e. 15.4% population

CAUSES OF INCREASING ADMISSIONS

1. Demographic changes
2. Social Deprivation
3. High Turnover : multiple admissions and re-admissions
4. Technical advances
5. Increased GP and patient expectation
6. Treatment success – chronic illness with acute exacerbations
7. Inappropriate admission
8. Junior Doctors in A & M Clinics
9. Downgrading of Primary Care

WHAT HAS BEEN WRONG IN THE PAST

RIGHT

TIME

PLACE

PERSON

Long delays,
Corridor Medicine

Seen by ED staff,
although not an
emergency, not
final destination

Patients requiring IP
services (i.e. admission)
are reviewed by ED staff
prior to being sent on.
Double handling Default
care

**If the problem is not an emergency,
why are patients being seen in the
Emergency Department?**

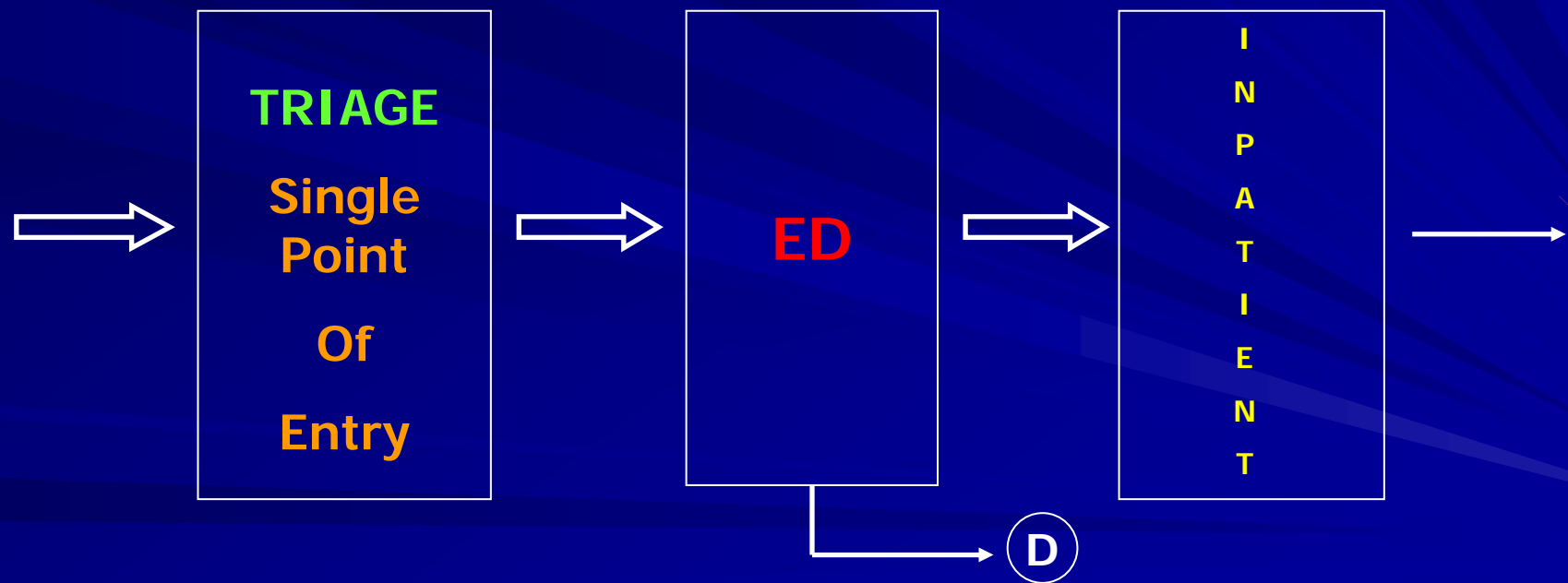
TERMINOLOGY

ACUTE – sudden onset / short duration (TIME)

EMERGENCY – CRISIS (Medical / Surgical Acuity)

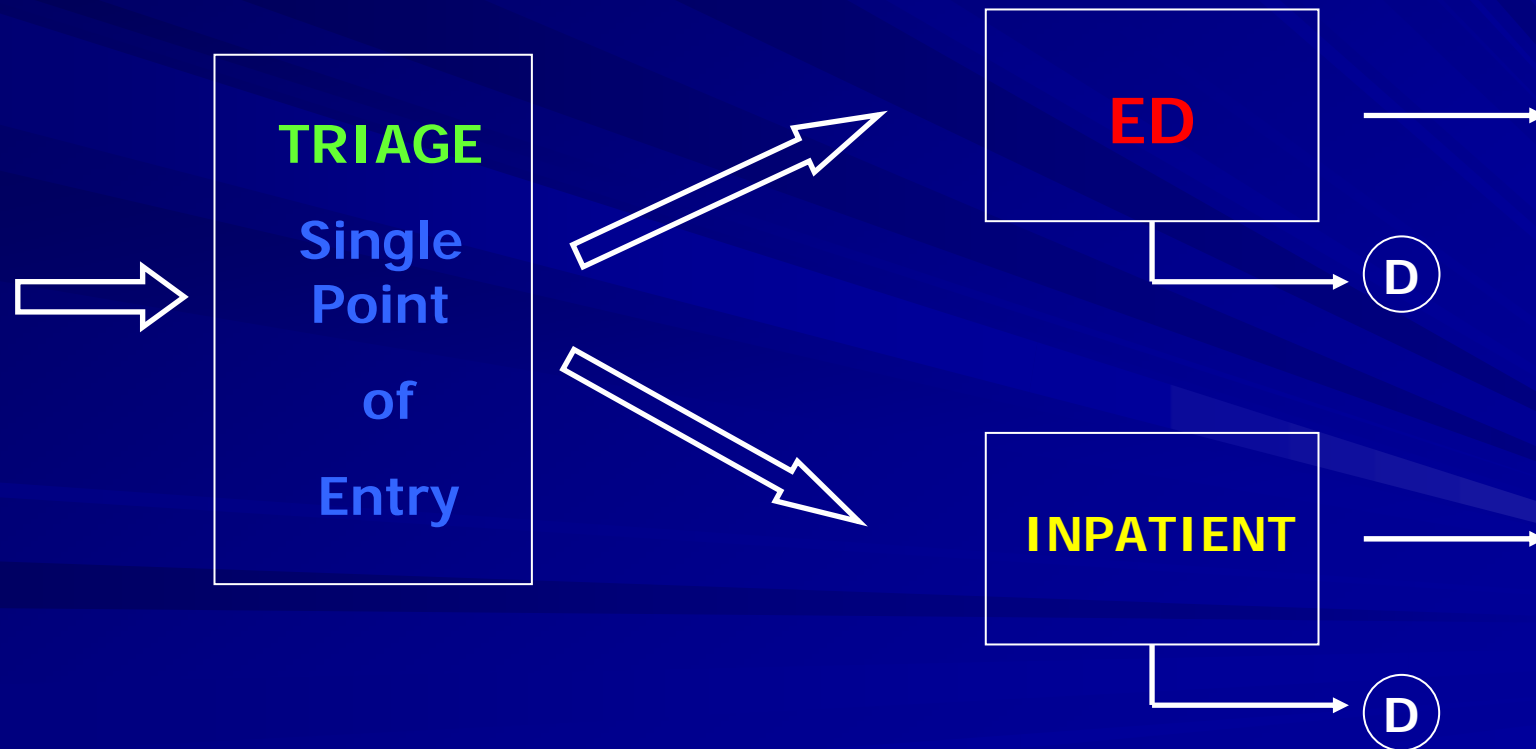
MANAGING ACUTE DEMAND

Resource Pooling



MANAGING ACUTE DEMAND

Demand Splitting

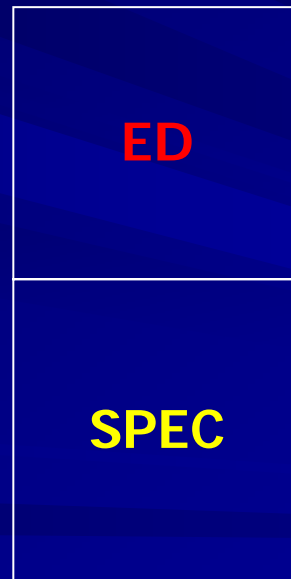


Medical Admissions The Past → Present

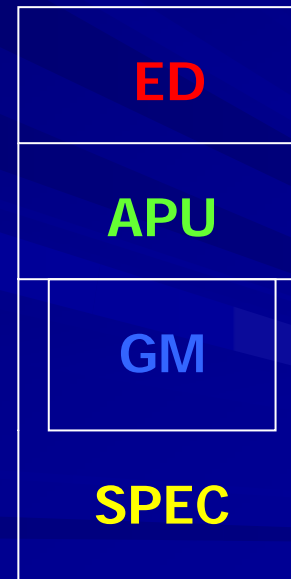
Acute Admissions



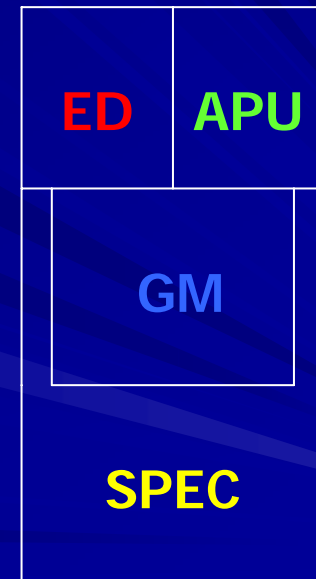
Acute Admissions



Weak GM
Presence



Strong GM
Presence



ADMISSION & PLANNING UNIT

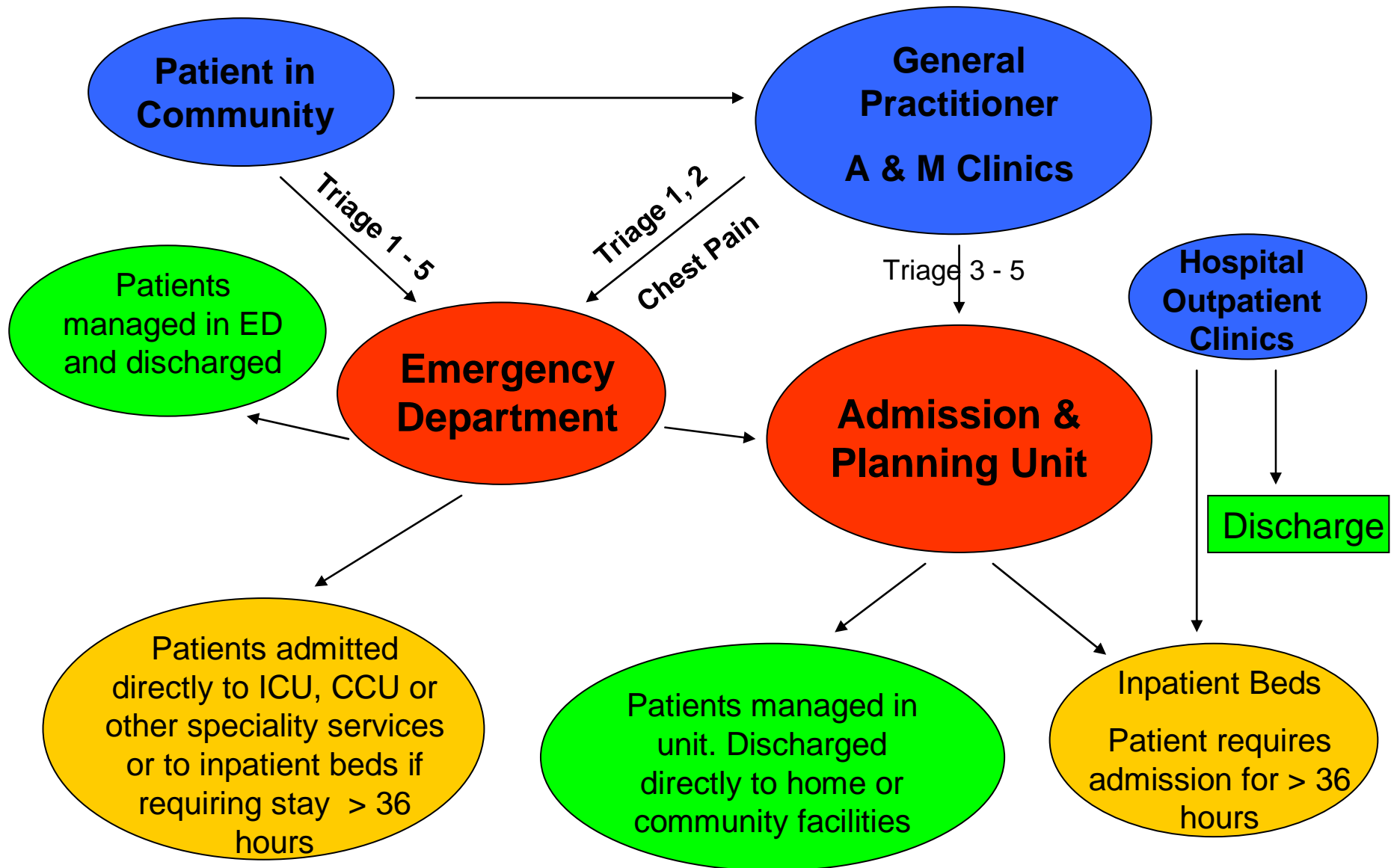
Objectives

1. Provide a purpose built facility for inpatient services to admit, assess and manage patients. (Admission and Planning Unit).
2. Enhance and facilitate the assessment and management of acute medical and surgical patients.
3. Prevention of double handling of patients, by allowing direct access to an inpatient unit from the primary care sector (bypassing ED).

Objectives (Cont)

4. Reduce the number of unnecessary admissions to inpatient beds.
5. Expedite rapid assessment, treatment, investigation, admission or discharge of all acute patients who present to Auckland City Hospital.
6. Improve the assessment of chest pain patients, with cardiac monitoring, blood testing and exercise tolerance tests before discharge.
7. Provide facilities for seriously ill patients who do not meet the criteria for admission to Intensive care, who can be stabilised before transfer to an inpatient ward.

PROCESS MAP (ADULT) ACUTE MEDICAL AND SURGICAL ADMISSIONS



Strategies

1. Enhanced discharge process
2. Improved bed management
3. Senior presence on 'hot floor'.
4. Maintenance of strong GM teams.

Senior Presence on 'hot floor'

1. Advice
2. Taking GP phone (alternative ways of coping with problems)
3. Marshalling the troops
4. Admitting if necessary
5. Reviewing patients for early discharge
6. Role different to Acute care physician / hospitalist
7. Teaching role

Also Medical staff

Ward rounds every morning (and often afternoon)

GP Hot line

Other Strategies

1. Integrated general Med / Geriatric teams
2. Rapid OPH review
3. Tight control on process
4. Increasing theatre efficiency - day surgery
- no elective loss

4 – Year Activity Analysis of Acute Admissions ADMISSION & PLANNING UNIT Auckland City Hospital

	2004	2005	2006	2007	Total
Admissions to APU	17,043	16,499	17,262	17,239	68,043
Admission Source					
Directly from Community	11,577 (68%)	11,017 (67%)	11,947 (69%)	12,235 (71%)	46,776
Transfer (mostly from ED)	5,310 (31%)	4,956 (30%)	4,845 (28%)	5,004 (29%)	20,115
Destination					
Transferred to IP Ward	9,082 (53%)	8,700 (53%)	8,912 (52%)	8,828 (51%)	35,522
Discharged from APU	7,961 (47%)	7,749 (47%)	8,350 (48%)	8,411 (49%)	32,471
Average length of stay	16.3 hours	16.5 hours	18.2 hours	18.2 hours	

General Medicine CBU Discharges

APU Top Ten Discharges by DRG

DRG	DRG Description	Total Discharges	% of APU Discharges
F74Z	Chest Pain	1141	63%
G67B	Oesophagitis; Gastroent & Misc Digestive Systm Disorders Age>9 W/O Cat/Sev CC	529	57%
F73B	Syncope and Collapse W/O Catastrophic or Severe CC	442	61%
F71B	Non-major Arrhythmia and conduction disorders W/O Cat/SevCC	301	61%
B77Z	Headache	216	71%
T63B	Viral Illness Age <60 W/O CC	150	73%
L63C	Kidney and Urinary Tract Infections Age <70 W/O Cat or Sev CC	227	47%
J64B	Cellulitis 9Age>59 W/O Catastrophic or Severe CC) or Age <60	375	24%
D61Z	Dysequilibrium	161	53%
171C	Other Musculotendinous Disorders Age <70 W/O CC	97	88%
		3639	

In hospital strategies to cope with acute volumes

1. Triage at single point of entry
2. Demand splitting
3. 'Hot Floor' co-operation
4. Enhanced investigative procedures
5. Senior presence on 'Hot Floor' – phone referrals
6. Enhanced discharge process / Nurse Facilitated
7. Transition Lounge
8. Improved Bed management
9. Hospital 'buy in' – shared risk
10. Integrated Gen Med / Geriatric Teams
11. Rapid OPH review and acceptance
12. Tight control on process – surgical / medical
13. Increasing theatre efficiency – no elective loss
14. Collaborative hospital culture

Primary Care Critical to Success



Primary Sector

Must be upgraded by:

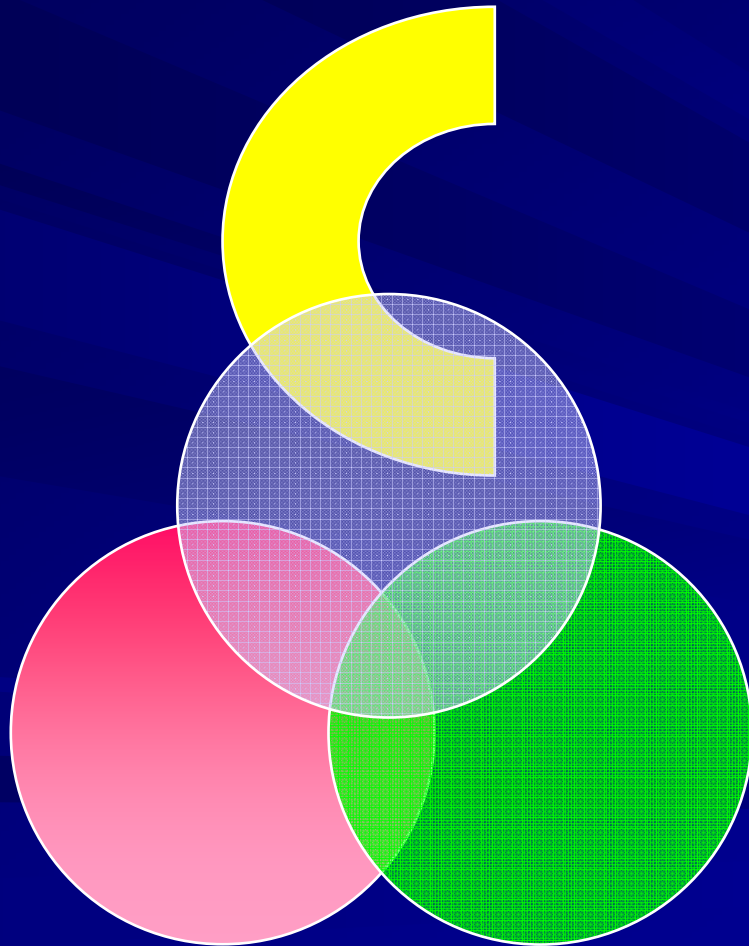
- a) Funding adequately
- b) Enhance program particularly in rural sector
- c) Training to increase scope of practice
- d) Increase use of multi skilled specialists (generalists)
- e) Access of GP to inpatient services for advice, admission rights, with ability to bypass ED (non emergency)

Barriers to accepting new ways of doing things

1. Bureaucracy and money concerns
2. Egotism and patch protection – Doctor centred
3. Lack of flexibility:
 - a) Model of care
 - b) Disturbance of own timetables
4. Financial disincentives

“The chaos in General Medicine today represents an opportunity for innovations, not a time for paralysis due to an uncertain future.”

- Larsen



The Creative Generalist

**How Broad Thinking
Leads to Big Ideas**

