Central East **LHIN**

Update on ED/ALC and Stocktake Report

CE LHIN Board Meeting: May 19, 2009

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Presentation Overview

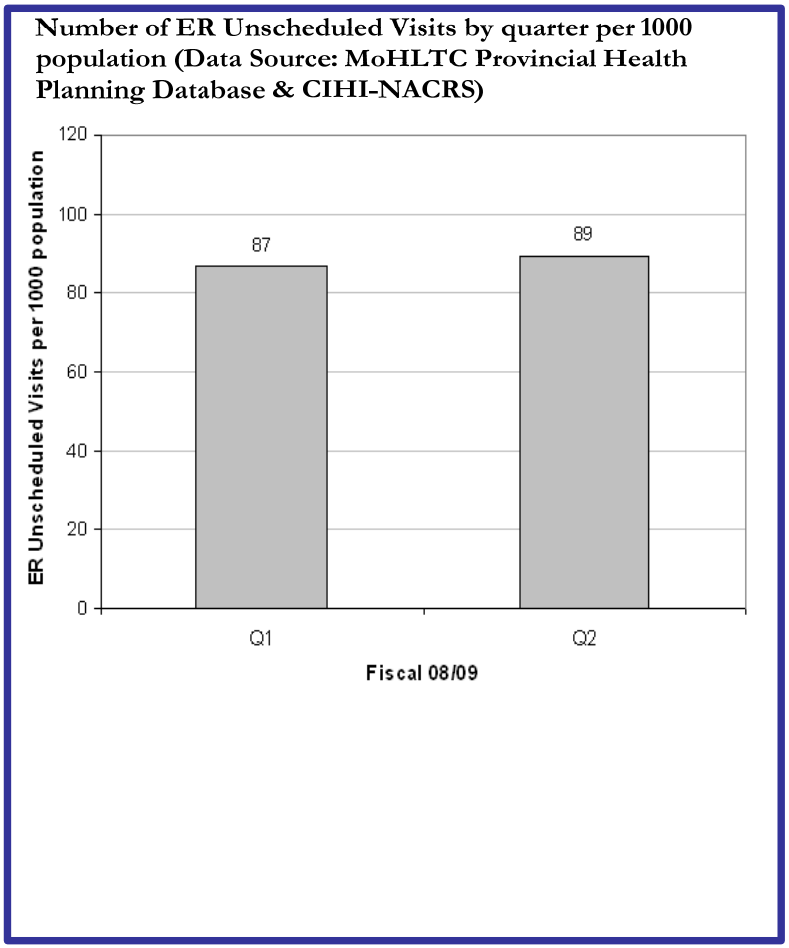
- Stocktake Report Review – results, interpretation and initiatives for each section
  - Highlights – General and by Site
  - ED Diversion
  - Pay 4 Results Year 1
  - ER Capacity and Performance
  - Bed Utilization
- Triple Aim, ED/ALC Priorities and IHSP

Stocktake Report – CE LHIN Highlights

General

- Low visits per 1000 pop compared to provincial average
- Higher ER Wait times for both high and low acuity patients
- ER Wait Times increased between Q2 and Q3 in 2008/09, especially high acuity
- Substantial decrease in the percent of ALC days from Q1 to Q2 and substantially lower percent than the province – Improving; In Corridors and Equals or Below LHIN starting point

Goal 1: Reduce ER Demand



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Stocktake Report – ED Diversion

Supplementary Data

- In Q2 (2008/09), CE LHIN had the fifth lowest number of ER Unscheduled Visits in the province
- In 2006/07, CE LHIN had the sixth lowest age-standardized rates for All Unscheduled ED visits
- In 2006/07, CE LHIN had the sixth lowest age-standardized rates for CTAS IV and fifth lowest for CTAS V

Data interpretation

- If the CTAS IV/V trend continued into 2008/09 then a misalignment existed with the relatively high LOS for CTAS IV and V reported in the current Stocktake report, suggesting improvements are needed to service that target population

Planning Partners - ED LHIN Lead; ED Chiefs; ED Task Group; ALC Task Group; Hospitals

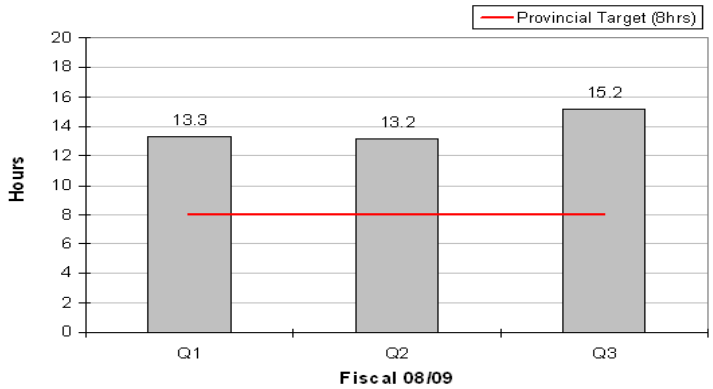
- Suggested that AAH and UPF initiatives targetted at ED Diversion have had an effect but few would have taken effect in time to impact results. However, profile of need for ED Diversion was raised among stakeholders and providers during this time period.

Reduce ER Demand – reducing the number of non-urgent cases that present at the ER will enable emergency clinicians to focus on patients with critical needs

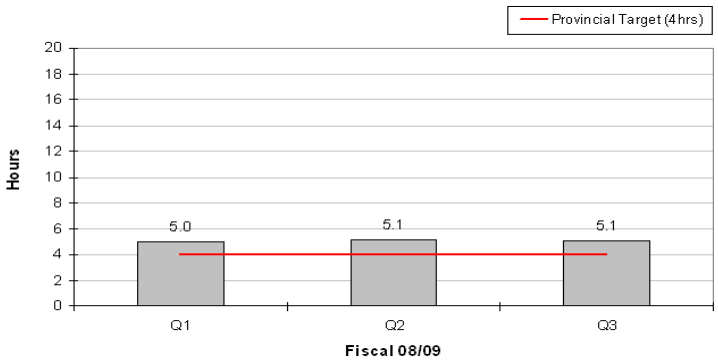
Initiative	Impact	In Progress/ Planned	Funding	ED Diversion	Capacity and Performance	Bed Use
NP Outreach Teams	**All hospital sites and selected LTCHs**	**In progress**	**MOHLTC - $250,000 08/09-11/12; UPF 08/09 - $250,000; AAH 09/10 - $600,000; P4R Yr 2 - $100,000**	√		√
MH Crisis Response and Community Beds	**LHO, LHB, RVAP**	**In progress**	**P4R Yr 2 - $1,016,989**	√		√
CKD Early Intervention and Outreach	LHC, PRHC, TSH	In progress	UPF 08/09 - $605,000 UPF 09/10 - $875,000	√		
Self-Management Training for Consumers and Caregivers	All sites	In progress	UPF 07/08 - $97,507 UPF 08/09 - $523,212 UPF 09/10 - $671,420	√		
Wellness Recovery Action Plan	WMHC	In progress	UPF 08/09 - $40,000	√		
Timely Discharge Information System	TSH, PRHC	In progress	UPF 08/09 - $166,250 UPF 09/10 - $166,250	√	√	
Multi-disciplinary Palliative Care Team	TSH, RVHS	In progress	AAH Yr 1. - $422,000	√		√
Comprehensive Vascular Health Prevention and Management Initiative	PRHC	Planned	UPF 08/09 - $140,797 UPF 09/10 - $443,650	√		
Unattached Patient Initiative	RVC, TSH, Other TBD	Planned	Met with Josh Tepper - Fully supportive of the initiative and is looking for additional resources for supporting it.	√		

Goal 2: Increase ER Capacity/Performance

Time spent in the ER for high acuity patients (all admitted + non-admitted CTAS I, II, III patients). (Data Source: EDRS)



Time spent in the ER for low acuity patients (non-admitted CTAS IV & V patients). (Data Source: EDRS)



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Stocktake Report – CE LHIN Highlights for Designated Hospitals

Site Specific

- Bowmanville had highest percent for patients that met target LOS for all three Pay 4 Results goals
- RVAP had lowest % meeting target LOS for admitted patients
- TSH - General had lowest % meeting target LOS for high acuity patients
- RVC - had lowest % meeting LOS target for low acuity patients

Proportion of patients meeting target LOS from Q1 to Q3

Admitted

- Ross Memorial Hospital only hospital that did not decrease
- Bowmanville dropped 11 pts (59% to 48%) and RVAP dropped 9 points (30% to 21%)

High Acuity

- RVC improved the most (70 to 77%)

Low Acuity

- RVC improved the most (62 to 70%)

Stocktake Report - Increase ER Capacity and Performance

Supplementary Data (2007/08)

- Mental Health Patients – 18,533 ED visits (2007/08); 39% in Durham, 5800 of which were CTAS III, IV or V

Data interpretation

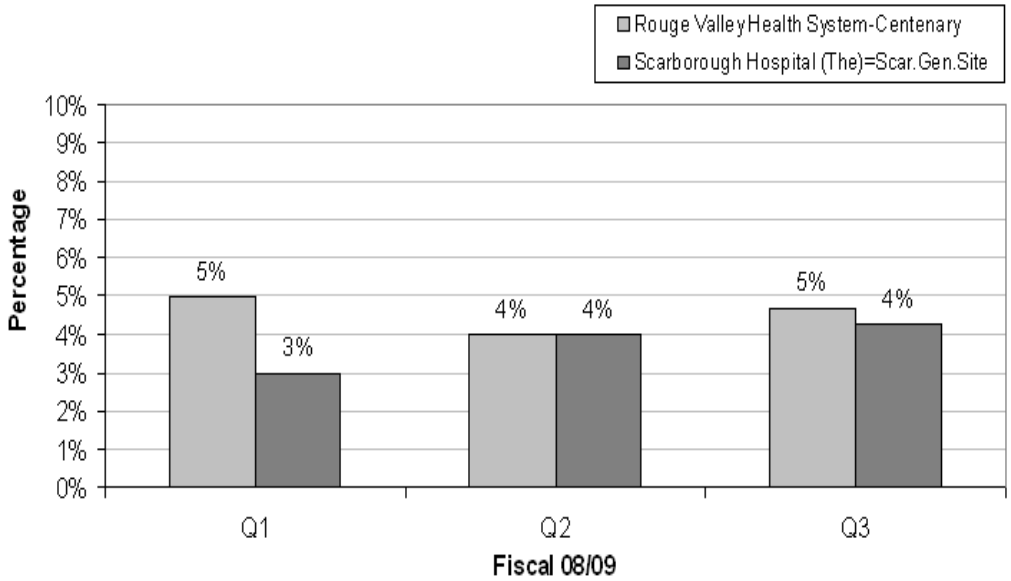
- Substantial increase for LOS for all CTAS levels from 2007/08 to 2008/09
- High 2008/09 Q3 results for high acuity patients seem to be primarily due to admitted patient LOS

Planning Partners - ED LHIN Lead; ED Chiefs; ED Task Group; ALC Task Group; Hospitals

- Seasonal trend – admissions and acuity tend to increase in Q3 and Q4 and be lower in the summer
- *"I feel it is due to issues with capacity, admitted pts in ER have increased markedly and referral patterns to ER have increased significantly. We have had significant bed closures and … the ER feels the pain."*
- Use of Med Emerg Physicians – very high utilization of diagnostics and admissions and also LOS
- *"Per capita health care spending is far less in Scarborough and Durham compared to rest of Ont."*
- *"We have been working in an over-capacity situation for a significant period of time. … Until we are able to define and manage flow given the limitations of the lack of acute care beds and the resultant ED "boarded" patients, we will continue to see these numbers."*

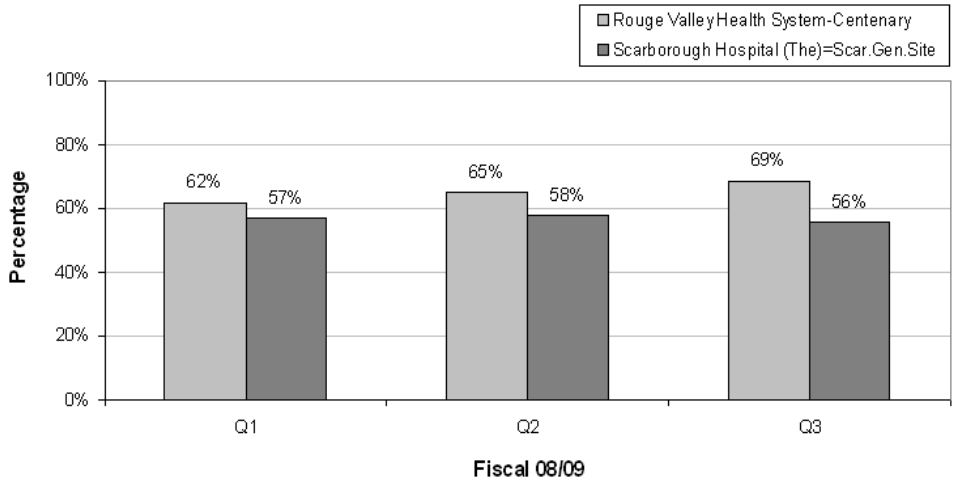
Intervention: ER Pay for Results Year 1 –

Supplementary Measures	Baseline (Q3/Q4 07/08)	Target	Current Performance
Proportion of ED-LOS exceeding 24 hrs	4%	No more than 2% of total volume by end of FY 08/09	4%

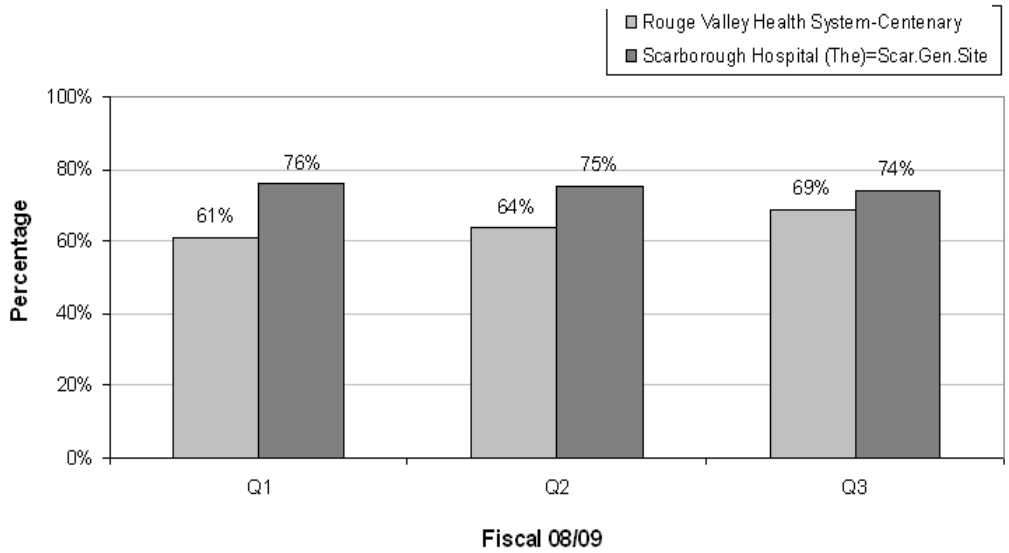


Intervention: ER Pay for Results Year 1 –

Supplementary Measures	Baseline (Q3/Q4 07/08)	Target	Current Performance
Proportion of CTAS I & II patients treated within ≤8 hours and within ≤6 hours for CTAS III	63%	5% Improvement in Q3/Q4 07/08	62%



Supplementary Measures	Baseline (Q3/Q4 07/08)	Target	Current Performance
Proportion of CTAS IV and V patients treated within ≤4 hours	69%	Stable or increasing by end of FY 08/09	71%



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Stocktake Report - Pay for Results Year 1

TSH

Results

1. Proportion < 24 hr LOS - % has dropped to 2.9 in Q4
2. Proportion CTAS I, II, III – marginal improvement from Q3 to Q4
3. Proportion CTAS IV, V – relatively flat performance

Quarterly Reporting

Site visit scheduled for May 27th with ED LHIN Lead

Recovery Process

Results only partially achieved and funding only partially spent – reviewing options for partial recovery if performance does not improve.

RVC

Results

1. Proportion < 24 hr LOS – relatively flat performance is a positive outcome given a number of inpatient bed closures
2. Proportion CTAS I, II, III – approaching target of 5% improvement despite interruptions caused by construction
3. Proportion CTAS IV, V – less improvement in this group but expecting ongoing positive results post-construction

Quarterly Reporting

Site visit – May 6th with ED LHIN Lead

Recovery Process

Results only partially achieved and funding only partially spent – reviewing options for partial recovery if performance does not improve

ED Pay-for-Results Year 2 - Overview

LHIN-Wide Community-Hospital Partnerships ($2.4M)

• MH Crisis Response and Community Beds	**$1,016,989** *(ED diversion, bed utiz.)*
• Nurse Practitioner Outreach Teams	**$100,000** *(ED diversion, bed utiz.)*
• Transitional Unit Beds	**$792,000** *(bed utiz.)*
• Wrap Around Service	**$200,000** *(bed utiz.)*
• CCAC Case Coordinator in the ED	**$270,000** *(ED diversion, capacity and perf.)*

Hospital Site-Specific Initiatives ($4.1M)

• LEAN – throughout hospital, including ED	**$1,389,000** (c*apacity and perf.)*
• Ambulatory Care Units/Rapid Assessment Zones	**$1,135,701** (*capacity and perf.)*
• Admission Units	**$240,000** *(capacity and perf.)*
• Other	**$1,335,000** (*ED diversion, capacity & perf., bed utiz.*)

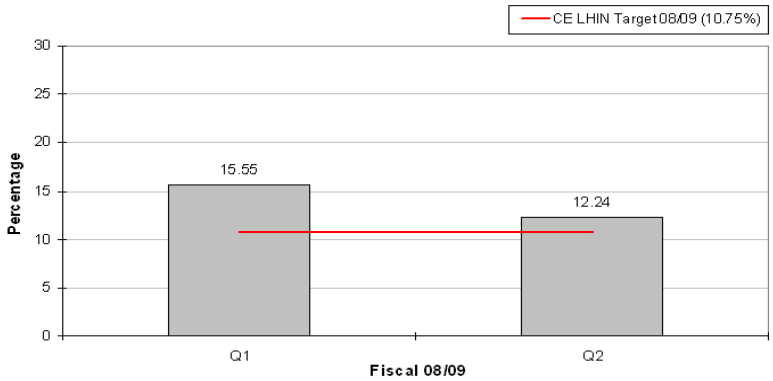
Performance Fund ($525,000)

Increase ER Capacity / Performance – improving triage and admission processes and reducing ambulance offload times will enable emergency clinicians to provide more efficient care

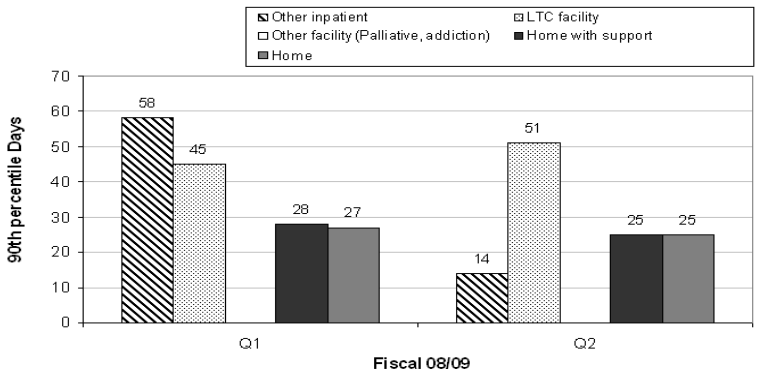
Initiative	Impact	In Progress/ Planned	Funding	ED Diversion	Capacity and Performance	Bed Use
ALC Assessment and Coaching Team	**PRHC**	**In progress**	**UPF 08/09 - $60,000**		√	√
LEAN	P4R Yr 2 sites (RVC, RVAP, TSH Gen, RMH, LHO, LHB)	In progress and planned	P4R Yr 2 - $1.4 M		√	
Rapid Assessment Zones/Ambulatory Care Units	RVC, RVAP, LHO, LHB	In progress and planned	P4R Yr 1 - $972,000 P4R Yr 2 - $1,135,701		√	
GEM	All sites except HH, CMH, LHPP	In progress	AAH 09/10 - $1.3 M	√	√	
Admission Unit	TSH, RMH	In progress and planned	P4R Yr 1 - $730,000 P4R Yr 2 - $240,000		√	√
Clinical Services Plan	All sites	In progress and planned	UPF 07/08 - $258,100 08/09 - $600,000		√	√
CCAC Case Coordinator in ED	RVC, RVAP, LHO, LHB	In progress and planned	P4R Yr 1 - $85,000 P4R Yr 2 - $270,000	√	√	
Home At Last	All sites	In progress	UPF 07/08 - $47,075 AAH Yr 1 - $501,642		√	
Virtual ED – Psychiatric Services	All sites	In progress	MOHLTC - $174,000		√	
Transportation	All sites	Planned	UPF 09/10 - $60,000 P4R Yr 2 - $65,000		√	

Goal 3: Improve Bed Utilization

Percentage ALC Days (Data Source: CIHI-DAD)



<u>Proposed Measure</u>: Number of days from ALC designation to discharge by discharge disposition (90th percentile Days) (Data Source: CIHI-DAD)



<u>Note</u>: Patients discharged against medical advice and those who died are excluded from analysis. Q1 and Q2 08/09 has not been finalized by CIHI. LHIN target TBD.

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Stocktake Report – Bed Utilization

Supplementary Data

- Long stay wait-lists in CE LHIN = 3,423 (highest in the province)
- Long stay demands in CE LHIN (combination of Long Stay Residents and Long Stay Wait List) = 12, 794 (second highest in the province)
- Even though primary discharge destination and longest ALC days are for LTC, substantial improvement could be achieved for Home with Home Care (14 days) and Home (11 days)

Data interpretation

- ALC rates may well have improved as a result of increased attention to this issue through the Provincial ED ALC Implementation Strategy and the CE LHIN ED and ALC Task Group recommendations and reports
- Expected increase in Q3 due to seasonal fluctuation; return of PRHC to “normal” levels

Planning Partner Input - ED LHIN Lead; ED Chiefs; ED Task Group; ALC Task Group; Hospitals

- “we closed an entire surgical unit during this time...so total bed days would be down as well”
- “positive impact of ALC Task Group report and implementation of initiatives, including GEM nurses”
- PRHC move – high ALC discharges prior to move in Q1 and didn’t build back up until Q3

Improve Bed Utilization – improving bed utilization expedites patient throughput and maximizes hospital capacity

Initiative	Impact	In Progress/ Planned	Funding	ED Diversion	Capacity and Performance	Bed Use
Comprehensive Community Geriatric Assessment	**TSH, RVHS, LHC**	**Planned**	**AAH Yr 2 - $2.4 M**	√	√	√
Wrap Around	**RMH**	**In progress**	**P4R Yr 2 - $200,000**		√	√
ALC Client Activation	**RMH**	**In progress**	**UPF - $289,925**			√
Supportive Housing	**NHH, RMH, HH, LHC, RVHS**	**In progress & Planned**	**AAH Yr 2 & UPF 08/09 - $2.0 M**	√		√
Caregiver Supports	All sites	In progress	AAH Yr. 1 - $1,001,975 AAH Yr. 2 - $350,000	√	√	√
Community Support Services	All sites	In progress	AAH Yr. 1 - $1,336,342 AAH Yr. 2 - $624,310	√	√	√
Transitional Beds	LHO	Planned	P4R Yr 2 - $792,000			√

Triple Aim, ED/ALC Priorities and the IHSP

Triple Aim - simultaneous pursuit of Population Health, Improved Patient Experience and Improved Cost per Capita

System Goals (Big Goals) – designed to align thinking and action. These goals will frame the content of the Integrated Health Service Plan (IHSP) and set the planning and achievement priorities for all planning partners and HSPs within CE LHIN until 2013.

DRAFT GOAL 1: Save X number of hours spent in the ER by 2013

DRAFT GOAL 2: Reduce the Impact of Vascular Disease by X% by 2013

Green Dots Goals within Population Health, Patient Experience and/or Cost per Capita, including targets TBD. Example: Save 30,000 ALC days across CE LHIN by December 2010. Moving forward .... **All initiatives will be able to articulate goals in support of the System Level Goals including measurement of expected and actual impact.**

ED, ALC and Diabetes Priorities – will be encompassed within the Green Dots and sub-goals of all planning partners and all CE LHIN activity

Planning Partners (Steering Committees, Networks, Collaboratives, Task Groups, etc) will be able to focus their thinking, planning and project implementation to align with the Big Goals and Big Green Dots and, if necessary, create sub-goals (Small Green Dots) to align action

We also hope to create a focused "ripple effect" of energy and activity leading to achievement of these goals. In so doing, all activity will also achieve the Ministry priorities to reduce ED LOS, ALC days and address Diabetes and these priorities will be articulated in several Green Dots