Central East LHIN | RLISS du Centre-Est

2016-19 Integrated Health Service Plan Strategic Aim Update: Seniors

Central East LHIN Board of Directors Meeting
October 24, 2018

Presented by: Lisa Mizzi, Director, Home and Community Care
Kelly Kay, Executive Director, Seniors Care Network
Marilee Suter, Director, Decision Support

Ontario
Local Health Integration Network

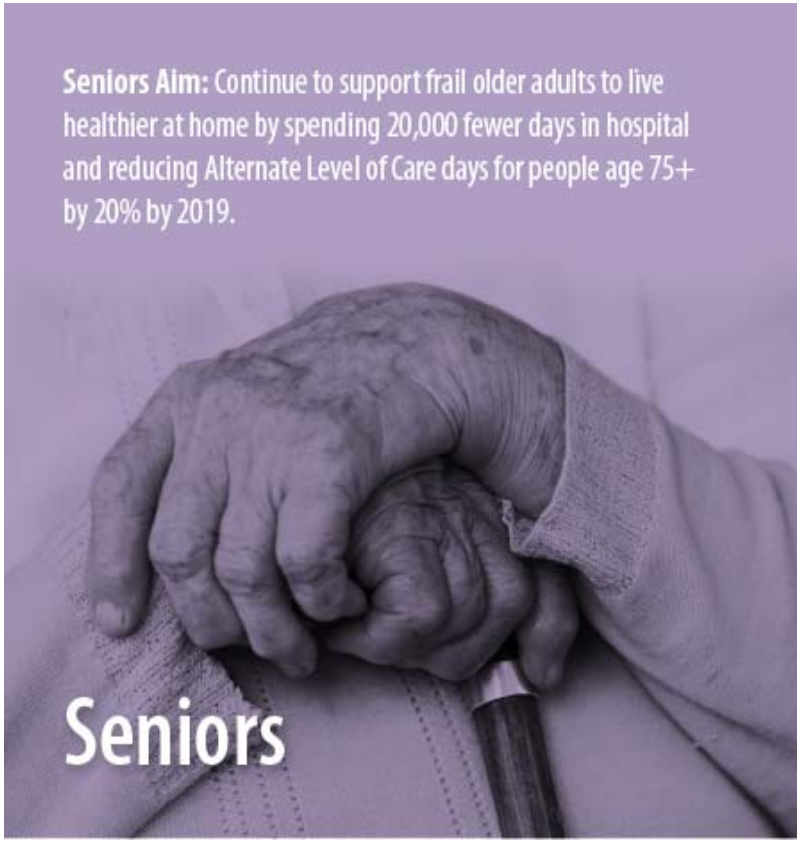
Objectives

- Provide current status of Central East LHIN Strategic Aim Performance Metrics
- Provide an update on Central East LHIN Seniors Strategy-related initiatives
- Next Steps
- Appendix 1 – Supporting Metrics
- Appendix 2 – Investments
- Appendix 3 – Performance Metrics Excluding Dementia

Acronyms

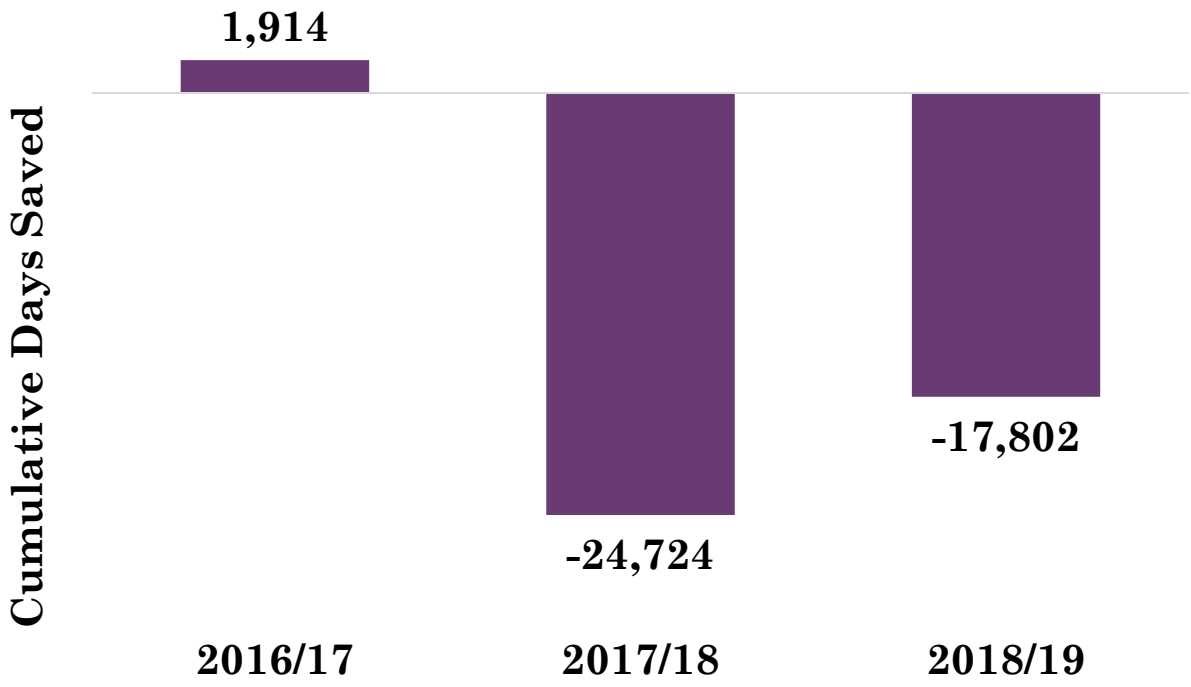
- Total Length of Stay (TLOS)
- Home and Community Care (HCC)
- Long-Term Care (LTC)
- Long Term Care Home(s) (LTCH)
- Emergency Department (ED)
- Nurse Practitioners (NP)
- Nurse Practitioners Supporting Teams Averting Transfers (NPSTAT)
- Behavioural Supports Ontario (BSO)
- Geriatric Emergency Management (GEM)
- Geriatric Assessment and Intervention Network (GAIN)
- Assisted Living Services for High-Risk Seniors (ALS-HRS)
- Multi-Sector Service Accountability (MSAA)
- Senior Friendly Care (SFC)
- Provincial Senior Friendly Care (sfCare)
- Assess & Restore (A&R)
- Expression of Interest (EOI)

2016-19 Central East LHIN Integrated Health Service Plan



Central East LHIN Seniors Strategic Aim Performance Metrics

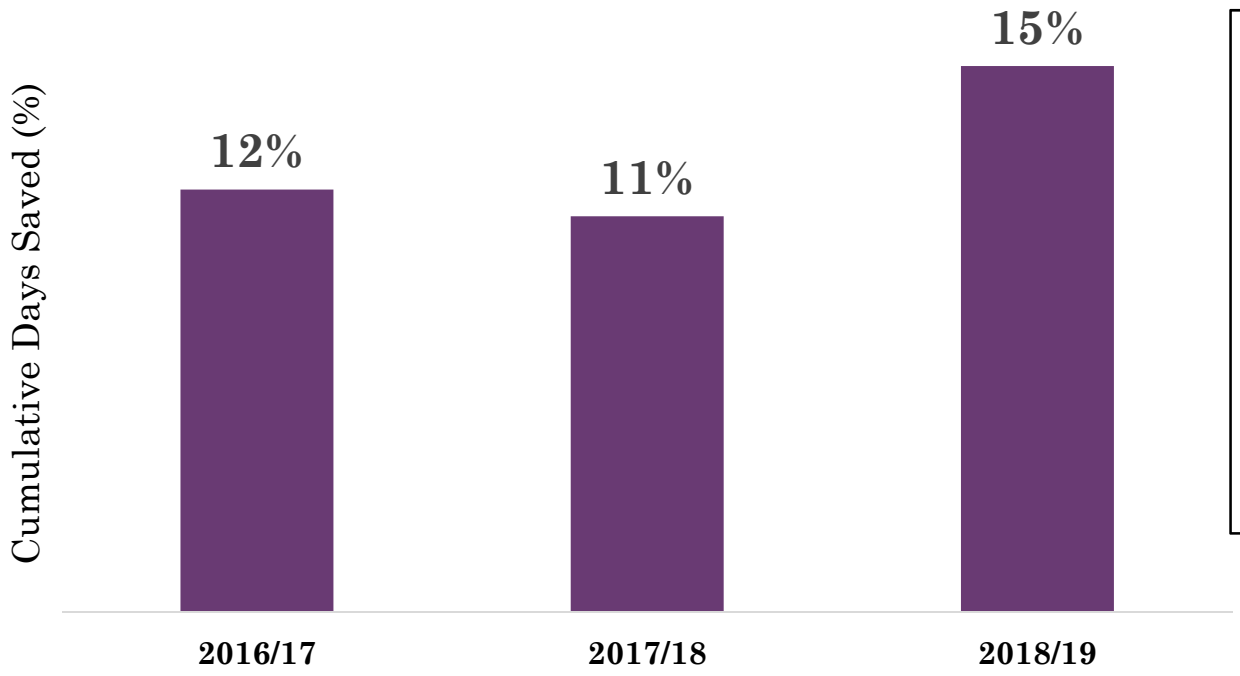
Seniors Strategic Aim: Cumulative Days Saved



Based on performance to Q4 2017/18, Central East LHIN is not currently on track to reach 20,000 days saved by 2019.

	2016/17	2017/18	2018/19
Projected TLOS (days)	279,202	283,006	286,810
Estimated TLOS (days)	277,288	309,644	279,888
Cumulative Days Saved	1,914	-24,724	-17,802

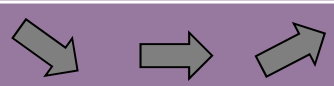
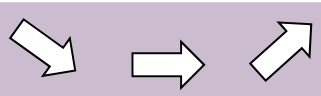
Seniors Strategic Aim: Percentage of Alternate Level of Care Days for People Aged 75+



Based on performance to Q4 2017/18, Central East LHIN is not currently on track to reduce Alternate Level of Care days for people aged 75+ by 20% by 2019.

	2016/17	2017/18	2018/19
Projected Alternate Level of Care (75+ (%)	30.0%	31.6%	33.2%
Estimated Alternate Level of Care 75+ (%)	26.6%	28.2%	28.3%
Cumulative (%)	11.5%	10.8%	14.9%

Supporting Metrics - Definitions

Terms	Definition
Baseline	Where there is sufficient data, the baseline is the average of the two most recent fiscal years.
Central East LHIN Target	The formal Central East LHIN target for an indicator (typically developed for use in existing scorecards, such as MLAA). This formal target is indicated by **bold formatting**. Where there is no formal target, the baseline less 10% is used as an informal Central East LHIN target.
Current Performance	The Central East LHIN performance for the indicator using the most current data available.
Current Status	The current performance is compared to the Central East LHIN target and the result is summarized by a coloured dot following the parameters below: • A red dot indicates that current performance deviates from the desired target by more than 10%; • A yellow dot indicates that current performance is within 10% of the target; • A green dot indicates performance meets or exceeds the target.
Direction of Trend	The direction of trend uses all the data from the baseline and any additional data, up to and including the most recent data available.
	A gray arrow indicates that there are at least 7 data points available to calculate the direction of the trend.
	A white arrow indicates that there are fewer than 7 data points available. The direction of the data should be interpreted with caution.

Seniors Strategic Aim: Supporting Metric Update

Indicators	Time Period for Current Performance	Baseline	CE LHIN Target*	Current Performance	Current Status	Direction of Trend
Home and Community Care (HCC) – 90th Percentile Wait Time for Home Care Services From Discharge to First Service (in Days for Hospital Clients) *(Goal is to decrease 90th percentile wait time)*	17/18 Q4	10.8	**6.5**	9.0		
Clients With MAPLe Scores High And Very High Living In The Community Supported by HCC *(Goal is to increase clients with MAPLe Scores high and very high living in the community with HCC support)*	17/18 Q4	8,533	**6,000**	13,051		
Falls-Related ED Visits in older adults aged 75+, Rate per 1,000 *(Goal is to decrease falls-related ED visits)*	17/18 Q4	17.7	15.9	20.8		
Low-Acuity Emergency Visits for Long Term Care Home (LTCH) residents, Rate per 1,000 *(Goal is to decrease low-acuity ED visits for LTCH residents)*	16/17 Q4	32.3	29.07	23.6		
Individuals on LTC Wait List, Rate per 1,000 (Goal is to decrease number of individuals on LTC wait list)	17/18 Q4	34.9	31.4	55.9		

*Targets that are shown in bold text are formal targets. Other targets are calculated as 10% greater or less than the baseline (depending on the desired direction of the indicator)

Seniors Strategy-Related Initiatives

Adult Day Programs (ADP)

- In 2017/18, ADPs provided 139,797 of 136,822 budgeted attendance days (e.g. one space, per one individual, on one day), or 102% of planned attendance days, and served 2965 of 2916 individuals targeted for services (102%).
- The individuals who may benefit from ADPs include:
  - Older adults with complex and long-term medical, physical, social and/or cognitive conditions.
  - Seniors who are at risk of avoidable hospital admission/readmission, emergency departments visits, ALC, or other care issues, if not adequately supported in the community.
- In 2017/18, Central East LHIN received $306,000 in one-time funding to support enhancements to community dementia programs. This was directed to support efforts within ADPs to increase the overall inventory of spaces in ADP and reduce barriers to participation. Results of this investment included the addition of 1015 new attendance days for daytime, evening and weekend hours; subsidies for attendance (1067), meals (577) or transportation (1110 trips); education for 178 staff and therapeutic resources.
- In 2018/19, Central East LHIN received an additional $1,322,200 for community dementia programs, including ADPs.

ADP Annual Targeted Individuals Served

Sub-region	Health Service Provider	Individuals Served at Q4 2017/18	Service Delivery Relative to Lower Corridor of Target at Q4 2017/18
Scarborough North/ Scarborough South	Carefirst Seniors & Community Services Association	395	**148%**
	Les Centres d'Accueil Héritage	20	**88%**
	Scarborough Centre for Healthy Communities	104	**126%**
	Senior Persons Living Connected	293	**119%**
	TransCare Community Support Services	131	**104%**
	Yee Hong Centre for Geriatric Care	259	**142%**
Durham West/ Durham North East	Brain Injury Association of Durham Region	160	**132%**
	Community Care Durham	261	**150%**
	Oshawa Senior Citizens Centres	272	**107%**
	Regional Municipality of Durham	148	**119%**
Northumberland County/ Peterborough City and County	Four Counties Brain Injury Association	112	**127%**
	Victorian Order of Nurses for Canada - Ontario Branch	506	**112%**
Haliburton County and City of Kawartha Lakes	Community Care City of Kawartha Lakes	192	**123%**
	Haliburton Highlands Health Services	63	**107%**
Total		**2,916**	

Assisted Living Services for High-Risk Seniors (ALS-HRS)

- ALS-HRS assist older adults to maintain their independence and remain in their homes for as long as possible.
- High-risk seniors are supported at home through the assistance of both scheduled and non-scheduled personal support services, homemaking, security checks, and reassurance services on a 24/7 basis.
- ALS-HRS hubs are located across all LHIN Sub-regions.
- The Central East LHIN invests more than $15M in annual base funding to support ALS-HRS across all seven Sub-regions.
- ALS-HRS serve over 1,500 individuals across the Central East LHIN each year.

ALS-HRS Annual Targeted Individuals Served

Sub-region	Health Service Provider	Targeted Individuals Served at Q3 2017/18	Service Delivery Relative to Lower Corridor of Target at Q3 2017/18
Scarborough North/ Scarborough South	Carefirst Seniors & Community Services Association	332	**115%**
	TransCare Community Support Services	192	**112%**
	Yee Hong Centre for Geriatric Care	159	**127%**
Durham West/ Durham North East	Community Care Durham (Oshawa and Courtice)	314	**166%**
Haliburton County and City of Kawartha Lakes	Community Care City of Kawartha Lakes	121	**128%**
	Haliburton Highlands Health Services	67	**156%**
Across Sub-regions	Victorian Order of Nurses for Canada	403	**123%**
Total		**1,588**	

Exercise and Falls Prevention Classes

- Exercise classes focus on helping seniors stay active and improve and maintain balance, strength, and mobility.
- Falls prevention classes are taught by a physiotherapist or other regulated health care professional.
- The Central East LHIN allocates $1.2M in annual base funding to support 248 exercise and 634 falls prevention classes across all sub-regions in the Central East LHIN.
- Exercise and falls prevention classes are also offered for Francophone patients, cardiovascular patients, and individuals with dementia.

Sub-region	Lead Agency
Scarborough North/ Scarborough South	Carefirst Seniors and Community Services Association
	TransCare Community Support Services
Durham West/ Durham North East	Community Care Durham
	Oshawa Senior Citizens Centres
Northumberland County	Community Care Northumberland
Peterborough City and County	Community Care Peterborough
Haliburton County and City of Kawartha Lakes	Community Care City of Kawartha Lakes
	Haliburton Highlands Health Services
Across Sub-regions	Cardiovascular Rehabilitation & Secondary Prevention Program

Central East LHIN Investments in Exercise and Falls Prevention Classes

Fiscal Year 2017/18

Sub-region	Lead Agency	# Exercise Classes	# Falls Prevention Classes	Total Class Summary
Scarborough North/ Scarborough South	Carefirst Seniors and Community Services Association	23	120	$ 170,400
	TransCare Community Support Services	50	140	$ 254,500
Durham West/ Durham North East	Community Care Durham	39	72	$ 162,720
	Oshawa Senior Citizens Centres	27	72	$ 133,920
Northumberland County	Community Care Northumberland	33	74	$ 151,200
Peterborough City and County	Community Care Peterborough	44	116	$ 216,960
Haliburton County and City of Kawartha Lakes	Community Care City of Kawartha Lakes	21	28	$ 77,280
	Haliburton Highlands Health Services	5	12	$ 23,520
Across Sub-regions	Cardiovascular Rehabilitation & Secondary Prevention Program	10	0	$ 24,000
Total		**248**	**634**	**$ 1,214,500**

Assess & Restore (A&R) Base Funding

Funding decisions have been made, and five programs have been selected to receive base funding beginning April 1, 2018, including:

Health Service Provider	Program
Scarborough and Rouge Hospital	Virtual Ward
Carefirst Seniors and Community Services Association	Integrated Assess and Restore Program
Peterborough Regional Health Centre	Seniors Wellness Activation and Treatment (SWAT) Program
Ross Memorial Hospital	Assess and Restore Mobile team
Northumberland Hills Hospital	Assess and Restore Intervention

Funding letters and Service Accountability Agreements (SAAs) are in the process of being sent to Assess and Restore programs, with programs reporting bi-annually using an updated standardized reporting template.

Attending Nurse Practitioner in the Long-Term Care Home

- The Ministry of Health and Long-Term Care funded Attending Nurse Practitioners (NP) to work as primary care providers in Long-Term Care Homes (LTCHs) across the province in three phases (2015, 2017 and 2018).
- In a novel care model proposed by the Central East LHIN, Phase 2 and 3 NPs were allocated to the Nurse Practitioners Supporting Teams Averting Transfers (NPSTAT) team. This includes 4 NPs providing care to all residents of 6 LTCHs:

Sub-region	LTCH Supported (FTE)
Durham West	Ballycliffe Lodge (0.5) Bay Ridges LTC (0.5)
Haliburton County and City of Kawartha Lakes	Extendicare Haliburton (0.5 pending) Highland Woods (0.5 pending) Victoria Manor (1.0)
Northumberland County	Golden Plough Lodge (1.0)

- While metrics are developed to identify the system outcomes of the program, NPSTAT has begun its focus on quality indicators in the Continuing Care Reporting System for LTCH. Data will be available in Q3 2018/19.

Specialized Geriatric Services: Behavioural Supports Ontario

- Behavioural Supports Ontario (BSO) is focused on supporting older people in LTCHs and the community with responsive behaviours associated with cognitive impairments due to complex mental health, addictions, dementia, or other neurological conditions, and their caregivers.
- On average in 2017/18, BSO supported more than 2,700 care partners of LTC and community residents (combined) per quarter. Already, in Q1 of 2018/19, this number has risen to more than 4300 as a result of new investments in Q4 2017/18.
- Central East LHIN has received $938,809 in additional base funding in the 2018-19 fiscal year and ongoing base funding to support the expansion of embedded dedicated BSO staff resources in additional LTC homes. This brings the total annual Central East LHIN BSO investment to $7,224,599 bringing the number of Central East LTC homes with dedicated BSO resources to 61 of 68 homes.
- An additional $956,500 has been received for behavioural supports at home and in the community to expand services and to continue to support central coordination of service in the Central East region. In addition to proposed expansions to Community Dementia Programs, this funding will support the deployment of six BSO Registered Nurses to hospital GAIN teams to support patients in acute care hospitals.

Program accomplishments include:

Metric	2017/18 (Year-end)	2018/19 (Q1)
LTCH residents supported per quarter (average)	4630	5369
Community patients supported per quarter (average)	409	490
Staff trained in BSO approaches	1703	576

Specialized Geriatric Services: Geriatric Assessment and Intervention Network (GAIN)

- Approximately $11 M in annual base funding invested in the 12 GAIN teams to provide specialized geriatric care, to support older adults living at home with frailty (including multiple, complex medical and social problems).
- In 2017/18 across all GAIN teams, the program made 28,037 appointments available, and experienced 30,521 visits. This reflects a utilization rate of 109%.
- At year-end 2017/18, GAIN reported providing ongoing care to 6987 community dwelling patients requiring team-based intensive case management and interventions (i.e. caseload). This care was provided at an estimated average cost of less than $1500/patient.
- Program accomplishments include:

Metric	2017/18 (Year-end)	2018/19 (YTD at Q1)
Visits provided	30,521	7366
Patients receiving intensive case management (12 month rolling caseload)	6987	7561
Patients served with moderate to severe dementia	900+	284
Patients served with moderate to advanced frailty	1,500+	468

Specialized Geriatric Services: Geriatric Emergency Management (GEM) Nurses

- Geriatric Emergency Management (GEM) programs provide specialized geriatric emergency management services, including targeted geriatric assessment to older adults with frailty in nine hospital Emergency Department (ED) locations in the Central East LHIN.
- GEM nurses help seniors access appropriate services and/or resources that will enable a return home and enhance functional status, independence, and quality of life.
- In 2017/18 the average age of patients seen was 84.32 (SD=7.73), with the majority being 85 and older (49%) and the majority were moderately frail and triaged at CTAS 3 (Urgent).
- Program accomplishments:

Metric	2017/18 (Year-end)	2018/19 (YTD at Q1)
Individuals served	4418	1154
Referrals to alternate sources of care (following targeted geriatric assessment)	4510	1182

Specialized Geriatric Services: Nurse Practitioners Supporting Teams Averting Transfers (NPSTAT)

- NPSTAT provide direct clinical care to LTCH residents across all sub-regions in the Central East LHIN by responding to acute and episodic changes in the resident's condition to reduce unscheduled transfers to a hospital.
- When LTCH residents are hospitalized, NPSTAT helps coordinate transitions back to the LTCHs, which can decrease hospital length of stay, enhance continuity of care, and provide support and resources to LTCH staff to help manage returning LTCH residents with increasingly complex medical needs.
- Program accomplishments include:

Metric	2017/18 (Year-end)	2018/19 (YTD at Q1)
Unique Patients Receiving Direct Clinical Care	5574	1187
ED Transfer Rate (average)	1.7%	1.6%
Capacity building activities provided	212	55
Facilitated LTC Repatriations from ED	123	23

Specialized Geriatric Services: Seniors Friendly Care (SFC)

- Overseen by a committee comprising representatives from all Central East LHIN hospitals who collaborate to promote and provide strategic direction and leadership for the Senior Friendly Care (SFC) Strategy.

- A Provincial Senior Friendly Care (sfCare) Framework has been developed and finalized with input from Central East health service providers and the Central East LHIN Patient and Family Advisory Committee.

- The sfCare Framework has been incorporated into Dementia Capacity Planning, to ensure that decisions about ideal state components for dementia care align with optimal care approaches for frail seniors.

- As a result of the work of the SFC Committee and to raise the profile of senior friendly care within their respective organizations, all hospitals in the Central East LHIN have now requested and received presentations/information at the senior team/board level from Seniors Care Network staff, and/or included senior friendly care in their strategic plan and /or goals & objectives.

Specialized Geriatric Services: Primary Care Collaborative Memory Services (PCCMS)

- The Central East LHIN provides approximately $1 M to support a regional approach to Primary Care Collaborative Memory Services.
- This program supports cognitive health and quality of life for adults and seniors living in the community while ensuring the patient's family physician maintains a central role in their patient's care. There is strong collaboration between this program and GAIN.
- PCCMS enhances the capacity for early detection, diagnosis, and treatment of dementia.
- Interprofessional teams, hosted by Alzheimer Societies of Durham Region and Peterborough, Kawartha Lakes, Northumberland & Haliburton and two GAIN teams (HHHS and PHCHC) provide Social Workers, Behavioural Support Ontario Nurses, and Occupational Therapists.
- The PCCMS interprofessional teams
  - Work collaboratively with family physicians in six memory clinic locations across Durham, Scarborough, the newest locations in Northumberland and Haliburton.
  - In 2017/18, the six locations provided 851 visits to 472 patients.

Dementia Capacity Planning

- Research and development of an initial ideal state and logic model, drawing on current evidence and the Central East Action Plan for Dementia (2016).
- Extensive consultations with 17 groups, and more than 200 participants, including people living with dementia and care partners.
- Qualitative analysis of roughly 850 textual statements/lines to extract themes.
- Development of evidence informed planning assumptions.
- Refinement of ideal state, which has achieved consensus-based approval from the Planning Committee.
- Completion of current state data collection across relevant programs and LHIN departments. A draft report summarizing supply and utilization data is currently being reviewed and vetted by contributors.

Assess & Restore (A&R)

- Assess & Restore (A&R) initiatives support high risk frail seniors to live in the community and maintain their functional independence for as long as possible.
- The Central East LHIN previously funded four projects focused on facilitating independence for frail seniors through A&R initiatives; funding for these initiatives changed to base funding for 2018/19.
- The Central East LHIN issued an Expression of Interest (EOI) process and evaluated all project proposals based on A&R eligibility criteria set by the MOHLTC and priorities identified by the Central East LHIN to ensure a fair and transparent process for distributing base funds.

Next Steps

Next Steps

- Continue to implement Seniors Strategic Aim initiatives as outlined in the 2016-19 Integrated Health Service Plan and 2018/19 Annual Business Plan.
- Continue to collaborate with the Seniors Care Network, Seniors' Physician Lead, along with key stakeholders and partners, to design, implement and evaluate programs that strengthen integrative health services and their delivery for frail seniors.
- Better understand frail senior populations at a sub-region level and identify opportunities to meet their health needs to support them living at home.
- Integrate seniors health within sub-region planning.
- Conduct targeted program evaluation.
- Launch dementia capacity planning.
- Spread programming and address any gaps at the sub-region level.

Questions?

Appendix 1 – Supporting Metrics

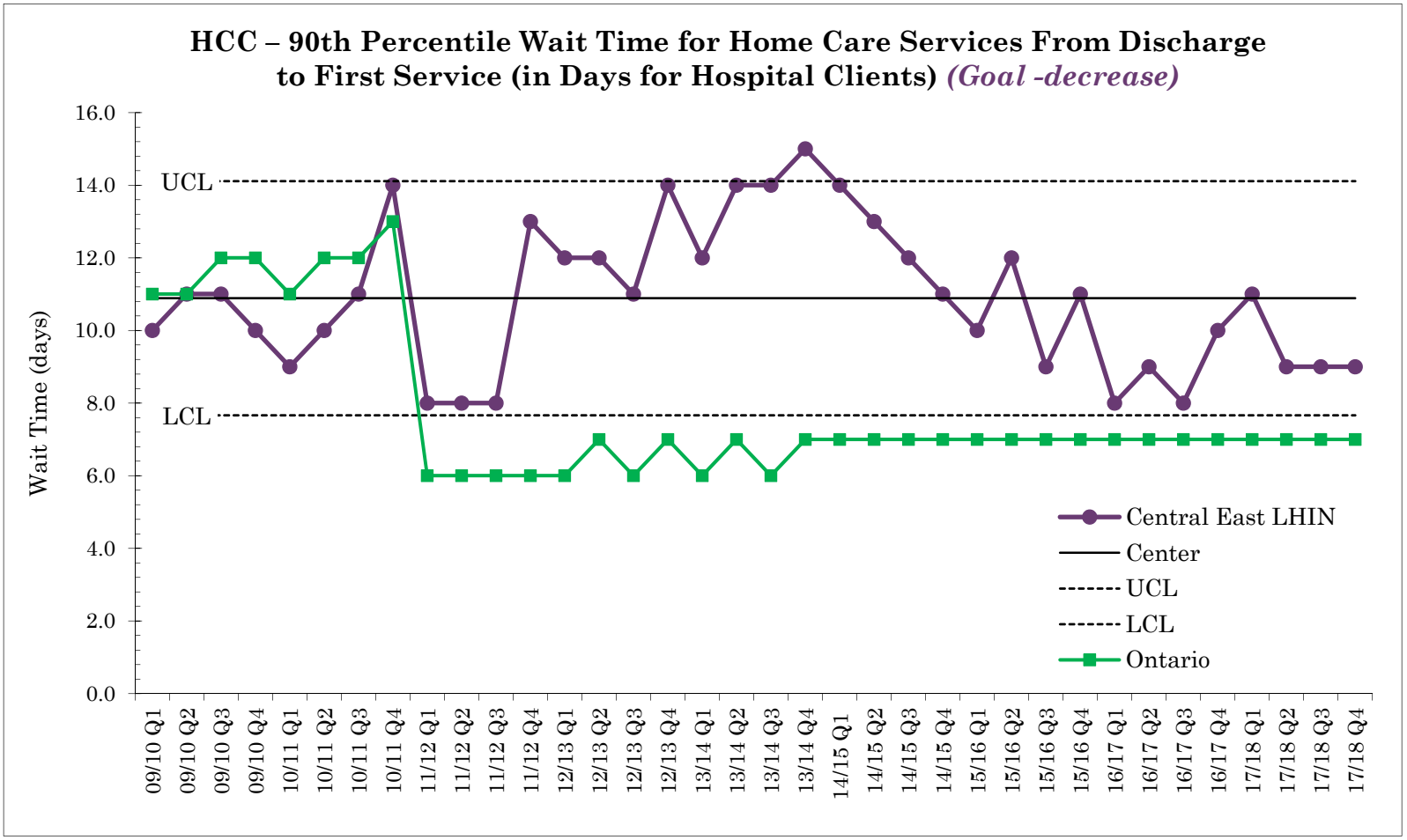
How are Savings Calculate?

Goal: Continue to support frail older adults to live healthier at home by spending 20,000 fewer days in hospital by 2019

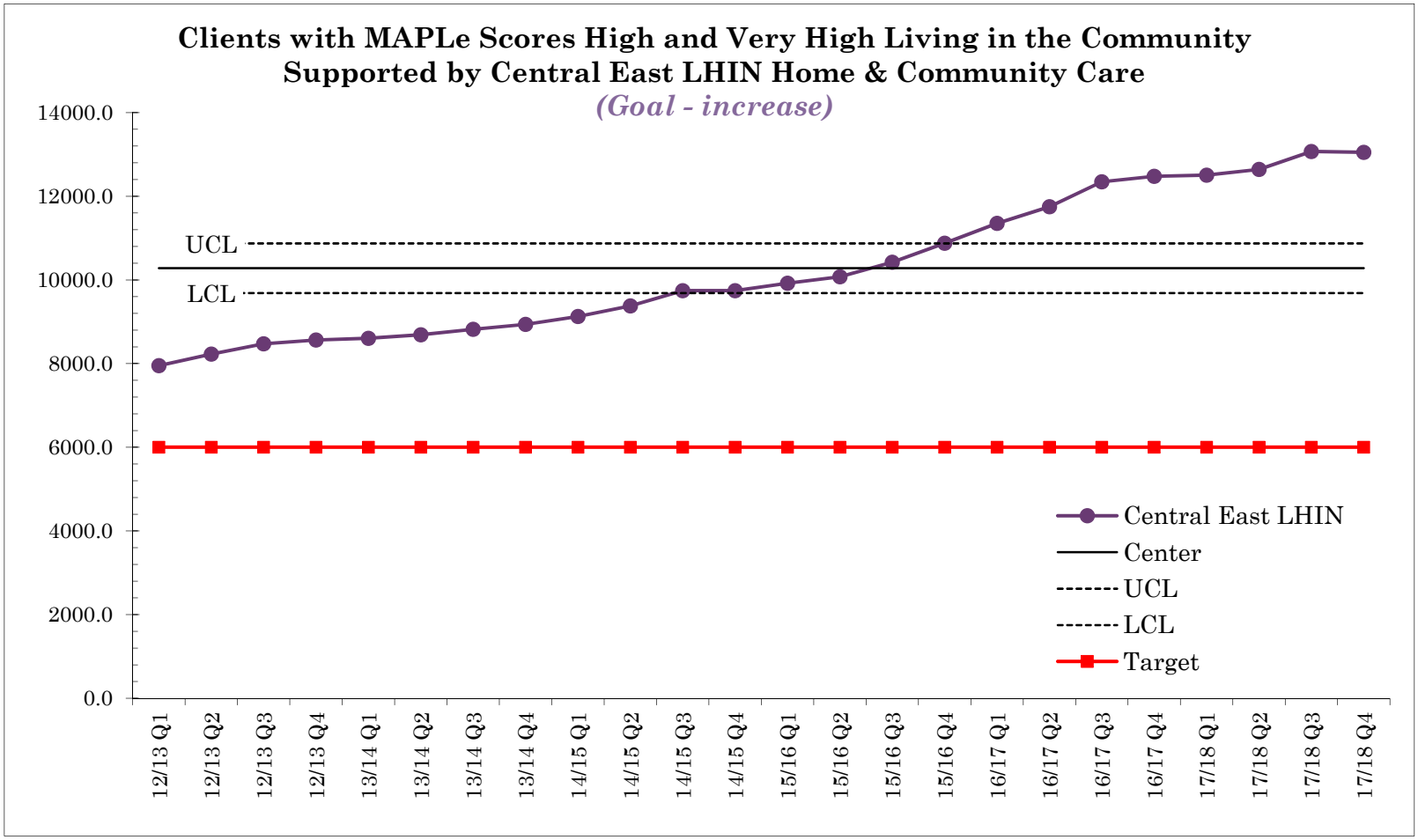
- Cumulative Days Saved = Projected Total Length of Stay (TLOS) – Estimated TLOS
- Projected TLOS represents a projection of what the TLOS would potentially be based on three years of historical data.
- Estimated TLOS represents the actual length of stay for each fiscal year. Estimated values based on aim assumptions are used until actual values are known. Values are known to Q4 2017/18.

Goal: Reduce Alternate Level of Care (ALC) days for people aged 75+ by 20% by 2019

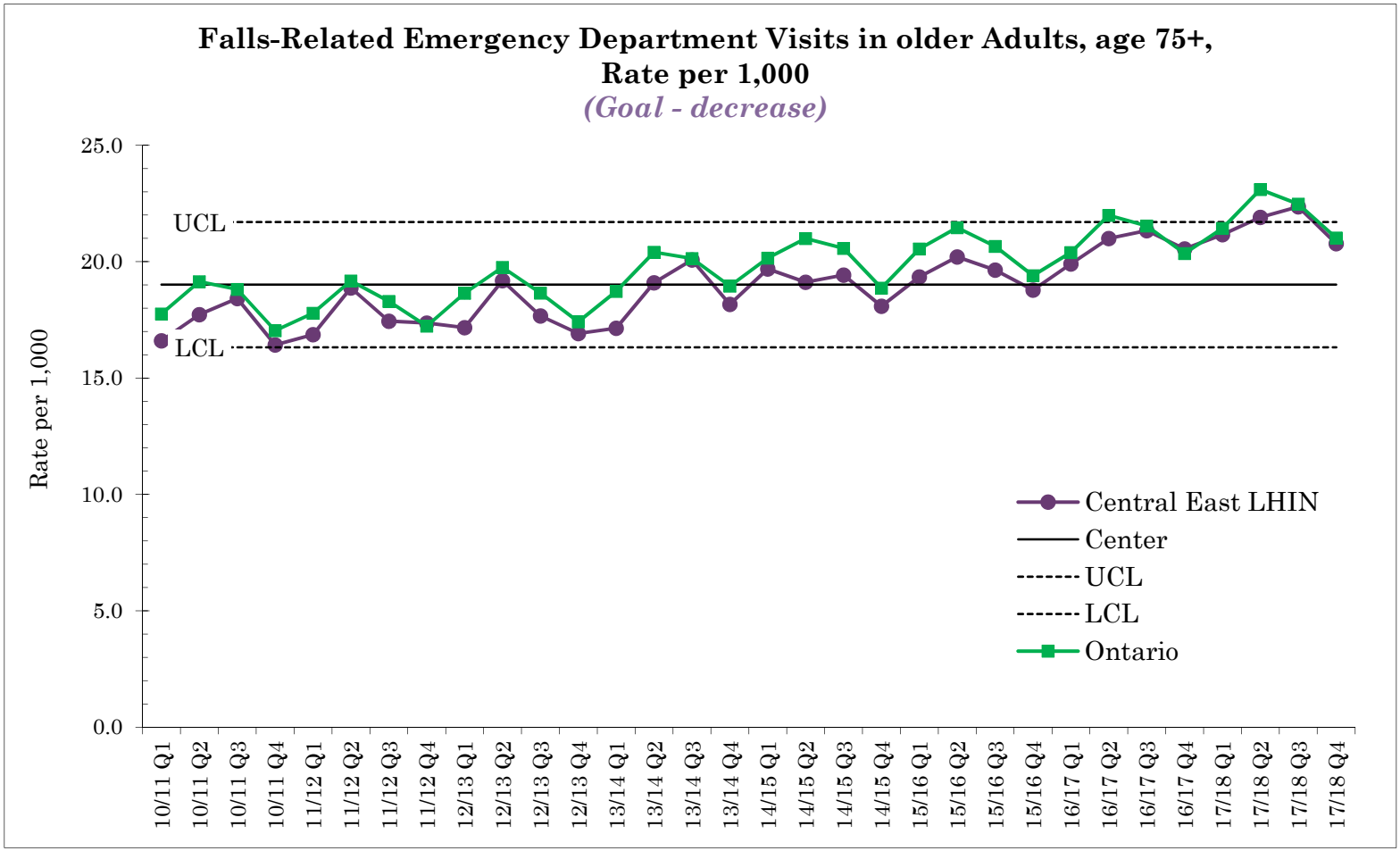
- Cumulative Days Saved (%) = (Projected ALC days – Estimated ALC days) / Projected ALC days.
- Projected Alternate Level of Care (ALC) represents a projection of what the percentage of ALC days would be based on three years of historical data.
- Estimated Alternate Level of Care (ALC) represents the actual percentage of ALC days for each fiscal year. Estimated values are used until actuals are known. Values are known to Q4 2017/18.



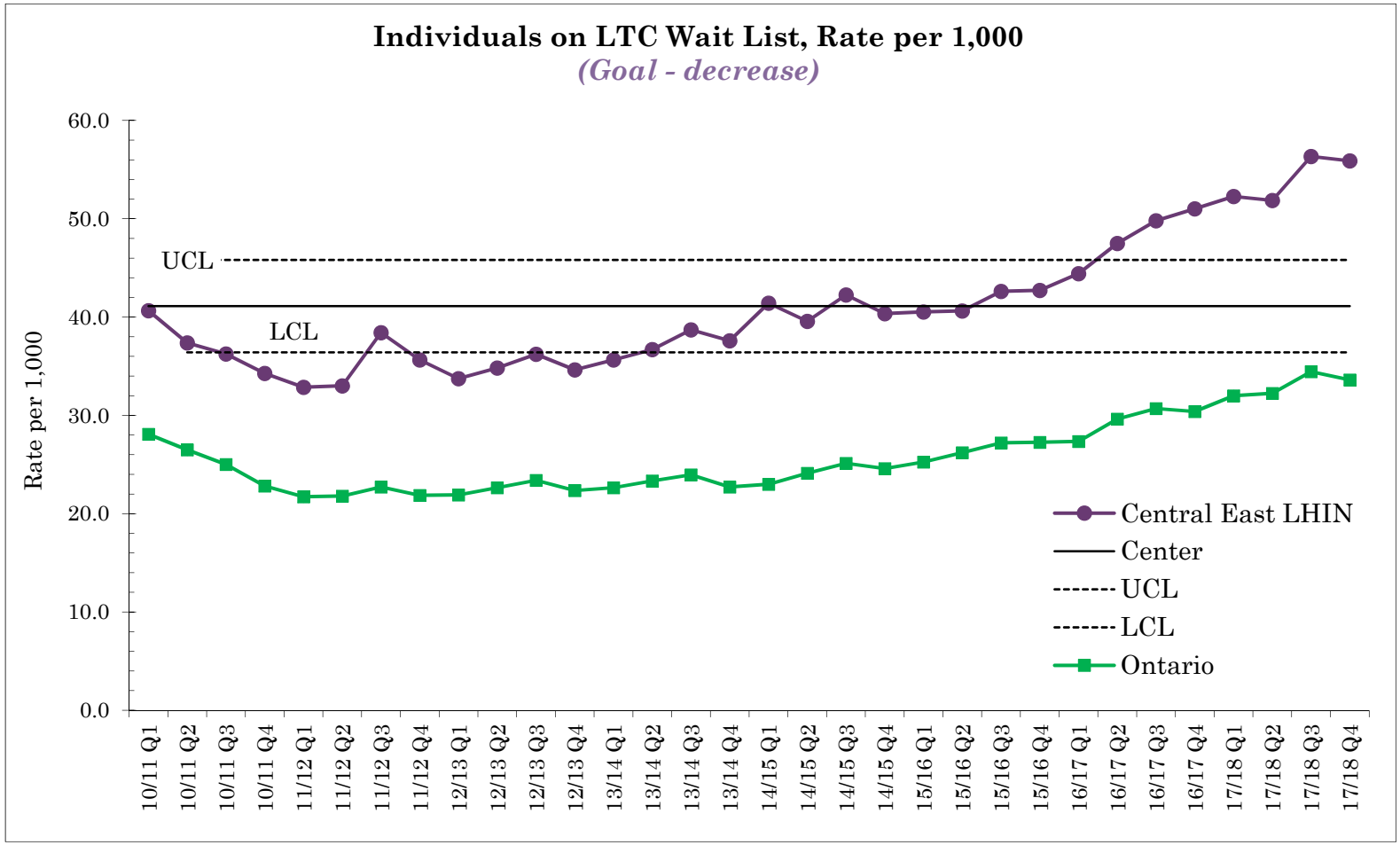
Analysis: In the 4th Quarter of 2017/18, the 90th Percentile Wait Time for Home Care Services (Discharge to First Service) Hospital Setting (all clients) for Central East LHIN was 9 days; consistent with the 3rdQuarter of 2017/18. The 90th Percentile Wait Time across Ontario was 7 days during the same time period.



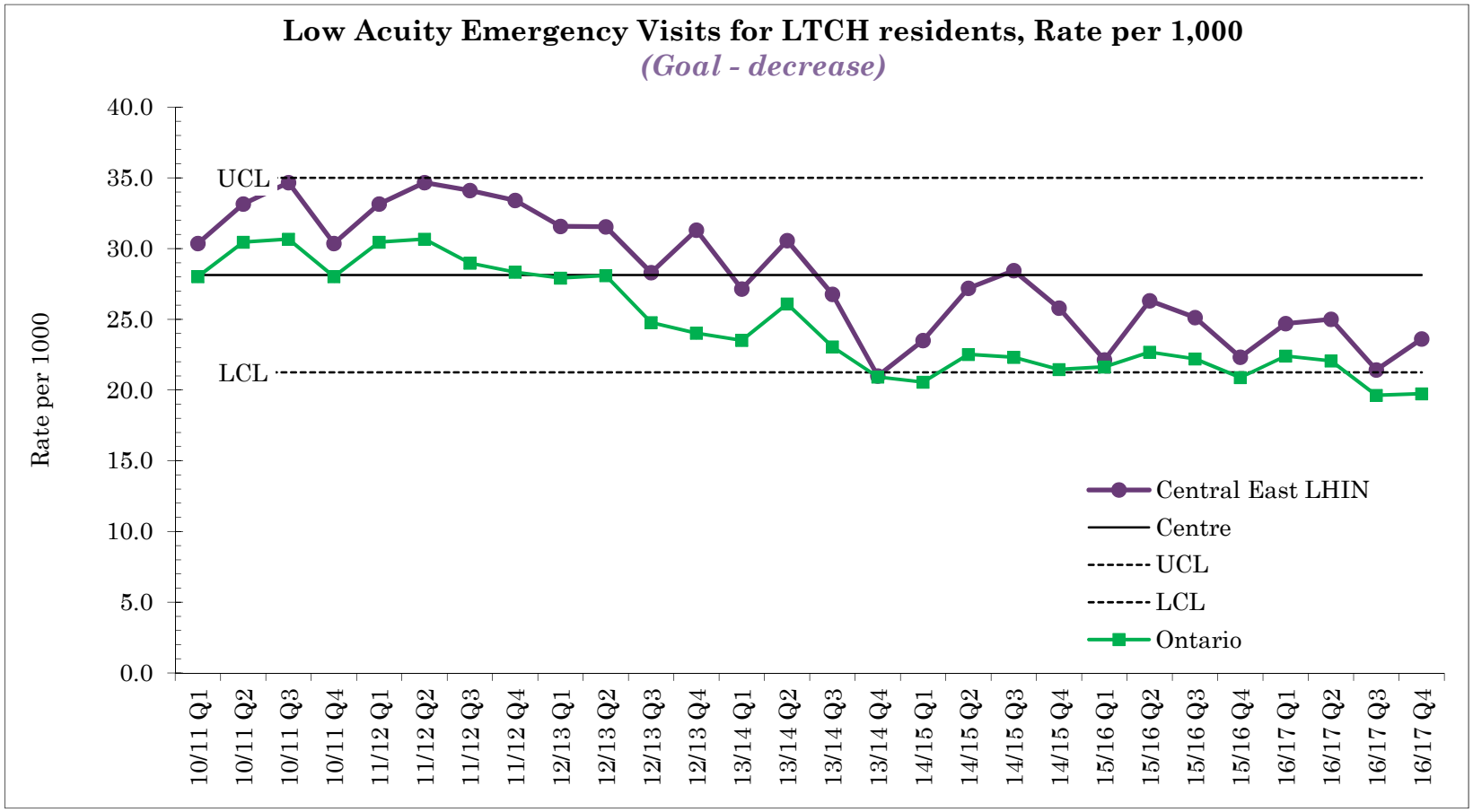
Analysis: Central East HCC client volume in 2017/18 continued to exceed the Multi-Sector Service Accountability (MSAA) target of 6,000. This would imply that the Central East HCC was doing a better job at keeping clients in the community than expected. The goal of the Seniors Aim is to keep clients in their homes and in their community and this is a positive correlation.



Analysis: The rate of falls-related Emergency Department visits in older adults in Central East LHIN continues to be comparable to the Provincial rate (20.8 per 1,000 versus 21.0 per 1,000 provincially in the 4th Quarter of 2017/18). This indicator excludes patients living at home with homecare and patients living in Long-Term Care Homes. The goal is prevention of falls and subsequent visits to the Emergency Department.



Analysis: As in previous years, the rate of individuals on wait lists for Long-Term Care (LTC) per 1,000 in the 75+ population continues to increase. Across the 14 LHINs, Central East LHIN has the highest rate of waitlisted LTC patients per 1,000. This disparity has been highlighted by the Integrated Health Service Plan Environmental Scan and is one of the key reasons for identifying Seniors as a priority population.



Analysis: In the 4th Quarter of 2016/17, which is the most up-to-date reporting available, the Central East LHIN rate increased to 23.6 Low Acuity ED visits per 1,000 LTCH residents, which is above the provincial value of 19.7. However, the overall trend is a decrease. Initiatives such as LHIN sub-regions, Community Investments, and Hospitals and Community Health Services integrations are expected to reduce ED demand by facilitating ED avoidance and diversion, and by supporting individuals post-discharge. The goal is for the residential care population to receive quality and non-hospital end-of-life care in order to reduce transfers to the ED. NPSTAT collaboration is a key player in the Central East LHIN Behavioural Supports Ontario strategy, which will have a positive impact on ED diversions from LTCH for behavioural reasons.

Appendix 2– Investments

Central East LHIN Investments in ADPs and Annual Targeted Individuals Served

Sub-region	Health Service Provider	Targeted Individuals Served	2018/19 Allocation
Scarborough North/ Scarborough South	Carefirst Seniors & Community Services Association	395	$1,511,871
	Les Centres d'Accueil Héritage	20	$59,142
	Scarborough Centre for Healthy Communities	104	$341,189
	Senior Persons Living Connected	293	$1,163,672
	TransCare Community Support Services	131	$475,715
	Yee Hong Centre for Geriatric Care	259	$1,418,008
Durham West/ Durham North East	Brain Injury Association of Durham Region	160	$325,912
	Community Care Durham	261	$981,085
	Oshawa Senior Citizens Centres	272	$1,213,334
	Regional Municipality of Durham	148	$519,968
Northumberland County/Peterborough City and County	Four Counties Brain Injury Association	112	$215,797
	Victorian Order of Nurses for Canada - Ontario Branch	506	$1,270,987
Haliburton County and City of Kawartha Lakes	Community Care City of Kawartha Lakes	192	$554,586
	Haliburton Highlands Health Services	63	$210,212
Total		**2916**	**$10,261,478**

Note: Central East LHIN did not issue any additional funding amendments to HSPs for the Adult Day Program in the 2017/18 Fiscal Year.

Central East LHIN Investments in ALS-HRSs and Annual Targeted Individuals Served

Sub-region	Health Service Provider	Targeted Individuals Served	2018/19 Allocation
Scarborough North/ Scarborough South	Carefirst Seniors & Community Services Association	332	$2,345,456
	TransCare Community Support Services	192	$1,084,204
	Yee Hong Centre for Geriatric Care	159	$1,678, 604
Durham West/ Durham North East	Community Care Durham (Oshawa and Courtice)	314	$4,143,481
	Victorian Order of Nurses for Canada	403	$3,682,828*
Haliburton County and City of Kawartha Lakes	Community Care City of Kawartha Lakes	121	$1,427,082*
	Haliburton Highlands Health Services	67	$912,885
Total		**1,588**	**$15,274,540**

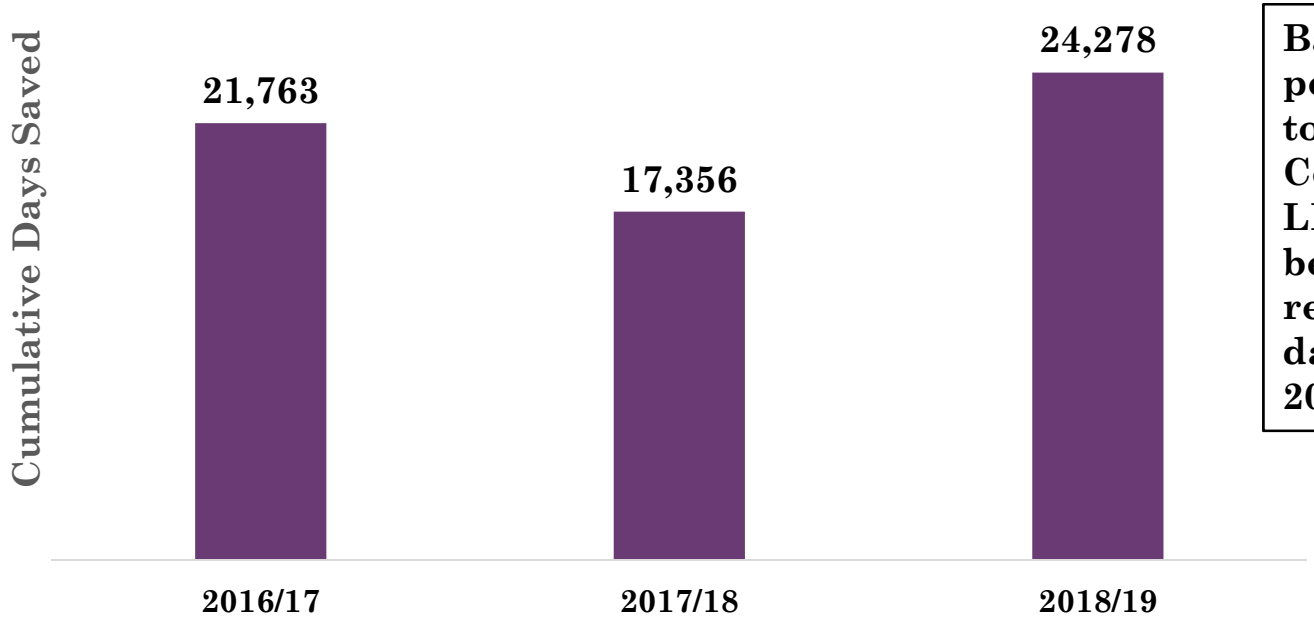
Note: The targets for individuals served include Assisted Living Services for High-Risk Seniors (ALS-HRS) and Supportive Housing, as affected health service providers report combined numbers for these services to the Central East LHIN.

* The funding allocated to the Victorian Order of Nurses is recorded as part of the Durham West/ Durham North East sub-regions, but also supports service provision in four additional sub-regions.

* Only Community Care City of Kawartha Lakes received additional funding for the Assisted Living – High Risk Seniors program in 2017/18. The 2018/19 allocation includes the additional annualized base funding of $166,826. In Q3 2017/18, a pro-rated base of $51,448 was provided.

Appendix 3 – Performance Metrics Excluding Dementia Supplementary Information

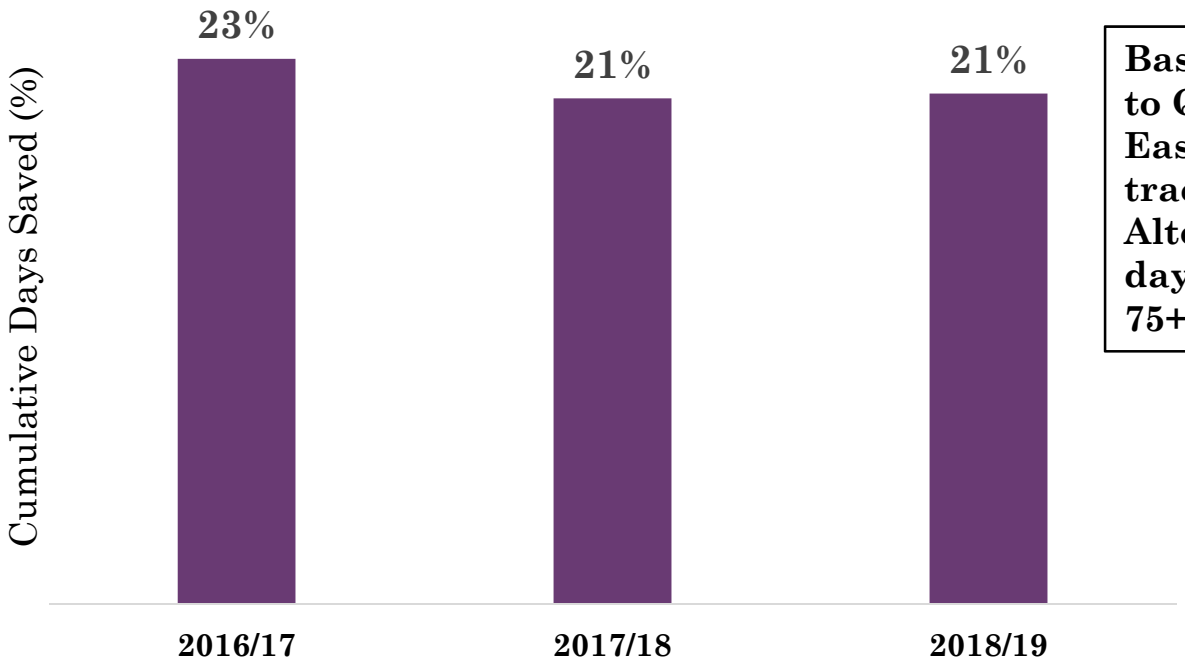
Seniors Strategic Aim: Cumulative Days Saved for People Aged 75+ Excluding Dementia Discharges



Based on performance to Q4 2017/18, Central East LHIN would be on track to reach 20,000 days saved by 2019.

	2016/17	2017/18	2018/19
Projected TLOS (days)	279,202	283,006	286,810
Estimated TLOS (days)	257,439	287,413	279,888
Cumulative Days Saved	21,763	17,356	24,278

Seniors Strategic Aim: Percentage of Alternate Level of Care Days for People Aged 75+ Excluding Dementia Discharges



Based on performance to Q4 2017/18, Central East LHIN would be on track to reduce Alternate Level of Care days for people aged 75+ by 20% by 2019.

	2016/17	2017/18	2018/19
Projected Alternate Level of Care 75+ (%)	30.0%	31.6%	33.2%
Estimated Alternate Level of Care 75+ (%)	23.2%	24.9%	26.1%
Cumulative (%)	22.9%	21.2%	21.4%

Dementia Discharges: Comparison for People Aged 75+

Acute Inpatient Discharges	2016/17		2017/18	
Total discharges	**28,632**	**100%**	**29,039**	**100%**
Discharges for Dementia	524	1.8%	520	1.8%
All other discharges	28,108	98.2%	28,519	98.2%
Length of Stay (LOS)	**2016/17**		**2017/18**	
Total LOS days	**277,288**	**100%**	**309,644**	**100%**
LOS days for Dementia discharges	19,849	7.2%	22,231	7.2%
LOS days for all other discharges	257,439	92.8%	287,413	92.8%
Alternate Level of Care (ALC) days	**2016/17**		**2017/18**	
Total ALC days	**73,667**	**100%**	**91,965**	**100%**
ALC days for Dementia discharges	14,064	19.1%	15,838	17.2%
ALC days for all other discharges	59,603	80.9%	76,127	82.8%