

**MOHLTC - HSAPD
ER/ALC Quarterly Stocktake Report**

LHIN: North Simcoe Muskoka LHIN

Report Date: July, 2009



SYSTEM FOCUS: Reduce time spent in the ER across Ontario

What is the problem?

Almost 50% of ER visits are made by patients with non-urgent or less urgent needs

Time spent in the ER is too long: 90% of patients are treated within 9.4 hours from triage to discharge

Time in the ER is five times longer for ER patients admitted to hospital (35 hrs); 75% of their total ER time (26 hrs) is spent waiting for an inpatient bed

GOALS

What are we striving to achieve?

1 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

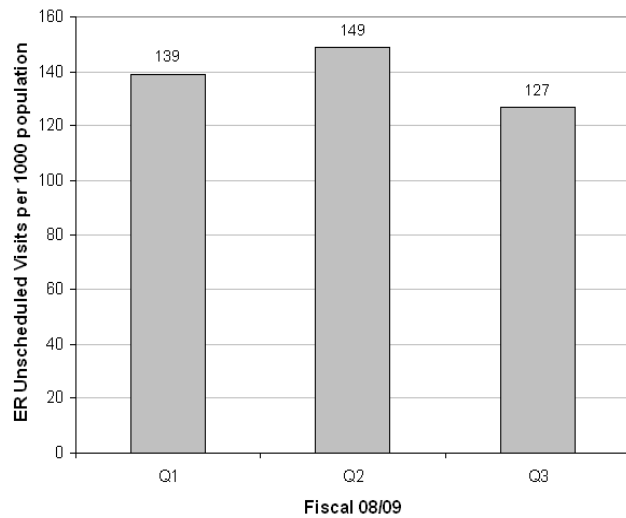
2 Increase ER capacity/performance
Improving triage and admission processes and reducing ambulance offload times will enable emergency clinicians to provide more efficient care

3 Improve Bed Utilization
Improving bed utilization expedites patient throughput and maximizes hospital capacity

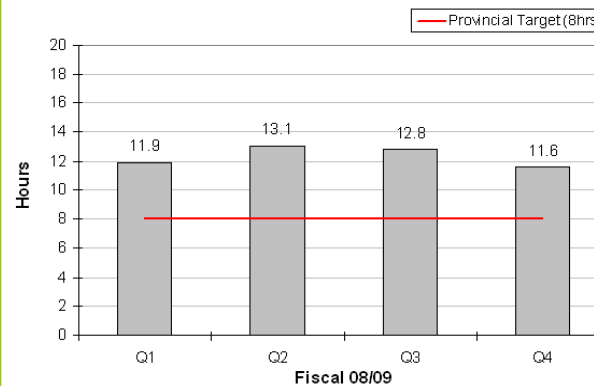
PROGRESS

Have we achieved our goals?

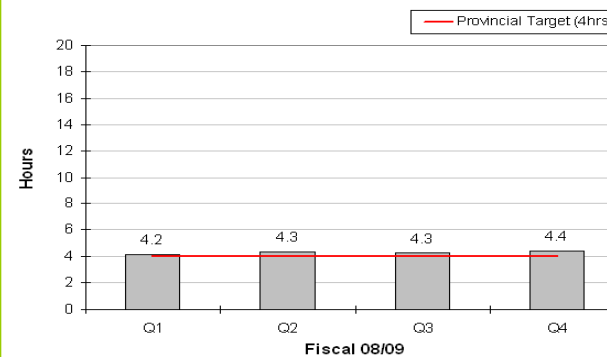
Number of ER Unscheduled Visits by quarter per 1000 population (Data Source: MoHLTC Provincial Health Planning Database & CIHI-NACRS)



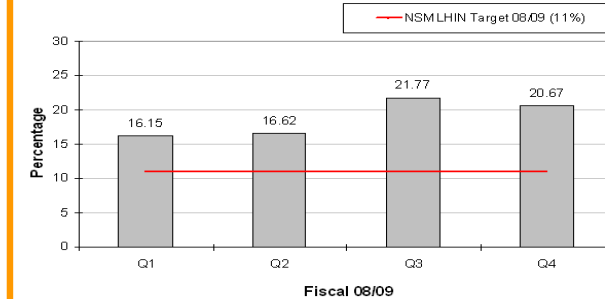
Time spent in the ER for high acuity patients (all admitted + non-admitted CTAS I, II, III patients). (Data Source: EDRS)



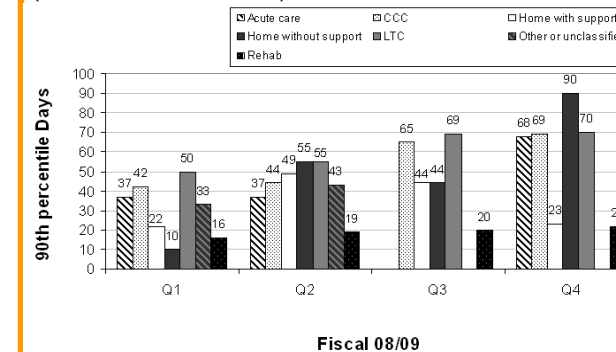
Time spent in the ER for low acuity patients (non-admitted CTAS IV & V patients). (Data Source: EDRS)



Percentage ALC Days (Data Source: CIHI-DAD)



Proposed Measure: Number of days from ALC designation to discharge by discharge destination (90th percentile Days) (Data Source: CIHI-DAD)



Note: Patients discharged against medical advice and those who died are excluded from analysis. Q1, Q2, Q3 and Q4 08/09 has not been finalized by CIHI. LHIN target TBD.

HIGHLIGHTS

Evidence of achievements and/or obstacles to progress

From Q2 to Q3 of 2008-09, the number of ER unscheduled visits per 1000 decreased from 139 to 127. Stakeholders and the public have been engaged in an ER survey to inform the ER/ALC Steering Committee's development of a three-year Strategy and gauge/enhance awareness of other health care options. The Re-ACT program outcomes in Q1 09/10 include a 50% reduction in events resulting in ER visits, decreased falls by 85%, 98% of clients maintained within community, and a significant cost savings in nursing and personal support services of \$40,937, whereas program costs were \$39,843. The Integrated Intensive Case Management initiative has resulted in a sizeable decrease in the average number of client ER visits from 12 to one per month in 08/09, an estimated annual cost savings of \$23,760 at \$180 per ER visit. Victorian Order of Nurses Falls Prevention Strategy resulted in 98% of clients avoiding falls with an average of 1 in 3 falls clients going to the ER in Q1 09/10.

The NSM LHIN has two sites participating in the ER Pay for Results initiative in Year Two. With implementation as of April 2009, data for Q1 09/10 has already demonstrated solid strides in working toward the 10% performance improvements, including an average of 12% improvement between both sites for the proportion of admitted patients treated within the length of stay target of 8 hours. Orillia Soldiers' Memorial Hospital's (OSMH) initiatives include a transfer admission discharge team and lounge, follow up clinic, waiting room nurse, and mental health crisis after hours coverage. OSMH will also be participating in Wave 2 of the ER Process Improvement Program. Royal Victoria Hospital's initiatives include a patient flow project, admission and bed allocation process improvement, bed board project, and ER process improvement project including planning for a rapid physician assessment zone.

In 08/09, NSM LHIN had the 4th highest % of ALC days compared to other LHINs. Enhanced accountability and reporting will inform decision-making of strategic investments and the three-year ER/ALC Strategy. Fifty-three percent of ALC patients are awaiting LTC. The overall population awaiting LTC is being targeted; strategies include diverting clients from the LTC waitlist, delaying admission to LTC through enhanced home supports, and expediting hospital discharge with enhanced home supports for patients awaiting LTC. Initiatives include an Integrated Transitional Care Team, Wait at Home, Balance of Care, and CCAC Enhanced Service Maximums. VON's Home at Last settlement services outcomes in Q1 09/10 include 36 of 95 clients having their discharge date moved up, resulting in 449 hours less inpatient hospital stay equivalent to \$9,107 in savings, with an investment of \$21,034. Strategies continue to be implemented around increased bed capacity for transitional care, complex continuing care and long-term care.

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Reduce ER demand	➤ Aging at Home (AAH) and Urgent Priorities Fund (UPF)	Page 7
Increase ER capacity/performance	➤ Pay-for-Results (P4R) Y1 ➤ Pay-for-Results (P4R) Y2	Page 8 Page 9
Improve Bed Utilization	➤ Aging at Home (AAH) and Urgent Priorities Fund (UPF)	Page 10

LEGEND: Interpreting intervention performance

Supplementary Measures	Baseline	Target	Quarterly Performance	Key Considerations
<ul style="list-style-type: none"> A set of measures associated with a specific intervention/strategy that are indirectly linked to one or more overarching goals of the strategy 	The determined baseline will be inserted here and will remain the same each quarter	The determined target will be inserted here and will remain the same each quarter	<p>Illustrates current performance with respect to the supplementary measure against defined targets. Graphs/charts are inserted by Access to Care.</p> <p>The red, amber and green color coding of performance results is a visual guide that allows users to easily identify their performance relative to the specified target for a particular indicator; there will be a selected target for each supplementary measure associated with an intervention. Indicators included in the MLAA will be coloured accordingly to the LHIN corridors.</p> <div style="display: flex; flex-direction: column; align-items: center;"> <div style="background-color: #006400; color: white; padding: 2px; margin-bottom: 2px;">Doing Well – Below Corridors & LHIN Starting Point</div> <div style="background-color: #00CED1; color: white; padding: 2px; margin-bottom: 2px;">Improving – In Corridors & Equals or below LHIN Starting Point</div> <div style="background-color: #FFFF00; color: black; padding: 2px; margin-bottom: 2px;">Monitor – In Corridors & above LHIN Starting Point</div> <div style="background-color: #FF0000; color: white; padding: 2px;">Attention – Above Corridors, Reporting Required</div> </div> <p>Additional indicators will be coloured according to the following corridors.</p> <p>Green: performance result meets or exceeds the specified target</p> <p>Amber: performance result is less than or equal to 10% from the specified target</p> <p>Red: performance result is more than 10% from the specified target</p>	Explains current performance and what proposed changes could be put in place to improve performance. Information is inserted by LHIN. (These are guiding questions only)

NORTH SIMCOE MUSKOKA LHIN

Goal: Reduce ER Demand

Intervention: Aging at Home (AAH) and Urgent Priorities Fund (UPF) –

Through Aging at Home's intervention strategies, investments have made an impact on reducing ER demand in NSM LHIN. The Re-ACT program outcomes in Q1 09/10 include a 50% reduction in events resulting in ER visits, decreased falls by 85%, 98% of clients maintained within community, and a significant cost savings in nursing and personal support services of \$40,937, whereas program costs were \$39,843. The Integrated Intensive Case Management initiative has resulted in a sizeable decrease in the average number of client ER visits from 12 to one per month in 08/09, an estimated annual cost savings of \$23,760 at \$180 per ER visit. Victorian Order of Nurses Falls Prevention Strategy resulted in 98% of clients avoiding falls with an average of 1 in 3 falls clients going to the ER in Q1 09/10.



Supplementary Measures	Quarterly Performance	Key Considerations								
<p>Number of ER Unscheduled Visits by quarter per 1000 population</p>	<table border="1" style="margin: 10px auto;"> <caption>ER Unscheduled Visits per 1000 population - Fiscal 08/09</caption> <thead> <tr> <th>Quarter</th> <th>Visits per 1000 population</th> </tr> </thead> <tbody> <tr> <td>Q1</td> <td>139</td> </tr> <tr> <td>Q2</td> <td>149</td> </tr> <tr> <td>Q3</td> <td>127</td> </tr> </tbody> </table> <p>(Data source: MoHLTC Provincial Health Planning Database & CIHI-NACRS)</p>	Quarter	Visits per 1000 population	Q1	139	Q2	149	Q3	127	<p>The number of ER unscheduled visits by quarter per 1000 in the NSM LHIN demonstrates seasonal variations. From Q2 to Q3 of 08-09, this number decreased from 139 to 127. Seniors represent nearly one quarter - 22% of all ER visits. CTAS IV and V account for 51% of all ER visits; the provincial average is 43%. There are a high percentage of NSM seniors who have diabetes, arthritis, hypertension and Chronic Obstructive Pulmonary Disease, a higher prevalence than Ontario's senior population. The top problem presented at NSM ERs is injury, poisoning and certain other consequences of external causes, such as falls, which accounts for 22% of all ER visits. 8.6% of NSM patients are without a family physician; the provincial average is 7.4%.</p> <p>A patient survey was developed in consultation with stakeholders for NSM LHIN's hospital emergency departments. The survey will inform the development of the three-year ER/ALC Strategy as well as the Access to Appropriate Care priority of the Integrated Health Services Plan for 2010-13. Key questions will capture the patient's experience, awareness of other health care options available, as well as inform and educate the public. An ER Public Service Announcement will run on television for three weeks.</p> <p>The NSM ER/ALC Steering Committee is currently working on finalizing its Strategic Framework which will facilitate the development of the 3-year ER/ALC Strategy and inform the Integrated Health Services Plan 2010-13. The ER/ALC Steering Committee has discussed direct, diversion, and prevention and wellness strategies to achieve the outcomes outlined in the draft Strategy Map (see Appendix A). The next steps for the Committee will be to detail the strategies through the identification of activities and milestones, which will inform the Annual Business Plan 10/11. We believe there is a lag in impact as appropriate evaluation and data collection mechanisms have been newly implemented in 09/10. This is required to enable informed decision-making and planning of strategic investments.</p> <p>A significant number of interventions are primarily focused on seniors as the patient population driving nearly one quarter - 22% of all ED visits. Aging at Home direct, diversion, and prevention and wellness strategies have contributed to reducing the number of ER visits. In addition to the interventions and outcomes of programs such as Re-ACT, Integrated Intensive Case Management, and Falls Prevention with VON; several other key initiatives have directly impacted the prevention or diversion of ER visits.</p> <p>The Health Care Connects program has matched 173 unattached patients to a family health care provider as of July 31, 2009. The Regional Falls Prevention program is a first step toward the development of a comprehensive integrated seniors health care system; comprised of a Regional Advanced Practice Nurse, Geriatric Emergency Management service, Seniors Maintaining Active Roles Together (SMART), In Home and Group Exercise Programs delivered through VON, and OSMH's Geriatric Day Program and Falls Prevention Program. The Metis & Urban Aboriginal Home Care Program provides a basket of home support services which is expected to reduce ER visits, and improve bed utilization by decreasing hospital length of stay. In 09/10 with an investment of \$91k, the program has reached full capacity serving 30 clients at an annual cost of \$1,218 per client. First Link continues to provide referral services and early intervention for Alzheimer's and Dementia patients, resulting in fewer demands on the system during the later stages of the disease.</p> <p>The introduction of a Nurse-led Long Term Care Outreach Team (Pro-ACT) began in June 2009, providing assessments and early interventions for LTC home residents. To date, Pro-ACT has been initiated in one LTC home - Trillium Manor in Orillia, and has engaged three of six identified residents. Current outcomes include no ER visits or hospital admissions for these patients. Planning is underway to expand this initiative into other LTC homes.</p> <p>In Q3 08/09, NSM LHIN had the 4th highest Number of ER Unscheduled Visits by quarter per 1000 population across the province. Given the rural and northern geography included within NSM boundaries, the ER volumes are comparable to other LHIN counterparts in the NE, NW, SE, and SW, with limited primary care options.</p> <p>It is expected that mainly as result of winter influx in the Collingwood area, the number of unscheduled visits will rise in Q4. It is projected that for Q1 09-10, the number of unscheduled visits will rise by 3% from Q4.</p>
Quarter	Visits per 1000 population									
Q1	139									
Q2	149									
Q3	127									

NORTH SIMCOE MUSKOKA LHIN

Goal: Increase ER Capacity/Performance

Intervention: ER Pay for Results Year 2 –

The NSM LHIN has two sites participating in the ER Pay for Results initiative in Year Two. With implementation as of April 2009, data for Q1 09/10 has already demonstrated solid strides in working toward the 10% performance improvements, including an average of 12% improvement between both sites for the proportion of admitted patients treated within the length of stay target of 8 hours. Orillia Soldiers' Memorial Hospital's (OSMH) initiatives include a transfer admission discharge team and lounge, follow up clinic, waiting room nurse, and mental health crisis after hours coverage. OSMH will also be participating in Wave 2 of the ER Process Improvement Program. Royal Victoria Hospital's initiatives include a patient flow project, admission and bed allocation process improvement, bed board project, and ED process improvement project including planning for a rapid physician assessment zone.



Supplementary Measures	Baseline Fiscal 08/09	Target	Current Performance	Quarterly Performance (Data Source: EDRS)	Key Considerations															
Proportion of admitted patients treated within the LOS target of ≤ 8 hours	31%	10 point improvement in percentage	29%	<table border="1" style="display: none;"> <caption>Admitted Patients Performance (Fiscal 08/09)</caption> <thead> <tr><th>Quarter</th><th>OSMH (%)</th><th>RVH (%)</th></tr> </thead> <tbody> <tr><td>Q1</td><td>42</td><td>33</td></tr> <tr><td>Q2</td><td>33</td><td>27</td></tr> <tr><td>Q3</td><td>33</td><td>29</td></tr> <tr><td>Q4</td><td>35</td><td>27</td></tr> </tbody> </table>	Quarter	OSMH (%)	RVH (%)	Q1	42	33	Q2	33	27	Q3	33	29	Q4	35	27	<p>Orillia Soldiers' Memorial Hospital</p> <p>For the proportion of admitted patients treated within the LOS target of ≤ 8 hours, OSMH 08/09 data demonstrated that 36% met the benchmark. With a target of 46% for 09/10, the first two months averaged a solid improvement in performance at 43.5% representing a 7.5% improvement. For the proportion of non-admitted high acuity patients treated within their respective targets of ≤ 8 hours for CTAS I-II and ≤ 6 hours for CTAS III, OSMH 08/09 and YTD 09/10 data remain unchanged. Data for high acuity non-admitted patients remains stable at 92-93% of patients meeting the target. This supports that easy wins have already been made as the provincial performance for 08/09 is at 82% for comparison. For the proportion of non-admitted low acuity patients treated within the LOS target of ≤ 4 hours, OSMH 08/09 and YTD 09/10 data is unchanged. Data for high acuity and low acuity non admitted patients remains stable at 92-93% of patients meeting the target. This supports that easy wins have already been met as the provincial performance for 08/09 is at 85% for comparison.</p> <p>The addition of the Transfer Admission Discharge Team and Lounge has improved timeliness planning activities to support earlier discharges resulting in decreased hospital length of stay, improved throughput of ER admitted patients reducing their length of stay, and improved patient and staff satisfaction. The enhanced mental health after-hours crisis coverage continues to reduce wait time for mental health patients in the ER, as well as improve continuity of care and defer admissions through linkages to services. The addition of the waiting room nurse on June 1st has been instrumental in initiating medical directives for treatment of pain and early diagnostics in the waiting room, improving patient throughput. The follow-up clinic post discharge provides an alternative for low acuity patients to receive timely assessment, care planning, and primary care prevention. The expected outcome is a shorter length of stay for these admitted patients with an earlier discharge date facilitating increased in-patient access for acute care patients admitted through emergency. The follow-up clinic is expected to be functional in the early Fall, pending physician availability. The addition of the ED PIP project will examine opportunities to improve all processes through effective value laden efficiencies to work towards sustainability. The expectation is to further increase this gain to 10% consistently over the remainder of 09/10.</p>
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NORTH SIMCOE MUSKOKA LHIN

Goal: Improved Bed Utilization

Intervention: Aging at Home (AAH) and Urgent Priorities Fund (UPF)–

Enhanced accountability and reporting will inform decision-making of strategic investments and the three-year ER/ALC Strategy. Fifty-three percent of ALC patients are awaiting LTC. The overall population awaiting LTC is being targeted; strategies include diverting clients from the LTC waitlist, delaying admission to LTC through enhanced home supports, and expediting hospital discharge with enhanced home supports for patients awaiting LTC. Initiatives include an Integrated Transitional Care Team, Wait at Home, Balance of Care, and CCAC Enhanced Service Maximums. VON's Home at Last settlement services outcomes in Q1 09/10 include 36 of 95 clients having their discharge date moved up, resulting in 449 hours less inpatient hospital stay equivalent to \$9,107 in savings, with an investment of \$21,034. Strategies continue to be implemented around increased bed capacity for transitional care, complex continuing care and long-term care.



Supplementary Measures	Baseline	Target	Current Performance	Quarterly Performance	Key Considerations
Percentage ALC Days	13.20% Q4 FY06/07, Q1-Q3 FY07/08	11.00%	20.67%	<p style="text-align: center;">Fiscal 08/09</p> <p>Data Source: CIHI-DAD</p>	<p>The % ALC days provincial target is 9.46%. NSM LHIN MLAA target for 09/10 is 9.5%. In 08/09, the proportion of ALC days decreased from 21.8% in Q3 to 20.67% in Q4, although both are significantly higher than the baseline of 13.2%. According to NSM LHIN weekly hospital reporting ending August 6, 2009, performance is reported at 19.1% of ALC days (128 patients). (See Appendix B) In 08/09, the number of days between ALC designation and discharge from an acute care facility for 9 out of 10 patients decreased from 61 days in Q3 to 52 days in Q4; in Q4 only 12% were designated ALC within two days of admission compared to 18% in Q3 08/09.</p> <p>The NSM LHIN has improved its accountability, reporting, and meetings with health service providers at all levels. Appropriate evaluation and data collection mechanisms have been newly implemented in 09/10 for Aging at Home, Urgent Priorities Fund, and CCAC, along with weekly hospital ALC reporting implemented since June. The ER/ALC Steering Committee is finalizing its Strategic Framework and Map to develop the 3-year ER/ALC Strategy (See Appendix A). Next steps will detail the strategies by identifying activities and milestones. The Committee and LHIN have engaged the Transitional Care Working Group to conduct an evaluation of resources and make recommendations regarding these strategic investments. To date, the Working Group has implemented a collaborative strategy to increase transitional care bed utilization in retirement homes by expanding the criteria to include restorative care. As a continuation of the Muskoka Algonquin Healthcare ALC Task Force, the Implementation Group has implemented a number of process and patient flow improvements: nursing coordinators are identifying ALC clients and facilitating physician designation; and ER visits and patient admissions to hospital are diverted in the first place through education of client care coordinators in the community. The MAHC LTC first available bed policy was fully implemented effective April 2009. The Group recognized the need to implement an interim solution for palliative care patients (4 as of July 30th) pending the new five bed hospice facility. As a result, the LHIN and NSM Palliative Care Network are developing a proposal to redirect a portion of the Huntsville Hospice allocation through Aging at Home resources.</p> <p>In 08/09, NSM LHIN had the 4th highest % of ALC days compared to other LHINs at 18.8%, and the province at 15.98%. While NSM demonstrated a drop in % ALC days from Q3 to Q4, the provincial level witnessed a rise for the same period. NSM moved from being the 3rd highest % ALC days in the province to 4th in Q4 and for 08-09. For 08-09, six out of 14 LHINs have higher % ALC days than the province. As in NSM, most of these LHINs experience higher ER visits, limited primary care options, and geographic/ demographic challenges. Of the top four LHINs with the highest % ALC days, only NSM showed an improvement of more than 1% from Q3 to Q4. For the month of March 2009, the % ALC days was 19.51%. As is the case for approximately 10 out of the 14 LHINs, this value remains higher than the expected performance corridor for % ALC days. 53% of all ALC patients are designated for LTC in NSM. Other top destinations continue to include rehabilitation (11.3%), complex continuing care (10.3%), palliative care (8.5%), and convalescent care (8.2%). Significant progress has been made in % ALC cases designated within two days of admission for those patients waiting for LTC, dropping from 22% in Q3 to 10% in Q4. Strategies have been implemented to improve bed utilization, targeting the population awaiting LTC with several key initiatives. These include diverting clients from the LTC waitlist, delaying admission to LTC homes through enhanced home supports, and expediting discharge from hospital with enhanced home supports for patients waiting for LTC. With an investment of \$2.5M in 09/10, CCAC Enhanced Service Maximums have greatly improved flexibility in supporting clients by expanding care for high risk-need clients and offering respite care. Outcomes include faster and more sustainable discharges from hospital resulting in reduced LOS and prevention of repeat hospitalizations. Some cases have enabled returning a LTC resident to their home and community, reducing institutionalization. The Balance of Care program provides a customized care package for LTC waitlist clients, with an investment of \$400k in 09/10 focusing on the 11% in hospital awaiting LTC. It was estimated that an average of 27% could be served and diverted from the LTC wait list. The potential system cost savings are tremendous given an average estimated cost per client of \$2,071 in comparison to NSM estimated costs per LTC client of \$7,491.</p>
Number of days from ALC designation to discharge by discharge destination	37 Days Q1-Q4 FY 07/08	TBD	52 Days	<p style="text-align: center;">Q4 08/09</p> <p>Data Source: CIHI-DAD</p>	<p>In 08/09, MAHC had the highest 90th percentile wait times (81 days) in Q4 between ALC designation and discharge, driving NSM's % ALC days. As of August 6th, MAHC was at 17% total ALC days representing 22 patients down from a high of 48 patients on April 3rd. They are no longer the top hospital driving the LHIN's performance, and in fact are 4th of 6 hospitals. During the same time period, the LTC destination was dramatically reduced by 20% (19 patients). The additional resources and initiatives implemented by the Task Force have demonstrated significant results can be realized in a short period. Focusing on an interdisciplinary team approach, MAHC's Integrated Transitional Care Team comprised of the ALC Patient Flow Manager, Enhanced Case Management, and Geriatric Emergency Management Nurse, are expanded resources to enhance patient flow, system navigation and case management; supporting expedient assessments in determining ALC patient destinations and developing care plans within 48 hours. The Wait at Home program implemented for MAHC provides enhanced home support at approx. \$6,854 monthly per client; targeting high risk-need ALC patients, estimated at serving four patients each month. To date there has been only one client served costing \$4,575, who went home and subsequently was removed from the LTC waitlist. The ALC patients eligible for this program need to be identified early for successfully discharge. We anticipate more clients as longer stay ALC patients' cycle through. VON's Home at Last settlement services enables safe and expedient discharge from hospital for frail elderly patients. In Q1 09/10, outcomes include 36 of 95 clients' discharge date moved up, resulting in 449 hours less inpatient stay equivalent to \$9,107 in savings (based on average daily inpatient cost of \$486.98 in NSM), whereas program expenditures were \$21,034. Most clients are aged 71+, and live at home alone with top conditions including cardiovascular and diabetes. Supportive Housing programs have expedited hospital discharge, reducing LOS and improving bed utilization.</p> <p>Increased capacity investments through the Urgent Priorities Fund total \$1.9M for both 08/09 and 09/10, with more than 51% directed to transitional care (37 beds). In July 2009, the average LOS was 28 days, which varies between the four facilities. Occupancy levels remain consistently between 90-100% for both hospital sites at an average cost per day of \$240, while occupancy levels range from 30-40% at both retirement homes, costing an average of \$155 per day. These beds are recognized as an effective short term strategy which is not sustainable and are currently being evaluated. In contrast, the NSM average daily cost for LTC is \$139; inpatient hospital care is \$487. The LHIN has also made investments in an Integrated Complex Continuing Care Regional Service (67 beds), which is currently under review to recommend an appropriate delivery model and bed capacity. Given the maximum capacity of LTC, wait times are much higher at 174 days in comparison to the provincial average of 104 days in 08/09. Impact have seen the number of clients waiting for LTC decrease from 1,758 in January to 1,361 as of May 2009; however demand is expected to grow for reasons including lack of affordable housing options. New LTC beds (64) became operational in early 2009 resulting in a decrease of 72% of acute beds occupied by ALC patients at Huronia District Hospital, which has been sustained at 7.4% ALC days (8 patients) as of August 6th. With the addition of 160 new beds in 09/10, we anticipate further success in the Barrie area. Trending indicates that there has been little change in % ALC days from March to July. Analysis indicates there has been some improvement for the last three quarters. A 3-year ER/ALC Strategy, along with fast-tracking modifications of current interventions and implementation of strategic investments through reallocations and systemic changes will promote sustainability. Progress in performance is expected to be realized in the % ALC days later in 09/10.</p>