

# Alternate Level of Care (ALC) - A Provincial Perspective

Presentation to North East LHIN  
Alternate Level of Care Summit

June 6, 2007

# What is an ALC Patient?

Patients who are waiting for an appropriate level of care to meet their needs.

Most often, refers to ALC patients in hospitals - patients who have completed the acute phase of their care and who are waiting for an alternate and appropriate level of care to meet their needs.

# Impact of ALC

- Hospitals are facing increasing pressures on inpatient beds due to:
  - o Growth in Emergency Department (ED) volumes
  - o Growing number of alternate level of care (ALC) patients
  - o Increasing demand for hospital beds during the flu and winter season, and due to higher surgical volumes (e.g., Wait Time Strategy)
  - o Lack of appropriate non-acute resources
  - o Reduction in system flex in number of beds, coupled with higher acute inpatient bed occupancy rates
- These challenges are manifested in all areas of the hospital, creating bottlenecks in the system:
  - o Overcrowding in EDs, delays in offloading patients from ambulances, delays to admit urgent emergent patients
  - o Delayed admissions to acute beds, rehabilitation and chronic care beds
  - o Surgical cancellations due to lack of inpatient beds, affecting Wait Times
  - o Delayed access for chemotherapy patients requiring inpatient beds
  - o Deferred regional referrals (trauma, medical, cardiac, etc.)

# Magnitude of the Problem

- Acute hospital days attributed to patients designated ALC
  - o 6-16% across all LHINs
  - o 9.3 % average in Ontario (expecting an increase in 2006/07)
  - o 10% in Canada
- Average length of stay (LOS) for ALC patients is five times greater than average acute LOS (36.1 days versus 6.5 days)
- Trends:
  - o From 2003/04 to 2005/06, ALC represents between 8.9% and 9.3% of total inpatient days (approximately 1,600 beds)
- ALC patients in acute care beds use resources that are:
  - o more appropriate for acute patients
  - o more expensive than required to provide their care

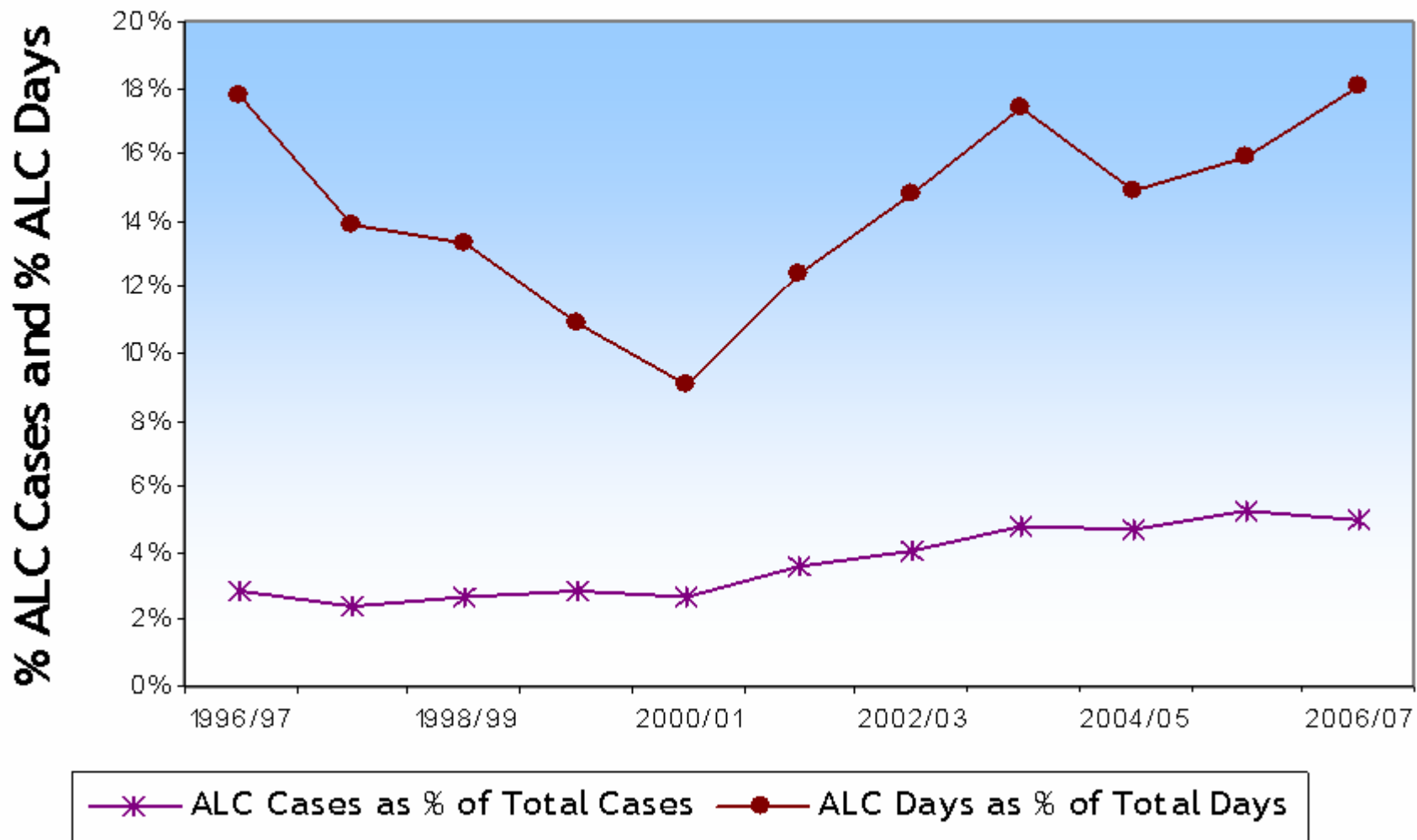
(2005/06 data)

# ALC Acute Care

- Of patients designated ALC, upon leaving acute hospital:
  - o 24% go to LTC homes
  - o 24% go to complex continuing care
  - o 20% go to rehabilitation
  - o 14% go home without home care
  - o 13% go home with home care
  - o 5% other
  
- 82% are seniors (mean 75.4 years); 58% female

(2005/06 data)

## North East LHIN ALC %



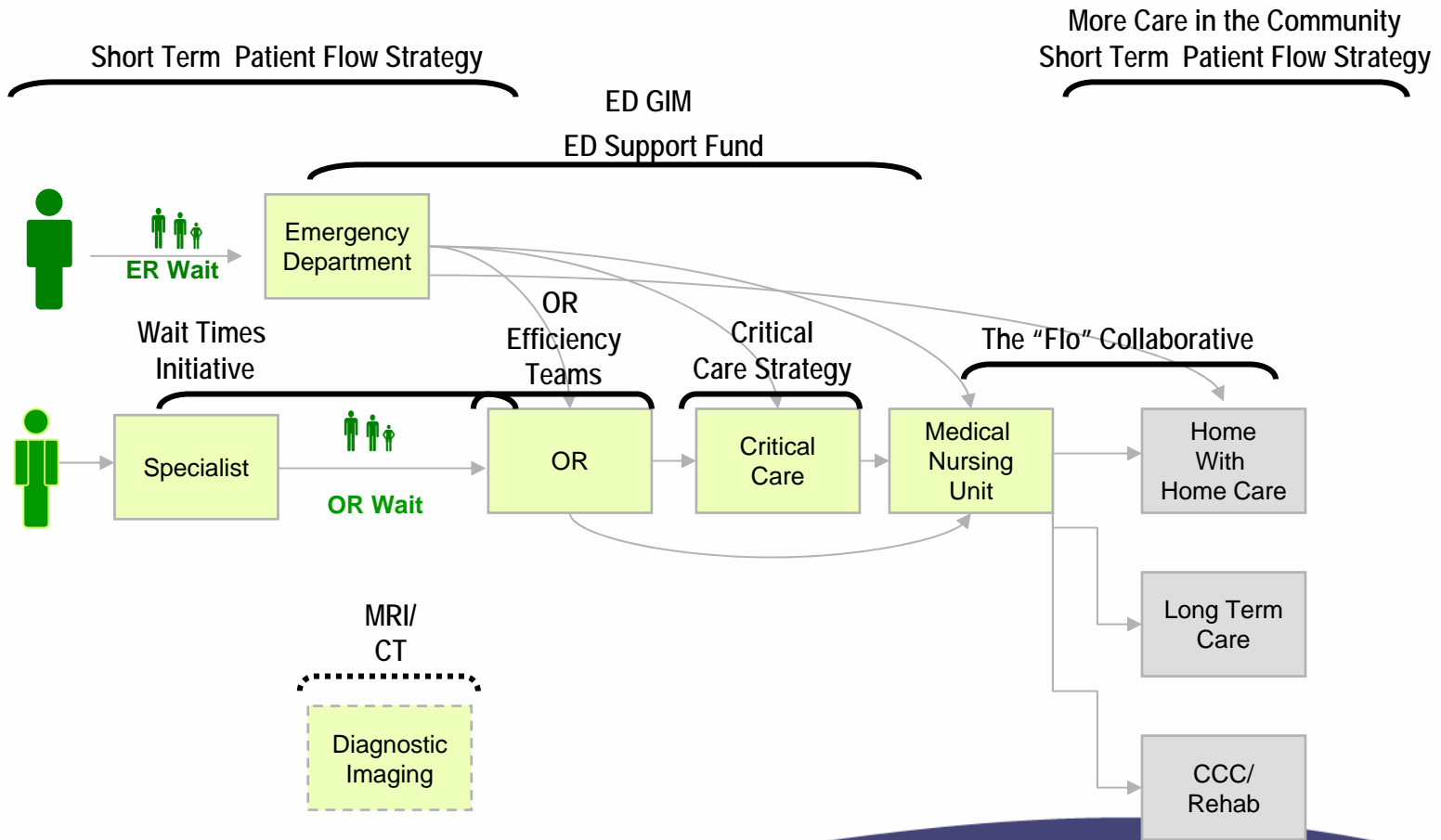
# LHIN ALC Performance Indicators

- Each LHIN has had recent discussions with ministry on ALC indicators for 3 years (2007/08 to 2009/10)
- Ministry and LHINs are close to agreeing on targets to work towards, and have had good discussion on challenges and initiatives
- Reducing ALC days is a high priority for LHINs - most have working groups in place to identify barriers and implement solutions
- Ministry recognizes a need for some short term solutions, as well as longer term solutions
- Discussions with LHINs also reiterated that performance on various indicators is inter-related - issues with ALC patients may affect key wait times when beds are blocked leading to elective surgeries cancelled, resulting in longer wait times for procedures

# Local Strategies to Address Pressures

- Some hospitals have implemented innovative solutions, e.g.:
  - o Improving coordination between hospital and community services to effect timely discharge and placement of patients in appropriate post acute settings
  - o Discharge planning assessment before admission
  - o Partnerships with long-term care homes
- Recognition that it is not only a hospital-based problem, requiring appropriate strategies for admission avoidance and getting patients to the right level of care. Innovative solutions include:
  - o Advanced Home Care Teams that provide acutely-ill patients with treatment at home
  - o Enhanced risk-screening and assessment of geriatric patients in hospital and community
  - o Enhanced geriatric support services, such as continence training, fall prevention, attendance outreach, system navigation to help access and correctly utilize existing services, palliative care support and volunteer development
  - o Transportation assistance for clients with cognitive impairment and others who may require assistance

# A variety of initiatives have been launched that target different components of the care continuum



# Provincial Strategies to Address Pressures

With a number of ongoing initiatives to deal with improving patient flow and providing appropriate care in the appropriate setting, the ministry has recently made additional investments that target different components of the care continuum.

- o \$5.3M Emergency Department Action Plan (EDAP) for Community-Based Care
- o \$10M ED Support Fund
- o New Long Term Care beds to be built
- o \$13.7M Patient Flow Initiative
- o The “Flo” Collaborative
- o Family Health Teams

# \$142M Emergency Department Action Plan

- On October 27, 2007 the ministry announced a three-point ED Action Plan, investing more than \$142 million in three critical areas - health human resources, hospitals and community care. Investments included:
- \$5.3M for Community-Based Care
  - Investment in 10 communities experiencing the most serious long-term care and community pressures.
  - \$233,600 allocated to NE LHIN targeted towards increased CCAC capacity and to maintain CCAC outpatient service.
- \$10M ED Support Fund
  - Local health care providers applied with initiatives that support emergency departments (such as rapid response teams to provide urgent care to residents in long term care homes rather than sending them to the local ED)
  - \$525,000 to The Hopital Regional de Sudbury Regional Hospital to strengthen the links between the emergency department and community providers
  - \$208,830 to the Sault Area Hospital in partnership with the Algoma CCAC, for Community Enhanced Emergency Care. An outreach team is to provide urgent and less urgent care to residents in long term care homes

# Other Investments to Increase Local Capacity

- Interim Long-Term Care Beds announced since 2005/06:
  - o 26 in North Bay
  - o 43 in Sault Ste Marie
  - o 52 in Sudbury
- Convalescent Care Beds announced in 2006
  - o 6 in North Bay
  - o 12 in Sault Ste Marie
  - o 12 in Sudbury
- Long-Term Care Beds Scheduled to be Developed:
  - o 96 in Sudbury

# Short-Term Strategies to Address Patient Flow - \$13.7M One-Time Funding

- In January and February 2007, Ministry worked with LHINs to identify potential strategies to immediately relieve ALC pressures in hospitals
- Based on these discussions, Ministry selected key short-term strategies and determined funding for each community, by strategy, to be distributed over two years
- \$2.35M Allocated to NE LHIN:
  - o \$1,027,000 to increase home care and community support services.
  - o \$600,000 to assign CCAC case managers to hospital emergency departments to assess and divert clients to more appropriate community services.
  - o \$168,000 for a geriatric emergency management program to increase emergency department nursing services for seniors with complex functional and/or psychological challenges
  - o \$537,000 for 25 temporary transitional beds, 15 in Sault Ste. Marie and 10 in Sudbury, for patients who no longer need acute hospital services and are awaiting placement in a long-term care home or other community-based setting

# Recommended Short Term Strategies

1. Strengthen the team member approach to case management to facilitate discharge to appropriate services
  - Build relationships between CCAC Case Managers and hospital EDs
  - Link these relationships to community support service providers (CSS), mental health and addiction (MHA) services and primary care
  - Identify patients at risk for hospital admission and/or long-stay hospital placement and match clinical support services available in the community to provide care, for example, Alzheimer Support Groups
  - Align Case Managers with ED peak times
2. CCAC Case Managers review all ALC designated patients in hospitals to determine if their needs can be met in their own homes with appropriate community-based services
3. LHIN-led direction with hospitals, CCACs and community-based providers (CSS, MHA, primary care) to hold frequent meetings to resolve ALC issues

# Other Suggested Short Term Strategies

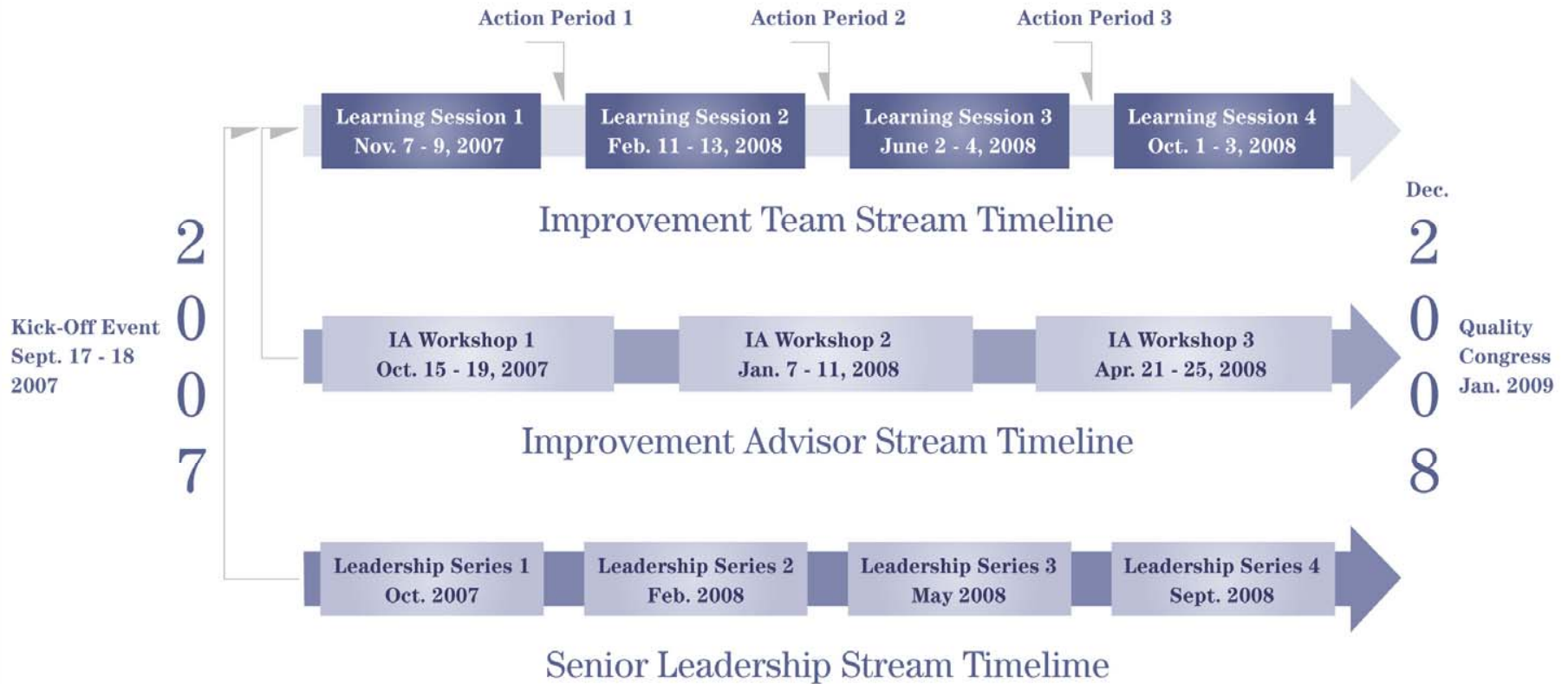
Discussions with LHINs identified various local solutions that could improve patient flow in the short term, such as:

- o Increasing access and coordination of home care and community support services to prevent hospital admissions and facilitate timely discharge
- o Increasing geriatric nursing services in EDs for seniors with complex functional and /or psychosocial challenges
- o Ensuring availability of weekend admission and discharge planning
- o Increasing transportation options
- o Staff education on enhanced care for IVs, wound care, etc, in long-term care homes and other community based settings
- o Linking with Family Health Teams for admission avoidance programs and follow up for at-risk residents

# The “Flo” Collaborative

- A component of the provincial ALC strategy designed to support LHINs and their health system providers
- The Ontario Health Performance Initiative (OHPI), with a mission to accelerate quality improvement in the province, is initiating and coordinating a large quality improvement project focused on improving patient flow, over the next 18 months.
- The goal is to partner with LHINs to select and recruit hospitals and CCACs into the “Flo” Collaborative, to flow project funds to participants through the LHINs, and to engage LHINs and other senior leaders in the project.
- Integrates 3 critical components
  - Strategic and tactical support of quality through the Senior Leadership Series
  - Intensive capability training through the Improvement Advisor Stream
  - Team-based implementation of quality improvement strategies through the Improvement Team Stream

# The Flo Collaborative



Understanding current process and identifying opportunities for improvement will be key to the role of Improvement Teams

## CHANGE CONCEPTS

1. Use timely, structured methods for multidisciplinary communication focused on discharge planning.
2. Minimize duplication of efforts (e.g., roles, resources, data collection).
3. Develop partnerships among care providers.
4. Enhance patient, family, and caregiver communication about transition planning.
5. Enhance capacity to meet demand within and between different care locations.
6. Develop methods for earlier, standardized discharge processes.

# The Flo Collaborative will include three levels of measurement

- **High Level Collaborative Measures**
  - All Improvement Teams must report centrally on a monthly basis to OHPI
    - Total cycle time between admission to a medical unit and patient transition to subsequent care destinations
    - Number of patient days spent awaiting transition care destinations once patient defined ready for discharge (RGP focus group)
    - Readmission rates within 7 days of hospital discharge
  
- **Routinely Collected “Behind the Scenes” Measures**
  - Key contacts within each organization will provide on a monthly basis to OHPI, such as:
    - ALC days
    - Number of days from hospital referral to CCAC to initial RAI assessment completion
    - Percentage of LTC applications for hospital-based clients meeting 5-day turn around time
  
- **Measures that Improvement Teams May Choose to Collect**
  - Process measures that will not be reported centrally, but will be shared through storyboards at scheduled learning sessions. Examples may include:
    - Percent of patients with an EDD assigned within 48 hours of admission

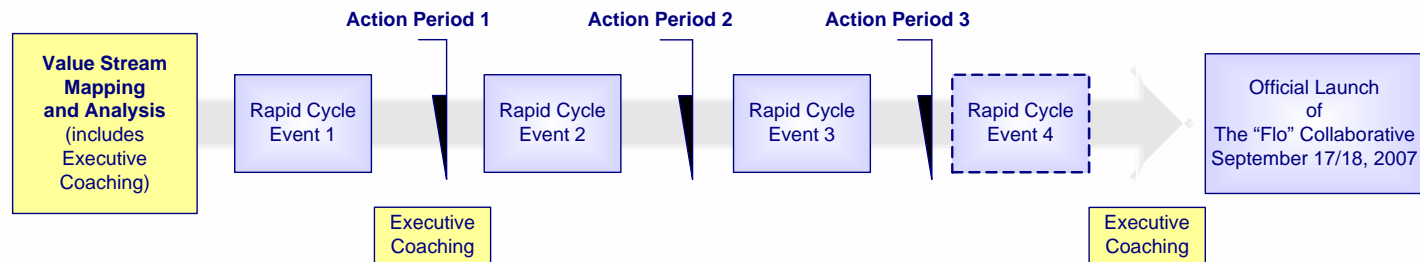
# The process for recruitment of organizations into the Collaborative is well underway

- Invitations sent by LHINs in late May to acute care hospitals, CCACs and other organizations (e.g., rehabilitation facilities) based on a combination of factors including provincial contribution to ALC days
  
- **Next Steps:**
  - **June-August 2007:**  
Follow-up with organizations to ensure they have a full understanding of the commitments required and to answer questions
  - **August 1, 2007:**  
Formal agreement to participate signed by senior executives
  - **Mid-August:**  
Select organizations and Improvement Advisors (IAs), ensuring a balance between hospitals and CCACs for IAs
    - Limited to approximately 30 trained IAs
  - **September 2007:**  
Kick-off event for all three streams of the initiative

In parallel with LHIN recruitment of hospitals and CCACs from May to July 2007, two pilot sites will run from June to November 2007, providing early results and champions for the larger Collaborative

## The “Flo” Collaborative

Quality Transitions for Better Care



### TIMELINE FOR PILOT SITES

North York General Hospital and Central CCAC  
 Hotel Dieu Grace Hospital and Erie-St. Clair CCAC

# LHINs' Role in Reducing ALC Pressures

- LHIN-led direction with hospitals, CCACs and community-based providers (CSS, MHA, primary care) to set up processes to assist in resolving ALC issues
  - Ongoing communication of issues, facilitating discussion
  - Sharing/communicating best practices
  - Working with health service providers (HSPs) in identifying areas and/or strategies to target resources to meet community needs (e.g., through CCACs), with a partnership approach in implementing appropriate strategies
- Coordinating implementation of strategies to reduce ALC pressures within the LHIN
- Continuing focus and strengthening/targeting resources for successful strategies, ensuring ongoing collaboration between partners, to meet local needs
- Evaluation of ALC indicators, progress and success of strategies within the LHIN, at the HSP level and LHIN level