The Case for Change

ALTERNATE LEVEL OF CARE, LONG TERM CARE, HOME & COMMUNITY CARE

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Purpose

To introduce and discuss options that are available in the healthcare system that can positively impact the patient journey.

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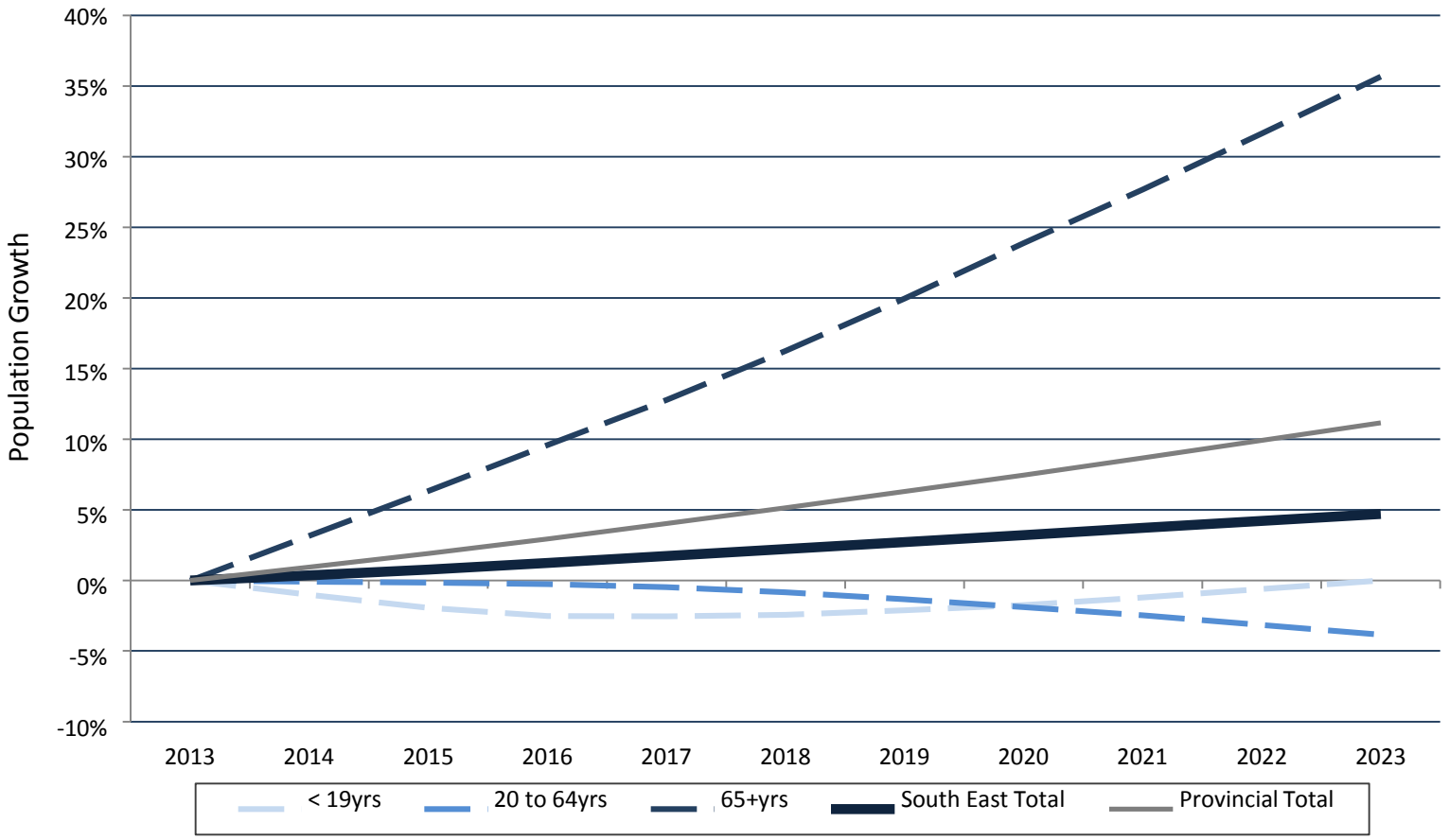
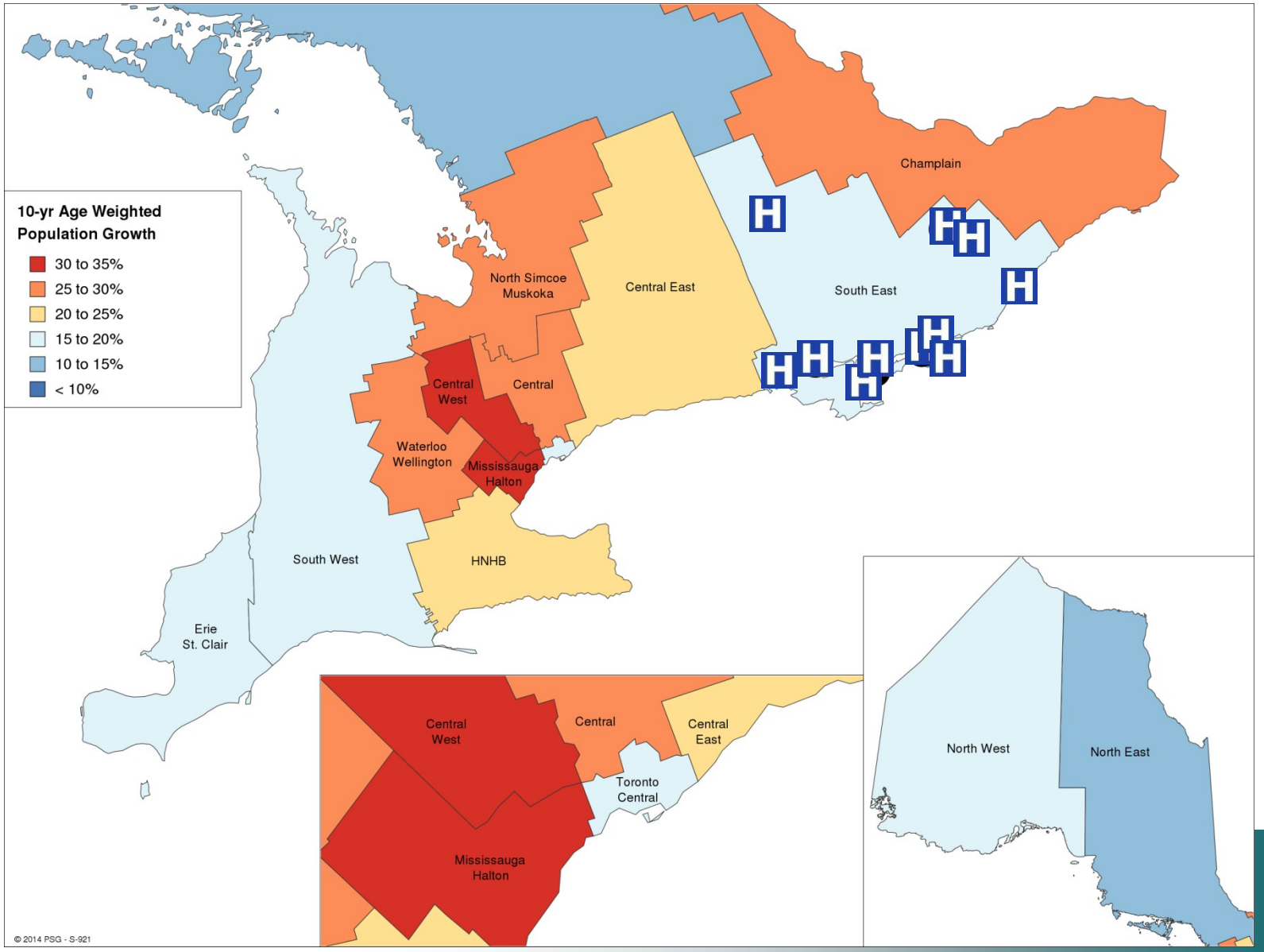
How will the South East LHIN's population change over the next 10 years?



Data Source: Stats Can, MOF Pop Projections, 2013/14 – 2023/24

Forecast growth in demand for hospital care varies by Local Health Integration Network



Data Source: DAD 2013/14, Stats Can, MOF Pop Projections, 2013/14 – 2023/24

Regional Opportunities

To identify the top leading practices for regional adoption/enhancement in the South East to improve patient flow and ultimately reduce Alternate Level of Care (ALC) levels.

1. ALC metrics and investment analysis at a regional level

2. Recommended leading practices:
   - “In-flow” initiatives
   - “In-Hospital” initiatives
   - “Out-flow” initiatives

3. Initiatives on the Horizon

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Suggested Best Practices – "In-Flow" Targeted Initiatives

- **Health Link Collaborative Care Plans** – *advance spread*
- **Assessment Urgency Algorithm and iCART** – *full regional implementation and use of information to inform in hospital and CCAC actions*
- **Information sharing** – *South East CCAC Healthline & Providence Care - Sagelink*
- **Seniors Managing Independent Living Easily (SMILE**) – *enhance as funds available*

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Suggested Best Practices – "In-Hospital" Initiatives

- **Predicted Discharge** – *all hospitals to implement/reinforce processes, tools and measurement for all units with target of 95% achievement rate*
  - Patient engagement and communication
  - Corporate patient flow accountability and real-time communication
  - ALC Policy and Escalation process

- **Assessment tools for Dementia, Functional decline and readmission** – *implement/enhance use of tools and resulting information to inform care pathway/actions in care*
- **Restorative models of care – H.E.L.P, Enhanced Activation**

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Suggested Best Practices – "Out-Flow Initiatives"

- **Enhanced CCAC services (Home First)** – *reinvigorate with leadership support by hospitals/CCAC*
- **Convalescent Care Beds** – *maximize utility*
- **Assisted Living** – *evaluate efficacy of initial roll-out and plan for spread where funding available*
- **Behavioural Support Transitional Unit** – *launch and evaluate utility*
- **LHIN wide repatriation policy** – *maintain and monitor across*
- *the region*

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Community Resources

- Rapid Response Nurses
- Nurse Practitioners for integrated palliative care
- Residential Hospice
- Enhanced Services for specific populations
- Care Coordination
- Assisted Living for Frail Seniors
- Convalescent Care
- Ambulatory Nursing Clinics
- Community supports including nursing, allied health and personal support and homemaking

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What is Alternate Level of Care?

Definition MOH Alternate Level of Care

- When a patient is occupying a bed in a hospital and does not require the intensity of resources/services provided in this care setting (acute, complex continuing care, mental health or rehabilitation), the patient must be designated ALC1 at that time by the physician or his/her delegate.
- The ALC wait period starts at the time of designation and ends at the time of discharge/transfer to a discharge destination2 (or when the patient's needs or condition changes and the designation of ALC no longer applies).

Discharge Destinations

- Home (with/without services/programs),
- Rehabilitation (facility/bed, internal or external),
- Complex continuing care (facility/bed, internal or external),
- Transitional care bed (internal or external),
- Long term care home,
- Group home,
- Convalescent care beds,
- Palliative care beds,
- Retirement home,
- Shelter,
- Supportive housing.

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ALC Volumes across SE LHIN hospitals FY2014/15

		Discharged ALC Patients, FY2014/15			Open Cases, March 31, 2015		
		#	Days	Avg. LOS	#	Days	Avg. LOS
BGH	Acute	18	291	16.2	11	362	32.9
	MH	3	180	60.0	3	220	73.3
	CCC	31	3135	101.1	16	2777	173.6
	Rehab	1	2	2.0	0	0	
	Total	53	3608	68.1	30	3359	112.0
KGH	Acute	72	8139	113.0	41	5219	127.3
	MH	5	617	123.4	3	1184	394.7
	Total	77	8756	113.7	44	6403	145.5
LACGH	Acute	31	1801	58.1	14	1049	74.9
PSFDH- Perth	Acute	36	2320	64.4	5	264	52.8
PSFDH-SF	Acute	35	1819	52.0	7	307	43.9
PSFDH	Total	71	4139	58.3	12	571	47.6
Prov Care	CC	15	1968	131.2	15	3071	204.7
	Rehab	4	349	87.3	0	0	
	MH	6	1615	269.2	19	12254	644.9
	Total	25	3932	157.3	34	15325	450.7
QHC-Ban.	Acute	7	295	42.1	0	0	
QHC-Bell.	Acute	19	477	25.1	2	38	19.0
	CC	22	1760	80.0	2	511	255.5
	MH	1	438	438.0	0	0	
	Rehab	7	276	39.4	2	11	5.5
QHC-Picton	Acute	18	571	31.7	1	6	6.0
QHC-Trenton	Acute	33	4993	151.3	11	875	79.5
QHC	Total	107	8810	82.3	18	1441	80.1

Initiatives on the Horizon

1. **Senior Assessment Clinic** – identified seniors (presenting in ER or in primary care) who need immediate specialist care (chronic disease, geriatric medicine or rehabilitative care) are rapid-assessed in a centre which provides timely, easy access to diagnostic, treatment and direct linkage with primary care. Responsive follow-up will occur with multi-health care providers i.e. Primary care, sub-acute care and medical specialists

    - Facilitating coordinated care plans in the Hospital.
    - Linking complex unattached patients to primary care.
    - Case finding within the Hospital setting.

Initiatives on the Horizon

2. Geriatric Emergency Management (GEM) Nurse

- Geriatric specialized trained nurses who assess and refer to seniors for care needs and specialists follow-up to avoid repeat ER visits, avoidable admissions and aide in system navigation – *re-engage*

3. South East LHIN Falls Prevention Programs

- Providing consistent, timely access to falls prevention classes across the LHIN with the assistance of all four Public Health Units - *spread*