

Hamilton Niagara Haldimand Brant **LHIN**
RLISS de Hamilton Niagara Haldimand Brant



Two Day ALC Designation Report

Cross-LHIN Priority Project
January 2011

Imagine a health system where you....

Give your health history
once

Have
easy to understand information
to help you make informed choices

Have
24 hour access
to a primary care provider

Have
one test
that is shared among your providers

Know your doctor receives
timely information
about you from others

Can make an appointment for a
visit to a clinician, a diagnostic
test or a treatment
with one phone call

Have a
wide choice
of primary care providers who can
give you the time you need

Get the right care
at the right place
at the right time

HNHB LHIN **...the works**
to get you there

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LHIN Names

The names of the LHINs have been shortened throughout this report as follows:

1	ESC	Erie-St. Clair
2	SW	South West
3	WW	Waterloo Wellington
4	HNHB	Hamilton Niagara Haldimand Brant
5	CW	Central West
6	MH	Mississauga Halton
7	TC	Toronto Central
8	C	Central
9	CE	Central East
10	SE	South East
11	Champ	Champlain
12	NSM	North Simcoe Muskoka
13	NE	North East
14	NW	North West

Introduction

The majority of Ontarians who require acute hospital care are discharged home when their acute care is finished. Those individuals, whose physician has determined that their acute care phase is completed, but continue to occupy an acute care bed, are identified as waiting for an alternate level of care (ALC)¹. A high number of individuals waiting for an ALC in acute hospital beds and their subsequent length of stay is a reflection of a healthcare system that is not providing clients timely access to post acute care, poor patient flow and reduces Ontario's acute care bed capacity.



The Ministry of Health and Long-Term Care (Ministry) and Ontario Local Health Integration Networks (LHIN) have identified improving individuals' healthcare experience *within* and patient flow *through* the acute care hospital system as priorities.

At the September 2010 Stocktake meeting between the Ministry and LHIN CEOs, the *percentage of individuals identified ALC within two days of being admitted to an acute care bed* was identified as an area requiring further review for potential cross LHIN strategies. For fiscal years 2008-09 and 2009-10, Ontario hospitals reported approximately 12% of all ALC discharges were designated ALC within two days of admission.² The rationale for examining this ALC population was to identify whether individuals who are designated ALC within two days of admission to an acute care hospital represent a population that with the appropriate interventions or systems in place could experience shorter hospital stays or avoid hospital admissions.

Subsequently, the LHIN CEOs identified *ALC within two days* (2D ALC) a cross LHIN project.

This report describes the findings of the working group assigned to this project.

1 Ministry of Health and Long-Term Care MLPA; a technical document November 2010

2 Inpatient Discharge Main Table (DAD, CIHI), IntelliHEALTH, Ministry of Health and Long-Term Care.

Project Objective and Scope



In September 2010, a working group comprised of LHIN staff from the Hamilton Niagara Haldimand Brant (HNHB) and North East (NE) LHINs was established and charged with preparing a report for the LHIN CEOs by mid-January 2011 on the patient population designated ALC within two days of admission to acute care beds (2D ALC).

The report was to include:

- a review of the patient population designated 2D ALC by: most responsible diagnosis, population characteristics, location and time of admission and discharge destination by hospital and by LHIN
- a determination if common patterns or populations emerged
- an identification of opportunities for dissemination of best practices and /or the development of strategies that would result in improved health outcomes, reduce 2D ALC designations and timely access to the appropriate level of care for those individuals designated 2D ALC.

The working group agreed that, given its relatively short mandate and the inability of LHINs to track patient movement across bed categories the project scope would be limited to inpatient acute care beds.

Project Process

As an initial step, the working group completed an analysis at the provincial level comparing the Discharge Abstract Database (DAD) data from 2008-09 and 2009-10 provided by Access to Care Informatics Cancer Care Ontario.¹

To ensure that all LHINs were actively involved in the project and to optimize stakeholder engagement, a fan-out approach was taken. Each LHIN CEO was requested to identify a lead contact. The lead contact was responsible for reviewing LHIN specific data, engaging key stakeholders and responding to a list of predetermined questions.

To assist their review each lead contact was provided with their LHIN's data on 2D ALC for the fiscal years 2008-09 and 2009-10. The information included:

- ALC volume for each fiscal year.
- percentage of the provincial total.
- the volume and percentage by location at admission, by clinical diagnosis.
- their total ALC days by designation at discharge.

The working group also engaged and invited input from the Ontario ED physician leads on the 2D ALC population admitted through the ED.

The working group further reviewed the data at a LHIN level to identify common drivers, patterns, populations and practices/strategies focusing on 2009-10 data. This review incorporated information submitted by each LHIN contact. A follow-up telephone conference was held with the lead contacts to review the findings and draft recommendations.

Project Process Limitations

- In limiting the scope to inpatient acute care beds, the working group recognized that the ALC days attributed to this population could be higher than reported if patients were discharged to other post acute beds such as complex care to await discharge to their final care destination.
- Limiting the review to two fiscal years prevented trend analysis.
- The implementation of the provincial ALC definition in 2009-10 is a potential variable that needs to be considered in the volume changes that occurred over the two fiscal years.

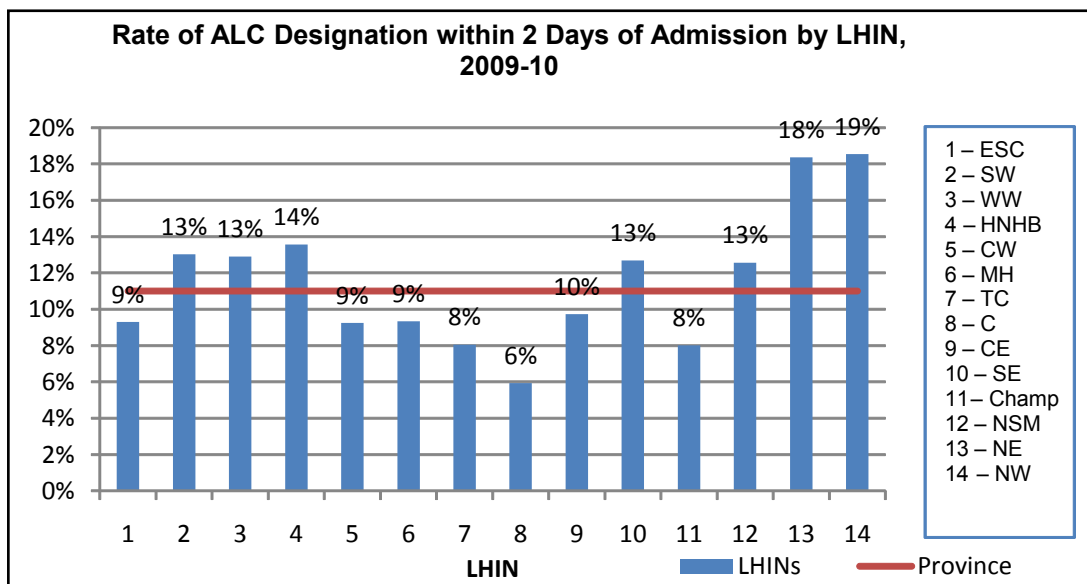
A copy of the project charter and questionnaire distributed to the LHIN contacts are attached as Appendices A and B.

¹ In completing their analysis of the DAD data, the working group assumed that "Blank" in the Institution From field referred to admissions from the facility's own emergency department.



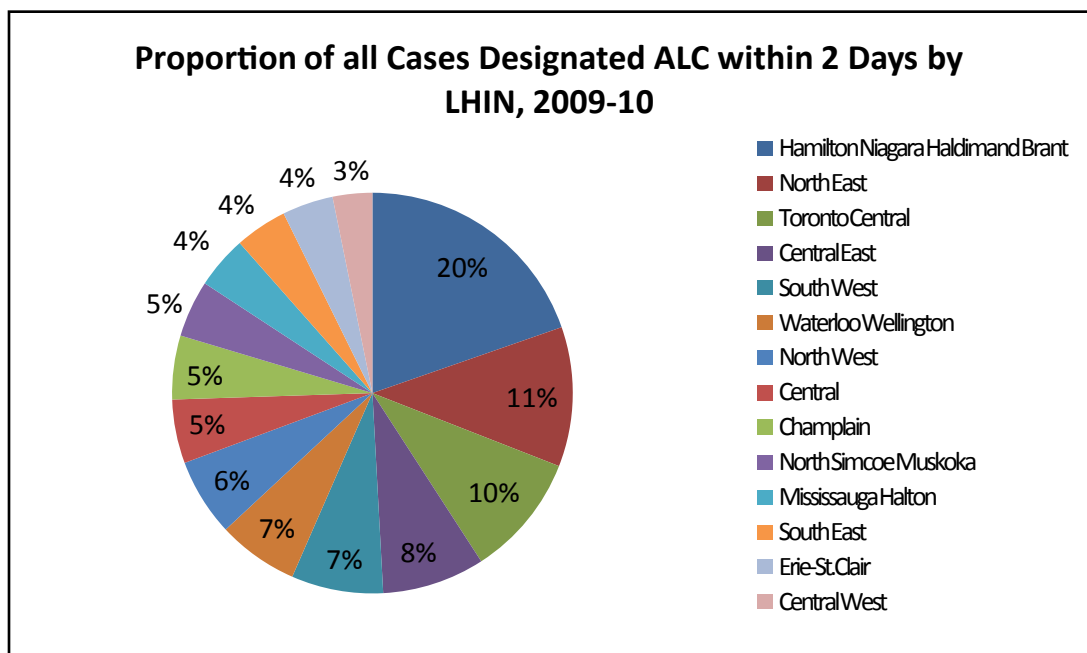
Provincial Overview

Figure 1



Sources: Inpatient Discharge Main Table (DAD, CIHI), IntelliHEALTH, Ministry of Health and Long-Term Care and Access to Care Informatics, Cancer Care Ontario: CIHI-DAD, 2009-10.

Figure 2



Source: Access to Care Informatics, Cancer Care Ontario: CIHI-DAD, 2009-10

Provincial Overview cont...

The analysis of data related to cases designated ALC within two days (2D ALC) revealed consistent findings between 2008-09 and 2009-10. Over this period, the number of cases provincially increased by 1% (from 5,832 to 5,883) while the rate decreased by 1% (from 12% to 11%). (See Table 1)

Three-quarters of patients (75%) were admitted to an acute inpatient bed through the ED or via acute to acute transfer, with the ED accounting for more than half of all admissions in both years. For patients admitted through the ED across both years, approximately 70% of all patients were 75 years or older, of which over 60% were female. Of the remaining 30% of patients under 75 years, the distribution was roughly equal between males and females.

Patients were most often discharged to long-term care or complex continuing care. These discharge destinations also accounted for over 60% of acute ALC days in both 2008-09 and 2009-10.

For cases designated 2D ALC the most noticeable difference was seen in the accumulative lengths of stay between 2008-09 and 2009-10. The number of acute ALC days (and thus bed equivalents) attributed to cases designated 2D ALC decreased by 12% over this time in spite of the number of cases increasing slightly. In 2008-09, 5,832 cases accounted for 137,210 acute ALC days (or the equivalent of 376 beds); a year later, 5,883 cases resulted in 120,675 acute ALC days (or the equivalent of 330 beds). (See Table 2)

Further analysis of the 2009-10 data revealed that;

- Of the 52,822 acute ALC discharges, 11% or 5,883 cases were designated 2D ALC.
- In total, the 5,883 cases designated 2D ALC represented 120,675 ALC days or the equivalent of 330 acute care beds.
- The rate of 2D ALC varied across LHINs from 6% in Central LHIN to 19% in the North West LHIN. (See Figure 1)
- The proportion of cases attributed to each LHIN revealed that HNHB and NE LHINs reported the highest number of cases designated 2D ALC (See Figure 2)

Table 1

	Cases Designated 2D ALC (n)		Volume Change (%)
	2008-09	2009-10	2008-09 to 2009-10
ESC	198	242	22%
SW	422	436	3%
WW	287	384	34%
HNHB	1638	1157	-29%
CW	211	188	-11%
MH	232	250	8%
TC	472	584	24%
C	260	303	17%
CE	372	487	31%
SE	168	248	48%
Champ	323	303	-6%
NSM	283	270	-5%
NE	675	663	-2%
NW	291	368	26%
Provincial Total	5832	5883	1%

Source: Access to Care Informatics, Cancer Care Ontario: CIHI-DAD, 2008-09 and 2009-10

Table 2

	ALC Days at Discharge (n)	
	2008-09	2009-10
ESC	2335	2586
SW	6541	7303
WW	6518	7043
HNHB	43982	29212
CW	1901	1775
MH	5203	2999
TC	6751	7551
C	4458	5217
CE	8413	9710
SE	3114	3097
Champ	8699	10834
NSM	6275	5145
NE	27087	21802
NW	5933	6401
Provincial Total	137210	120675

Source: Access to Care Informatics, Cancer Care Ontario: CIHI-DAD, 2008-09 and 2009-10



Provincial Overview cont...

- The majority of cases (75.6%) were acute to acute transfers (19%) or were admitted through the emergency department (56%). (See Figure 3)
- 49% of the cases (1,642) admitted through the ED were associated with three clinical groups. (See Figure 4)
 - Factors influencing health status and contact with health services (903). Of these, 54% (485) were identified as encountering health services for 'specific procedures and health care' and 45% (405) for 'other circumstances'.
 - Injury, poisoning and certain other consequences of external causes (387). Of these, 86% (331) were related to injury.
 - Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified (352).
- Of the cases admitted through the ED:
 - 69% were for adults 75 years or older, of which 62% were female.
 - Of the remaining 31% under 75 years, the majority were male (53% to 47%, respectively).
- Long-term care (LTC) (22%) and complex care (20%) were the two top discharge destinations. At 43%, discharges to LTC was associated with the highest proportion of acute ALC days (52,254 days) compared to discharges to complex care which accounted for 18% of acute ALC days (22,003 days). However, as this project is limited to acute beds, there is the potential that the population discharge to complex care may be associated with additional ALC days. Of note, patients discharged as deceased or left against medical advice comprised 14% of the cases and represented 12% of all acute ALC days - 14,383 days. This may represent a patient population that received or required palliative care.
- Of the cases admitted through the ED:
 - 505 (15%) were discharged as deceased or left against medical advice. The two LHINs with the highest number of patients for this population were NE (122) and HNHB (97). (See Table 3)

Table 3

	Patients who Died or Left AMA 2009/10	
	#	%
ESC	18	11%
SW	35	16%
WW	38	18%
HNHB	97	17%
CW	5	4%
MH	10	6%
TC	67	14%
C	16	8%
CE	23	7%
SE	18	22%
Champ	12	14%
NSM	22	16%
NE	122	30%
NW	22	12%
Provincial Total	505	15%

Sources: Access to Care Informatics, Cancer Care Ontario; CIHI-DAD, 2009-10 and NACRS, 2009-10, CIHI Portal

Provincial Overview cont...

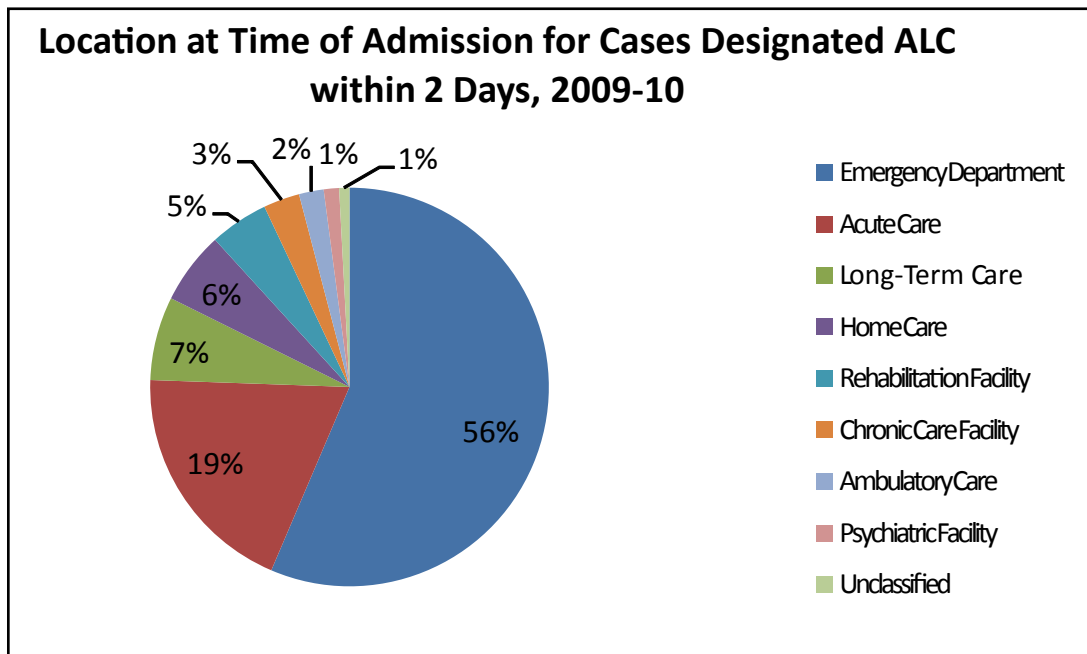


Figure 3

Source: Access to Care Informatics, Cancer Care Ontario: CIHI-DAD, 2009-10

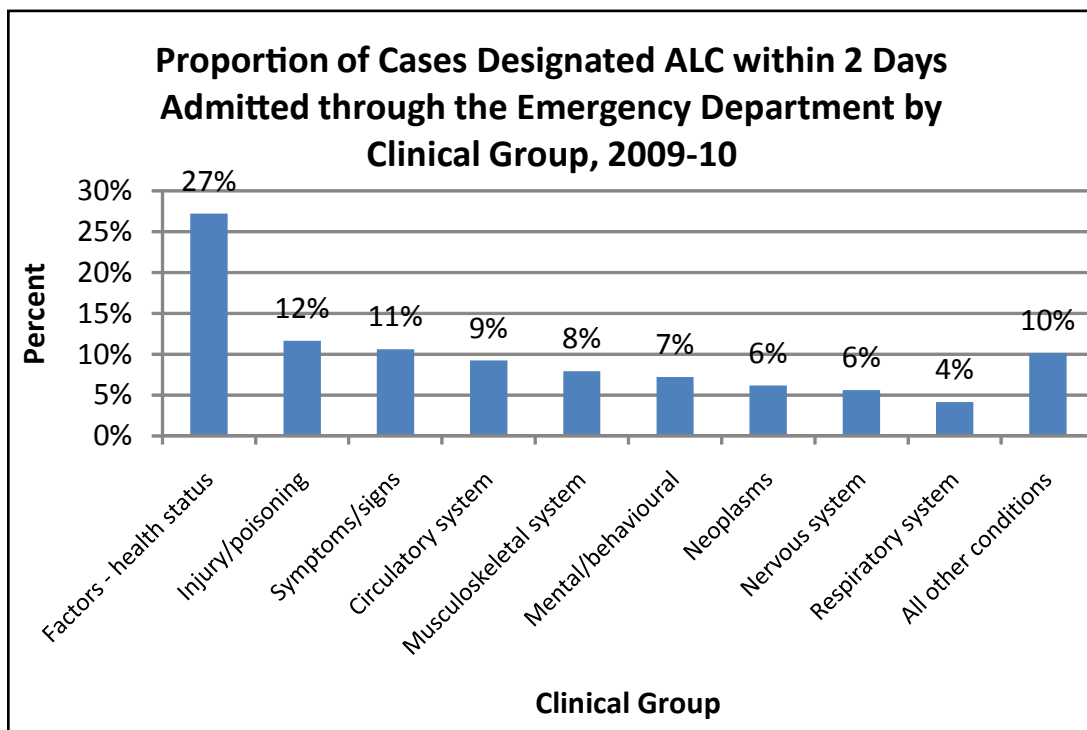


Figure 4

Source: Access to Care Informatics, Cancer Care Ontario: CIHI-DAD, 2009-10

LHIN Overview



To identify if common drivers, populations or patterns emerged across LHINs, a more detailed review of the 2009-10 data was completed. The review showed that:

- For twelve LHINs, the majority of cases designated 2D ALC were admitted from acute care or through the ED. Exceptions were Champlain and South East LHINs where 16% to 20% of the cases were admitted from home care and or a rehabilitation facility. (See Table 4)
- Seven LHINs reported 2D ALC designation rates in 2009-10 that were higher than the provincial average (SW, WW, HNHB, SE, NSM, NE and NW). A review of the data revealed that of these, four LHINs (SW, WW, SE, and NW) reported increased volumes over 2008-09 ranging from 3% (SW) to 48% (SE). (See Table 1 on Page 9)
- In total, nine LHINs showed an increase in volumes in 2009-10 over 2008-09 ranging from 3% (SW) to 48% (SE). The greatest decrease (29%) was seen in HNHB LHIN. On review this was attributed to the introduction of the provincial ALC definition and reclassification of acute care beds to complex care beds at three of their multi-site hospitals.
- The clinical group associated with the highest number of admissions (25% - 57%) designated 2D ALC in 11 LHINs was 'Factors influencing health status and contact with health services'. (See Table 5)

Table 4

	Admitted from Acute (%)		Admitted through ED (%)	
	2008-09	2009-10	2008-09	2009-10
ESC	13	13	56	66
SW	27	26	57	50
WW	10	13	47	54
HNHB	33	34	49	49
CW	17	19	70	63
MH	6	9	47	64
TC	4	3	81	83
C	7	8	70	67
CE	18	15	57	64
SE	17	18	43	33
Champ	17	20	27	28
NSM	16	16	48	51
NE	17	22	62	61
NW	15	20	53	49
Provincial Total	20	19	55	56%

Source: Access to Care Informatics, Cancer Care Ontario: CIHI-DAD, 2008-09 and 2009-10

- LHINs that reported a lower number of cases associated with the clinical group 'Factors influencing health and contact with health services', reported a higher percent of cases associated with the following clinical groups:
 - Injury, poisoning and certain other consequences of external causes.
 - Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified.
- Of cases admitted through the ED:
 - Females accounted for the majority of cases designated 2D ALC in each LHIN, particularly in the 75 years or older cohort
 - The 75 years or older cohort accounted for the majority of cases in each LHIN, ranging from 61% (CW) to 79% (MH).
 - Conversely, males comprised the majority of patients under 75 years in 11 of the 14 LHINs
- HNHB reported the highest number (572) of cases designated 2D ALC admitted through ED. Of these, 62% or 353 cases were attributed to the Niagara Health System. The key drivers identified by the hospital were the same key drivers identified by all LHINs
- Three LHINs had a high number of hospitals report volumes lower than six cases admitted through the ED; SW (10 of 19), Champlain (10 of 17) and NE LHINs (14 of 25).

Table 5

- A review of discharge destination data showed that:
 - 36% of NE and NW’s 2D ALC designation cases were designated ALC to home (with or without support). The volume of cases was spread across the hospitals with many volumes less than six. This may be a reflection of availability of community resources.
 - Four LHINs (NW, ESC, MH, Central) had hospitals that at discharge had a substantial number (22%-45%) of their total 2D ALC designation cases accumulate an average of 3-7 ALC days per case.
- Two LHIN’s (Champlain and TC) reported that the two day ALC designation metric is monitored but not considered a significant issue. These two LHINs in 2009-10 reported a 2D ALC designation rate of 8% each.
 - Champlain reported a decrease in the total number of cases designated 2D ALC in 2009-10. The working group noted that while the volume decreased, the number of ALC days accumulated for this population increased by 25% (2,135 days) over 2008-09. This was in contrast with the other LHINs that reported a volume decrease in 2009-10 (and also reported decreased accumulated ALC days at discharge). A review of Champlain’s discharge data at the LHIN level revealed that higher ALC lengths of stay were accumulated for these discharge destinations over the two fiscal years: died/left against medical advice (12 to 25 days), home with support (13 to 19 days) and long-term care (LTC - 44 to 56 days). Of note, many of these hospitals reported less than six cases for each of these discharge destinations.
 - The majority of TC’s 2D ALC population for both fiscal years was admitted through ED (81% and 83% respectively). In 2009-10, this represented 483 cases, of which 48% were associated with the three main clinical groups. Given the total ALC days at discharge reported for TC’s 2D ALC population (7,551 days), further analysis by TC would be needed to determine; 1) whether there is an opportunity to reduce hospital admissions for this patient population: and 2) the cost benefit of resources targeted at increased interventions against reduced ALC days.

	Cases with Health Status Factors ¹ (%)		Cases with Injury and Other ² (%)	
	2008-09	2009-10	2008-09	2009-10
ESC	26	31	12	10
SW	52	45	12	15
WW	48	44	11	12
HNHB	56	57	11	12
CW	11	15	19	19
MH	29	13	10	25
TC	13	19	18	25
C	25	25	23	22
CE	30	32	17	16
SE	52	49	NV	8
Champ	63	57	6	8
NSM	53	48	8	6
NE	50	48	12	13
NW	38	45	16	14
Provincial Total	45	42	15	17

Source: Access to Care Informatics, Cancer Care Ontario: CIHI-DAD, 2008-09 and 2009-10
 1 - Clinical Group 'Factors influencing health status and contact with health services'
 2 - Clinical Groups 'Injury, poisoning and certain other consequences of external causes' and 'Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified.'
 *Notes: NV means cell suppressed due to small counts (<6 cases). Clinical diagnosis group represents the ICD-10-CA chapter description for the patient's most responsible diagnosis.

As the majority of cases designated 2D ALC were admitted from acute and ED, the working group focused further review on these two populations. While a small number of LHINs reported a high percentage of admissions from other locations, the volumes were small as was their percentage of the provincial ALC total.

Admissions from Acute Care



In 2009-10, 1,126 cases admitted from an acute bed were designated 2D ALC.

In nine LHINs, the acute to acute transfer population accounted for 15% or higher of the cases designated 2D ALC. Reporting as a percentage for small volumes can overestimate the impact, and therefore the working group focused on LHINs that reported high volumes: HNHB (395 cases), SW (113 cases) and NE (143 cases).

Of cases designated 2D ALC, a review of LHIN responses revealed that most acute to acute cases were the result of:

- Single corporation with multiple sites and separate facility codes transferring between sites.
- Repatriation to a referring hospital or a hospital closer to the patient's home.
- Individuals admitted from another acute site with a fractured hip.

The working group concluded that the majority of the cases identified as acute to acute transfers and designated 2D ALC did not represent a population that was inappropriately designated or were potential avoidable admissions.

While a provincial "baseline" rate for the 2D ALC designation had not been identified, excluding the acute to acute transfers that are designated 2D ALC from the calculation would reduce the provincial rate for 2009-10 from 11% to 9%¹.

¹ Sources: Inpatient Discharge Main Table (DAD, CIHI), IntelliHEALTH, Ministry of Health and Long-Term Care and Access to Care Informatics, Cancer Care Ontario: CIHI-DAD, 2009-10.

Admissions from ED

As previously noted, the majority of cases (56%) designated 2D ALC were admitted through the ED. Of these 49% were associated with three clinical groups (See Figure 4, Page 11).

The majority of LHINs reported that the number of cases designated 2D ALC was identified as an issue on some level either for an organization or at the LHIN level. However, LHINs with large remote rural areas reported that their hospitals did not identify 2D ALC designation as an issue. These hospitals felt that given the lack of community resources admission into an acute care bed and subsequent designation was appropriate.

Key factors/drivers identified by the majority of the LHIN Leads in consultation with their stakeholders for the population admitted through the ED and designated within two days included (See Appendix C):



- Social admissions such as:
 - failure to cope.
 - caregiver burden.
 - crisis situation.
 - complexity of social situation that results in admission to acute care.
- Time required to arrange community support services.
- An acute event where the individual is unable to return home.
- Palliative care – end of life.
- Behaviours that cannot be managed (at a variety of settings, including retirement homes).
- Sudden change in mobility.
- Referral from primary care provider.
- Care exceeds retirement homes capacity to safely care for the resident.
- Lack of community support services.
- Hospital practice to save acute bed days.

Admissions from ED cont...



LHINs did not identify specific strategies targeted to the 2D ALC population, reporting that their overall ALC strategies incorporated this population. Key strategies identified by more than two LHINs included:

- GEM nurses.
- Assess/Restorative transitional care models.
- Outreach teams to targeted populations (i.e., mental health and LTCHs).
- Home First.
- Palliative outreach.
- Community Care Access Care (CCAC) Case Managers/Discharge Planners.
- ED notification.

ED Physician Lead Feedback

Populations identified by the LHIN ED Physician Leads admitted to the ED and most likely to be designated 2D ALC include:

1. Persons previously coping, who may live alone, suffer an acute injury and because of that injury are unable to care for themselves until recovered. These individuals may not need surgical intervention but are often unable to go home. Examples include:

- non-operative pelvic fracture, or a combination lower extremity and upper extremity injury that precludes use of a walker - e.g. an ankle fracture and a Colle's wrist fracture.

These individuals require convalescent care or restorative care which often cannot be arranged in a timely fashion, which results in a referral for a general internal medicine consult and admission to an acute care bed.

2. Persons who are identified as not coping well, e.g. dementia or failure to thrive and are waiting for long-term care home (LTCH) placement or require more care than can be provided at home but refuse LTCH placement, who present to the emergency as a result of:

- an acute event to themselves or their caregiver
- caregiver exhaustion
- gradual decline resulting in a crisis situation (i.e. wandered away, left the stove on) where the risk of discharging the patient home is too great.

These individuals do not have a reversible condition that can be treated in an acute care hospital but need to be admitted until the appropriate setting can be identified where their long-term care needs can be safely met.

3. Persons (and their families) who are too ill to go back home and need further assessment of their long-term care needs and care options. Discharging these clients may result in a repeat ED visit. Admitting these individuals to hospital for 48 – 72 hours provides time for the individual (caregiver) to respond to the acute treatment and allows for an evaluation of their coping skills and identification of the level of support required to meet their long-term care needs.

Ontario demographics suggest that the number of seniors presenting to the ED with acute issues that prevent the return home will likely increase. Despite increased investments in community resources admission to an acute care bed may be the only alternative available to ED physicians when the individual is in the ED. Greater consideration needs to be given to increase capacity to convalescent/assessment units/models.



General Observations



- Strategies aimed at decreasing the number of ALC days accumulated by the population designated 2D ALC maybe of greater benefit to the client and the system than reducing the number of cases designated. The data revealed that, while at the provincial level the number of cases may seem high, at the hospital level, for a majority of hospitals, the number of cases is relatively low.
- The majority of cases admitted through the ED or from acute to acute transfers and designated 2D ALC were 75 years or older.
- Greater effort is needed by hospitals and the CCAC to target and tailor care plans to address the health care needs of seniors who are designated 2D ALC so that they can 1) maintain and/or improve their functional status; 2) be assessed within a targeted time frame for their long term care needs; and 3) have timely access the most appropriate level of care.
- For the majority of LHINs, the greatest opportunity to reduce days associated with the 2D ALC population is to target the population admitted through the ED.
- For select populations admitted to an acute care bed, ALC designation within two days is appropriate.
- Select populations admitted through the ED to an acute care bed may be able to have their care needs met through admission to an Assess/Restore type unit. This will provide an area where individuals can be assessed for their long term care needs, thereby avoiding admission to an acute care bed.
- Many of the hospitalizations for select populations admitted through the ED that are designated 2D ALC (and accumulate a significant number of ALC days) could potentially be avoided by early identification and intervention within the community and/or through primary care.
- In Ontario, the number of seniors aged 65 and over is projected to more than double from 1.8 million, or 13.7 per cent of population, in 2009 to 4.2 million, or 23.4 per cent, by 2036¹. Recognizing that the growth in the senior population will increase in varying degrees across LHINs, focusing on strategies in those LHINs that currently demonstrate a need will assist the LHINs and the Ministry of Health and Long-Term Care to identify successful strategies that can be adopted as the demand increases.
- Hospital designation practices may inadvertently contribute to a number of cases designated 2D ALC.

¹ Source: Ontario Population Projections 2009-2036 Ministry of Finance 2010

Goals

1. That hospitals have standard processes in place that promptly identify clients who, due to their age or health condition, are at high risk of being designated ALC within two days of admission so that care plans can be initiated that will improve their health outcomes and facilitate them receiving the right care in the right place within an appropriate timeframe.
2. That seniors living in the community, whose; 1) health status puts them at risk of losing their independence; or 2) caregivers are at risk of being unable to continue to provide support, are identified before a crisis event occurs so that interventions can be set in place that allows them to have their long term care needs assessed and met.
3. That individuals presenting to the ED for select clinical groups (failure to cope, caregiver exhaustion) who do not need acute care services but are unable to return home have timely access to assessment services to identify their long term care needs.



Performance Metrics

1. Accumulated ALC days at discharge for cases designated 2D ALC.
2. Increased referrals to CCAC from Primary Care Clinicians that result in identifying persons unknown to CCAC who are determined to need support services or an alternate care setting.
3. Reduction in the number of individuals presenting to the ED for select populations (factors influencing health status and contact with health service).
4. Reduction in the number of admissions through the ED for the three clinical groups that are designated 2D ALC.
5. The number of individuals admitted directly from the ED to Assess/Restore-transitional care model and their discharge outcomes.

Recommendations



The following recommendations may align with work that is already being undertaken by other committees. As such, the recommendations below should be taken into consideration by these groups as they complete their mandate.

1. That the LHIN CEOs table and agree to request either through a Lead CEO, the LHIN- Collaborative or the Ministry of Health and Long Term Care that:
 - a. The Physician LHIN Tripartite Committee in consultation with the Ontario Hospital Association by June 1, 2011, identify risk stratification criteria and a process that can be implemented;
 - i. by Ontario hospitals through their existing patient information systems to identify individuals admitted to hospital that are likely to be designated ALC within 2 days so that targeted strategies/ interventions can be implemented to 1) meet their care needs; and 2) improve their health outcomes; and
 - ii. by Primary Care physician patient management systems to identify clients who due to their health status are at risk of losing their independence or having to leave their current home environment.
 - b. The Ontario Association of Community Care Access Centres by June 1, 2011, develop processes to identify clients (caregivers) on service who are declining and are at risk of having to leave their current location. This will allow clients and their families the opportunity to make life changing decisions in a less stressful environment outside of a crisis situation. The processes developed to target an implementation date of September 1, 2011 or earlier.
2. That LHINs review with their hospitals opportunities to incorporate the risk stratification process identified by the Physician LHIN Tripartite Committee and as appropriate incorporate the update into future service accountability agreements.
3. That LHINs with a high volume of cases admitted through the ED and designated ALC within two days of admission complete an in-depth review of the population to determine if there is an opportunity to pilot targeted strategies that will result in improved outcomes at the individual and system level. As part of their review these LHINs should review the analysis and outcomes of the Four LHIN Patient Flow Performance Improvement Pilot Project.

4. That LHINs in collaboration with the most appropriate experts identify strategies to better meet the needs of specific populations identified below admitted to hospital and designated ALC within two days of admission;
 - a. Behavioural
 - b. Palliative
 - c. Homeless

Recent reports and or key stakeholders that should be consulted to provide direction for these populations include:

- The anticipated Behavioural Support Systems Project – Phase 1
- The Provincial End of Life Care Network and the Quality of Hospice Palliative Care Coalition of Ontario
- The Ontario Association of Community Care Access Centres - Integrated Client Care Project – Palliative Care
- *Respect, Recovery, Resilience: - Recommendations for Ontario's Mental Health and Addictions Strategy*, Ministry of Health and Long Term Care

In addition, if specific LHINs have implemented strategies for these populations that have demonstrated through evidence improved outcomes at the client and system level these strategies should be assessed as to their feasibility for implementation in other areas.

5. That LHINs in collaboration with their hospitals and CCAC explore the potential to develop an admission process that would fast-track admissions from the ED to Assess/Restore-transitional care type units (where available) for individuals who need assessment of their long-term health care needs but do not require admission for acute care services.



Appendices



Appendix A - Project Charter

Title

ALC 2 Day Designation

Introduction and Background

Reducing ALC and emergency room wait times are a Ministry and LHIN priority. Timely access to acute care hospital services can be impacted by the number of patients waiting in a hospital bed for an alternate level of care after their acute care stay is over. Many hospitals and LHINs across Ontario are challenged with a high ALC rate, which is impacting their ability to reduce emergency room wait times and complete elective surgery cases within the recommended wait time.

Purpose

To identify the number, patient populations and potential strategies that could be implemented to reduce the number of patients designated alternate level of care (ALC) within 2 days of admission to an acute care hospital across Ontario.

This project is to gain a better understanding of the hospital population that is designated ALC within 2 days of admission. For the period January – March 2010, Ontario reported 12% of hospitals admissions were designated ALC within 2 days of admission.

This project will focus initially on admissions to acute care beds and identifying the patient population that is designated ALC within 2 days from admission by LHIN of hospital. The review will include:

- A review of the data for the following
 - the number of patients designated ALC within 2 days of admission
 - most responsible diagnosis where they are admitted from i.e. another hospital, emergency
 - discharge destination by hospital site and LHIN
 - number of ALC days for cases that are designated within 2 days by hospital sites and LHIN total
- Environmental scan – conducted by each LHIN
 - Each LHIN to review data and consult with hospitals, CCAC re drivers, presence of avoidance programs and their success, service gaps and potential strategies to address the issue.

Key Deliverables

See next page

Appendix A - Project Charter cont...

Key Activities and Timelines

	Deliverable	Timeline
1	<p>Identify the number (percent) and patient population that are designated ALC within two days of admission to an acute care bed by hospital sites and LHIN</p> <ul style="list-style-type: none"> Identify the patient population by most responsible diagnosis, age, sex, where they are admitted from i.e. another hospital, emergency, discharge destination by hospital site and LHIN <p>Determine if common patterns/populations emerge</p>	30 day (Oct 22, 2010)
2	<p>Share findings with LHINs and with the Provincial ED Leads</p> <p>Each LHIN to engage stakeholders to identify drivers, any strategies in place to manage the identified population/reduce hospitals admissions for individuals who could be managed elsewhere</p> <p>LHINs to submit reports to project team by November 27, 2010</p> <p>Provide update at November/December Stocktake meeting.</p>	60 day (Nov 27, 2010)
3	<p>Review LHIN data for:</p> <ul style="list-style-type: none"> Common drivers/issues (i.e. age group, CMGs, availability of alternate care setting i.e. supportive housing, LTCH) Examples of best practices for dissemination, opportunities Other – <p>Prepare final report</p> <ul style="list-style-type: none"> Circulate to LHINs for feedback Revise report for submission to LHIN CEO group 	90 day (January 17, 2011)

Roles and Responsibilities

Identify who will have responsibility for providing oversight of the project, and monitoring and reporting progress. Identify who will provide the expertise and support required to achieve the project deliverables.

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Appendix B - Questionnaire

The following questions were sent to each LHIN to complete.

- 1 a. Has the number of ALC cases designated within 2 days been identified as an issue in your LHIN? Describe why or why not.
- 1 b. What discussions have you had with your key stakeholders (e.g., hospitals, CCAC) about this issue?
- 2 a. If your rate of cases designated within 2 days is low, have you had strategies in place to address this issue? Please describe:
- 2 b. If your rate of cases designated within 2 days is high, do you have strategies in place/to be initiated to address this issue.?
3. Based on consultation with your stakeholders, please describe key factors/ drivers for cases designated ALC within 2 days. Reflect on the top sources of admission identified for your LHIN in the summary. (e.g., If you have a high percentage of transfers from an acute hospital who are designated within 2 days what are the factors?)
4. Is the data for your LHIN consistent with your LHINs understanding of the issue?
5. For discharges to Complex Care, was this the end hospital destination or were these patients redesignated ALC after admission to Complex Care?
6. Do you feel that your LHIN has any unique issues related to cases designated ALC within 2 days?
7. Does this information lead you to consider implementing new/different strategies? Please describe.

Appendix C - Responses

	Initiatives identified to avoid 2D ALC admits	Specific Populations Identified	Other considerations
Erie St Clair	<ul style="list-style-type: none"> GEM nurses, Assess Restore programs (includes CCAC), ambulation teams, Palliative Outreach teams, Mental Health Outreach teams and LTC Nurse Led Outreach have assisted with the 2D ALC, with focus on the <i>Home First</i> model. Deployment of Fractured Hip Best Practice Model, but rehab capacity remains an issue. Developing CHC Rehab Outreach Teams to support chronic disease management. 	<ul style="list-style-type: none"> Behavioural LTC transfers to hospital. Fractured hips (transfers from another hospital). Failure to thrive patients. 	<ul style="list-style-type: none"> ESC LHIN considers volume small considering the large number of ER visits. ESC LHIN has high LTC Demand to Supply ratios and higher rates of chronic disease than the province – COPD, HF, Arthritis, etc. 65 LTC beds lost from the system (beginning).
SW	<ul style="list-style-type: none"> GEM nurses. CCAC discharge planners at all hospitals. LHIN initiated conversations with hospitals and CCAC; working group may be established. In discussions regarding roll-out of initiative(s) to support <i>Home First</i>. 	<ul style="list-style-type: none"> Volumes are higher at rural hospitals as there are fewer supports in the community. 	<ul style="list-style-type: none"> A culture shift regarding the most appropriate patient destination is required. Communication campaigns/ strategies could be useful tools in changing public perceptions of appropriate destinations for patients.
WW	<ul style="list-style-type: none"> Numerous existing, expanded and new services in WWLHIN assist with addressing the needs of those who are, or may be deemed, 2D ALC including: <ul style="list-style-type: none"> GEMs nurses in all EDs. CCAC Case Managers in all Eds. Community Palliative Care Teams. New Residential Hospice (Guelph). Interim LTC beds and planned permanent LTC capacity expansion. <i>Home First</i> launched across all hospitals/CCAC. Restorative care beds. Intensive Geriatric Support Workers. Integrated Assisted Living Program, and others. 	<ul style="list-style-type: none"> Self-discharges. Social admissions. Social/care issues: family unable care for patient at home, caregiver burnout and caregiver illness. Palliative patients. Retirement homes' residents sent to hospital when the facility has reached its care capacity to care safely for the resident. 	<ul style="list-style-type: none"> Need for additional residential end-of-life care. CCAC working on addressing supports for retirement home residents and improving access to <i>Wait at Home</i> program.
HNHB	<ul style="list-style-type: none"> Ongoing education regarding ALC definitions and designation. Working collaboratively with and partnering with CCAC. CCAC case managers in the ER avert hospital admissions to appropriate destination. Hospitals embracing <i>Home First</i> philosophy and incorporating patient flow into hospital initiatives. Transitional care/discharge specialists to mediate ALC challenges and complex discharge situations. Development of ALC Steering Committee. Development and use of LTCH Nurse Practitioner Outreach Team. Increasing focus and partnerships with LTCH sector and physician group. 	<ul style="list-style-type: none"> HNHB LHIN has the highest number of seniors in the province. Social issues: patients unable to cope/thrive in the community, family can no longer manage, dementia and behavioural issues. Caregiver burnout. 	<ul style="list-style-type: none"> The median age of patients designated 2D ALC in the Niagara Region is 81 years, and the majority of patients report pensions and savings do not allow for a retirement home option.

Appendix C - Responses

	Initiatives identified to avoid 2D ALC admits	Specific Populations Identified	Other considerations
CW	<ul style="list-style-type: none"> No ALC specific strategies in place. Multiple strategies incorporated that deal with ALC issue: <ul style="list-style-type: none"> <i>Home First</i> Philosophy. Transitional Beds in the community. <i>Home at Last</i> Program. CCAC case managers in the ED ER Notification. Palliative Care Outreach Team managed by the CCAC. Specialized Geriatric Services in the LHIN include GEM nurses, a NP in the ED, and Geriatric Outreach teams. 	<ul style="list-style-type: none"> LTC Residents with behavioural issues. Acute event. Social factors. Complexity of patient(s). 	<ul style="list-style-type: none"> Lack of supports to manage LTCH residents with behavioural issues. Lack of rehab beds. Need for additional outpatient dialysis clinics.
MH	<ul style="list-style-type: none"> No ALC specific strategies, however there are strategies in place which address this group. There are current community investments in place (to prevent the acute event) as well as established enhanced services - as necessary - to divert admissions. Process in place to deliver <i>respite</i> care for short periods of time (ie: 1 to 2 days) until patients are assessed by NP and seen by CCAC. The engagement of the ED LEADS group in the MH LHIN, as well as the Department of Medicine, will be key in safe quality management of this population. CCAC is working with hospital ERs during 12 of the busiest hours of the day to avoid admissions and support patient/family in the <i>Home First</i> philosophy. 	<ul style="list-style-type: none"> Acute event. Social factors. Complexity of patients (difficult to sort appropriately in ER so they are admitted). 	<ul style="list-style-type: none"> Internal hospital factor: physicians wanting to save acute days admit patients as ALC and then these patients are discharged the next day.
Toronto Central	<ul style="list-style-type: none"> No ALC specific strategies in place, however we do have initiatives to help avoid 2D ALC for social admits. These include: <ul style="list-style-type: none"> CCAC-ED notification. Home First. Home at Last. Outreach teams to identify these cases in the ER. Links in ERs with Outreach teams. 	<ul style="list-style-type: none"> Socially complex patients which can't be managed in the ED or discharged. 	<ul style="list-style-type: none"> TC LHIN considers the volume of these patients to be small considering the large number of ER visits overall.
Central	<ul style="list-style-type: none"> Specialized Human Resources in Emergency Department that are targeted to preventing admission to hospital (e.g. CCAC case managers, GEM Nurses, Social Workers, Physiotherapy, Occupational Therapy, and ED Flow and Discharge Nurse). Central LHIN – Central CCAC Medication Management Support program for seniors. Physician education (hospitalists, ED Physicians) regarding alternatives to hospital admission. Education/coordination with retirement homes so they take residents back with supports. <i>Home First</i> Program has now been implemented at all hospital sites. Geriatric Outreach Program. 	<ul style="list-style-type: none"> Crisis placement for complex frail elderly patients/caregivers with burnout. Patients referred to ED by their primary care physicians for quicker access to an internal medication or other specialist consultation. Patients with medication issues. 	<ul style="list-style-type: none"> Although the volume of these patients is currently considered to be low, Central LHIN and hospitals within the LHIN monitor trends for this metric to determine if improvement is required.

Appendix C - Responses

	Initiatives identified to avoid 2D ALC admits	Specific Populations Identified	Other considerations
CE	<ul style="list-style-type: none"> • <i>Home First</i> program is looking carefully at all ALC designations. • CE LHIN has communicated the message to their hospitals that the LHIN expects this rate to be low. • CE LHIN is pursuing standardized clinical software that will provide admission recommendations at each hospital. 	<ul style="list-style-type: none"> • Social admissions. 	<ul style="list-style-type: none"> • CE LHIN's highest discharge destination is rehab (not a surprise given that we do not have a rehab facility). • Confident that rollout of <i>Home First</i> will reveal the driving forces behind the 2D ALC and help address them.
SE	<ul style="list-style-type: none"> • CCAC has placed case managers in every ER based on identified need. • Several ER/ALC projects have been focused on caring for these individuals at home. • <i>Home First</i> philosophy is being adopted in the ER department, therefore fewer clients entering system • Nurse Led Outreach Team. • Many CSS initiatives. • CCAC is currently reviewing services provided in LTCH. From the information gathered, further development of initiatives may occur to address ALC transfers from LTCHs. 	<ul style="list-style-type: none"> • Frail elderly. • LTCH patients that require care not available in the home (behaviour issues, UTIs, etc.). 	<ul style="list-style-type: none"> • One of the SE LHIN's hospital's transfers potential high risk ALC clients to CCC beds in order to ensure newly admitted clients have access to the right bed in the right area to receive the right care. • 66% of SE LHIN d/c to CCC days.
Champlain	<ul style="list-style-type: none"> • GEM Nurses in ED. • CCAC case managers in the ED (higher volume hospitals). • Discharge planning nurses are very active within the hospital setting. • Social workers are available to aid and promote the appropriate navigation of services. • Certain hospitals have enhanced Complex Continuing Care services to optimize restorative and rehabilitative processes to maximize patient function and thereby patient's return to previous community living situations. • Monitor and encourage the utilization of <i>Home First</i> and Aging at Home programs. 	<ul style="list-style-type: none"> • Social admissions. • Evening and night admissions due to inability to arrange community support during those hours, so patient is admitted. • Patients who can't cope at home. 	<ul style="list-style-type: none"> • Smaller community hospital in our region experience repeat admissions; the family physician cares for patients within the hospital setting. This may have an impact on 2D ALC. • Stakeholders are confident that ALC designations were appropriate. • Other institutions (psychiatry, rehab, etc.) are discharging patients to larger hospitals, to the hospital's <i>awaiting placement</i> unit, and patients are therefore designated ALC.
NSM	<ul style="list-style-type: none"> • Lean Six Sigma approach to the analysis of this issue is to be carried out by two hospitals. • An ALC working group was developed and will determine next steps in regard to 2D ALC. 	<ul style="list-style-type: none"> • Financial issues identified: higher rates for Home, Palliative and Rehab destinations in comparison to Long-Term Care. • Social admissions. • Failure to cope. • Dementia patients. • Insufficient caregiver supports due to caregiver burnout, or loss of a caregiver. • Palliative and end-of-life patients. 	<ul style="list-style-type: none"> • All organizations expressed concern over data presented for analysis. • There are cases identified early on as ALC but this is revised upon identification of acute issues underlying the admission. • On Fridays and over the weekend, patients are admitted to ensure they will be there on Monday when clinical/testing services are available for assessment and intervention.

Appendix C - Responses

	Initiatives identified to avoid 2D ALC admits	Specific Populations Identified	Other considerations
NE	<ul style="list-style-type: none"> • Aging At Home programs developed. • ED diversion. • Community Services engagement. • Utilization/Discharge Planning staff hired. • Hospitals and CCAC coordinate the following: <ul style="list-style-type: none"> • review of internal transfer processes. • ED Team review of potential ALC admissions. • GEM Nurse. • LTC Outreach program . • Hospital & CCAC strategies already in place: <ul style="list-style-type: none"> • Discharge planners/Social workers using screening to identify ALC patients. • Daily bullet & bedside rounds to identify ALC patients. • CCAC case managers present on Acute Care units. • Medworxx implementation has increased the accuracy of ALC designations. 	<ul style="list-style-type: none"> • Patients with the following are sent to hospitals and re-accepted back to LTC/group homes is refused: <ul style="list-style-type: none"> • dementia. • developmental disabilities. • aggressive behaviour. • tendency to wander. • Older population in NE LHIN compared to Central/Southern Ontario. 	<ul style="list-style-type: none"> • LTCH facilities unable to keep patients with behavioural challenges. • Limited affordable supportive housing. • Repatriation of old and very frail patients with little or no home support 2 - 3 days after surgery. • NE LHIN percentage of the population over 65 is high compared to the provincial average. • Hospice and convalescent beds unavailable. • High orphan patient population (lack of primary care).
NW	<ul style="list-style-type: none"> • Development and use of Utilization Coordinator in the ED who works closely with ED physicians and CCAC to better coordinate return to the community (attributed to decrease at TBRHSC). • Development and use of Utilization Coordinators in every medical unit. • Joint Discharge Committee put in place with our <i>Home First</i> implementation, which will continue to address ALC issues, including those designated 2D ALC. • <i>Wait at Home</i> programs and AAH strategies put in place which include increased respite/supports for caregivers to help prevent burnout and failure to cope. • No ALC specific strategies in place in rural hospital. 	<ul style="list-style-type: none"> • Frail elderly. • Failure to cope by patient or caregiver. • Rehab patients. 	<ul style="list-style-type: none"> • Rural hospitals throughout our region have seen increases in cases designated 2D ALC, largely attributable to the ALC definition change in July 2009. • Limited services in the community throughout the region, especially in areas of supportive housing, respite and services for patients with cognitive impairment. This impacts <i>Home to Wait</i> and <i>Home First</i> initiatives. • Transportation to and from appropriate care setting (respite or community) is a barrier for remote northern and aboriginal communities.



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