

North East Local Health Integration Network

Alternate Level of Care (ALC) Briefing Note

ISSUE

The four large NE LHIN community hospitals (North Bay, Sault Ste. Marie, Sudbury and Timmins) have been facing growing numbers of alternate level of care (ALC) patients which restrict patient flow and create bottlenecks in the system that lead to:

- Overcrowding in Emergency Departments (EDs) and delays in off-loading of patients from ambulances;
- Delayed admission to acute, rehabilitation and chronic care beds;
- Surgical cancellations due to lack of in-patient beds, affecting the Province's Wait Time Strategy; and
- Deferred regional referrals (trauma, medical, cardiac, cancer, etc).

The ALC is not simply a hospital problem. Rather, it relates to the overall capacity and range of options (or lack of both) in how the health care system is currently configured and resourced. There are gaps along the continuum of needed services that result in an over-reliance on high cost (intensive) care environments.

The NE LHIN has been working with the Ministry of Health and Long Term Care and local stakeholders to identify specific strategies to address the ALC issue in our region. The following briefing note provides an update on the activities related to action being taken in North Eastern Ontario, including:

- Short-Term Hospital Patient Flow Strategies
- ALC Task Forces
- NE ALC Summit
- The FLO Collaborative
- Aging at Home

SHORT-TERM HOSPITAL PATIENT FLOW STRATEGIES

In October 2006, the Ministry of Health and Long-Term Care announced \$52.4M in Emergency Department Action Plan funding. These funds were to be invested in community resources to provide more care to patients that would allow them to remain safely and independently in the community.

Then on February 16th, 2007, the NE LHIN announced the Ministry of Health and Long-Term Care's investments to improve access to acute care, community services and quality home care. These investments were targeted towards improving patient flow and to help ease hospital overcrowding. Funds were announced for two specific initiatives:

- Emergency Department Action Plan (EDAP) – a \$5.3 million provincial initiative as part of a multi-year strategy to address pressures in communities experiencing the most serious long-term care and community care pressures, and
- Patient Flow initiative - \$13.7 million provincially to alleviate pressures in hospitals by building the capacity of community-based health care providers.

The specific funding for the NE LHIN related to these announcements is attached as an appendix.

ALC TASK FORCES

Given the increasingly high percentage of ALC beds in the North East's four large community hospitals, the NE LHIN established four ALC Task Forces in North Bay, Sault Ste. Marie, Sudbury and Timmins in March 2007. The Task Forces are currently finalizing their reports to be brought forward to the NE LHIN Board of Directors at its November 2007 meeting.

ALC Task Forces were created to facilitate the ability of health service providers, communities and individuals to work together to adopt a system-wide approach to address the complex ALC issue facing Northeastern Ontario. The Task Forces used a collaborative approach to develop community profiles and to identify strategies and recommendations to address and mitigate the ongoing pressures. The composition of ALC Task Forces was reflective of the key sectors affected by, or having potential to assist with, the community's ALC challenges.

Supported by the NE LHIN, each ALC Task Force is completing a report that will:

- Detail the profile of hospital patients classified as ALC;
- Document trends and possible causes of ALC pressures;
- Establish specific ALC targets for the community;
- Make recommendations to all stakeholders on means of achieving these ALC targets; and
- Provide advice on the allocation or reallocation of resources to achieve local strategies.

Methodology

The Task Forces reviewed a series of data sets to assist them with their analysis of the ALC situation in their respective communities. Data sets included: North East environmental profile (census data); health status profile; utilization data (hospital ALC, emergency department, mental health, LTC placement); and ALC point-in-time analysis. The data collected through these various sources was reviewed in the context of the Task Forces' understanding of the range of services already in existence in their communities in order to identify a number of key strategies to help address the ALC pressures currently facing the system.

Point-in-Time Analysis

A point-in-time analysis of the ALC situation in the four large hospitals in the North East was undertaken by the NE CCAC in order to help inform the work of the ALC task forces. Data was

collected at three key intervals in 2007: at the onset of the establishment of the ALC Task Forces (February), mid-way through their seven month mandate (June/July), and at the end of their mandate (September).

The data gathered provided a profile of the 'faces of ALC' in each community on a given day. Data includes sex and age patient, family physician, CCAC services prior to admission, most prevalent diagnosis, types of ALC required (rehabilitation, palliative, LTC placement etc), living situation, and MAPLe score (method for assigning priority levels to individuals). The NE CCAC staff involved in the completion of the point in time analyses provided comments on realities that affect the ALC issue, suggested strategies that could assist with the reduction in ALC cases, and highlighted systemic gaps that contribute to ALC challenges.

Recommended Strategies

The deliberations of the ALC Task Forces resulted in the creation of work plans which identified a number of strategies that would collectively mitigate in the short, mid and long-term, the ALC pressures facing each community. The work plans attempt to link goals and outcomes to each strategy, and identify the resources required to implement the strategy. Also noted on the work plans are expected reductions in ALC cases/days, where possible.

The recommended strategies identified by the Task Forces cut across the system and reflect the reality that the ALC issue is one that is not solely the result of challenges found in any one sector. Rather, strategies must be introduced that address gaps along the continuum of care. The following are noted as an example of the type of strategies being suggested by the Task Forces:

1. Community Services and Supports

- Increase supportive housing resources
- Expand In-Home Services of NE CCAC - Expand funding for respite, personal support, and rehabilitation therapies (occupational therapy, physiotherapy, speech-language pathology) to support patients in their home setting
- Expand Activities of Daily Living (ADL)/Instrumental Activities of Daily Living (IADL)
 - Enhancement of Community Support Services programs
- Develop a residential hospice
- Initiate a cross-sector collaboration in developing a Chronic Disease Prevention Management Plan (CDPM)
- Request funding to assist an additional 200 clients with door to door transportation to medical appointments, adult day care, shopping, and other community services
- Base funding required to reopen four bed respite unit to provide:
 - housing for individuals with newly acquired physical disabilities
 - housing for clients in crisis
 - housing to provide caregiver relief
 - housing to assess independent living skills to assist patients discharge from the hospital

2. Hospital/Acute Care

- Develop a Geriatric Emergency Management (GEM) Program

- Base funding to continue the operation of a Comprehensive Assessment and Re-evaluative Clinic

3. Long-Term Care Homes

- Enhance staffing: Expand the number of RNs, RPNs, and PSWs in long-term care homes to support medically complex individuals
- Develop a dementia unit
- Increase number of LTC beds

4. Mental Health

- Develop a Rapid Response Seniors Assessment Team
- Enhance funding to CSS agencies that will facilitate transition of mental health patients from hospital back to structured community programs
- Develop intensive clinical services providing ongoing management and support to maintain the older adults living with mental illness in the community.

5. North East Regional Projects

- Development of a Regional Geriatric Program / Network for the North East
- Implementation of ISAR tool (Identification of Seniors at Risk)

During the month of October the four ALC Task Forces will be reviewing the final report and recommending priorities for the strategies required to address the ALC problem in each of their respective communities.

REGIONAL ALC SUMMIT

The June 2007 Alternate Level of Care Summit, organized by the NE LHIN, brought together more than 125 health care providers to review ALC issue and challenges facing the region. Collectively, participants worked on the identification of strategies that would lessen pressures on the system, in the short, mid, and long-term.

Over two days, health care providers were familiarized with the ‘faces of ALC’, the role of community-based care, and the provincial perspective on the ALC issue. Health care providers then participated in group discussions and were asked to document effective strategies in their community or elsewhere, identify opportunities and challenges relating to the implementation of these strategies, and identify resources and partnerships needed to operationalize these strategies.

Summaries of the presentations of key note speakers and small group break-out session notes are posted on the NE LHIN website (www.nelhin.ca). The following high level overview provides some of the key findings:

- Develop IADL services for individuals living at home
- Develop/collaborate on disease prevention & promotion (i.e., falls, nutrition, chronic obstructive pulmonary disease)
- Establish early risk screening for high risk people

- Educate public & health service providers on health promotion, early identification and intervention measures
- Make supportive housing a priority for seniors
- Expand and coordinate transportation services for seniors
- Establish a Regional Geriatric Resource Program;
- Reimburse volunteers for out of pocket expenses
- Increase day-programming capacity for caregiver respite and client stimulation;
- Expand CCAC case management and in-home services
- Provide incentives for health service providers to explore coordination and integration;
- Provide more flexible service mandates
- Create greater public awareness regarding how to access and navigate the health care system
- Encourage service providers to share best practices
- Speed up the implementation of an electronic patient record
- Explore partnering with retirement and relaxation homes;
- Develop rate subsidy to allow greater access to respite and short-stay beds;
- Develop an integrated system of medication management
- Increase levels for high intensity funding
- Provide specialized staff in LTCH to cope with behavioural management residents

THE FLO COLLABORATIVE

There are a variety of contributing factors that impact on the ALC problem facing our major urban communities in the North East. These factors can be broadly clustered into issues related to:

1. Processes of care delivery;
2. Policy barriers; and,
3. Resource/capacity issues.

The MOHLTC recently initiated the 'Flo' Collaborative to address the first issue; processes of care delivery. Under the Flo Collaborative, hospitals, CCACs, LHINS, and other sectors such as complex continuing care, rehabilitation and long-term care have come together to participate in a Quality Improvement Collaborative supported by the Ontario Health Performance Initiative.

Starting in September, 2007 teams of professionals began working together under the guidance of leading quality improvement experts to study, test, implement and spread change to improve care processes related to patient flow, from acute care to subsequent care destination.

On behalf of the other large hospitals in the North East, and with their financial support, the Timmins and District Hospital has agreed to participate in the Flo Collaborative with the NE CCAC. It is anticipated that NE FLO Collaborative will contribute to the identification of 'key learnings' that will benefit all hospitals in the North East.

AGING AT HOME

The Aging at Home Strategy is a provincial, \$702 million investment (over 3 years) that will provide seniors and their caregivers with an integrated continuum of community-based services to enable them to stay healthy and live more independently in their homes.

This strategy involves a significant shift in emphasis away from long-term care (LTC) home beds to providing a comprehensive mix of community-based services for seniors linking existing services and providers with new and different approaches to service and non-traditional providers. This strategy has a strong focus on innovation and prevention. It presents an exciting opportunity for LHINs, in a leadership role, to leverage significant change to improve services for seniors and to integrate and fund services at the local level.

The Aging at Home Strategy aims to keep seniors healthy through traditional services combined with innovative practices by providing a comprehensive mix of services for seniors and their caregivers through:

An increase in the overall mix and quantity of services (represents up to 80% of LHIN allocation) that support seniors to stay healthy and live with independence and dignity in their homes, *such as*:

- Community support services
- Home care
- Assistive devices
- Supportive living
- Long-term care beds
- End-of-life care

Leveraging change through innovation (represents 20% or more of LHIN allocation) by developing innovative approaches to keeping seniors healthy, through preventive and wellness services and partnerships with non-traditional providers.

The Health Based Allocation Methodology (HBAM) was used to allocate the Aging at Home funding to LHINs across the province. The NE LHIN's allocation is noted in the table below:

Local Health Integration Network (LHIN)	2007/08 Planning Funding	Three Year Allocations to LHINs			
		Initial Investment 2008/09	Planned Base Increase 2009/10	Planned Base Increase 2010/11	Planned Three-Year Funding
NE LHIN	\$202,000	\$4,290,570	\$10,662,643	\$18,831,868	\$33,785,081
Ontario Total	\$3,000,000	\$75,603,669	\$187,209,085	\$330,640,046	\$593,452,800

The timelines being followed by the NE LHIN to meet the first year of investment include:

Early October 2007: CEO Round Tables review the NE LHIN's high level 2008/2009 plan identifying traditional and innovation service expansion and enrichment priorities for the North

East (based on draft ALC Task Force recommendations, ALC Summit discussions and RFI's received in July, 2007)

October 26, 2007: NE LHIN Board of Directors provides final review and approval of the Plan before it is submitted to the MOHLTC by the October 31 deadline.

Nov/Dec 2007: MOHLTC reviews the NE LHIN Aging at Home Plan

January 2008: A final detailed NE LHIN Plan which outlines commitments for 2008/2009 is submitted to the MOHLTC

April 2008: The NE LHIN 2008/09 Aging at Home plan is implemented

SHORT TERM ONE-TIME FUNDING

The NE LHIN recognizes that additional funding to address ALC pressures is required in the short term. LHIN reallocation funds in addition to the NE LHIN's urgent funding envelope will be used in the short term to help immediately establish strategies to alleviate ALC pressures. The total LHIN urgent funding for 2007/08 is \$1.6M. LHIN reallocation funds will be identified by the end of November 2007. The distribution of these one-time funds will need to be reviewed by the CEO Roundtables and recommendations made to the NE LHIN Board in December 2007 for distribution in January 2008.

In the short term, the NE LHIN will look to this onetime funding to support programs related to the aging at home strategy (and thereby addressing ALC pressures). These programs would then receive base funding April 1, 2008 by using the \$4.3M year-one funding for this initiative.

For the longer term, the NE LHIN has included ALC as a priority in its draft Annual Service Plan submission which outlines several ALC high level business cases (strategies). These business cases if approved would receive funding through the 2008/09 provincial budget and would be made available after April 2008.

CONCLUSION

As described above, the ALC challenge is one in which the solution must be found across the continuum: it is truly a system issue. The NE LHIN has called upon its system partners through the ALC Task Forces, ALC Summit, and CEO Roundtables etc to find solutions that can be put in place to begin to help ease the pressures that result from increased numbers of ALC patients. The strategies that will be brought forward to the NE LHIN Board of Directors will be targeted to improve ALC in the short-term, mid-term, and long-term. While resources are required, the ALC issue will not be solved simply through funding. Strategies such as Aging at Home, which focus on increasing the overall mix and quantity of services and the leveraging of change through innovation, are pivotal in solving the ALC issue within our region.

APPENDIX

Funding Announcement	Type of Funding	INTERIM BEDS		GEM NURSING		INCREASED COMMUNITY CAPACITY		ED CASE MANAGERS	
		2006/07	2007/08	2006/07	2007/08	2006/07	2007/08	2006/07	2007/08
\$52.4 M EDAP	ONE TIME					\$384,400			
	BASE						\$384,400		
\$5.3 M EDAP	ONE TIME					\$233,600			
	BASE						\$233,600		
\$13.7 M Improving Access	ONE TIME	\$536,800		\$42,100	\$126,300	\$154,700	\$872,550	\$154,400	\$462,800
	BASE								
TOTAL	ONE TIME	\$536,800		\$42,100	\$126,300	\$772,700	\$872,550	\$154,400	\$462,800
	BASE						\$618,000		

TOTAL 2006/07 ONE TIME \$1,506,000

TOTAL 2007/08 ONE TIME \$1,461,650

TOTAL 2007/08 BASE \$618,000

EDAP – Emergency Department Action Plan

GEM – Geriatric Emergency Management Nursing