Central East **LHIN**

2008-09 Urgent Priority Fund
Update and New Approvals

Presentation to the Central East LHIN Board
January 20, 2009

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Local Health Integration Network

Urgent Priority Funding in the CE LHIN

- In 2008-09 UPF increased $1.688M
- Based on this increase and prior year commitments, $1.195M is available to fund new priorities.
- The Ministry requires that all new initiatives having a **direct impact** on ALC
- It is CE LHIN Management's continued expectation that out-year funding commitments be addressed through internal LHIN re-allocations or new funding through the Annual Service Plan process.

	2007-08	Incremental Increase **(ALC Component)**	**2008-09**
LHIN Allocation	$2,149,223	**$1,688,675**	$3,837,898
LHIN Commitments	$2,149,223		$2,642,426
Difference	0		**$1,195,472**

MOHLTC UPF ALC Component: Definition and Criteria

- The Ministry has adopted the following definition for Direct impact on ALC :

  is moving someone who has completed their acute care treatment phase to a more appropriate location or;
  providing a person presenting at an emergency department - who might have been admitted without additional support - with adequate resources allowing them to return home as an alternative to hospitalization.

- The Ministry will apply this definition to all UPF ALC proposals to ensure initiatives appropriately move patients to an alternative level of care.

Examples

- Transitional care unit for patients waiting in acute care beds; interim long-term care beds while patients are waiting for permanent long-term care beds; convalescent care beds; case manager/ED referral capacity; Home at Last, Geriatric Emergency Management Nurses

Previous 2008-09 Urgent Priority Funding Plan Approvals

In August 2008 the CE LHIN Board approved an intial set of projects that support of ALC and ED Diversion strategies, and the continued implementation of local priorities as identified in the IHSP:

Mental Health & Addictions	0.040M
Chronic Disease Prevention & Management	0.325M
ALC-Wait Times	0.625M
Unallocated	0.205M
TOTAL:	**$1.2M**

Management was committed to bring back a plan in the Third Quarter that allocated the “unallocated” portion of $.205M

Ministry – LHIN Negotiation on UPF

- September: CE LHIN submits to the Ministry its Urgent Priorities Plan, including its ALC plan.
- October: The Plan was resubmitted to meet Ministry template requirements
- October – Nov: Several negotiations took place between MOH and the LHIN to determine
  - What 2008-09 projects met/did not meet ALC-Direct requirements?
  - What previous 2007-08 and on-going projects satisfied ALC-Direct requirements so that LHIN could maximize its flexibility in funding its priorities
- November: Revised plan submitted
- January 9, 2009: Final response from MOH on our Plan
- Current: Discussions continue.

Previous Board Approvals (Aug. 2008)

Project Name	Funding		Update
ALC Activation*	$75,000	ALC Direct	Met requirements.
Nurse-Led Outreach Teams to LTCH*	$250,000	ALC Direct	Met requirements.
ALC Report Implementation Team*	$250,000	ALC Direct	Met requirements.
Hypertension Management Initiative*	$325,000	ED Diversion	Did not meet requirements. *Will look now to other funding sources*
PSW for Supportive Housing*	$50,000	ALC Direct	Did not meet requirements. *Will look now to other funding sources*
Mental Health Wellness Recovery and Action Plan*	$40,000	Core	Did not meet requirements. *Will look now to other funding sources*
** - details located in Appendix A*			

Current Status: Shifting Terrain

- Negotiations with MOHLTC continue categorizing CE LHIN Projects
  - E.g.: to date, Supportive Housing project at KPP has provided occupancy for 7 direct ALC clients, but not classified by MOHLTC as direct ALC because CE LHIN funded it last year.

- Responses required from HSPs on volumes, targets and effectiveness of new proposals

- Finding alternative revenue sources for those projects that we consider of strategic importance to our IHSP.

New UPF Projects Requiring Board Approval

- Given the previous unallocated UPF of $.205M, and Ministry's direction on projects that cannot be funded through the UPF, the CE LHIN is now presenting new projects for the Board's endorsement.

- Pending Board approval and MOHLTC/Health Service Provider confirmation, staff will flow these funds so they can create an impact for the remaining of this Fiscal Year

New Projects

Project Name	Funding		
PRHC - ALC Assessment and Coaching Team	$60,000	ALC Direct	Details in following pages
1% Challenge Initiatives • Non-urgent Transportation • Transitional Beds • Support Services for Ventilated Clients	$30,000	ALC Direct & ED Diversion	
Transitional Bed Capacity using Retirement Homes	$195,000	ALC Direct	Placeholder: Initial Target PRHC and LH. Issue RFP.
CCAC Funding for Home Care Service Maximums	$125,000	ALC Direct	Placeholder. CCAC to confirm expected volumes and impact.
Note: Should these projects proceed, there will continue to be a maximum of $130,000 surplus.			

Context for the Assessment and Coaching Team (ALC ACT)

- Ministry target for CE LHIN is 10.75% ALC days (2008/09) and 9.46% ALC days (2009/10)
- 2007/08 Q4, the CE LHIN ALC rate was 15.66%
- % ALC days at Peterborough Regional Health Centre (PRHC) increased 129% from 10.2% (2006/07) to 23.4% (2008/09)
- % ALC days increased 11% in other CE LHIN hospitals during the same time period, from 10.8% to 12.0%
- As a rule of thumb (at this point) a 25% improvement at PRHC translates to approximately a 1% improvement in the overall ALC rate across CE LHIN

PRHC – Related ALC initiatives

- Additional Case Management Supports
- Supportive Housing Investments
- GEM nurse in the Emergency Department
- Interim long-term care beds and transitional retirement home beds
- Flo Collaborative
- EMS Offload nurse

PRHC ALC Assessment and Coaching Team (ACT)

Strategy

- To assemble a local expert, peer-review ALC Assessment and Coaching Team (ACT) to review and report on the extent and causes of the ALC issues and patient experience and draft recommendations for improvement.

Purpose

- To fully understand the ALC issue as it pertains to the catchment area and to recommend short- and medium-term solutions to mitigate the current problems and minimize the risk of their recurrence.

PRHC ALC Assessment and Coaching Team (ACT)

Goals

- Quantify the extent of the ALC issue at PRHC including the following:
  - Individuals
  - Hospital
- Provide recommendations to PRHC for improving patient flow and reducing ALC
  - Hospital-focused
  - Partner-focused (interactions with provider partners)
- Provide a report to the hospital and the CE LHIN

PRHC ALC Assessment and Coaching Team (ACT)

Deliverables

1. PRHC ALC Data review
2. PRHC ALC Process improvements
   - ALC Task Group report recommendations
   - impact of FLO Collaborative and spread
   - Other initiatives targeted at reducing ALC
3. Charting the Patient Experience – assess and describe current ALC clients
4. Description of Patient Need – description of care needs and care alternatives

PRHC ALC Assessment and Coaching Team (ACT)

Anticipated Outcomes

- An improvement plan that will:
  - Fully articulate the issues and needs related to ALC clients and PRHC
  - Enhanced patient experience for those deemed or prevented from becoming ALC
  - Recommendations targeted to achieve a 30% reduction of current PRHC % of ALC days
  - Implement relevant recommendations of the CE LHIN ALC Task Group and other recommendations of the ACT

Board Motions

- The Central East LHIN Board authorizes Management to allocate the remainder of the 2008-09 Urgent Priority Funds in a manner that will support some or all of the following initiatives:

  - ALC Assessment and Coaching Teams
  - 1% Challenge Initiatives
  - CCAC home support services directed to ALC or ED diversion
  - Transitional care, assisted living, and convalescent care beds that will assist ALC clients
  - Previously approved LHIN UPF priorities (i.e., Hypertension and Mental Health Wellness)

- Management will report back to the Board in February 2009 regarding these allocations and its on-going discussions with the Ministry of Health and Long-Term Care

Appendix A:

Details on Previous UPF Projects Approved by the CE LHIN Board

Nurse-Led Outreach Teams (2008-09 UPF: $250,000)

- The Nurse Practitioner Outreach Program is the cornerstone of the CE LHIN ALC plan for 2008-09. This initiative is intended to leverage to other investments:
  - MOHLTC commitment to fund 14 such teams provincially. The CE LHIN has put forward a business case for one (1) expanded team to serve the rural areas of the LHIN.
  - The investment in GEM nurses that began in 2007 as part of the provincial ED strategy. The GEM/NP Outreach tandem offers to be an effective means to promote quality of care to frail seniors and reduce hospital admissions and ALC.
  - The CE LHIN will allocate UPFs to two (2) teams that will create a standard of care across the region. Each team will be unique but driven by common performance standards.

Nurse-Led Outreach Teams – Central East LHIN statistics

- 66 LTCH in the CE LHIN and 9489 beds
  - 4104 beds in Scarborough
  - 1433 beds in Durham North-Central and West
  - 2902 beds in HKPR
- 7437 transfers to ED from LTCH for CTAS 3, 4 and 5 patients (FY 2006/07)
- 9815 transfers to ED from the LTCH (FY 2006/07)
- 1874 total ALC days resulting from transfers from LTCH (FY 2006/07)
- Average LOS = 8.4 Days; Average acute LOS = 7.4 Days
- Average time between registration and discharge for transfers from LTCH = 6.98 hours (68,468.2 hours total) (FY 2006/07)

ALC Activation Program (2008-09 UPF: $75,000)

- Program is a priority recommendation of the ALC Task Group
- Hospital –based program with CCAC support to implement demonstration project
- Directly targeted at non-acute patients residing in Complex Continuing Care and/or Acute beds as ALC patients
- Intention is to spread project across the LHIN if it proves efficacious. A business case as been submitted to the MOHLTC as part of the Priorities for New Investment/Annual Service Plan 2009-10.

ALC Activation Program

- 34%-50% of seniors experience a decline in their functional status between hospital admission and discharge. The loss of functionality may be as much as 5% every day due to inactivity and lack of stimulation and can be permanently debilitating

  (Hollander Analytical Services. The National Evaluation of the Cost-Effectiveness of Home Care)
- Target numbers:
  - 167 - 246 patients at Ross Memorial hospital may have experienced a decline in functional status in FY 2007/08.
  - 1592 - 2341 patients in the CE LHIN may have experienced a decline in functional status in FY 2007/08

Ross Memorial Hospital - Functional Enhancement Discharges by Discharge Destination

	Discharge Destination						
Type of Care	Death	Admitted to Rehab Unit	Admitted to Acute Care	Discharged to Place of Residence	Discharged to Retirement Home	Discharged to LTC	Totals
Functional Enhancement - Rehab		1					1
Functional Enhancement - LTLD		1	2	2			5
Functional Enhancement-Restorative	3	1	6	33	4	1	48
Grand Total	3	3	8	35	4	1	54

ALC Task Group Report Implementation (2008-09 UPF: $250,000)

- ALC Coordinator position to support activities of the ALC Implementation Task Group, with resources for contracting out individual projects including the following:
  - Standardized risk screening and assessment tools for the early identification of people in ED at high risk for “medically unnecessary” admission and early linkage with community supports
  - Development of enhanced Discharge Planning Process for acute patients at high risk of becoming ALC that begins upon admission (or earlier)
  - Standard policy framework for management of ALC including expansion of definition beyond acute care, public and family awareness/education strategy

ALC Task Group Report Implementation

- The ALC Task Group recommendations have the potential to reduce ALC volumes by 10% per year
- The ALC Task Group recommendations represent a comprehensive system-approach to addressing ALC issues through early identification and prevention of avoidable hospitalizations, improved hospital and patient flow processes and timely discharge practices, and increased community capacity to care for people in their own homes.
- ALC occupancy rate in acute care beds in the CE LHIN is approximately 18% and is equivalent to 165 hospital beds.

ALC Task Group Report Implementation

- Average LOS for ALC patients who were discharged home with supports was 10.8 days
- Hospital staff indicate a lack of information about available community programs, how to refer or what level of care they offer.
- The ALC definition is inconsistently applied across hospitals and thus not reliable. An ALC designation only applies to acute care patients and not other levels of are within the hospital.

Personal Support Workers for Supportive Housing (2008-09 UPF: $50,000)

- To promote equity among PSW's in LTC, CCAC and SH environments and limit service disruptions that may result in ability to discharge clients to supportive housing programs.
- St. John's Retirement Homes is funded by the CE LHIN to provide supportive housing to 75 clients year / 70 units.

Hypertension Management Initiative (2008-09 UPF: $325,00; 2009-10: $443,650)

- Project will integrate and expand scope of current vascular health Emergency Department diversion/referral service and leverage learnings from existing community-based hypertension and vascular health screening and referral programs
- An 18 month demonstration project to increase access to hypertension screening, assessment and multi-disciplinary team-based management across the CE LHIN
- Implementation of the Heart and Stroke Foundation of Ontario's Hypertension Management toolkit in clinical and community settings
- Project will identify strategies for integrated hypertension management that can be applied in various primary health care, hospital and community settings and prevent patients from requiring emergency care
- Impact Targets: 1500 patients attached to primary health care provider; 1000 patients with no primary health care provider
- ***Note*:** The investment by the CE LHIN is leveraging significant matching investments from the Heart and Stroke Foundation of Ontario and a major pharmaceutical provider.

Hypertension Management Initiative – CE LHIN statistics

- 15.5% of CE LHIN residents (age 12+) reported having high blood pressure (approximately 195,100 people). This is higher than the prevalence rate in Ontario of 14.7% (approximately 1,515,600 people).
- 7.9% of CE LHIN residents (age 12+) reported having heart disease (approximately 71,000 people). This is higher than the prevalence rate in Ontario of 7.2% (approximately 530,400 people)
- Approximately 22% of the Canadian adult population has hypertension.
  - 42% are unaware of their condition
  - Only 16% have it treated and under control.
- 90% of CE LHIN residents who reported having high blood pressure reported taking medication for high blood pressure, a similar proportion to Ontario (86%).

Hypertension Management Initiative – CE LHIN statistics

- Among Ontario residents (aged 12+) who reported having hypertension:
  - 59% had at least one other chronic condition
  - 24% had 2 or more other chronic conditions
  - 39% had arthritis/rheumatism
  - 17% reported having been diagnosed with diabetes
  - 15% had heart disease
- 2010 people visited the ED in the CE LHIN with the main problem reported as “hypertension” with an average length of stay in the ED of 4.5 hours (FY 2007/08).
- In 2007 the VHN saw more than 6100 people through its outreach BP clinics. Only 33% (approximately) of those seen had an optimal BP of 120/80.
- There are approximately 90,000 unattached patients in the CE LHIN.

Hypertension Management Initiative – Vascular Health Network Facts

- Patients referred to the VHN from the ED are seen the same day or the following business day. Testing is done at the clinic (off site from the ED) decreasing the time that patients spend in the ED. The vascular physician admits patients to hospital if necessary directly decreasing the number of patients held in the ED or admitted.
- Traditionally, a patient who has had a TIA is held in the ED or admitted. Physicians are aware that the quickest way to get the necessary investigation and consultation for someone with a TIA is through the VHN.
- The chest pain fast track clinic is currently receiving approximately 75 monthly referrals and the TIA clinic is receiving approximately 50 monthly referrals.

Hypertension Management Initiative – Hypertension Management Clinic

- Unattached patients often visit the ED for a prescription renewal. A hypertension management clinic could service these patients, directly decreasing visits to the ED.
- If an unattached patient is found to be hypertensive in the ED there are few options for the physician. Hypertension management is not a one time event as routine monitoring of blood pressure and blood work is required. Patients must return to the ED slowing down the flow. A referral to the hypertension management clinic would negate these return visits.

Wellness Recovery Action Planning (WRAP) (2008-09 UPF: $40,000)

- Collaboration across LHIN's 4 Consumer Survivor Initiatives
- Provides opportunities for consumer/survivors and consumer-operated services to access and integrate evidence-based self-help wellness education and tools by offering Like Minds Peer Support Education to prepare consumers/survivors for volunteer and paid employment roles in mental health and addiction system
- Comprehensive education strategy (train the trainers) where facilitators are trained in facilitating WRAP groups and Pathway to Recovery Groups.
- Data supports that initiative reduces hospital admissions and lengths of stay

Wellness Recovery Action Planning (WRAP)

- One of the biggest challenges identified by ED nurses and medical personnel is access to mental health beds
- ED Task group members gave consideration to opportunities for new or alignment of existing resources, and recommended that the MOHLTC should fund and evaluate a series of pilots for comprehensive Chronic Disease management strategies for mental health and palliative care
- Evaluation of a WRAP pilot project indicated a 15-25% improvement in aspects of recovery such as: realizing hope and personal strengths; negotiating distress; interpersonal comfort and skill. Qualitative feedback indicates that people found the knowledge and skills acquired in WRAP education was pivotal in their recovery.