Central East **LHIN**

Aging at Home

Central East LHIN Board of Directors

September 22, 2010

Engaged Communities.
Healthy Communities.

Ontario
Local Health Integration Network

Presentation Overview

- Setting the Context:
  - ED /ALC in Central East LHIN
- Aging at Home:
  - Chronology of Past 6 Months
  - Major Initiatives
  - Summary of Funding
  - Decisions Required/Motions

The ED/ALC Performance Puzzle

Accountability & Performance Management

Accountability Agreements

Monthly Reporting & Tracking

HSP Dashboards (Hospital/CCAC)

CE organizational alignment of AAH/P4R/UPF

Services & Programs

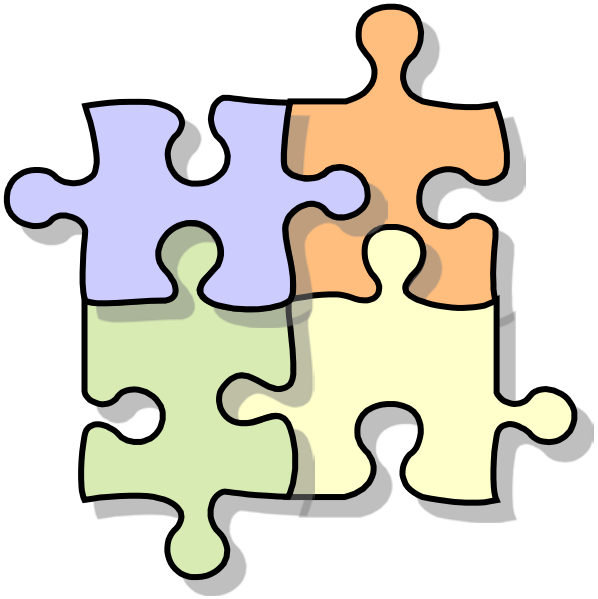
Transitional Care Beds

Home First

Geriatric Urgent/Emergent Clinics

Hospital Renewal Strategies

Others



Leadership

Hospitals Boards, CEO, Sr. Teams

CCAC Board, CEO, Sr. Team

LHIN Board, CEO, Sr. Team

Community Boards, ED's

ED Strategic Aim Coalition

Capacity Planning, Integration, & Evaluation

IHSP and 2 Strategic Aims

AAH Evaluation; U of T & MOHLTC

Convalescent Care / Rehab Services and Resource Management Strategy

Maximizing existing CC bed capacity

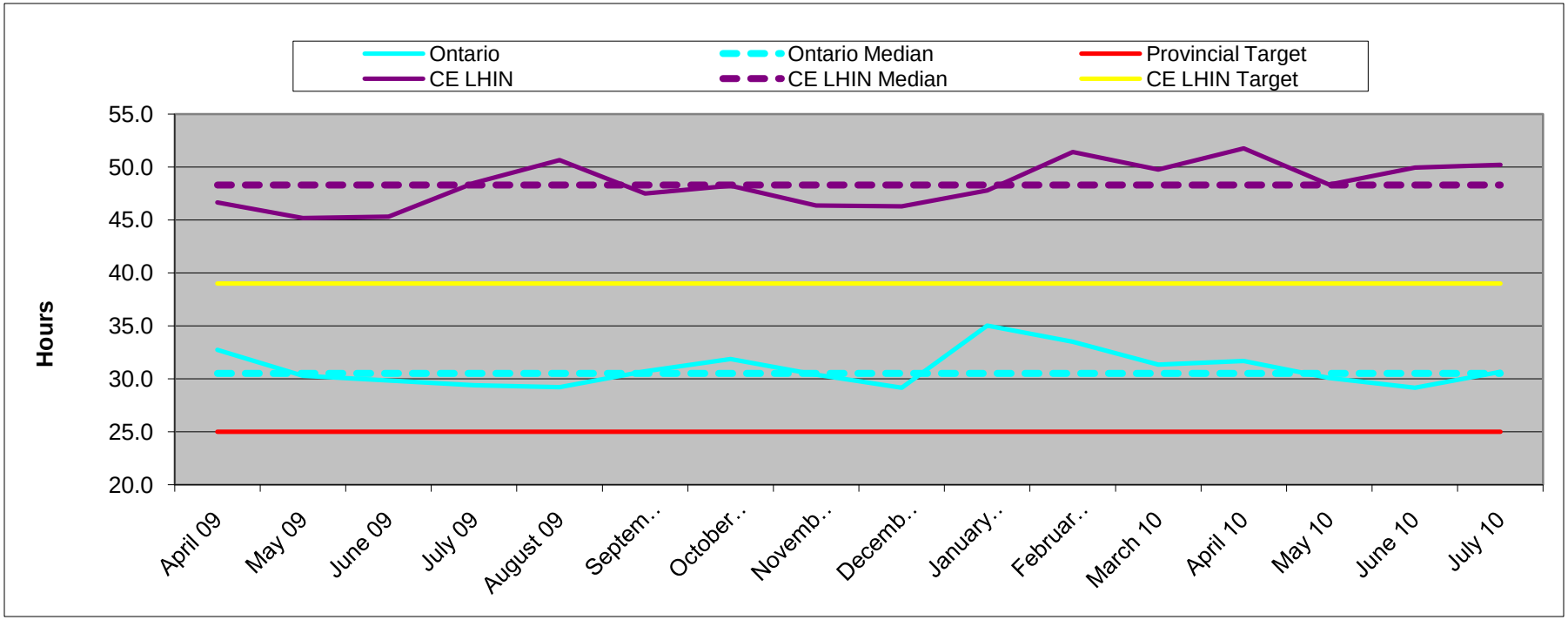
NP Outreach and Home at Last program Evaluation

CE LHIN FY2010 ED/ALC Targets (MLPA)

	Baseline (FY2009)	Target (FY2010)	Q1 Performance
% ALC Days	15.26%	12.2%	unknown (Q4 2009=19.21%)
90th Percentile ED LOS (Admitted)	48	39	50.2
90th Percentile ED LOS (Non-Admitted Complex)	8	7.6	7.7
90th Percentile ED LOS (Minor/Uncomplicated)	5.1	4.2	4.6

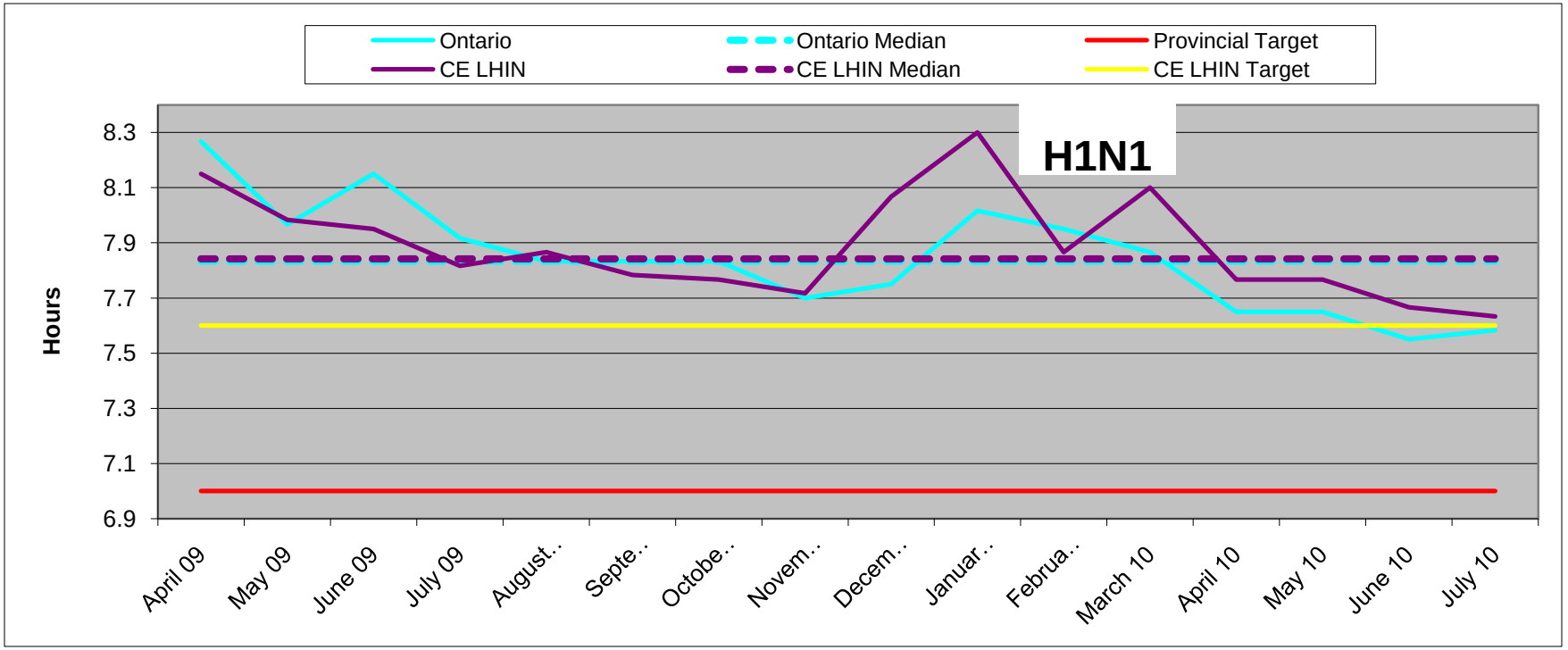
MLPA Performance Variation: ER (Admitted)

Indicator	Current Performance	Target	Variance		Provincial Target	Variance	
	Q1 2010/11	2010/11	Current vs. Target		2010/11	Current vs. Provincial Target	
ER Capacity / Performance	**Hours**	**MLPA**	**Hrs +/-**	**% Diff**	**Hours**	**Hrs +/-**	**% Diff**
90th Percentile ER LOS for admitted patients	50.2	39.0	11.2	**-28.7%**	25.0	25.2	**-100.8%**



MLPA Performance Variation: ER (Non-Admitted High)

Indicator	Current Performance	Target	Variance		Provincial Target	Variance	
	Q1 2010/11	2010/11	Current vs. Target		2010/11	Current vs. Provincial Target	
ER Capacity / Performance	**Hours**	**MLPA**	**Hrs +/-**	**% Diff**	**Hours**	**Hrs +/-**	**% Diff**
90th Percentile ER LOS for non-admitted complex patients	7.7	7.6	0.1	**-1.3%**	7.0	0.7	**-10.0%**



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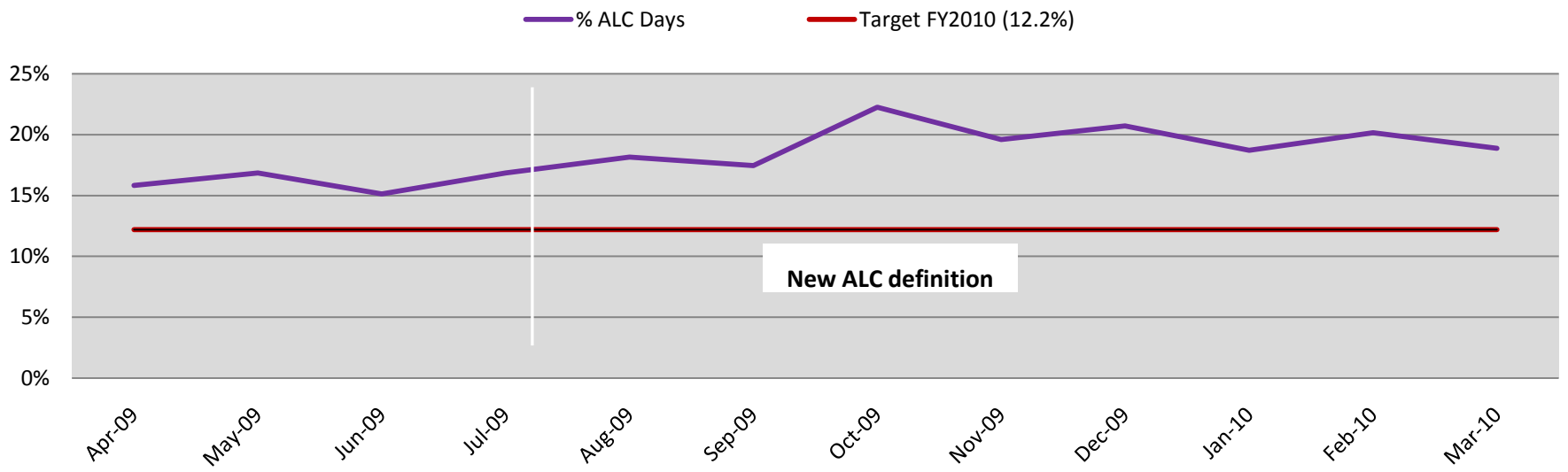
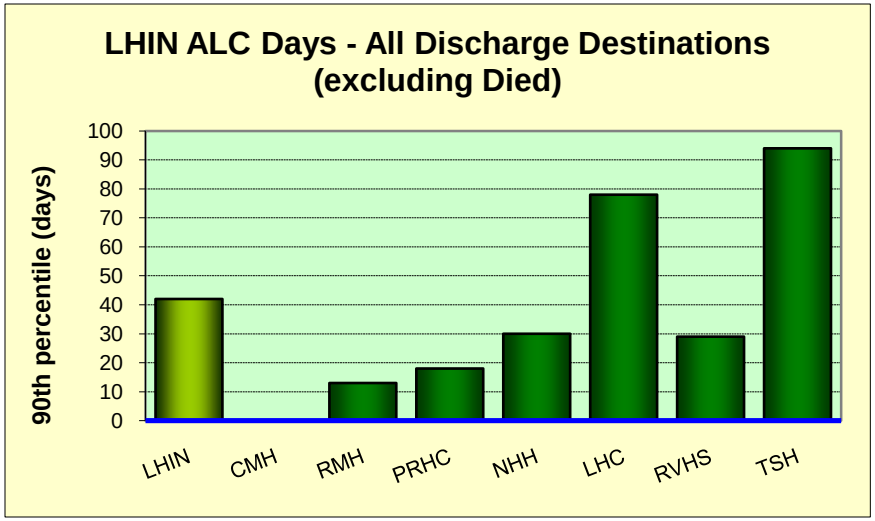
MLPA Performance Variation: Bed Utilization

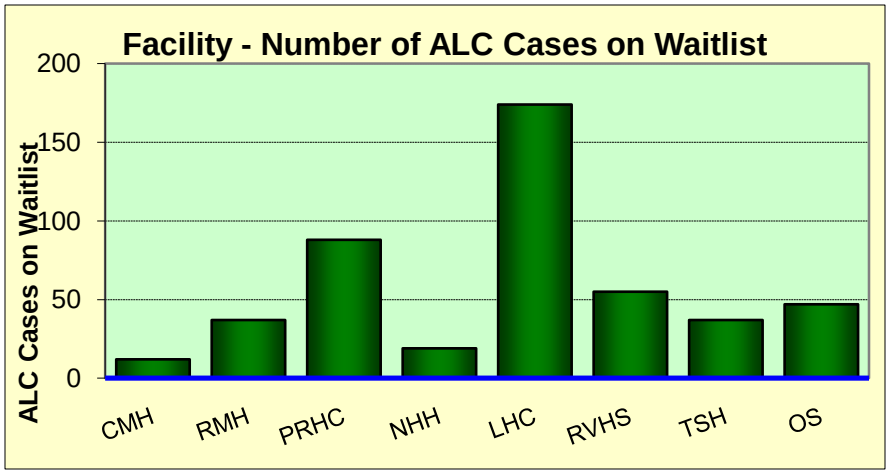
Indicator	Current Performance	Target	Variance		Provincial Target	Variance	
	Q4 2009/10	2010/11	Current vs. Target		2010/11	Current vs. Provincial Target	
Bed Utilization	**Q4 2009/10**	**MLPA**	**% +/-**	**% Diff**	**%**	**% +/-**	**% Diff**
% ALC Days	19.21%	12.20%	7.01%	**-57.46%**	9.46%	9.75%	**-103.07%**



Current ALC Status (July 2010)

	Acute ALC Days (90th %ile) [CCO]	% Acute ALC Days [DataMart]	All Cases on Waitlist [CCO]
CMH	NV	unknown	12
HHHS	unknown	28.60%	unknown
LHC	78	30.16%	174
NHH	30	21.40%	19
OS	unknown	unknown	47
PRHC	18	unknown	88
RMH	13	11.70%	37
RVHS	29	14.39%	55
TSH	94	10.30%	37





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Data from reports uploaded to MIKE, DataMart

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Aging at Home

Year 3

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Aging at Home: We've Come a Long Way…

✓	February:	Submitted Detailed Service Plans to MOHLTC
✓	April:	Transitional Care Bed Calls for Proposals
✓	May:	Home First implementation planning initiated
✓	May/June:	MOHLTC Aging at Home Forums for LHINs
✓	June/July:	Toronto Central LHIN Peer Coaching Process
✓	July/August	GAIN and Beds implementation planning initiated
✓	August:	Reworked Detailed Service Plans submitted
✓	August:	Approvals for some projects received from MOHLTC
✓	August:	Home First implemented at LHC
✓	Sept.:	Implementation planning in full swing for all 3 initiatives
✓	October:	First GAIN Clinic to open
✓	November:	First beds to open

Geriatric Assessment and Intervention Network (GAIN)

THEN

- Focused on creating capacity for geriatric care in the community
- Working with primary care practitioners
- Access to 2 specialized teams in the LHIN
- More “upstream” approach

WHY?

➢**To make a larger impact on ED/ALC**

➢**To support behaviour change in care for the elderly in hospital**

NOW

- Focus on establishing 4 geriatric urgent/emergent clinics
- Linked to acute care sites
- Access to specialized teams at each site
- Access to inpatient geriatric medical units

GAIN: Overview

- Simultaneous impact on ED and ALC anticipated and supported through Toronto Central LHIN Peer Coaching process
- Regional Program - project managed centrally by Lakeridge Health
- Establish specialized clinics at PRHC, RVHS, LHC and TSH
- Supported by inter-disciplinary teams at each site
- Hospitals supporting the clinic investment by establishing geriatric medical units that will enable direct access to in-patient capacity for frail seniors

- Operational: First Clinic at LHC, October 2010, followed by three other openings prior to March 31, 2011
- Funding: Aging at Home Years 2/3
- Total: $4.8M

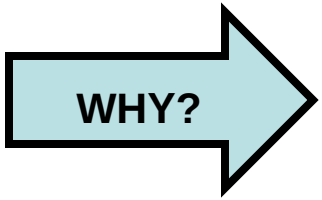
GAIN: Status

- ✓ Due to the largest volume of ALC residing with LHC, the first clinic will open in Oshawa end of October 2010.
- ✓ All funding for Year 1 of operations will be flowed to LHC who will in turn have MOUs with PRHC, RVHS and TSH
- ✓ Under the leadership of LHC, a LHIN-wide governance structure for the project has been established with a Steering Committee, an Implementation Team and Working Groups at each clinic site.
- ✓ Three positions have been posted to support the implementation including a Project Manager, Regional Program Director and clerical staff
- ✓ Funding letters from the LHIN to LHC have been signed off
- ✓ A communications plan for implementation is being developed
- ✓ Engagement of various constituencies is occurring weekly.

HOME FIRST

THEN

- Focused on CCAC services only
- Specific strategy to serve high needs clients waiting at home for long-term care home placement.



- **To make a larger impact on ED/ALC**
- **To support behaviour change in discharge planning**
- **To enable newly legislated role of CCAC**

NOW

- Focus on changing culture and practice in how discharge planning in the acute care setting is approached
- Developing a coordinated pathway from hospital to community by improving the integration of hospital, CCAC and community support services (CSS)
- Establishing clear roles and accountabilities

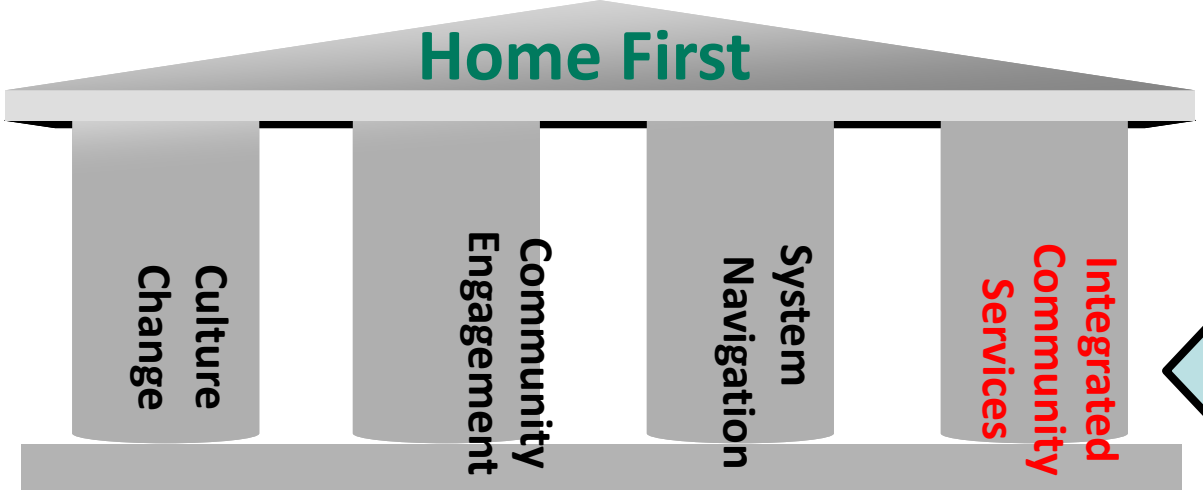
HOME FIRST: The Philosophy

- Home (wherever the patient came from) is the default destination for all patients admitted to hospital
- Decisions about major changes in lifestyle should be made from home, not from hospital
- CCAC is the destination determiner and discharge planner for all patients
- Enhanced coordination of hospital, CCAC and community support services towards the safe and timely return of the patient home

HOME FIRST: Status

- ✓ Due to the largest volume of ALC residing with LHC, Home First is being rolled out at LHC now
- ✓ CCAC critical to success and as such very engaged at all levels
- ✓ Soft launch: August 23rd followed by official launch Sept. 7.
- ✓ Governance structure includes a Steering Committee, an Implementation Team and several Working Groups at LHC.
- ✓ Home First will be implemented across the LHIN by March 31, 2011.
- ✓ Funding letters from the LHIN to CCAC have been signed off
- ✓ A communications plan for implementation has been developed
- ✓ Engagement of various constituencies is occurring weekly.
- ✓ Root Cause Analysis Team has been implemented to review how and why future ALC designations are occurring.

Home First



- Create a shared belief by providers that the patient is best served when we think, **"Home First"**
- CCAC builds an early relationship with patient/family along with the hospital team
- Team includes hospital , physician, CCAC, CSS and patient/family – in other words – each role is appreciated and involved where necessary
- Coordinated communication about discharge
- PDSA premise adopted

- Create improved awareness and understanding of the best environments to make decisions and deliver care.
- Improve the management of community expectations about discharge practices from hospital
- Develop greater understanding among all members of healthcare system about optimal patient flow

- Early engagement with patients and other members of multidisciplinary team by CCAC
- CCAC assessment and determination of discharge destination with patient/family
- CCAC involves other members of team including CSS in ensuring patients return home safely .

- Every appropriate client receives an individualized community service package to support a safe transition from hospital (CCAC and/or CSS services)
- Earlier and enhanced coordination between providers to engage community services as required by patient
- Innovative solutions to support safe discharges which allow individuals to get and remain at home

HOME FIRST: Funding Service Components

- Investing **$2,004,680** through AAH Year 3 funding to support the implementation of Home First and enable the CCAC to serve clients with specific care needs to return home

- Target
  - 30 New Very High Needs Clients
  - 335 Existing CCAC Clients on Waitlist for Enhanced Services
  - 26 New Clients at High Risk of ALC
    - In total: 64,000 PSW; 696 Nursing; 348 therapy

- Also, increase of **$4,090,600** of Service Maximum Funding to Support
  - Clients waiting at home for long-term care
  - Enhanced Services to Clients

Home First: CSS Service Component

New: For Board Decision

- CSS provide a range of services that enable individuals to remain at home and when necessary return home from hospital including meals on wheels, respite, adult day programming, friendly visiting, transportation, security checks, etc.
- The CE LHIN has already funded CSS led programs in the LHIN that enable safe and timely discharge from hospital i.e. Home at Last and Wrap Around/Hospital to Home
  - Northumberland Hills Hospital / Ross Memorial Hospital
- Based on the learnings from these programs and premised on the Home First philosophy, staff have been engaging planning partners in the development of a robust and **consistent approach across the LHIN to engaging the CSS sector in contributing to the ED and ALC targets.**

Home First: CSS Service Component

Premises of Concept

- Experience has shown that in order for individuals to take advantage of services offered by CSS, it takes more than a simple referral
- It requires an improved understanding in the system of the role the CSS sector can play in attaining mutual outcomes
- It requires an understanding of the “basket” of services the CSS can offer to those who, as assessed by the CCAC, require a “suite” of supports in order to return home safely
- Current user pay system cannot be seen as a barrier to discharge
- There is an opportunity to better “package” and coordinate a variety of existing services in a single, comprehensive HOME FIRST approach.

Home First: CSS Service Component

Draft Concept – Key Components

1. **Lead CSS agency** determined by "region" within the LHIN
2. **CSS Care Coordinator** working within hospital-CCAC discharge planning teams to facilitate HOME FIRST and coordination of supporting CSS Services
   - A flexible basket of services that can be arranged through Lead CSS on a "unit cost" basis and at NO COST to the client
   - Hospital is pay master. Care coordination is built into the unit cost rather than a fixed cost. Allows for greater precision of targeted population.
   - Finite length of "funded" service defined with reassessment at specific intervals by CCAC
3. **Supported Referral Coordinator** working within CCAC branch offices to enable quick linkages to service for individuals residing in the community (ED diversion)
   - In support of wait-listed services or enhanced services. Current CSS capacity and policies apply.
4. **The CSS component of this project is proposed to be funded through Urgent Priorities Funding-ALC**

HOME FIRST: Considerations

- The Home First and GAIN Steering Committees as well as other thought leaders across the LHIN strongly support the concurrent implementation of these CCAC-CSS initiatives given the significant synergies anticipated in doing so.
- All parties (Hospital/CSS/CCAC) are required to enter into a Memorandum of Understanding to formalize service delivery coordinaton as part of Home First. The required coordination of all parties is in-depth and critical. **Hence,** it is the recommendation of the staff that the Board views execution of Home First as an **Integration through Funding**
- While additional consultation and development is required, staff is now seeking Board approval to move this concept forward as an integration through funding.

CSS Service Components: Supported Referral Coordinators

- Based on pro-rated number of LTC ALC days and hospital census, the following is recommended
- Investment: $275,000 annualized

Community Care	FTE
TransCare (Scarborough)	1.5
Community Care Durham	1.5
Community Care Northumberland	0.8
Community Care Peterborough	1.0
Community Care Haliburton	0.2
Community Care Kawartha Lakes	0.5
TOTAL	5.5 FTE

CSS Service Components: Support Services

- Based on pro-rated number of LTC ALC days, hospital census, and prior commitments*, the following is recommended
- Investment: 2010: $1,225,000. 2011: Recalculated based on %

Hospital	% 2010-11	$	*% 2011-12*
The Scarborough Hospital	22%	274,127	*21%*
Rouge Valley Health System	15%	179,236	*14%*
Lakeridge Health Corporation	32%	390,675	*30%*
Northumberland Hills Hospital		nil – previous allocation	*6%*
Ross Memorial Hospital	7%	86,397	*7%*
Peterborough Regional	21%	253,917	*20%*
Campbellford Memorial Hospital	2%	30,241	*2%*
Haliburton Highlands	1%	10,406	*1%*
TOTAL		**$1,225,000**	

CSS Service Components: Support Services

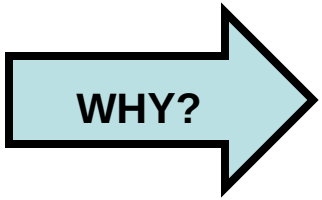
What services does $1,225M purchase?

- Estimate $3,000 / client
- 408 Clients or 17136 Days of Service
- 40833 units of service
- Units of service include:
  - Food Services
  - Adult Day Program
  - Transportation
  - Respite
  - Friendly Visits
  - Settlement Support
  - Homemaking / Home Help / Home Maintenance
  - Other One-Time Expenses

TRANSITIONAL CARE BEDS

THEN

- Focused on two calls for proposal processes
  - Convalescent care beds in Bowmanville
  - Working with NHH as it reconfigured its bed complement (interim LTC beds and restorative beds being added)
- An analysis of options was underway with PRHC through the HIP process.



➢**To make a larger impact on ED/ALC**

➢**To support hospitals in ensuring the beds available were more aligned with the needs of the patients they were serving**

NOW

- Moving ahead with convalescent care beds in Bowmanville and plans at NHH.
- Now have a solid plan at PRHC
- NEW: More recent discussions with hospitals have surfaced plans at both TSH and RVHS
- Discussions are ongoing at other hospitals but no firm details at this time.

Transitional Care Beds

- The longer a patient remains in the hospital the more likely they will experience functional decline and require additional supports to return home.
- Patients who require assistance or are dependent on others for their self-care are at higher risk of requiring LTCH placement.
- Thus, the desire to limit functional decline wherever possible.
- A day spent in a transitional care bed is a day not spent in ALC designation in hospital.
- The introduction of these beds is assisting hospitals in managing their overall planned bed reconfigurations.

Transitional Care Beds

In general, the target population for the beds will benefit from a limited time spent in a restorative care environment from which they will be able to return home safely.

Location	Bed/Program Type
Strathaven, Bowmanville	Convalescent Care Beds (15)
Northumberland Hills Hospital	Restorative/Rehab Beds (8) Enhanced Therapy Model of Care
Peterborough Regional Health Centre	Restorative/Rehab Beds (12) Interim Long-Term Care Beds (7)
New: The Scarborough Hospital	Geriatric Activation Model of Care (Acute)
New: Rouge Valley Health System	Restorative Care Beds (20)

Previously Approved Beds and Related Programs:

Bowmanville

- **Convalescent Care Beds (15)**
- Retirement section of LTCH
- Accessed through CCAC
- Engaged Compliance Branch
- Working with provider on necessary retrofits
- Funding: AAH Year 3
- Operational: November 2010

Northumberland Hills Hospital

- Reducing 16 acute, 7 CCC
- Opening 16 r**ehab/restorative care beds of which 8 are LHIN funded**
- **Enhanced therapy** model of care including extended hours of service
- Targeting 16% reduction in ALC
- Funding: AAH Year 3
- Operational: March 2010

Previously Endorsed Beds and Related Programs:

Peterborough Regional Health Centre

- 12 rehab/restorative care beds
- 7 Interim LTC Beds
- Supports Hospital Improvement Plan
- Maximizes unit efficiencies
- Targeting 10% reduction in ALC
- Funding: AAH Year 3
  - 2010: $349,886 (includes one-time start-up costs)
  - 2011: $651,488
- Operational: November 2010

This investment was endorsed In principle through the PRHC HIP

New Negotiations Based on Discussions with Hospitals

Rouge Valley Health System

- Establishing a **20 bed restorative care unit** at A/P site
- Will contribute to improved ED wait times and patient flow
- Provide a setting where patients who cannot go home and do not require acute care, receive the appropriate level of care to prepare them (recover strength, endurance & functioning) for discharge to their home.
- Based on targeted patient population, a win-win for
  - ED / ALC Reduction & Vascular Aim & Readmissions by CMG (MLPA)
- Funding: AAH Year 3
  - 2010: $696,850
  - 2011: $2,087,800
- Operational: December 2010

New Negotiations Based on Discussions with Hospitals

The Scarborough Hospital

- Introducing a **geriatric activation program** for 75+ on two acute care units (no new bed capacity)
- Program will optimize patients ability to return home after an acute care episode
- Improve ED wait times by reducing the number of ALC patients
- Providing an education and training program to build capacity for geriatric care
- Funding: Split AAH Yr 3 and UPF-ALC
  - 2010: $165,750 ($32,000 AAH, $133,750 UPF-ALC)
  - 2011: $355,000 UPF
- Operational: November 2010

Funding Summary – Previously Approval

Proposal	HSP	2010-11	2011-12	NEW
GAIN	Lakeridge Health	$2,400,000	$2,400,000	
CSS - Meals	St. Paul's L'Amoreaux Centre	$100,000	$100,000	
CSS - SH	St. John's Centre	$69,000	$69,000	
CSS - SH	Kawartha Participation Projects	$82,500	$82,500	
CSS	Community Care Northumberland	$145,000	0	
Home First	CE CCAC	$2,004,680	TBD	update
Bed Capacity	NHH	$402,225	$601,520	update
Bed Capacity	Strathaven Life Care Convalescent Care	$346,441	$600,005	update

Funding Summary – Requiring Approval

Proposal	HSP	2010-11	2011-12	NEW
Bed Capacity	PRHC iLTC (7) and Rehab (12)	$349,886	$651,488	yes
Bed Capacity	RVHS Restorative Care (20)	$696,850	$2,087,800	yes
Activation	TSH (partial – see UPF)	$32,000	0	yes
SUMMARY				
	Total Funding AAH Yr 3	$6,628,583	$6,592,313	
	Total Allocation AAH Yr 3	$6,628,583	$6,628,583	
	Difference	0	$36,270.00	