Champlain LHIN
Short Term Strategies to Improve Access

January 9, 2007

Overview

The high number of people in acute care hospitals that are waiting for **'alternative levels of care' (ALC)** is having an impact on the delivery of health services in the Champlain LHIN and the ability of hospitals to deliver on provincial priorities. The increasing number of ALC days has led to high occupancy of acute beds which often leads to people receiving care in inappropriate settings, an overload of patients in **emergency rooms (ERs)** awaiting admission, cancelled surgeries and compromised management of trauma patients. In fact, high occupancy of acute care beds related to people awaiting ALC is one of the primary reasons for Champlain LHIN hospitals not being able to meet targeted volumes for specific **wait time procedures**.

Considerable effort has been undertaken over the past few years by our local health system partners to monitor the ALC situation and develop and implement strategies to address system challenges. Despite this innovative and collaborative work, the number of patients awaiting ALC continues to escalate. Over the holiday season, there were more than 230 people awaiting ALC in Ottawa acute care hospitals and more than 350 people awaiting ALC across the Champlain LHIN. The vast majority of these ALC patients are waiting for Long Term Care Home (LTCH) placement. It should also be noted that most LTCHs, including all Ottawa LTCHs, have waiting lists and due to the increasing number of 1A crisis patients in the community, the number of LTCH placement bed offers available for hospital patients is decreasing.

In August 2006, the health system partners in Ottawa submitted a report ("From Alternative to Appropriate Levels of Care") to the ministry outlining recommendations to help address the situation over the short and long term. In December 2006, local partners from 3 areas surrounding Ottawa (Renfrew County, Eastern Counties and North Lanark/North Grenville) submitted their respective ALC pressures and short-term strategies to the LHIN. The details of the short-term strategies that have been submitted to the LHIN are provided in Appendices A to D.

Several considerations have prompted the Champlain LHIN and its system partners to develop <u>short term strategies</u> for further consideration that would have a short term impact to reduce ALC occupancy and ER pressures, and freeing up acute capacity to meet wait time targets. These considerations include:

- ALC pressures continue to escalate across the Champlain LHIN and the pressures are anticipated to rise over the coming months;
- The October 27th announcement of funding for local hospitals (across Champlain LHIN) and the long term care sector (in Ottawa) to reduce pressures on emergency departments

provides an opportunity to collectively direct these resources to strategies that have the potential to improve performance related to both the ER and ALCs; and

- Wait Time Strategy Office has expressed interest in short term strategies to increase local capacity and reduce the risk of future surgical cancellations;
- The provincial ALC Expert Panel will deliver its report that will provide important recommendations to address system issues and patient flow, however the recommendations will take time to implement and will not provide short term relief for Champlain LHIN communities.

This report provides an overview of the proposed strategies and implementation considerations for each sub-area of the Champlain region. Several criteria were considered by the Champlain LHIN to assess the proposed strategies and determine regional priorities. The criteria were:

- Occupancy/capacity challenges;
- Impact on ALCs / emergency rooms / wait time strategy;
- Feasibility for rapid implementation (e.g., legislation / regulatory considerations);
- Appropriateness of care;
- Timeframe for implementation; and
- Cost effectiveness.

Based on the assessment, the Champlain LHIN sorted the full list of proposed strategies into three categories: Priority 1; Priority 2; and other strategies. The table below shows the strategies and required resources by priority level and geographic area. The Champlain LHIN is strongly supportive of the implementation of strategies in the top 2 priority levels.

Champlain LHIN - Short-Term Strategies (Annualized Costing)

LHIN Priority Level	Ottawa			Renfrew			Eastern Counties			North Lanark & North Grenville			Total Cost ($)	Total MOH ($)	Total Partner ($)
	Strategy	MOH $	Partner $	Strategy	MOH $	Partner $	Strategy	MOH $	Partner $	Strategy	MOH $	Partner $			
1	Geriatric Emergency Management (GEM)	0.60	0.50	RISC	0.19		GEM (CCH & WDMH)	0.52		Adopt Most Appropriate Bed Policy	0	0	1.81	1.31	0.50
	50 Interim LTC Beds	2.00		Interim LTC Beds (12 beds) (Renfrew & Pembroke)	0.48		Quick Response Home Care	0.10		Reallocate 4 Interim Beds (KDH to NL/NG)	0	0	2.58	2.58	0.00
	Quick Response Unit	0.55		Priority Access - Respite Care	0.01					Regular Partner Mtgs	0	0	0.56	0.56	0.00
	Services to Sub. Seniors Apartments (Phase 1)		0.30										0.30	0.00	0.30
Total Priority 1		3.15	0.80		0.68	0.00		0.62	0.00		0.00	0.00	5.25	4.45	0.80
2	Subsidized Assisted Living (30 beds)	1.40		Supportive housing in exiting subsidized seniors housing	1.00		Subsidized Assisted Living (Corn 12 beds & Win 12 beds)	1.12					3.52	3.52	0.00
	Services to Sub. Seniors Apartments (Phase 2)	0.36		Interim LTC Beds (Barry's Bay) (4 beds)	0.16		Services to Sub. Seniors Apartments (Cornwall)	0.27					0.79	0.79	0.00
							Top Up Residential Care (HGH/CCAC)	0.40					0.40	0.40	0.00
							Interim LTC Beds (Cornwall)	0.40					0.40	0.40	0.00
Total Priority 2		1.76	0.00		1.16	0.00		2.19	0.00		0.00	0.00	5.11	5.11	0.00
Total Priorities 1& 2		**4.91**	**0.80**		**1.84**	**0.00**		**2.81**	**0.00**		**0.00**	**0.00**	**10.35**	**9.55**	**0.80**
Other Strategies							Interim ALC Beds (WDMH)	0.85					0.85	0.85	0.00
							Interim ALC Beds (CCH)	0.85					0.85	0.85	0.00
							Quick Resp Unit (HGH)	0.30					0.30	0.30	0.00
							Quick Resp Unit (CCH)	0.65					0.65	0.65	0.00
	LTC Preferred Rate Subsidy			LTC Preferred Rate Subsidy			LTC Preferred Rate Subsidy						0.00	0.00	0.00
Total Other Stageies		0.00	0.00		0.00	0.00		2.65	0.00		0.00	0.00	2.65	2.65	0.00
Total Strategies		**4.91**	**0.80**		**1.84**	**0.00**		**5.45**	**0.00**		**0.00**	**0.00**	**13.00**	**12.20**	**0.80**

Proposal

The total of the short-term strategies have an estimated annual cost of approximately $13.0M. Based on the assessment of the strategies, the LHIN supports the implementation of priority 1 & 2 short-term strategies (as noted in the table above). The total annual cost of the priority strategies is $10.4M. The annualized cost would translate into a 2006/07 (2 months – February 1 to March 31) ministry pressure of $1.6M.

The local partners are committed to contributing to the solutions to address the critical challenges facing the community over the next few months. In fact, the hospitals in Ottawa have agreed to direct a significant portion of the recently announced Emergency Room (ER) pressures funding to cover some of the 2006/07 pressure and a proposal is being developed to direct the new community resources for Ottawa (part of the same announcement) to one of the short term strategies in Ottawa.

This proposal requests support and funding from the ministry for the proposed priority initiatives. The decision regarding the number of initiatives to be implemented is dependent on the level of resources available. Implementation of:

> <u>Priority 1 initiatives only</u> requires a ministry contribution of $0.74 M for 2006/07 (2 months – February 1 & March 31); and
> <u>Priority 1 & 2 initiatives</u> require a ministry contribution of $1.6 M for 2006/07 (2 months – February 1 & March 31).

In addition to resources, ministry approvals are required to implement several of these strategies, specifically:

Priority 1 Initiatives require ministry approval to:

- Establish interim LTC beds (50 beds for Ottawa and 12 beds for ALC patients in Renfrew County hospitals);
- Shift the priority of access to 4 of the existing interim LTC beds in Kemptville from ALC patients located in Ottawa hospitals to those located in North Lanark and North Grenville hospitals; and
- Convert short stay respite beds to long stay beds for an interim period (Renfrew County).

Priority 2 Initiatives require ministry approval to:

- Initiate a request for proposal (RFP) process for a subsidized assisted living pilot program;
- Establish interim LTC beds (12 beds in Cornwall).

<u>Appendices</u>:

The Appendices provide the detail of the short-term strategies that have been developed by the system partners and submitted to the LHIN for consideration

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Appendix A - Ottawa

The short-term strategies that are proposed are:
1. Geriatric Emergency Management (GEM) Program ($1.1M);
2. Interim LTC Capacity ($1.5M operating and $0.5M capital);
3. Subsidized Assisted Living Program ($1.4M);
4. Increased Services Directed to Subsidized Apartments ($0.69M);
5. Quick Response Unit ($.55M); and
6. LTCH Preferred Bed Rate Subsidy.

Ottawa Strategy 1	**Geriatric Emergency Management (GEM) Program**
Priority	High
Brief Description	The cohort of patients 75 years of age or more have a high frequency of repeat visits (43%) which result in hospital admissions accounting for as much as 9 % of all acute hospital days in the region. The Regional Geriatric Program has developed an efficient GEM practice model integrating evidence-based automated and clinical screening for high-risk seniors in the ER, and an abbreviated geriatric assessment complemented by community and /or geriatric follow up as required. Evidence suggests significant improvements in quality and utilization are achieved by integrating Geriatric Emergency Management RNs into the ER environment. Findings indicate a 25% reduction in ER visits and 10% reduction in acute hospital admission are realized as a result of comprehensive geriatric follow up for high risk patients. An opportunity to evaluate further reduction in repeat visits and admissions exists, through adding a CCAC quick response home care follow-up service, providing enhanced rapid service in the home within 24 hours, for a period of up to five days.
Estimate of ALC Impact	Per ER: <u>Impact</u> (Admission avoidance based on Deed Study*) Annual caseload 2,891 Reduced ER Visits** 723 ** assumes 25% reduction in ER visits Reduced Admissions*** 289 *** assumes 10% reduction in admissions (based on Deed Study). Reduced Pt. Days 3,469 **** Pt. days based on ALOS 12 days for all 75+ @ TOH → therefore it is a very conservative estimate Bed Equivalent (95%) 10.0 Note *: A Randomized Control Trial of Comprehensive Geriatric Assessment and Multidisciplinary Intervention After Discharge of Elderly from the Emergency department – The DEED II Study. (Caplan et al; Journal of the American Geriatric Society 52:1417-1423, 2004.)
Financial Impact	<u>Per Site</u> <u>4 Sites</u> Staffing Costs: 12hr/day* 7 days /week. 2.5 FTEs per ED $220,000 **$0.88M** *Afternoon/evening shifts (noon to midnight) <u>Quick Response Home Care</u>: It is assumed 20% of high-risk seniors discharged home might benefit from a quick response service. To add this level of follow up would require up to an additional $20,000 to $45,000 per ER. For four sites**: $80k to $180k**. (Note: this is different than the Quick Response Unit outlined in Strategy 5) Ottawa hospitals have indicated support for directing a portion of recent ER pressures funding to support this initiative (assume a 50% cost share with ministry); however success of this initiative is dependent on availability of adequate alternative, appropriate capacity in the community.
Timelines	Phase 1 could be implemented by mid-January 2007.

Other Considerations	GEM program should be complemented by an investment in capacity/community options for placement. It should also be noted that GEM requires follow-up by CCAC and geriatric assessment. A 60-day post implementation evaluation of Phase 1 will assess impact of program and opportunities to improve effectiveness (i.e., ER coverage times and system gaps).

Ottawa Strategy 2	**Interim LTC Capacity**
Priority Rank	High
Brief Description	Two locations have been identified for potential interim LTC bed capacity: Fairview Manor (Almonte): Once the construction of the new LTCH facility is completed in January, the upper floor of the existing space at Fairview Manor (D Facility) could be used for interim LTCH beds. The current operation at Fairview Manor operates within regular LTC funding, therefore an expanded operation at LTC per diem rates should not be an issue. Some one-time capital is required to purchase equipment. SCOHS: Utilization of patient space at the St. Vincent's site of SCOHS and Residence St. Louis (LTCH). Feasibility requires further assessment by SCOHS.
Estimate of ALC Impact	Fairview Manor: 50 LTCH beds. An analysis of placement choices of current ALC patients in Ottawa hospitals indicates that locating 50 interim LTC beds in Almonte is reasonable. SCOHS: 20 LTCH beds (@ St. Vincents) and 7-beds at Residence St. Louis (LTCH).
Financial Impact	Interim LTCH beds are traditionally funded at $30,295 ministry subsidy per bed per year and $10,000 per bed in capital. If 50 interim LTC beds were approved, the estimate for 50 LTCH beds the annual cost is approximately **$1.5M operating and $0.5M in capital.**
Timelines	Fairview Manor: Space will become available by mid-January 2007. May require additional equipment since beds may be utilized in new facility. No environmental assessment in required. SCOHS: The ministry conducted an environmental assessment. Based on the assessment, the SCOHS will further consider feasibility of the interim LTC bed approach.
Other Considerations	Do to staffing implications and future placement needs of patients the interim LTC beds would need to be in place for at least a year and a decision to close the beds should be aligned with a future increase in capacity for appropriate placement opportunities.

Ottawa Strategy 3	**Subsidized Assisted Living Program**
Priority Rank	High
Brief Description	The program will be a partnership between the ministry, Champlain LHIN, Champlain LHIN hospitals, the CCAC and the private residential care provider. Residents, who are admitted to the program from the hospital ALC population, will need level 2 or 3 care, as defined by the retirement residences' acuity scale (i.e., will require: staff assistance with activities of daily living (ADL): assistance with bathing and eating; and supervision of medication administration), and regular assistance with cuing. In the proposed model, the residents would agree to transfer to the subsidized assisted living program until an appropriate placement is available (within 90 days). Once an appropriate setting is available, such as a LTCH bed, the resident will agree to accept the placement or assume responsibility for the financial subsidy.

Estimate of ALC Impact	Capacity for up to 30 clients.
Financial Impact	Total cost of $128 per resident day. - ALC patient agrees to pay the co-payment (equivalent to the basic accommodation co-payment) ($50/day). Hospital practice is such that often ALC patients are exempt from the copayment for the first 30 days in the hospitals. After the initial 30 days, 85% to 90% of ALC patients pay the co-payment. A condition of accepting placement to this option will be for the patient to pay the co-payment – there will be issue with achieving full occupancy with this condition. - A subsidy of $78/ day is required. - Hospital and CCAC to provide expertise/consultation as required. - If CCAC can provide home support and nursing care to clients the rate would be adjusted. Total Subsidy : 30 beds * 365 days * $78/day = **$0.85M / year** CCAC Subsidy: 30 beds * 365 days * $50/day = **$0.55 M / year**
Timelines	To be determined.

Ottawa Strategy 4	**Services Directed to Subsidized Apartments**
Priority Rank	High
Brief Description	"From Alternative to Appropriate Levels of Care" states that hospital utilization of seniors living in City of Ottawa subsidized apartments is about 1,700 emergency room visits and inpatient stays equivalent to 25 acute beds. The proposed model of prevention and support for this at-risk population involves a coordinated community response and builds on existing resources but will require enhancements to succeed. The 5 City of Ottawa apartment blocks with the highest proportion of the utilization noted above will be targeted. (This data is available from review of postal codes associated wit hospital separations). A single point of onsite contact would be provided by placing a community support coordinator in a "store-front" site in each building during regular business hours 7 days per week. This required an in-kind contribution of office space from the City of Ottawa. The community support coordinator would provide information and referral for individual clients and would develop programs within each building. It is anticipated that the individual service plans would focus on meals, transportation to medical appointments and to community support activities such as Day Away programs. Program development may include congregate meal and exercise programs and health screening. The community support coordinator would be supported by a CCAC case manager assigned to each of the buildings. The case manager would be on-site 2-3 half days per week to start, providing assessment, service linkages, information and referrals. Personal care and professional services provided by the CCAC would be organized as a coordinated team, to ensure continuity and efficiency. Any enhanced CCAC service delivery would be based on individual determination of need as assessed by the case manager. The most effective way to meet the medical care needs of this population will require further review. It may be that the population is well-served by community health centers and/or family physicians. If however, there are significant gaps in medical care, other models such as the addition of a Geriatric Nurse Practitioner may be considered. Also to be reviewed is the possible contribution of public health and the client resource workers already providing services to these buildings.
Estimate of ALC Impact	The potential impact of this program is moderate in terms of acute care utilization and significant in terms of quality of life for the individual seniors involved. Improved nutrition, access to needed services, transportation to medical appointments and continuous contact with caring, supportive services will do much to ensure that these vulnerable seniors are as safe and well as possible. Similar initiatives have demonstrated a 20% reduction in emergency room visits and hospital days.
Financial Impact	A proposal is being developed to direct the $300,000 of community funding from the October 27th announcement to implement a portion of this initiative. If additional resources were available, the initiative would target 5 buildings accounting for the most hospital activity.

	Total Annual Cost * (500 clients – 100 per 5 buildings) Coordination / Case Management for all 5 Buildings: - Community support coordinators (3 FTE) $57,000 *3 = $171,000 (includes benefits) - CCAC case management (1 FTE) $ 75,000 Services for 5 Buildings: - CCAC services (personal support and professional services) As per individual need * - Enhanced Community Support Services $412,800** (4 meals, 2 transp visits, 3 hrs home help + 2 foot care clinics) **Total** **$658,800** **If ER Pressures Proposal Approved** **($300,000)** **Additional Resources Required** **$358,800** *If clients required services beyond the existing CCAC regulatory maximums, these costs will need to be considered separately and have not been included in this proposal. Please refer to "From Alternative to Appropriate Levels of Care" ** Assume that only 20% of clients (i.e., 100 of the 500 clients) will require enhanced CS Services.
Timelines	The City of Ottawa is supportive. Services and enhanced case management could be implemented by January 2007.

Ottawa Strategy 5	**Quick Response Unit**
Priority Rank	High
Brief Description	Purpose of the Quick Response Unit would be to provide alternative service to ER patients (65+ years old) who do not require acute care observation or acute care support. Appropriate level of care is provided with a goal for the client to return to the community within 14 days of admission (typical stay < 4 days). Need to meet needs of clients requiring care such as antibiotic therapy and rehydration. Program characteristics: available 24X7, specific admission criteria, discharge planning (community-based care planning), interdisciplinary assessment, crisis intervention, and client and family teaching support. (NB – patients would be transported back to hospital for acute medical intervention if necessary)
Estimate of ALC Impact	A 10-bed unit with high through put.
Financial Impact	Awaiting formal proposal - Estimated per diem cost of $150 per day --> **$550k / year** for 10-bed program. - Potential for some minor capital costs
Timelines	This program would complement programs in a CCC environment.

Ottawa Strategy 6	**LTCH Preferred Bed Rate Subsidy**
Priority Rank	Medium
Brief Description	Up to 80% of patients waiting for LTC bed in Ottawa acute care hospitals are waiting for ward accommodation due to prohibitive cost of preferred accommodation. Because of this approximately 45% of daily LTC bed offers made to acute care cannot be "matched" with appropriate patients. One way to improve the uptake of LTC bed offers to hospitals and therefore reduce the number of ALC patients is to subsidize the cost differential to allow for patient flow into these beds.
Estimate of ALC Impact	12 patients per month. Over a 6-month period → 72 patients
Financial	- After 6 months, the monthly financial cost would be between $129k and $233k for the 72 patients.

Impact	- The total accumulated cost would be between **$453k and $816k**. Facts Informing the Estimate: - Cost differential from ward to semi private ($10/day) & to private ($18/day) - Assume 3 beds/week available --> 12 transfers/month - at end of first month maximum cost to hospital would be $ 2,150 - $3,870 - Assuming no discharges or transfers of these patients to ward beds occurring during that time
Timelines	Once funding is secured the timeline for implementation would be immediate. Determination of process re: payment flow, notification of patients of interim status, waitlist management would have to be determined prior to commencing.
Other Considerations	Limited patient movement from these interim placement arrangements to ward level LTC beds during the 6 month period will limit the ability to flow new patients through these beds and would require on-going financial resources to maintain the subsidy for the interim patients.

Appendix B - Renfrew

The following tables provide details regarding the implementation for several of the priority recommendations that could have a short-term impact to reduce ALC occupancy and ER pressures and free up acute capacity. In order to meet the person centered community needs in Renfrew County a range of innovative strategies have been explored to address our geographic and rural realities. The strategies are:

1. Interim LTC capacity
2. Priority access ALC to respite
3. Supportive housing in existing subsidized housing
4. LTC preferred rate subsidy
5. Resource integration for seniors in the community

Renfrew Strategy 1	Interim LTC Capacity
Priority	High
Current Reality	Over 90% of the patients in ALC beds in Renfrew County are waiting for placement in a long term care facility. Because of the lengthy wait lists especially for basic accommodation length of stay in ALC has increased over the past two years. Currently the 28 interim long term care beds are full in Renfrew County and residents are waiting over 400 days for placement.
ALC Improvement Program	Three locations have been identified for potential interim LTC capacity: Groves Park Lodge in Renfrew, ON – 11 beds would be ready for occupancy immediately upon approval; Marianhill, Pembroke, ON – 1 bed would be ready for occupancy within four weeks of approval. St. Francis Memorial Hospital, Barry's Bay, ON – up to 4 – 6 beds would be ready for occupancy within three months of approval.
Estimate ALC Impact	**Total of 16 to 18 beds – Impact on 1/3 of ALC beds** Depending on geographical issues this could potentially alleviate up to one third of the ALC beds within three months. Geographically this strategy will have the most impact in Barry's Bay and Renfrew. • Groves Park Lodge – 11 beds are currently available; • Marianhill – 1 bed would be available within four weeks of approval. • St. Francis Memorial Hospital – 4-6 beds within three months of approval.
Program Cost	Interim LTC beds are traditionally funded at $30,295 ministry subsidy per bed per year, plus capital costs o $10,000 per bed. Resident co-payments would also be applied to these beds. In Groves Park Lodge additional compensation for the preferred accommodation rates would need to be addressed ($9.00 per resident/day).
Implementation timelines	**Immediate: 12 beds** - Groves Park Lodge & Marianhill 3 months: 4-6 beds – St. Francis Memorial Hospital
Other considerations	Due to staffing implications and future placement needs of patients the interim LTC beds would need to be in place for at least a year and a decision to close the beds should be aligned with a future increase in capacity for appropriate placement opportunities.

Renfrew Strategy 2	Priority Access ALC –Respite- Dec. 2006
Brief Description:	The average utilization of Renfrew County's 9 short stay respite beds over the last year is 84%. Each long term care home was asked to estimate their capacity to allocate short stay days for ALC clients waiting for placement as a potential strategy to reduce length of stay for clients in ALC beds. Priority access will be given from Respite to first choice final placement.
Estimate of ALC Impact:	**6 beds** 1. North Renfrew Long Term Care- 1 bed→ 21 days vacant (Jan /07 - April 1/07) 2. Bonnechere Manor- 1 bed X 90 days (Jan. /07 – April 1/07) 3. Marianhill- 2 beds, 180 days available 4. The Grove- 30 days (Mar./07) 5. Miramichi Lodge- 90 days (Jan/07 – April 1/07) 6. Valley Manor- (Available capacity – but no resources) 90 days (Jan./07 – April 1/07)
Financial Impact:	• No cost – Respite beds already funded • 6 ALC clients could be immediately transferred to short stay respite for priority access to LTC. • Cost of new respite beds at Valley Manor → $115/day ministry subsidy (Coverage for Respite bed)
Timelines:	**Immediate** Following approval – strategy could be implemented immediately.
Other Considerations:	• Strategy would need to be piloted to evaluate average time lines from respite → LTC placement. • Evaluation also required re: impact on respite availability for community to ensure that balance of beds available to meet community needs. • This strategy will be implemented on a geographical basis

Renfrew Strategy 3	Supportive housing in existing subsidized housing
Priority	High
Current Reality	The majority of patients in ALC beds in local hospitals are seniors, many waiting for placement in a long term care facility as they are unable to return to their residences due to lack of support. The proposed model of support for this at-risk population involves a coordinated response and builds on existing resources as well as innovative application of these resources. Renfrew County stats would have similar assumption as the City of Ottawa regarding the high utilization level of emergency room visits and inpatient stays annually, of seniors living in subsidized apartments. This proposal takes advantage of existing support programs in the County of Renfrew augmenting the services available to seniors and providing care to reduce emergency room visits and accommodate seniors return to their own home.
Future State	Renfrew County has experienced continued utilization of ALC beds in local hospitals over the past three years. The waiting list for seniors requiring a long term care bed (basic accommodation) has also continued to grow. The Province of Ontario and the Champlain LHIN have both identified the lack of supportive housing as being a factor contributing to these demands, and increased access to supportive services are recognized as a viable strategy to ALC reduction.

ALC Improvement Program	Expansion proposals are currently at the MOHLTC for supportive housing in Deep River. The North Renfrew Long Term Care facility has proposed that it would add another 10 to 12 spaces in its supportive housing program. Marianhill also currently has a proposal in to the MOHLTC to expand its Assisted Living Program to a senior's apartment complex in Petawawa. This would provide services to 12 seniors. While the current expansion proposal in Eganville involves adding 6 clients. In order to address the need for basic accommodation it is now being proposed that a pilot project be established at the Renfrew County Housing (Wallace Street Apartments) in Eganville. In each of these locations, proposals involve the provision of 24/7 supportive care being provided to the seniors in the program. The pilot project in Eganville would be evaluated during its first year to measure its impact on seniors receiving income support from the County, with the goal in mind of expanding this model throughout the County. (Because seniors receiving income supportive housing do not have the financial means to purchase supportive services directly they are the most "at risk" for requiring services in a long term care facility due to financial issues. This model provides for the services in the senior's home enabling them to delay or negate admission into ALC beds and ultimately long term care.)
Estimate ALC Impact	**30 beds – Impact on approx. ½ ALC beds** **20% reduction in emergency room visits and hospital days.** The potential impact of this program is moderate to high in terms of decreased acute care utilization and significant in terms of quality of life for the individual seniors involved. Improved access to needed services, improved nutrition, assistance with transportation and continuous contact with caring, supportive services will do much to ensure that these vulnerable seniors are as safe and well as possible. Similar initiatives have demonstrated a 20% reduction in emergency room visits and hospital days.
Program Cost	North Renfrew Long Term Care Inc. Annual cost $350,000 plus one time capital funding of $120,000 Petawawa Assisted Living Program – Annual cost of $326,426 and startup costs of $166,243 Wallace Street County Building, Eganville – Annual cost of $326,426 and startup cost of $53,743
Implementation timelines	**3 months** North Renfrew Long Term Care Inc. and the Marianhill program in Petawawa in place for April 1, 2007. Marianhill program expansion to Renfrew County Housing (Wallace Street Apartments) in Eganville would be in place for April 1, 2007 dependent upon capital investments to the facility being completed as required
Other considerations	• Develop a partnership with CCAC for expanded case management; • Open a dialogue with the County of Renfrew to elicit support for expanding the program county wide; • Explore partnering with existing community support agencies for transportation, meals on wheels, programs, etc.

Renfrew Strategy 4	**LTCH Preferred Bed Rate Subsidy**
Priority	Moderate - High
Current Reality	65 out of 70 or 93% of the patients waiting for LTC bed in the 5 acute care hospitals in Renfrew County are waiting for ward accommodation due to cost of the preferred accommodation. Because of this, a significant percentage of the LTC offers to hospitals cannot be matched with appropriate patients.
Future State	Patients in an ALC hospital beds requesting a basic accommodation will be transferred to a semi-private or private LTC bed. The cost differential will be funded by this strategy.

ALC Improvement Program	Accelerated access for ALC hospital patients to a LTCH basic accommodation by providing limited (1 out of 3) preference from category 2 over the Placement Wait List person to a semi-private or private bed by funding the differential cost through the ALC Project for a period of 6 months
Estimate ALC Impact	**Estimate 2 placements per week** Note: There is currently in Renfrew County 6 placements in semi-private and private beds Estimate 8 patients per month Over 6 months period: 48 patients Geographically this strategy will have the most impact in the Pembroke area.
Program Cost	After 6 months, the monthly financial cost would be between $86K and $155K The total accumulated cost would be between $300K and $550K
Implementation timelines	**Immediate** Once funding is secured, the timeline for implementation would be immediate. Determination of process re: payment flow, notification of patients of interim status, waitlist management would have to be determined prior to commencing.
Other consideration	There will be a potential impact on those residents currently waiting for LTC preferred accommodation particularly in areas where the wait list is over three years.

Renfrew Strategy 5	**Resource Integration for Seniors in the Community (RISC) - Dec. 2006**
Brief Description	The RISC Program is defined as a co-ordinated system of care for the frail and elderly (75+) who are at risk for high use of other health care services, frequent hospital admissions and placement in long term care homes. This system of care is co-ordinated by an enhanced case management model which is integrated with E.R. departments and primary health care. Co-ordination of services involves establishing an enhanced level of services for the frail and elderly in the community, geriatric assessments and consultation through out-reach programs, geriatric emergency management (GEM) training for hospital staff and proactive education for clients and their families around chronic disease management. Data demonstrates that 15% of individuals over the age of 75 are frail and elderly. Currently Renfrew County CCAC provides service to 262 frail and elderly clients.
Estimate of ALC Impact:	Goals of the RISC program include the following: • To support the frail/elderly in the community. • To prevent and/or decrease hospital admissions. • To improve co-ordination of geriatric services across health care system. • To improve education of clients/families and providers. • To reduce premature placement to long term care and thus maintain appropriate CMI levels for LTCH's.
Financial Impact:	Benefit: Anticipate a net system benefit of more than $4,500 per client per year through hospital avoidance. Costs: 2 F.T.E. CM's → $155,000 annual funding Education $ for GEM, geriatric training, etc $30,000 Total Costs: (annually) =**$185,000**
Other Considerations:	• Integrate the RISC program with hospital avoidance initiatives and geriatric assessment program. • Develop common coding system between CCAC and hospital. • Track # of hospital admissions for target population. • Track ER visits. • Track length of time in own home v.s. LTC admission.

Appendix C - Eastern Counties

The following tables provide the details regarding the implementation considerations for several of the priority recommendations outlined by the communities in Eastern Counties that could have a short term impact to reduce ALC occupancy and ER pressures, and freeing up acute capacity to meet wait time targets. The strategies are:

Eastern Counties Strategies	Facility	EC Priority	Financial Annual	Financial Quarter
1. Interim Hospital Bed Capacity (6-12 beds)	CCH	1	$850,000	$212,500
	WDMH	1	$850,000	$212,500
TOTAL			$1,700,000	$425,000
2. Top up Residential Care Community	HGH/CCAC	1	$400,000	$100,000
3. Geriatric Emergency Management (GEM) Program	CCH	1	$270,000	$67,500
	WDMH	1	$250,000	$62,500
TOTAL			$520,000	$130,000
4. Interim LTC Bed Capacity	CCH	1	$400,000	$100,000
5. Quick Response Unit	HGH	1	$297,000	$74,000
	CCH	3	$650,000	$162,000
TOTAL			$947,000	$236,000
6. Subsidized Assisted Living Program	CCH/CCAC	2	$560,000	$140,000
	WDMH/CCAC	2	$560,000	$140,000
TOTAL			$1,120,000	$280,000
7. Increased Services Directed to Subsidized Apartments	CCH	2	$266,000	$66,500
8. Long Term Care Preferred Bed Rate Subsidy	CCH	3	TBD	TBD

CCH = Cornwall Community Hospital
HGH = Hawkesbury General Hospital
WDMH = Winchester District Memorial Hospital

$ = estimates

Eastern Counties (Cornwall)

EC Strategy 1 - C	Geriatric Emergency Management (GEM) Program
Priority	High
Brief Description	The cohort of patients 75 years of age or more have a high frequency of repeat visits which result in hospital admissions accounting for as much as **43%** of all acute hospital days at the Hospital. The Regional Geriatric Program has developed an efficient GEM practice model integrating evidence-based automated and clinical screening for high-risk seniors in the ER, and an abbreviated geriatric assessment complemented by community and /or geriatric follow up as required. Evidence suggests significant improvements in quality and utilization are achieved by integrating Geriatric Emergency Management RNs into the ER environment. Findings indicate that a reduction in ER visits and acute hospital admission are realized as a result of comprehensive geriatric follow up for high risk patients. An opportunity to evaluate further reduction in repeat visits and admissions exists, through adding a CCAC quick response follow up service, providing enhanced rapid service in the home within 24 hours, for a period of up to five days. In partnership with the CCAC, the Hospital has begun a Hospital Avoidance Prevention Service which includes on a part time basis, the introduction of GEM. The program will initially focus on unaffiliated patients and will be operational in January 2007. The program will be serviced by a Nurse Practitioner and supported by a Respiratory Therapist, when required. In order to fully maximize the utilization of the program, they will be a requirement for physician involvement.
Estimate of ALC Impact	Per ER: Impact Annual caseload 1,200 Reduced ER Visits* 300 Reduced Admissions** 75 Reduced Pt. Days 1,125 Bed Equivalent (95%) 3.0 * assumes 25% reduction in ER visits ** assumes 25% reduction in admissions. Pt. days calculated upon ALOS 15 pts. 75+
Financial Impact	Similar to the Ottawa Proposal, implementation would be phased in over the next three months. Suggested Staffing: 12hr/day 7 days /week. 2.5 FTEs (RN's) $220,000 Medical Staff 7.5hr/wk .20 FTEs $ 50,000 <u>Quick Response</u>: It is assumed 20% of high-risk seniors discharged home might benefit from a quick response service. To add this level of follow up would require up to an additional $20,000 to $45,000. CCH would consider directing a portion of recent ER pressures funding to support this initiative, however success of this initiative is dependent upon availability of adequate alternative appropriate capacity in the community.
Timelines	Approximately 2 to 3 months for recruitment and training of nurses.
Other Considerations	GEM program should be complemented by an investment in capacity/community options for placement. It should also be noted that GEM requires follow-up by CCAC and geriatric assessment. Evaluation of the program and it's effectiveness will be reviewed on a continuous basis.

EC Strategy 2 -C	Interim Hospital Bed Capacity
Priority Rank	High
Brief Description	On average the Hospital has in excess of 12 patients daily waiting for placement to long term care (LTC) facilities. The Hospital proposes to operate a dedicated Awaiting Placement Unit (APU) to alleviate and reduce the impact on surgical wait times and patient flow throughout the facility.
Estimate of ALC Impact	Hospital has physical capacity to create and house 12 additional ALC beds. Impact: Increase patient days by 12 beds X 365 or 4,380.
Financial Impact	The patient care unit would be staffed and operated by 2 Registered Practical Nurses 24/7. Staffing: 2 RPNs X 24 hour/day X 7days/wk 10.30 FTEs @ cost of $650,000 Other Costs: Food and Supply Costs Approximately 30% of staffing costs or $195,000 Total Cost of the Program is estimated to be at a minimum **$845,000** annually.
Timelines	Hospital is currently operating such a unit but it is negatively impacting the operating budget. We currently have no extra capacity in ER to manage these patients.
Other Considerations	Hospital could operate this unit for a dedicated time period (ie. winter months) to reduce the financial burden as long as an alternative community solution can be found.

EC Strategy 3 - C	Interim LTC Capacity
Priority Rank	High
Brief Description	Increase the bed capacity of local LTC facilities by approximately 12 beds and for these beds to be dedicated to Hospital patients only. A review of excess capacity should be undertaken by the MOHLTC.
Estimate of ALC Impact	Increase LTC capacity by 12 beds in Cornwall.
Financial Impact	$30,295 ministry subsidy per bed per year. For 12 LTC beds the annual cost is $0.4M
Timelines	Capital requirements may be needed in order to make these beds available at least in the mid to long term.
Other Considerations	Allow hospital to lease space to LTC facilities or residential operators to provide the service.

EC Strategy 4 -C	Subsidized Assisted Living Program
Priority Rank	Medium
Brief Description	The program will be a partnership between the Ministry, Champlain LHIN, Cornwall Community Hospital, the CCAC and the private residential care provider. Residents, who are admitted to the program from the ALC population, will need level 2 or 3 care, as defined by the retirement residences' acuity scale (i.e., will require: staff assistance with activities of daily living (ADL): assistance with bathing and eating; and supervision of medication administration). In the proposed model, the residents would agree to transfer to the subsidized assisted living program until an appropriate placement is available (within 90 days). Once an appropriate setting is available, such as a LTCH bed, the resident will agree to accept the placement or assume responsibility for the financial subsidy.
Estimate of ALC Impact	Capacity for a minimum of 12 clients will be required.
Financial Impact	- ALC patient agrees to pay the co-payment (equivalent to the basic accommodation co-payment) - Additional subsidy of $128 to $150 /day is required. - CCAC will provide home support and nursing care to clients that would otherwise be available to them (~$50/day) Total Subsidy : 12 beds * 365 days * $78/day = **$0.34M / year** CCAC Subsidy = **$0.22M** Total = **$0.56M / year**
Timelines	To be determined. Proposal from a private residential provider is required. Unlike the City of Ottawa, there are only several private residential care providers in the City of Cornwall thus may be difficult to start such a program. Further investigation is required.
Other Considerations	

EC Strategy 5 -C	Services Directed to Subsidized Apartments
Priority Rank	Medium
Brief Description	The report "From Alternative to Appropriate Levels of Care" states that hospital utilization of seniors living in City of Ottawa subsidized apartments is about 1,700 emergency room visits and inpatient stays equivalent to 25 acute beds. The proposed model of prevention and support for this at-risk population involves a coordinated community response and builds on existing resources but will require enhancements to succeed. The community support coordinator would provide information and referral for individual clients and would develop programs within each building. It is anticipated that the individual service plans would focus on meals, transportation to medical appointments and to community support activities such as Day Away programs. Program development may include congregate meal and exercise programs and health screening. The community support coordinator would be supported by a CCAC case manager assigned to each of the buildings. The case manager would be on-site 2-3 half days per week to start, providing assessment, service linkages, information and referrals. Personal care and professional services provided by the CCAC would be organized as a coordinated team, to ensure continuity and efficiency. Any enhanced CCAC service delivery would be based on individual determination of need as assessed by the case manager. The most effective way to meet the medical care needs of this population will require further review. It may be that the population is well-served by community health centers and/or family physicians. If however, there are significant gaps in medical care, other models such as the addition of a Geriatric Nurse Practitioner may be considered. Also to be reviewed is the possible contribution of public health and the client resource workers already providing services to these buildings. Further analysis is required to determine such a need in the City of Cornwall.
Estimate of ALC Impact	The potential impact of this program is moderate in terms of acute care utilization and significant in terms of quality of life for the individual seniors involved. Improved nutrition, access to needed services, transportation to medical appointments and continuous contact with caring, supportive services will do much to ensure that these vulnerable seniors are as safe and well as possible. Similar initiatives have demonstrated a 20% reduction in emergency room visits and hospital days.
Financial Impact	Annual Cost * (100 clients) - Community support coordinators (1 FTE) — $66,000 - CCAC case management (1 FTE) — Through existing resources - CCAC services (personal support and professional services) — As per individual need * - Enhanced Community Support Services for 100 clients — $200,000 estimate **Total** — **$266,000** *If clients required services beyond the existing CCAC regulatory maximums, these costs will need to be considered separately and have not been included in this proposal.
Timelines	Need to review with City of Cornwall and Subsidized Apartment owners.
Other Considerations	

EC Strategy 6 -C	Quick Response Unit
Priority Rank	Medium
Brief Description	Purpose of the Quick Response Unit would be to provide alternative service to ER patients (65+ years old) who do not require acute care observation or acute care support. Appropriate level of care is provided with a goal for the client to return to the community within 14 days of admission (typical stay < 4 days). Program characteristics: available 24X7, specific admission criteria, discharge planning (community-based care planning), interdisciplinary assessment, and non-medical crisis intervention, and client and family teaching support (NB – patients would be transported back to hospital for acute medical intervention if necessary)
Estimate of ALC Impact	A 12-bed unit or 4,380 patient days.
Financial Impact	Awaiting formal proposal - Estimated per diem cost of $150 per day --> **$650K / year** for 12-bed program. - Potential for some capital costs
Timelines	Unknown.
Other Considerations	Need to review in more detail.

EC Strategy 7 - C	LTCH Preferred Bed Rate Subsidy
Priority Rank	Low
Brief Description	Up to 80% of patients waiting for LTC bed in Ottawa acute care hospitals are waiting for ward accommodation due to prohibitive cost of preferred accommodation. Because of this approximately 45% of daily LTC bed offers made to acute care cannot be "matched" with appropriate patients. One way to improve the uptake of LTC bed offers to hospitals and therefore reduce the number of ALC patients is to subsidize the cost differential to allow for patient flow into these beds. A detailed analysis is required for the Cornwall Community Hospital to determine if such a problem exists in this area. Based upon previous experiences, we anticipate that the request for preferred accommodation is lower in the Cornwall area than Ottawa therefore such a strategy would have minimal impact on ALC days.
Estimate of ALC Impact	Unknown at this time
Financial Impact	Unknown at this time
Timelines	
Other Considerations	

Eastern Counties (Hawkesbury)

EC Strategy 1 - H	System navigator within ER (CCAC case manager) and service package
Priority	High
Brief Description	Adding a FTE CCAC case manager directly within the Emergency department with the goal of hospital admission avoidance and "navigation" of the system to ensure appropriate linkages. From the Ottawa report: "The cohort of patients 75 years of age or more have a high frequency of repeat visits (43%) which result in hospital admissions accounting for as much as 9 % of all acute hospital days in the region. Evidence suggests significant improvements in quality and utilization are achieved by integrating Geriatric Emergency Management RNs into the ER environment. Findings indicate a 25% reduction in ER visits and 10% reduction in acute hospital admission are realized as a result of comprehensive geriatric follow up for high risk patients An opportunity to evaluate further reduction in repeat visits and admissions exists, through adding a CCAC quick response follow up service, providing enhanced rapid service in the home within 24 hours, for a period of up to five days.." HGDH already has invested in the GEM program with an internal staff person, but requires the quick response component: the case manager within ER to set up required services and links from within the hospital. We are requesting funding for: • CCAC case manager in ER • The projected service bundles required to provide the patients with care in the "home"/residence, avoiding hospitalization.
Estimate of ALC Impact	* assumes 25% reduction in ER visits**:** these are stats from the Ottawa study, but applicable to all ER's ** assumes 10% reduction in admissions.
Financial Impact **HGDH**	For HGDH A) Staffing Costs for CCAC case manager: 12hr/day* 5 days /week. 2.5 FTEs = $252,700 * 0800-1600 and 1600until 2000 B) Quick Response service bundles cost: It is assumed 20% of high-risk seniors discharged home might benefit from a quick response service for a limited time period (4-5 days). This is dependent on the patient needs but would add $ 60/visit RN and $ 25/hr for PSW per patient. To add this level of follow up would require up to an additional **$20,000 to $45,000**
Timelines	2 months from approval for recruitment /training
Other considerations	HGH is applying for the recently announced ER funding also re: the case management. I*f successful* , we would only need the service bundle component via this proposal . If not , we need both.

EC Strategy 2 - H	"TOP up Residential care"
Priority Rank	High
Brief Description	Provide the CCAC with funding to provide "top up" to required care to ALC patients agreeing to wait for admission to a LTC bed in a residential facility. Residents, who are admitted to the program from the hospital ALC population, will need level 2 or 3 care, as defined by the retirement residences' acuity scale (i.e., will require: staff assistance with activities of daily living (ADL): assistance with bathing and eating; and supervision of medication administration). In the proposed model, the residents would agree to transfer to the residence, with "top-up "help via CCAC until an appropriate placement is available. Once an appropriate setting is available, such as a LTCF bed, the resident will agree to accept the placement or assume responsibility for the financial "top-up".
Estimate of ALC Impact	Capacity: TBD via CCAC, based on residential availability; Requirement: up to 10 patients at one time.(based on ALC stats for HGDH)
Financial Impact	CCAC will provide home support and nursing care to clients which would otherwise be available to them in a LTCF. The funding would be for CCAC to provide the top-up services required Total cost estimate : per month for up to 10 patients "top –up care" , which would be up to 1 RN visit /day = $60 2 hours of PCW/ day = $50 Total = $ 110/day /patient **Total = $ 401,500**
Timelines	1 month from approval, depending on staffing and residential availability
Other Considerations	• Patient still needs to consent • Residential spaces need to be available

Eastern Counties (Winchester)

EC Strategy 1 – W	Enhanced Geriatric Emergency Management (GEM) and Community Based Case Management Program
Brief Description	Patients aged 75 or more have a high probability of frequent ER visits and admissions to hospital. The Ottawa GEM initiative has demonstrated effectiveness in avoiding hospital admissions through accurate diagnosis, appropriate disposition and linkages to services for seniors. In partnership with CCAC, the hospital would hire a geriatric clinical nurse specialist to ensure high-risk seniors presenting in the ER receive an abbreviated geriatric assessment with community based CCAC follow-up and /or Quick Response services. This GEM Program Leader would also link with the CCAC Case Managers based in physician group practices to plan, develop and implement Hospital Admission Avoidance services to ensure a senior friendly continuum of care approach that links all existing seniors/geriatric service providers. This team of community and hospital based case managers will work together with the enhanced GEM Program Leader to focus on providing existing services to healthy and frail seniors in order for them to maintain independence, prevent functional loss and identify and help manage conditions the lead to frailty and functional loss as per the Regional Geriatric Assessment Program's framework for changing the trajectory to ALC designation. The WDMH / CCAC team's goals will include maintaining seniors independence in the community and prepare seniors for the day the will have to consider a more appropriate living/care environment or LTC placement before an acute care episode forces them to consider this reality at an inopportune time.

	Two additional CCAC case managers would be required for the remaining physician group practices.
Estimate of ALC Impact	Evidence suggests that every 10 cases that are screened prevent one admission. <u>WDMH (05/06 data)</u> Annual ER visits (75+): 1130 Reduced Admissions: 113 (assumes 10% as per Ottawa experience) Reduced Patient Days: 1243 (based on ALOS of 11 days for this cohort) Reduced ER visits: 283 (assumes 25% reduction in ER visits)
Financial Impact	Suggested Staffing to Start: 8hr/day (5days/week) 1 FTE RN (geriatric clinical nurse specialist): $100K 7hr/day (5 days/week) 2.4 FTE Case Managers: $186K
Timelines	3 months from approval required for recruitment and training
EC Strategy 2 – W	**Interim Hospital Bed Capacity (6 to 12 beds)**
Brief Description	The Hospital can temporarily increase its number of beds to match the average number of ALC patients waiting for placement in a long term care facility. This would avoid admitted patients spending the night in ER because of no bed availability on the medical / surgical unit due to high number of ALCs.
Estimate of ALC Impact	Increasing hospital bed capacity by 6 equates to 2190 patient days. An additional 6 beds for a total of 12 beds would associate with 4380 patient days annually (12 beds X 365 days = 4380 patient days).
Financial Impact	Beds would be added to the Complex Continuing Care unit and would require 2 additional Registered Practical Nurses 24 hours a day seven days a week with support from Rehabilitation department to prevent functional loss. Staffing: 2 RPNs X 24 hours/day X 7 days/week = 10.3 FTEs = $650,000 1 PT Aide X 2 hours/day X 5 days/week = 0.3 FTE = $15,000 Food and Supply Costs: Estimated at 30% of staffing costs or $199,500 Total Estimated Cost: Staffing $665,000 + Food & Supplies $199,500 = $864,5000 annually
Timelines	Immediate for 6 beds. 2 months for RPN recruitment for additional 6 beds.
EC Strategy 3 – W	**Interim Subsidized Assisted Living Program**
Brief Description	WDMH ALC patients with level 2 or 3 care requirements as defined by the retirement residences' acuity scale would agree to a transfer to a retirement home/apartment until an appropriate placement is available. CCAC would provide home support and nursing care as per maximum available service bundle. Once appropriate placement is located, the resident would accept placement or assume responsibility for the financial subsidies.
Estimate of ALC Impact	12 beds will be required for the Winchester District Memorial Hospital
Financial Impact	ALC patient agrees to pay for basic accommodation co-payment CCAC will provide basic home support and nursing care and enhanced community support services: $0.22M estimate for 50 clients Subsidy to a private residential retirement home / apartment operator is required for activities of daily living and medication administration: i.e. $78/day x 12 beds x 365 days = $0.34M
Timelines	Immediate, if local residential homes have capacity. Organizations in Williamsburg (3 beds) and Embrun (12 to 15 beds) have capacity and expressed interest. Contact names have been given to Eastern Counties-CCAC.

Appendix D - North Lanark & North Grenville

The high proportion of acute care bed days that are being utilized by alternate level of care patients is having an impact on the delivery of health services in the Champlain LHIN. The Ottawa ALC Strategic Committee has put forth a number of recommendations to address the ALC issue in both the long-term and the short-term. The ALC challenges and opportunities in Ottawa and the surrounding hospitals are inescapably linked.

Looking at opportunities, health care organizations in North Lanark/North Grenville continue to work collaboratively to assist Ottawa with ALC initiatives. One strategy identified by Ottawa is an increase in interim long term care capacity. At present, Almonte General Hospital does not anticipate pressures from ALC and has been identified as a possible site for 50 interim long term care beds. The Kemptville District Hospital currently operates 8 beds allocated to the Ottawa region.

Looking at challenges, increasing ALC pressures in Kemptville and Carleton Place have an impact not only locally but also regionally as the ability for timely repatriation is greatly restricted. A region approach is required.

The following three strategies are recommended to address the challenges associated with ALC pressures in the short term:

- Promote the efficiency of patient flow through weekly conference calls between the CCAC and the hospitals to review the wait list with a view to identifying priorities and possible alternatives for clients. The Leeds, Lanark & Grenville CCAC has had success employing this strategy with the Brockville General Hospital.
- Adopt the "First Available Bed" policy presently utilized by the Ottawa CCAC and Ottawa area hospitals. The Ottawa CCAC matches clients to available long term care beds whether or not the long term care facility is one of the client's three choices. Clients then wait for one of their three choices in a setting more suited to meet their needs then acute care. As well, hospitals are given first access to the beds that become available one day a week.
- Reallocate 4 of the interim LTC beds sited at the KDH to North Lanark/North Grenville. To assist with increasing overall capacity, ensure the number of beds allocated to Almonte is 50 beds.

Stakeholders in North Lanark/North Grenville are committed to working collaboratively to implement strategies aimed at increasing the efficiency of patient flow through the system to ensure timely access to an appropriate level of care. We look forward to continuing to collaborate with our partners within the Champlain LHIN to develop and implement innovate solutions to ALC pressures.