Central East **LHIN**

ED/ALC Overarching Plan

2008/09 and Beyond

CE LHIN Board of Directors Meeting February 17, 2009

Brian Laundry, Portfolio Lead, Wait Times

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Where have we been?

Where are we now?

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CE LHIN Strategies – ED and ALC Task Groups

ED Task Group:

Problem: Increasing patient flow times for entering, treating and discharging patients through CE LHIN EDs and increasing staffing pressures.

Mandate: To examine *internal hospital practices* and strategies that will improve Emergency Department efficiency and reduce wait times.

Outcomes:

- Decrease ED Wait Times for Emergency Care including EMS Off Load Times
- Improve patient flow
- Increase patient satisfaction
- Increase staff satisfaction
- Increase quality of care

CE LHIN Strategies – ED and ALC Task Groups

ALC Task Group

Problem: **"**ALC is a complex, serious system issue that impacts patient access to care, patient safety, and patient quality of life. It is costly to the health and well-being of the patient and their loved ones, and it is costly to the health care system… this pressure will continue to grow until ways are found to improve patient flow and system capacity." (CE LHIN ALC Task Group, 2008)

Mandate: **"**To determine the underlying causes and contributing factors to ALC issues in Central East, and recommend some practical ways that can be implemented locally to help alleviate and/or eliminate ALC pressures …"

Outcomes: Reduce ALC by 30% by December 2010 [approx. 9.73% based on 07/08 data]

ED Task Group Priorities

- LEAN processes **(most hospitals)**
- Human Resources: Recruitment and Retention **(deferred pending CE LHIN and MOHLTC HR strategy)**
- Human Resources: Credentialing / Scheduling **(addressed by Clinical Services Plan)**
- Patient Transport **(All hospitals – led by CMH)**
- Safety / Security **(All hospitals – led by RVHS and TSH)**

ALC Task Group Priorities

- Early identification of patients at risk … **(initiated in some hospitals; LHIN-wide application to be coordinated by Implementation Team/HSP)**
- Provide specialized staff resources in each hospital Emergency Department **(7 GEM nurses; NP Outreach team – HKPR, Durham, Scarborough; CCAC Case Coord - RVAP)**
- Implement a Central East LHIN standard policy framework **(to be initiated by Implementation Team/HSP)**
- Expand definition and recognition of ALC beyond acute care bed spaces **(being measured in monthly OHA survey; Implementation Team/HSP)**
- Provide in-hospital activation/exercise program to maintain optimal functioning **(pilot project – RMH, PNI request)**
- Increase the availability of housing by using retirement homes and/or supportive housing **(interest from several RH; 1% challenge submission)**
- Create Behavioural Support Unit(s) within LTCHs that include short-stay transitional beds **(HSIP submissions)**

ALC Task Group Priorities

- Implement enhanced/comprehensive community services discharge planning process **(Implementation Team/HSP)**
- Increase community support services for in-home personal support, homemaking and caregiver respite **(AAH)**
- Develop a Health Human Resource Strategy **(to align with CE LHIN and Ministry plans)**
- Undertake a Research Study to determine the percentage of hospital patients waiting for a LTCH placement that could be cared for elsewhere more appropriately **(to be coordinated by hospitals perhaps through Implementation Team/HSP)**
- Create a Central East LHIN Alternate Level of Care Implementation Committee **(ALC Task Group continued)**
- Extend CCAC service maximums

<u>Related Projects</u>

GEM Nurses **(7 hospital sites; 2048 referrals, 1588 assessments, 487 (30%) admitted, 841 (53%) discharged, 32% of assessed referred to CCAC)**

Nurse Practitioner Outreach to LTCH **(CCAC, LTCH - Oakwood, TSH)**

Flo Collaborative **(PRHC and CECCAC)**

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CE LHIN Emergency Department Data (CE LHIN ED Task Group Report, 2008)

2007/2008

Annual ED visits/yr	524,201
	81% CTAS* 3 and 4
Average Total Length of Stay	222 min / 3.7 hrs
Average Time to Physician	60 min
Average Length of Stay from Triage to Admit	
	455.5 min / 7.6 hrs

Emergency Department Reporting System (EDRS) – CE LHIN
Q1 and Q2 Combined 2008/09

	FY 2008-2009		
	Total ED Visits (CTAS I-III)	**Visits within target**	**Percent within target**
Province (all sites)	1,258,837	931,637	74%
CE LHIN (all sites)	139,513	104,360	75%
CE LHIN (designated sites)	29,504	17,816	60%
Campbellford Mem. Hosp.	3,980	3,432	86%
LHC – Bomanville	10,843	9,936	92%
LHC – Oshawa	25,481	20,396	80%
LHC – Port Perry	3,770	3,246	86%
Markham Stouffville Hosp - Uxbridge	2,855	2,481	87%
Northumberland Hills Hosp.	6,771	5,626	83%
Peterborough Reg. Health Centre	19,759	14,554	74%
Ross Memorial Hospital	10,838	7,948	73%
RVHS - Ajax	13,245	10,666	81%
RVHS – Centenary	14,236	9,042	64%
TSH – Grace	12,467	8,259	66%
TSH - General	15,268	8,774	57%

Analysis of % within CTAS Recommendation

3: Pay-for-Results Indicators

LHIN	Type	Apr-Oct 2008 (overall)	
Central East LHIN	Admitted Patient	27,973	Total
	Admitted Patient	9,832	Achieved Targeted LOS (#)
	Admitted Patient	**35.1%**	Achieved Targeted LOS (**%**)
	Non-Admitted Patient High Acuity Patient	134,615	Total
	Non-Admitted Patient High Acuity Patient	111,946	Achieved Targeted LOS (#)
	Non-Admitted Patient High Acuity Patient	**83.2%**	Achieved Targeted LOS (**%**)
	Non-Admitted Patient Low Acuity Patient	111,766	Total
	Non-Admitted Patient Low Acuity Patient	90,919	Achieved Targeted LOS (#)
	Non-Admitted Patient Low Acuity Patient	**81.3%**	Achieved Targeted LOS (**%**)

Data Source: EDRS (APR 2008-Oct 2008 data)
CTAS Recommendation:
Admitted patients treated within the LOS target of 8 hours
Non-admitted high acuity patients treated within their respective targets of 8 hours for CTAS I-II and 6 hours for CTAS III
Non-admitted low acuity patients treated within the LOS target of 4 hours

Projected Total Emergency Visits FY 2006-FY 2020

	FY 2006	FY 2010	FY 2015	FY 2020
Total for CE LHIN	**531,652**	**556,343**	**594,106**	**632,376**
% Increase from FY 2006	**-**	**4.6%**	**11.7%**	**18.9%**

ALC Data Update

Sorted by Facility Key & Institution Number

Facility Key	Inst Number	Institution Name	Q4 2007-2008 ALC Cases	Q4 2007-2008 ALC Days	Q4 2007-2008 Total Days	Q4 2007-2008 ALC Days as % of Total	2007-2008 ALC Cases	2007-2008 ALC Days	2007-2008 Total Days	2007-2008 ALC Days as % of Total
624	1597	CAMPBELLFORD MEMORIAL HOSPITAL	26	1,142	3,038	37.6%	106	4,882	12,517	39.0%
707	1893	ROSS MEMORIAL HOSPITAL	129	1,892	8,675	21.8%	492	7,617	35,940	21.2%
771	1768	PETERBOROUGH REGIONAL HEALTH CENTRE	350	6,213	25,104	24.7%	1274	22,862	97,775	23.4%
905	4465	MARKHAM STOUFFVILLE HOSP-UXBRIDGE SITE	13	670	1,620	41.4%	32	1,056	4,983	21.2%
938	3737	HALIBURTON HIGHLANDS HLTH SERV CORP-HALI	3	258	1,202	21.5%	16	1,163	4,828	24.1%
940	3860	NORTHUMBERLAND HILLS HOSPITAL	95	1,186	6,126	19.4%	355	5,872	24,344	24.1%
952	3932	LAKERIDGE HEALTH CORPORATION-OSHAWA SITE	233	3,633	23,729	15.3%	905	11,872	92,124	12.9%
952	4005	LAKERIDGE HEALTH CORPORATION-PORT PERRY	24	439	2,290	19.2%	92	1,845	8,884	20.8%
952	4008	LAKERIDGE HEALTH CORPORATION-BOWMANVILLE	88	1,154	4,643	24.9%	283	3,868	18,056	21.4%
954	3943	ROUGE VALLEY HEALTH SYSTEM-CENTENARY	91	953	17,673	5.4%	326	3,187	68,243	4.7%
954	4014	ROUGE VALLEY HEALTH SYSTEM-AJAX SITE	60	770	10,013	7.7%	266	4,502	39,300	11.5%
960	4152	SCARBOROUGH HOSPITAL (THE)-SCAR.GEN.SITE	90	1,910	25,846	7.4%	345	6,876	101,602	6.8%
960	4154	SCARBOROUGH HOSPITAL (THE)-GRACE SITE	58	1,505	17,257	8.7%	190	4,598	68,323	6.7%
			1,260	**21,725**	**147,216**	**14.8%**	**4,682**	**80,200**	**576,919**	**13.9%**

21,725 ALC Days

365 Days in Year

= 59.5 Bed Equivalents

80,200 ALC Days

365 Days in Year

= 219.7 Bed Equivalents

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Discharge Destination of ALC Cases

Sorted from highest to lowest

Data Source: Provincial Health Planning Database

Discharge Destination Facility Type	2006-2007 ALC Cases	2006-2007 ALC Days	2006-2007 Avg ALC LOS	2006-2007 % ALC Days of All ALC Days	2007-2008 ALC Cases	2007-2008 ALC Days	2007-2008 Avg ALC LOS	2007-2008 % ALC Days of All ALC Days
NURSING HOME & HOME FOR THE AGED	833	24,749	29.7	**40.8%**	1026	29,242	28.5	**36.5%**
CHRONIC CARE FACILITY	839	13,943	16.6	**23.0%**	879	16,880	19.2	**21.1%**
NO TRANSFER/UNKNOWN*	657	11,270	17.2	**18.6%**	887	15,603	17.6	**19.5%**
HOME CARE	414	4,466	10.8	**7.4%**	831	9,268	11.2	**11.6%**
GENERAL & SPECIAL REHAB FACILITY	614	5,122	8.3	**8.4%**	948	7,364	7.8	**9.2%**
ACUTE CARE FACILITY	38	697	18.3	**1.1%**	71	993	14.0	**1.2%**
PSYCHIATRIC FACILITY	13	161	12.4	**0.3%**	18	548	30.4	**0.7%**
UNCLASSIFIED/OTHER FACILITY	10	279	27.9	**0.5%**	12	212	17.7	**0.3%**
AMBULATORY CARE	1	5	5.0	**0.0%**	3	61	20.3	**0.1%**
Total - ALL Cases	**3,419**	**60,692**	**17.8**	**100%**	**4,675**	**80,171**	**17.1**	**100%**

NOTE: * Includes Deceased, Discharged Home with no Support Services, Discharged Home with Support Services (Home Care) & Left Against Medical Advice (With/Without Signout, AWOL)

Note: The above table illustrates the discharge destination of ALC cases which does not necessarily reflect the type of service required

'Snapshot' of ALC Patients in CE LHIN Hospitals Waiting by Type of Care

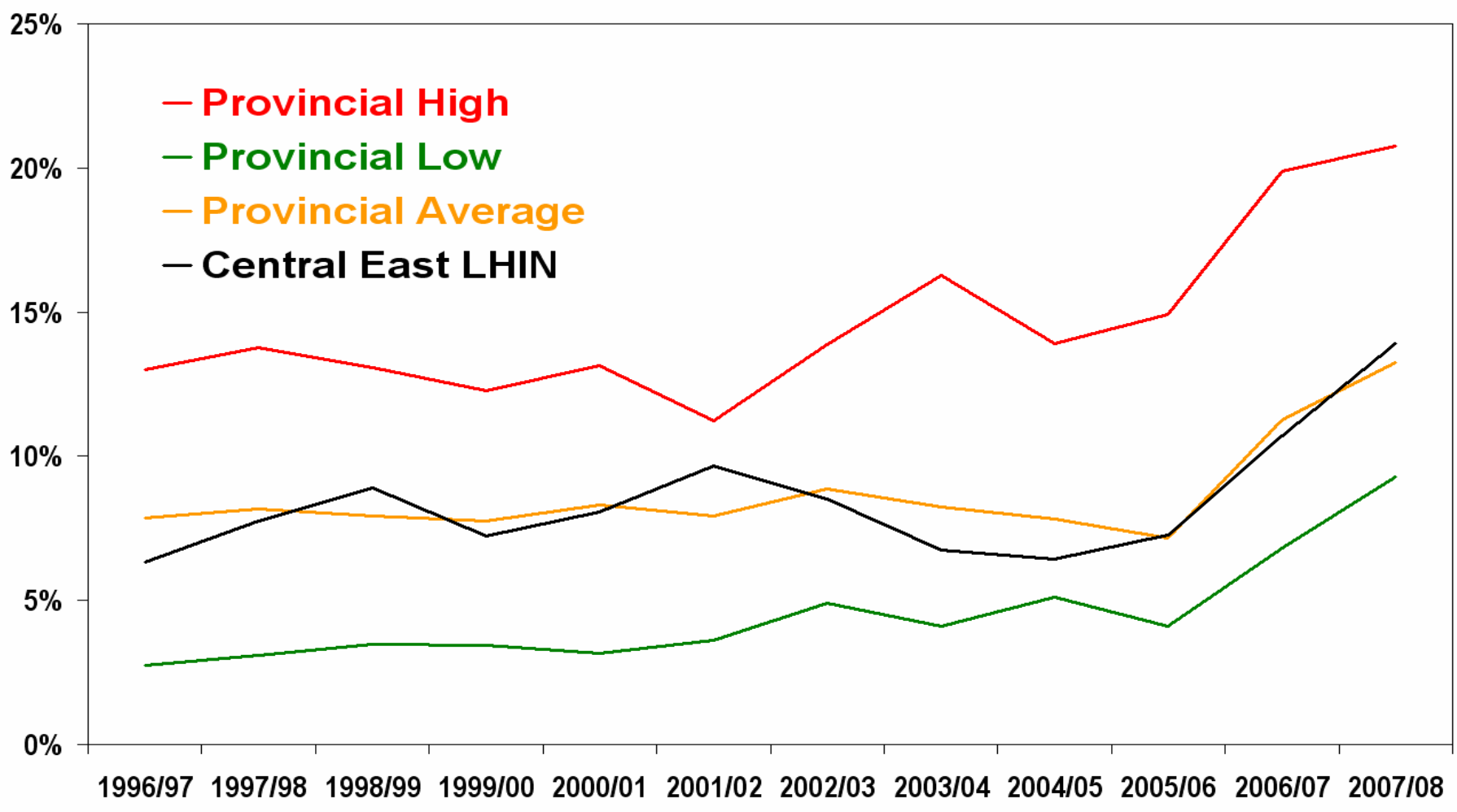
Sorted From Highest-to-Lowest

Type of Care	% ALC Patients In Acute Care Beds*	% ALC Patients In Other Inpatient Beds*
Long Term Care	66.2%	90.6%
Rehabilitation	11.6%	0.0%
Complex Continuing Care	9.7%	5.2%
Other	3.9%	0.0%
Convalescent Care	2.4%	0.0%
Palliative Care	2.4%	0.0%
Home	1.4%	0.0%
Assisted Living or Supportive Housing	1.0%	4.2%
Home Care	1.0%	0.0%
Mental Health	0.5%	0.0%
Total	**100%**	**100%**

** Data Excludes RVHS & NHH*

Source: December 2008 OHA ALC Survey Submissions

Relative Historical 'ALC Days as a % of Total Days' Performance by LHIN of Institution

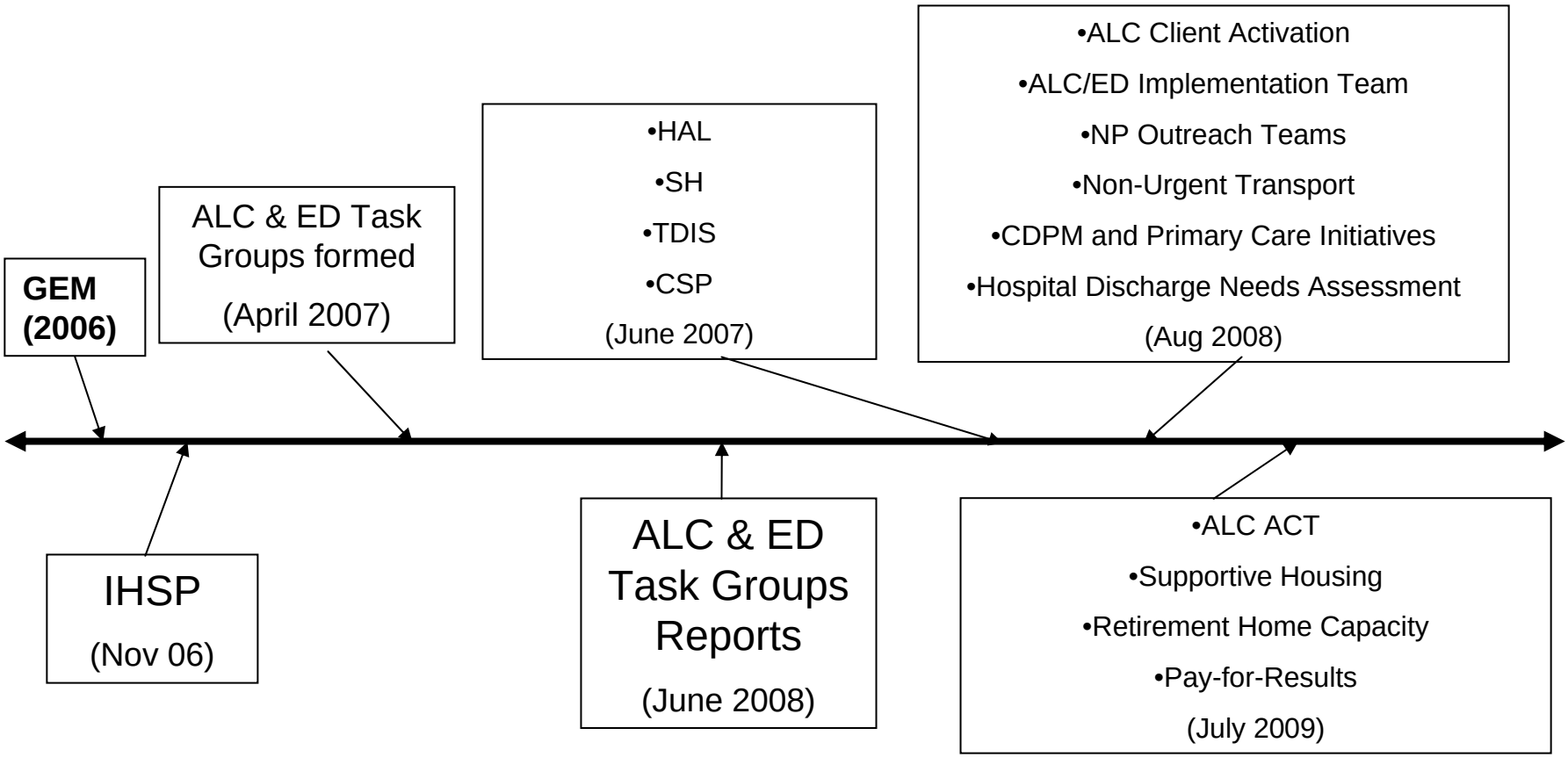


Long-Term Care Utilization

	Population Aged 75+	Long stay utili-zation	Long stay supply	Long stay residents	Long stay vacancies	Long stay wait-lists	Long stay demands	Clients placed per month
Ontario	815,957	99.3%	75,155	74,604	551	24,422	99,026	1,465
CE LHIN	99,208	99.3%	9,434	9,371	63	* 3,423	**12,794	163

* Highest value in Ontario
** Second highest value in Ontario
Note – Ontario benchmark for long stay utilization = 97%

Timeline


GEM (2006)
ALC & ED Task Groups formed (April 2007)
•HAL
•SH
•TDIS
•CSP
(June 2007)
•ALC Client Activation
•ALC/ED Implementation Team
•NP Outreach Teams
•Non-Urgent Transport
•CDPM and Primary Care Initiatives
•Hospital Discharge Needs Assessment
(Aug 2008)
IHSP (Nov 06)
ALC & ED Task Groups Reports (June 2008)
•ALC ACT
•Supportive Housing
•Retirement Home Capacity
•Pay-for-Results
(July 2009)

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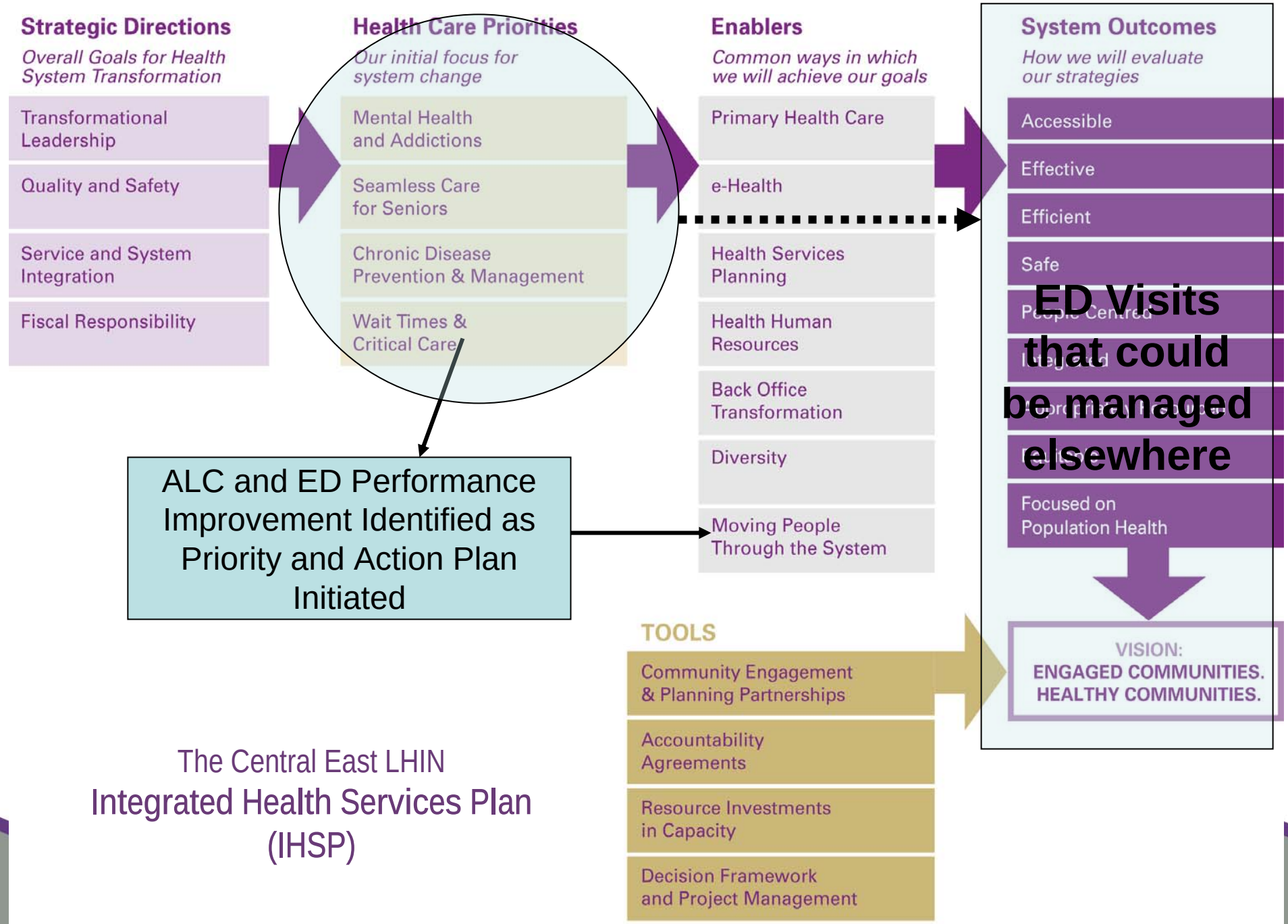

The Central East LHIN

Integrated Health Services Plan (IHSP)

CE LHIN Strategies – 2009/10

Utilize Triple Aim Planning and Measurement Framework – Population Health, Patient Experience, Per Capita Cost

Focus on MLAA measures:

- Hospitalization for Ambulatory Care sensitive conditions
- ED visits that could be treated elsewhere
- ALC %
- Wait Time to LTCH Placement

Enhanced quantitative analysis

- Description of ED clients (who?, where?, why?, what?)
- ED Wait Times (breakdown by CTAS and geography)
- Patient Flow (hospital measures)
- ALC breakdown (by *needs* and geography)
- Community Capacity (by geography and type of service)

ED Goals:

90% of Admissions Length of Stay (LOS) ≤ 8 hours
90% of Non-Admitted CTAS I / II LOS ≤ 8 hours and CTAS III LOS ≤ 6 hours
90% of Non-Admitted CTAS IV LOS ≤ 4 hours

Short-Term:

- Standardize data collection and review of Emergency Department Reporting System (EDRS) data across CE LHIN sites
- Initiate/continue projects directed to reduce ED wait times – ED Pay 4 Results

Medium-Term:

- 10% improvement in 3 performance goals for each of six designated hospitals
- Continued improvement in all CE LHIN hospitals toward 3 Goals

Long-Term:

- Maintain 90% targets and continuously improve quality of care and decrease LOS

ALC Goals:
Conserve 30,000 days Target: 50,000 ALC days

Short-Term Goal: Implement projects/programs that address community capacity and hospital practices issues that can alleviate urgent ED and ALC pressures and begin trend toward achieving targets in the medium and long-term.

Medium-Term Goal: Achieve positive outcomes through various direct impact, ED diversion and preventative projects implemented in the short-term. **Conserve 30,000 ALC days. Achieve 9.46% ALC days target**

Long-Term Goal: Maintain ED and ALC at optimum levels. Maintain ALC between 5% and 7% (or whatever is optimum predetermined level) and maintain 95% achievement of ED LOS targets.

LTC Demand/Supply, Beds/75+ ratio, ALC Snapshot

	Demand Supply Ratio	Rank Demand Supply	ALC	Rank ALC	Population	75+	% 75+	Rank % 75+	LTC Supply	LTC per 75+	Rank LTC beds per 75+	LTC Demand	Wait List
ONTARIO	1.32	7	13.95	9	13,007,380	815,957	6.3%	10	75,150	92.10	10	99,130	24,623
CE LHIN	**1.36**	**6**	**14.84**	**5**	**1,519,746**	**99,208**	**6.5%**	**9**	**9,434**	**95.09**	**8**	**12,822**	**3,469**

The Overall Perspective

(see details in handout)

ED Diversion	
- NP Outreach Teams	- **GEM** **(also a hospital flow)**
– **CKD Early Intervention and Outreach**	- **TDIS**
– Unattached Patient Initiative	- MH Wellness and Recovery Action Plan
Hospital Flow and Discharge	
-ALC Assessment and Coaching Team	- Non-urgent Transportation
-Hospital Discharge Needs Assessment	- **HAL**
-**ALC and ED Reports**	- **CSP**
-ALC/ED Implementation Team	- ED Pay for Results (also ED Diversion)
-**TDIS**	
Community Capacity	
-Case Management – ED and PC	- **Supportive Housing**
-Retirement Home Capacity	- Transitional Beds
Quality of Care/Restorative	
- ALC Client Activation	

ED/ALC Performance – new requirements of the LHIN

Participate in monthly performance meetings with the MOHLTC representatives to assess and discuss progress in achieving targets.

Participate in the Quarterly Results Meetings between the Assistant Deputy Minister (ADM) of the Health System Accountability and Performance Division (HSAPD) and the LHIN CEO.

Work with provincial and local data partners, such as EDRS site leads, Access to Care (CCO), and MOHLTC, to interpret performance data to support performance improvement discussions and intervene to correct deficiencies.

Review the Quarterly Stocktake Report* as populated by Access to Care (CCO) and by working with Access to Care and LHIN stakeholders, prepare data interpretations and provide supplementary information to explain performance.

**The Quarterly Stocktake Report is a detailed report illustrating provincial and LHIN performance against the set measures defined in the ER/ALC Funding Agreements. The Report is published quarterly for meetings with the ADM of HSAPD and the LHIN CEOs. It includes supporting data to provide insight on underlying details of performance.*

ED Pay for Results Initiative

Ministry ER/ALC Strategy goal …

"Reduce Time Spent in the ER and Improve Patient Satisfaction: Increase ER Capacity and Performance"

- $55M province-wide (additional $10M in December)
- CE LHIN - $7,095,207 to reduce ED LOS at 6 designated hospitals for 2009/2010
- LHIN plan due to Ministry in mid-March

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CE LHIN Strategies – 2009/10

Utilize Triple Aim Planning and Measurement Framework – Population Health, Patient Experience, Per Capita Cost

Plan across the full continuum of care simultaneously

ED Diversion

Hospital Flow and Discharge

Community Capacity

Quality of Care

Focus on MLAA measures:

- Hospitalization for Ambulatory Care sensitive conditions
- ED visits that could be treated elsewhere
- ALC %
- Wait Time to LTCH Placement

What We Will Achieve

ED Diversion

Sufficient community services exist to appropriately assess and care for people in the community (non-hospital based services) or support them in achieving optimum health – MLAA performance measures are met for “ED visits that could be managed elsewhere”

Ambulatory care sensitive conditions are managed in ambulatory care settings – MLAA performance measures are met for “Hospital Rate for Ambulatory Care Sensitive Conditions”

Hospital Flow and Discharge

People who access the emergency department are diverted to other more appropriate care services, if appropriate

ED Lengths of Stay are as short as possible and patient satisfaction is maximized – ED Pay for Results targets are met

Admitted patients access inpatient beds as efficiently as possible

Discharge planning begins early in the process with the expectation that clients will return home

Patients who become ALC have short lengths of stay and are discharged to services that meet their health needs without institutionalization – MLAA performance measures are met for “Percent of ALC Days”

Patients requiring LTC are able to access it in a timely manner – MLAA performance measure is met for “Median Wait Time to Long-Term Care Home Placement”

Community Capacity

Sufficient community capacity exists to allow people to stay in their own homes and/or non-institutional settings as long as possible

Sufficient community services exist to appropriately assess and care for people in the community (non-hospital based services) or support them in achieving optimum health

Quality of Care

All programs focus on and provide Quality care