

Divestment of Beds and Related Ambulatory Services to Other Communities While Maintaining a Patient- and Family-Centred Approach

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Abstract

Individuals living with serious mental illness who require acute and/or tertiary mental healthcare services represent one of the most complex patient groups in the healthcare service delivery system. Provincial mental health policy has been committed to providing services closer to home and in the community rather than an institution wherever possible for some time. This paper articulates the strategies used by one organization to ensure the successful transfer of beds and related ambulatory services to four separate communities. In addition a case study is also provided to describe in more detail the complex changes that took place in order to accomplish the divestments of beds and related ambulatory services to one of the partner hospitals.

Introduction and Context

St. Joseph's Health Care London is a publicly funded hospital that has led mental health service system transformation in southwest Ontario following directives from the Health Services Restructuring Commission (HSRC). The HSRC began its work in April 1996. In its report, one of the recommendations was for Ontario's nine provincial psychiatric hospitals to be divested to public hospitals.

London and St. Thomas Psychiatric Hospitals were divested to St. Joseph's Health Care London in 2001. For St. Joseph's, the directives also included two additional steps. The first was the

divestment of beds and related ambulatory services to four other hospitals, closure of beds, and transfer of employment services, assisting in the development of community capacity, and the second was the construction of two new state-of-the-art facilities.

This paper documents the processes used to ensure successful transfers of beds and services and, using a case study approach, describes the specifics of one of the four transfers of beds and related ambulatory services to another community.

Ontario's first mental health policy document (Heseltine 1983) provided an important guiding principle, namely focusing the primary objective on the achievement of a continuum of service delivery while ensuring that people with mental illness can receive appropriate help in their own communities, more commonly referred to as "receiving care closer to home."

Two of the four transfers involved the transfer of tertiary care beds and related ambulatory services at St. Joseph's to two organizations that were already providing tertiary level care – one that had provided only acute care services before and one that had not had any mental healthcare services previously.

The HSRC directives stipulated that St. Joseph's transfer a total of 138 beds to the four organizations: 59 tertiary care inpatient (IP) beds and related ambulatory services to one organization, 50 tertiary care beds and related services to a second, 14 tertiary care beds and services to a third and finally 15 acute care beds and related services to a fourth.

Recognizing the importance of timing in planning and executing the transfers to four different communities, factoring in the building of new construction or renovation in order to receive the beds and services and focusing on a patient- and family-friendly process, St. Joseph's initiated meetings with the partner hospitals to discuss timing and other issues important to well-planned transfer of services.

One of the principles understood from the beginning is that once the transfer was accomplished, the receiving organizations would then serve the counties aligned with their Local Health Integration Networks (LHIN), and St. Joseph's catchment area would be reduced accordingly. Following a format put in place at the first transfer, and utilizing project management strategies, a steering committee composed of representatives from both hospitals and both LHINs was formed to oversee the details of the transfer and ensure timely and participative communication and decision-making. A kick-off meeting between parties enabled partnership by providing an opportunity for all strategic players to meet each other prior to the start of the work.

The two vice-presidents of mental health at each hospital served as the project sponsors, and senior leaders from finance, human resources, facilities planning, communications and support from both hospitals were named to the committee. In addition, each hospital named a project lead, formed project teams at each site and formed an internal advisory committee to oversee the project internally. A project charter was developed and approved by both project sponsors.

Implementation of Directives at the Patient Care Level

Challenges and Strategies Employed

The primary planning principle agreed upon by all organizations was to ensure that individual patients and their families associated with the transfer were not impacted negatively. A patient transfer committee was formed within St. Joseph's, with a mandate to plan and implement communication and care planning strategies individualized to each patient and family. Their work started several months before the actual transfer and also included providing advice regarding how beds would be decommissioned in preparation for the transfer without unduly impacting access to remaining beds. Beds were to be decommissioned in several of the clinical programs. Each program had patients who were complex and had long lengths of stay.

A discharge planning exercise began, focused on long-stay patients. This strategy is further detailed in another article in this issue – "Mental Health System Transformation: Drivers for Change, Organizational Preparation, Engaging Partners and Outcomes." The exercise involved engaging community mental health agencies, the appropriate Community Care Access Centre (CCAC), Long-Term Care (LTC) home repre-

sentatives and the local LHIN in developing discharge plans for individuals with the right housing and right supports. Given the closure of beds, the CCAC was also able to grant "crisis" status to patients waiting for LTC. The committee recommended that phasing of bed decommissioning occur over 2 to 3 months in order to ensure access to beds in the time before the transfer took place. Using this approach, beds could be taken offline as discharges occurred.

While this work went on, meetings between clinical teams at both hospitals focused on planning for each individual IP transferring. This planning was designed to assist in the preparation of patients, families and clinicians for the transfer. Receiving hospitals included their community mental health agency partners and a representative of their LHIN to also explore possible community alternatives for individuals prior to being transferred to one of their beds. By the end of each process, fewer patients than those identified at the beginning of the process required transfer, with several others discharged to appropriate facilities and support in the local community. This strategy engaged community partners, the LHIN and other sectors early on, thereby preventing the filling and potentially blocking of beds as well as finding patient- and family-friendly alternatives to an IP bed.

Planning for the transfer also required agreement between partners, including any local acute care facilities, that there would be no new admissions or transfers from their area one month before the transfer date. This was meant to minimize patients and their families having to start their care in St. Thomas or London and then have it transferred shortly afterward to the receiving facility. Finally, it was agreed that the actual patient transfers would occur over several days in order to coordinate the movement of St. Joseph's staff who were also transferring with the beds to ensure the delivery of appropriate care at both facilities.

As noted below in the outcomes section, a considerable number of staff from St. Joseph's took advantage of transferring with the work. While this certainly assisted in minimizing the impact on staff, overall, it presented the St. Joseph's clinical programs with the challenge of staffing beds that had not yet been transferred and decommissioned, while the receiving organization oriented the transferring staff over a one-month period while the patients were still in St. Joseph's beds.

It was a little like "building a 727 while in flight," one leader said. In addition, one of the receiving hospitals was experiencing issues with recruitment of additional clinical staff in the local area that were needed to fully staff all of the beds, as they would be negatively impacting staffing at local acute facilities in the process. Agreement was reached at a local level and with St. Joseph's that only a portion of the transferring beds would be opening, with all of them being occupied with the identified IPs from St. Joseph's. The opening of the remaining beds was to be managed by the organization and the LHIN.

The transfer of assertive community teams (ACTs) associated with the geography of the receiving organizations was achieved without difficulty. The transfers were easier because the teams were already physically located in the locality of the transfer, with staff and patients already residing in their communities. One community was also able to accept the transfer of dual diagnosis OPs without difficulty, while another had to build capacity to receive these patients. St. Joseph’s worked with that community for more than a year to help build the capacity by providing education to local providers.

Other administrative issues that were managed included coordinating mitigation strategies to minimize staff impacts (internal transfers, early retirement offers, transfers with the work and voluntary exit packages), and the finalization of the transfer agreement between the two hospitals.

Outcomes

The project outcomes were identified at the beginning of the project and tracked regularly throughout. They are outlined below in Table 1.

Case Study – St. Thomas Elgin General Hospital

Context

The HSRC directives required St. Joseph’s to transfer 15 acute care IP beds and related ambulatory services to St. Thomas Elgin General Hospital (STEGH). After transfer, these services would provide the acute (both IP and OP) and emergency

mental healthcare needs for citizens of Elgin County previously provided by St. Joseph’s. After transfer, St. Joseph’s would continue to provide tertiary IP care when necessary for Elgin county residents and continue to provide ambulatory care in the county through ACTs and other OP services. As noted above, the same project management strategies were put in place.

Challenges and Strategies Employed

As noted above, planning for patients and families impacted by the upcoming transfer took centre stage. A patient transfer team was put in place and meetings arranged with STEGH clinical leaders, community mental health agency partners and representatives of the South West (SW) LHIN to discuss potential discharge planning for patients, which in the end resulted in only four IPs being transferred.

A bigger part of this transfer was the work that needed to be done to ascertain which of the approximately 1,000 OPs should continue receiving tertiary level, OP follow-up with St. Joseph’s, which patients could be transferred back to their family physicians for care, and which were in need of acute care-level follow-up. An extensive review of their clinical needs was completed by their clinical teams and resulted in the transfer of 300 OPs to STEGH.

Further complicating this transfer was the issue of new facilities for STEGH not being scheduled for completion until 2017/18. St. Joseph’s new facility in St. Thomas was due to be opened in June 2013 and the former facility decommissioned in the fall of 2013.

TABLE 1.
Project Outcomes

Project Outcome	How Was This Outcome Met?
Project completed on time and within budget	Local system issues and human resources challenges often delayed opening of the beds at receiving hospitals. Program transfer agreements were adjusted accordingly, extensive discussions were held with all affected and all parties agreed that the project was completed to all parties’ satisfaction.
“Successful” transfer of beds and ambulatory services	Transfer of identified IPs, ACTs and related ambulatory services for persons with dual diagnosis completed on time and within budget.
Preserve financial/budget resources	Decommissioning of units/beds at St. Joseph’s and financial transfer to receiving hospitals completed on time.
Minimize staff impacts	Staff was impacted by delays and lack of information at various points in the process, but in the end, after all transfers and bed reductions, more than 130 staff transferred with the beds, more than 170 were reassigned within St. Joseph’s, more than 60 accepted early retirement offers and voluntary exits, and less than 20 were given layoff notices and exit packages.
Minimize disruption to patient services	Disruption to patient services was minimal. Access to beds was maintained. Quarterly tracking of access to St. Joseph’s beds occurred during the period from 2011 to 2015. Bed access was maintained at an average of 11 days during 2011–2012 and was reduced to an average of 3 days thereafter. See further metrics data in “Mental Health System Transformation: Drivers for Change, Organizational Preparation, Engaging Partners and Outcomes” in this issue.
Minimize disruption to the individual patients impacted by these transfers and their families	Detailed planning by patient transfer team and weekly meetings between St. Joseph’s and receiving clinical teams in the weeks prior to the transfer resulted in minimal impacts to patients and families. Patient and family satisfaction was evaluated through feedback from these parties and was judged to be successful.

In consultation with the SW LHIN and the Ministry of Health and Long-Term Care, the decision was made to renovate existing space at STEGH to accommodate the acute care service as a temporary measure until the new building was completed. The first transfer date chosen was May 30, 2013, to coordinate with the opening of St. Joseph's new facility. Unfortunately, as sometimes happens with renovations of older buildings, unforeseen issues arose that made the May date impossible to achieve, and the transfer date was changed to September 30, 2013. Intensive discussions were held regarding options for delivering care in the interim and included representatives from STEGH mental health and emergency department leaders, local and provincial police, ambulance services, community mental health agencies and the SW LHIN. In the end, the decision was made to relocate the IP services to the St. Joseph's facility in London, relocate the OP services to a community location in the city of St. Thomas and provide clinician and physician support directly to the STEGH emergency department.

Strategies were also put in place to use the wait time to provide orientation to staff for the transfer to their new employer. Staff who had chosen to transfer with the work were assigned to the IP unit where the transferring beds were located and to the OP work that was relocated, and any other staff not transferring were reassigned within St. Joseph's. This strategy allowed for STEGH to plan and deliver the necessary orientation for their new staff while they were waiting for the renovations to be completed. A further delay in the transfer date to January 2014 emphasized the wisdom of relocating the services in preparation for the transfer.

Other administrative issues that were managed included the provision of beds and other furniture to STEGH (which was possible because St. Joseph's would be receiving new beds and furniture with its new facility) and the finalization of the transfer agreement between the two hospitals.

Outcomes

The project outcomes were identified at the beginning of the project and tracked regularly throughout. They are outlined below in Table 2.

Lessons Learned

- Factors such as careful, collaborative planning for patients who were transferring, timing of bed transfers and bed decommissioning, planning for discharge of long-stay patients and maximizing alternatives for staff to minimize impact on them all contributed to the success of the overall effort.
- Wait time for access to the remaining beds at St. Joseph's was reduced over time, thereby minimizing impact on the overall system dependent on those beds. Recognition in each transfer that it was not just the two hospitals impacted but also other hospitals and community partners was critical in completing the transfers. Working with all involved LHINs and Ministry of Health and Long-Term Care (MOHLTC) policy directives for levels of service assisted in sorting

TABLE 2.
STEGH Transfer Project Outcomes

Project Outcome	How Was This Outcome Met?
Project completed on time and within budget	Transfer of four IPs and related ambulatory services (300 OPs). Transfer was delayed twice and required a contingency plan that relocated IP and ambulatory services for 9 months.
"Successful" transfer of beds and service and patient demand to St. Thomas Elgin General Hospital and receiving community	Patient aspects of transfer were successful. Beds and other furniture were also transferred.
Preserve financial/budget resources	Decommissioning of units/beds at St. Joseph's completed on time, 33 staff transferred to STEGH, 9 staff reassigned and no layoff notices needed
Minimize staff impacts	Staff was impacted by delays and lack of information at various points in the process.
Minimize disruption to patient services	There was no disruption to patient services. Access to beds maintained with a weekend hold on admissions at the time of transfer.
Minimize disruption to the individual patients impacted by these transfers and their families	No negative impacts to patients and families were noted. Patient and family satisfaction was evaluated through feedback from these parties and was judged to be successful. STEGH acknowledged that mental healthcare was new to their organization and focused considerable efforts on preparing their staff and their community for the opening of their mental healthcare unit, with an emphasis on addressing stigma. The campaign entitled "Opening Hearts, Opening Minds" sought to build a welcoming environment for patients and families. See comments below.

out what was once thought to be the mandate of provincial hospitals and reaching agreement with partners regarding who was to provide what in the respective communities. In one community, St. Joseph's had for some years accepted acute care IP overflow but knew going forward that this could not continue. Negotiations with the LHIN, MOHLTC and a hospital not part of the transfers eventually resulted in an increase in acute care beds in the region to the satisfaction of all concerned.

- Minimizing staff impacts was also an important objective. St. Joseph's reached early agreement with the involved union locally to use mitigating strategies noted above in Table 1 with good effect. Additionally, for each transfer, meetings were held with receiving and sending unions to facilitate cooperation between unions.
- We learned the importance of ensuring communication with patients and families so that they are adequately informed of plans going forward.

Opening Hearts, Opening Minds

The central message of the campaign was "care closer to home means we now serve all community members in our hospital." St. Thomas is a community where everyone knows everyone. When the first patient arrived, the registration clerk remarked, "She is my best friend." This illustrated how people with mental illness keep the fact that they are receiving care from even their best friends. Later that day, a colleague told the leader that his mother's best friend was receiving mental healthcare and how pleased he was that STEGH had addressed stigma in their culture. **HQ**

References

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