Bispebjerg og Frederiksberg Hospital

Single point of contact – the hospital view

Valuebased acute care in Copenhagen. How we work and cooperate to support patients and reduce low-value admissions

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Our beautiful and historic "Hospital of the city" is located close to medieval Copenhagen Central area, and services 490,000 citizens - primarily from 2 municipalities (Copenhagen and Frederiksberg).
Bispebjerg og Frederiksberg Hospital

Capital region of Copenhagen.
4 districts = 4 acute hospitals = 4 emergency departments
but it is a coordinated and coherent acute system with EMS as the central player

North: Nordsjællands hospital

South: Amager Hvidovre hospital

City: Bispebjerg Frederiksberg hospital

Middle: Herlev Gentofte Hospital
BEFORE 2014: NO COORDINATION OF ACUTE CONTACTS

- **Patient**
  - 112/ambulance
  - Emergency room/Acute Ward
  - Home
  - Acute Ward
  - Home
  - Emergency room/Acute Ward

  - **Life threatening danger**
  - **Injury**
  - **Ordinary health issues**

- **GP Service** – 8-16
  - out-of-hour
2021 EMS = ONE 24/7 ACCESS POINT AND ACUTE COORDINATION CENTRE

Patient

GP clinic (when open)

Open 24/7

EMS

112

1813

Triage and coordination
Advice, treatment or further assessment?

GP/nurse treatment
Emergency room
Acute Ward 1
Acute Ward 2
Other service
HOSPITAL TRACKS FOR ADULTS
Visits pr year, Bispebjerg and Frederiksberg hospital

1813/112

GP
Monday-Friday 8-16

Treatment
76.000

Assessment
33.000/year

Admission
30.000/year

Injury
41.000

Disease
35.000

Treatment = Ambulatory (outpatient), acute hospital visit
Specific timeslots
MOVEMENT TOWARDS MORE INTEGRATED ACUTE CARE

Acute ward
- Asses patients quickly and safely - admission or home/GP service.
- Improve workprocesses in the acute ward.
- Data is used for capacity planning.

Acute Hospital
- Make sure patients are treated at the right level of speciality.
- Optimize episodes of care inside the hospital. Secure acces to specialist competences 24/7.
- Data supports efficient flow.

Acute System
- Reduce the need for acute admissions and keep patients at home.
- Cooperate with EMS, local authorities and GPs around prevention, medical support and referral to subacute ambulatory service.
- Data is shared across hospitals and sectors.
Cooperation and partnership towards integrated care
Regions and hospital services are included in an acute system with interdependencies

**Episode of care – elderly and/or chronical diseases**

**Referring “doctor”**
- GP
- Out of hour service/1813
- Ambulance
- Prior diagnostics

**Hospital**
- Acute ward
- Assessment
- Treatment

**Sub-acute ambulatory service/dayhospital**
- Datasharing platform
- Innovation/research

**Local authority**
- Homecare
- Visiting nurses
- Assistive devices
- Carehomes (long term)

**Readmission**

**Visitation and transport**

**Coordinated discharge**
IMPROVED WORK PROCESSES IN THE ACUTE SYSTEM

- EMS and the acute wards are partners
- We can influence the triage system and prioritization
- We are learning together and work to improve episodes of care
- Capacity usage is discussed and planned regularly across hospitals
- **Case: COVID-19 intake coordination**
- Next step is more coordination and innovation (supported by procedures, agreements and digital solutions) across sectors with municipalities and GPs to improve prevention and to do more treatment at home.
HIGH PATIENT SATISFACTION

2020 – Satisfaction in general

Regular, systematic measurement “LUP acute” dives into issues around patient satisfaction.

These reports document, that although we are doing well, we still have a potential for higher levels of patient satisfaction at acute wards in the Capital Region.

Especially around:
- Information on waiting hours.
- Access to food and drinks in the waiting area.
- Painrelief while waiting.
Our problem in a nutshell

- Too many patients – and often the wrong type of patients – are still acute admitted to the hospital, often at inappropriate hours.
- The reason is often lack of alternatives.
- Patients are too often referred and admitted due to insufficient prior clinical assessment of the patient.
We have to work together
Across organizational boundaries

NEW: Subacute Dayhospital Service

NEW: Acute team with specialized nurses

Hospital and EMS

Municipality social services

General Practice
Before:

New alternative referral opportunity: **subacute ambulatory visit in a Dayhospital setting.** Send the patient to the hospital for a planned visit and thorough examination the next morning.
Acute admission from a Patient-Perspective

Why should acute admission sometimes be avoided?

Not all facilities are present 24/7. You sometimes have to wait till monday anyway (or tuesday, or wednesday…).

Unexpected transportation and hospital admission can cause anxiety and confusion.

Sleeping at home in your own bed is related to quality of life.

Hospitalization may cause loss of functionality.

Are alternatives attractive to patients?

Feedback from patients admitted to daytime hospital are unambiguously positive.

We plan to meet patient needs: transportation, lunch etc.
How to...

- **Single point of contact is the beginning** of the journey into a coherent acute system
- **Supply alternatives such as:** dayhospital, subacute ambulatory service, home hospital settings
- **Build a platform within the hospitals** from where you can develop the work across the boundaries—rethink the culture and mind-set—Reach out to the partners outside the hospital
- **Agreement with local authorities (municipalities)**
  Cooperation with specialized nurses in local acute-team, referral procedures, legal issues/responsibility, discharge to nursinghomes and care-facilities
- **Agreement with local association of General Practitioners**
  Hotlines, referral procedures, prior clinical examinations of the patients before sent to hospital
Thank you for listening

Any questions or wishes for further knowledge sharing, please contact:

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