

North Simcoe Muskoka **LHIN**

Emergency Room and Alternate Level of Care Strategy (ER/ALC)

2010 - 2013



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Section 1 – Introduction

The purpose of this report is to describe the NSM Local Integration Network's (NSM LHIN) Emergency Room and Alternate Level of Care (ER/ALC) Strategy, to provide some details on the investments made to address ER/ALC and the challenges and strategies in addressing this issue both provincially and locally.

Individuals expect access to appropriate care, whether it is timely access to care in the emergency room or the timely discharge from the hospital when they no longer require this level of care and require an alternative level of care. The ER/ALC Strategy is an initiative which will address this by focusing on three key goals: reducing emergency room demand, building capacity and improving performance within the emergency rooms and improving hospital bed utilization.

Section 2 – Background

The Ontario Government has identified that reducing emergency room wait times is an important strategic priority. They have also recognized having individuals in a hospital bed, when they require an alternative or different level of care, is also contributing to the emergency room (ER) wait times. Over the past year, the Ontario Government and the Local Health Integration Networks (LHINs) have been working on strategies to reduce ER wait times and ALC days.

In January 2009 the Canadian Institute for Health Care Information (CIHI) released a report entitled Alternative Level of Care in Canada. They reported that ALC patients accounted for 5% of hospitalizations and 17% of hospital days in acute care facilities in Canada. They went on to say that on any given day, 5,200 beds in acute care facilities are occupied by ALC patients, or individuals who could be in an alternative level of care such as a long term care home, or their own home. In Ontario, the statistic is higher and ALC patients accounted for 7% of hospitalizations which equals approximately 2,590 hospital bed equivalents. In Ontario, approximately 57% were waiting for a long term care home, 17% were waiting to go home, and 10% were waiting for a rehabilitation facility. Common diagnoses associated with high ALC use include: dementia, stroke, trauma and general signs and symptoms. Key clinical interventions associated with high ALC use include: feeding tubes, ventilation and dialysis.

In the 2009 Budget the Ontario Government announced funding provided to directly or indirectly impact emergency room wait times and alternative level of care days. This included:

Reducing Emergency Room (ER) Wait Times

Hospitals' net expense will increase 3.5 per cent in 2009-10. This includes a 2.1 per cent increase in the overall base funding formula to meet the service requirements of hospitals

\$10 million in 2009-10 to high-growth hospitals to help increase hospital services in Ontario's fastest-growing communities to improve care and reduce wait times

\$361 million in 2009-10 to implement the comprehensive ER Wait Time Strategy

\$223 million in 2009-10 for the Aging at Home Strategy to provide support to seniors and their caregivers to stay healthy, live with dignity and independence, and also ease Alternate Level of Care (ALC) pressures.

Improving Access to Family Health Care

\$35 million over two years to create 22 nurse-practitioner-led clinics in addition to the three already announced

50 more Family Health Teams planned over the next two years

\$65 million, including \$39 million provided in 2008-09, for increased home care, personal support and homemaking services and enhanced integration between hospitals and Community Care Access Centres.

Modernizing Health Infrastructure

Approximately \$2 billion in the next three years to implement eHealth initiatives including the creation of an electronic health record by 2015

More than 40 hospital projects are under construction, with over 15 expected to be completed in 2009-10

Adding 1,750 long-term care beds in 10 communities across the province by 2012

\$35 million in capital investment to support the creation of 100 additional medical school spots. This initiative will be supported by associated operating funding.

The ER Wait Time Strategy in Ontario includes a number of initiatives which are currently underway including:

- Pay-for-Results program
- Aging at Home strategy
- Nurse-Led Outreach Teams in long-term care homes
- Ambulance offload nurses
- ER-CCAC notification system
- Emergency Department Performance Improvement Program (ED PIP)

Section 3 – The ER/ALC Strategy

The Ontario Ministry of Health and Long Term Care is currently developing a 10 year Strategic Plan for Ontario's health care system. The plan will promote equal access to health care for all Ontarians and is focused on improving access to care in three priority areas:

1. reducing wait times in emergency departments
2. reducing time patients spend in alternate level of care beds in hospitals
3. supporting the roll-out of Ontario's Diabetes Strategy

The Ministry has also identified Mental Health and Addictions and E-health as key areas of focus.

The North Simcoe Muskoka Local Health Integration Network (NSM LHIN) supports the Ministry's strategic plan through its own strategic priorities and initiatives in its Integrated Health Service Plan (IHSP) for 2010-13 and its ER/ALC Strategy.

North Simcoe Muskoka's Integrated Health Service Plan for 2010-13 focuses on three strategic priorities:

1. improving access to appropriate care, beginning with the emergency room and alternative level of care settings in the community or home
2. improving chronic disease management beginning with access to integrated diabetes care
3. creating an integrated design for the future health system in North Simcoe Muskoka

It is important to note, that the Ministry's Ontario Diabetes Strategy priority and the NSM LHIN's chronic disease management and integrated health system design priorities will both have an impact on ER/ALC as they will assist clients to self manage their care and they will help to foster an integrated health care system within and outside the hospital setting. Developing eHealth capacity will also assist with better communication and coordination across health care organizations.

Section 4 – LHIN Investments and Expected Outcomes

In 2010/11, LHINs are required to focus Aging at Home allocations according to four key priority areas:

Priorities	Description
Additional Temporary Care Bed Capacity	<ul style="list-style-type: none"> • Initiatives targeted to increase capacity across the post-acute spectrum of care including rehab, Complex Continuing Care, Convalescent Care, Interim LTC and other innovative settings to enable appropriate discharge from acute care and transition back to the community
Admission Avoidance / Timely Discharge Initiatives (Hospital process enhancements)	<ul style="list-style-type: none"> • Initiatives targeted to seniors to avoid unnecessary ER admissions and support timely discharge from ER and hospital Initiatives permitted: enhanced case management functions in the ER and hospital, Flow Coordinators, GEM nurses in the ER and hospital, psycho-geriatric nurses in ER and hospital
Enhanced Home Care (Building community based services)	<ul style="list-style-type: none"> • Initiatives that enhance the range of home care services for seniors to avoid unnecessary ER visits, ER and hospital admissions, and support timely discharge of seniors. Initiatives permitted: intensive community-based case management, in-home primary care, enhanced community support services, enhanced mental health and crisis services etc. • LHIN examples include Safe at Home, Wait at Home and Home at Last.

Outreach Teams	<ul style="list-style-type: none"> • Targeted support to provide enhanced nursing assessment and treatment services in any home setting (e.g. home, LTC home, Supportive Housing) • Targeted outreach service towards high risk seniors who comprise high ER volume or high volume of ALC patients (e.g. psycho-geriatrics, inter-disciplinary teams)
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Section 5 – ER/ALC in North Simcoe Muskoka

Emergency Room Use and Wait Times

In the most recent data from July 2009, wait times in the NSM LHIN are lower than the province. Some of the recent statistics indicate:

- 9 out of 10 ER patients spent at most 6.7 hours in the ER. NSM LHIN ranks 2nd among the LHINs and shares 5% of the total volume reported in the province
- The ER length of stay (LOS) for admitted patients (21.5 hours) is 16.2 hours longer than non-admitted patients (5.3 hours) and 8% of total ER visits are admitted
- In 2008/09, NSM LHIN had the 4th highest number of ER visits per 1000 population among LHINs across the province
- More than half (52%) of ER visits in North Simcoe Muskoka are by clients with less urgent and non-urgent needs who could be looked after in another setting
- Seniors 65+ represent nearly one quarter of all ER visits
- Others making frequent ER visits include individuals with mental health challenges, people with multiple and complex chronic diseases and those who've fallen and experienced a bone fracture

Alternate Level of Care (ALC) Use

North Simcoe Muskoka LHIN faces challenges in transferring patients out of hospital to alternate care settings, where they can receive the most appropriate care for their needs and which is less costly to the health care system. Clients in hospital awaiting transfer to another care setting, such as a long term care home or their home are designated ALC. Some of the recent statistics include:

- As of 12 November 2009, approximately 19.5% or 134 people in acute care hospital beds are not able to be discharged from the hospital due to the lack of appropriate alternate care options such as long term care or home support services
- Of those ALC patients, 62.7% of patients are awaiting Long Term Care placement
- In 2008/9, the NSM LHIN had the 4th highest percentage of ALC days compared to other LHINs. That rate of 18.88% was almost double the provincial target of 9.5%
- In this LHIN, seniors represent approximately 87% of people waiting in ALC beds in hospitals and 85% of the days are largely because long term care is fully occupied

Wait Times for Long-Term Care Placement

There are 2,796 long-term care beds located in 27 long-term care homes within North Simcoe Muskoka. This means there are approximately 98.1 beds per 1000 population 75 years and

over, which is just below the provincial standard of 100 beds per 1000 population. Not unlike other LHINs provincially the NSM LHIN has:

- A large waiting list for long term care home placement with approximately 1,300 individuals waiting for a bed and approximately 500 people are waiting for a long term care home of their first choice
- The NSM LHIN averaged a 130 day wait for placement into a long term care home in July 2009, as compared to a provincial average of 96 days
- Occupancy rates of long term care homes remain steady at approximately 99.8% which means they are operating at full capacity

It is also important to note that as the population of North Simcoe Muskoka continues to age, this problem will be exacerbated. Therefore, it is important that we develop a solution as an integrated health care system.

Section 6 – Access to Appropriate Care – The ER/ALC Strategy in NSM

NSM LHIN ER/ALC Steering Committee

In order to tackle the Emergency Room and Alternate Level of Care issue within North Simcoe Muskoka, the NSM LHIN ER/ALC Steering Committee was charged with exploring the issues and identifying goals, objectives, indicators and targets. They were also asked to recommend an ER/ALC Strategy to improve emergency room wait times and decrease ALC days. The steering committee's mandate is:

- To develop a NSM LHIN-wide strategy and action plan to address ER/ALC
- To develop a framework and criteria for monitoring performance data and metrics related to ER/ALC
- To identify how the ER/ALC Strategy will continue in the long term once the initial project phase is completed
- To identify strategies which are direct and have an immediate impact on clients already in ER/or ALC patients

Membership of the ER/ALC Steering Committee includes:

- Senior Director, Health System Performance Measurement and Integration, NSM LHIN (Chair)
- ER/ALC Performance Lead, NSM LHIN
- Addictions and Mental Health
- Community Health Centre
- Community Support Services
- Hospitals
- Emergency Department Physician Lead (Hospitals)

- Emergency Medical Services
- Family Health Team
- Housing sector (i.e., affordable, non-profit, supportive, retirement living)
- Long-Term Care Homes
- Municipal sector
- North Simcoe Muskoka Community Care Access Centre
- North Simcoe Muskoka Chiefs of Staff Committee (Hospitals)
- Seniors' Health Regional Action Group

NSM LHIN ER/ALC Strategy

Improving ER wait times and reducing the time that individuals spend in ALC beds requires improvements across the health care system. The Ministry of Health and Long Term Care has set targets for what they consider a reasonable time for individuals to wait in the emergency room. For less urgent or non-urgent conditions (CTAS IV and V) the provincial target is 4 hours. As mentioned earlier, approximately 52% of individuals seen in the ER are considered to be less urgent or non-urgent. For more urgent or more serious conditions (CTAS I, II and III) the provincial target is 8 hours.

Unfortunately, moving from the ER to a hospital bed within 8 hours is not always possible as the acute care beds may be occupied by an individual designated as ALC and could be receiving appropriate care in another setting such as long term care or home.

The NSM LHIN ER/ALC Strategy is comprised of three overarching goals:

1. Reduce Emergency Room demand
2. Build capacity and improve performance within ERs
3. Improve bed utilization – allocate patients to the appropriate level of care for their condition

This will be achieved through a comprehensive strategy which includes identifying the target population, the indicators and the three year targets and the development of a comprehensive action plan. The key initiatives impacting the ER/ALC overarching goals are outlined here as well as the major assumptions for the ER/ALC Strategy.

NSM LHIN Aging at Home Strategy

Aging at Home is one of the key strategies to achieve the ER and ALC targets. These services include home care, assistive devices, assisted living/supportive housing and end-of-life care. The Aging at Home program also encourages innovation at a local level, by giving LHINs the flexibility to start some creative projects that are tailor-made for seniors living in communities with specific needs. The following initiatives have been approved for funding in 2009/10.

Name of Project	Service Provider	Project Description
Inter-Professional Falls Clinic	Orillia Soldiers' Memorial Hospital	The established Day Hospital at Soldiers' will be expanded to support the development of the LHIN's first Falls Clinic. The clinic will provide services to seniors who have fallen or who are at risk of falling.
Regional Geriatric Emergency Management (GEM) Program	Orillia Soldiers' Memorial Hospital	Regional advanced practice nurse is part of the centralized core of the integrated senior's health care system. With a specific focus on falls, this individual is responsible for linking the various falls-related services, developing a standardized approach to care across the region and mentoring providers in the delivery of specialized services.
Falls Prevention Strategy	Victorian Order of Nurses for Canada - Ontario Branch, Simcoe County	To provide education for health care providers, a falls resources inventory, group physical activity outreach program and "SMART" program implementing a best practice model for volunteer-led-in home exercise visits.
Nurse Led Long-term Care Outreach Team	The Royal Victoria Hospital (RVH)	A RVH nurse practitioner will travel to long-term care homes to work with staff to provide comprehensive geriatric assessment and intervention through utilization of specially trained health care professionals and medical directives. Long-term care staff will access the RVH nurse-led outreach team when a patient is in need of medical attention prompting early action to avert the need for an ER visit.
Primary Health Care Access- A Foundation for Geriatric Outreach	Barrie Community Health Centre	This program will enhance the capacity of the North Innisfil Health Service's current primary health care program to provide comprehensive clinic based care as well as outreach services to seniors living in the North Innisfil catchment area.

Regional Aboriginal Seniors Cultural Support Program	Barrie and Area Native Advisory Circle	This program is a preventative - long-term impact intervention. The program will provide culturally focused and holistically based support to Aboriginal seniors/elders living in their own homes throughout the LHIN.
Balance of Care	North Simcoe Muskoka Community Care Access Centre	Assessing the health and social care needs of 12 - 15 ALC/LTC seniors by building a community care package to meet their needs. Balance of Care aims both to estimate the proportion of at-risk seniors that could be safely maintained in the community with better outcomes.
Re-ACT	North Simcoe Muskoka Community Care Access Centre	Re-ACT is a telehealth home care delivery system for people living with chronic disease. Through wireless technology, clients have access to a nurse who is able to monitor their status and medication compliance while providing assessment, support, information and adjustments to their care plan.
First Link	Alzheimer's Society of Greater Simcoe County	First Link is an innovative referral and early intervention program that links the person with Alzheimer's disease or a related dementia (ADRD) and their family members/caregivers to coordinated learning, services and support.
Coordination of Assistive Devices Information and Supports	Simcoe Association for the Physically Disabled	Coordination of assistive devices, information and supports.
Attendant Care	Helping Hands	To provide attendant care in order to reduce the number of ER and acute care beds which are being occupied due to a lack of appropriate and available beds for seniors requiring a care worker.
Behavioural Intervention Response Team	Mental Health Centre Penetanguishene	Behavioural Intervention Response Team (BIRT) is intended to provide a 'wrap around' service for those residents of long-term care homes in the NSM LHIN who have a

		significant cognitive impairment coupled with behaviours that are considered to be severe and high risk.
Care to Imagine	North Simcoe Muskoka Community Care Access Centre	<p>This initiative provides caregivers with the services, skills and supports to more effectively manage the needs of their loved ones, and to achieve better health and social outcomes for all involved. These charitable, in-home services include:</p> <ul style="list-style-type: none"> • Respite care • Counselling and support • Health care education • E-learning • Resources for caregivers • Linkages to community support services
Home Support	Deaf Access Simcoe	To provide clinical and home support services to hard of hearing, deafened and deaf seniors, as well as their families and caregivers, in Muskoka.
Enhancement of the Basket of Services	Muskoka Seniors Home Assistance	To provide for an increase in the overall supply (quantity and range) of 5 current programs: congregate dining, transportation, frozen meals on wheels, friendly visiting and telephone security/reassurance
Transportation	Barrie Area Native Advisory Circle	To have a dedicated part-time driver to provide transportation for Aboriginal and Métis seniors in support of active lifestyles
Enhanced Transportation	Canadian Red Cross - Muskoka District Branch	The expansion of Canadian Red Cross, Community Health Services – Transportation Program will promote and assist services for frail, elderly and disabled seniors as well as those living in more rural locals within NSM LHIN.

Home at Last	Victorian Order of Nurses – Ontario Branch – Simcoe County	The Home at Last (HAL) program enables a safe and smooth transition from hospital to home for frail at risk elderly patients.
Community Connection – Volunteer 211	North Simcoe Muskoka Community Care Access Centre	Community Connection - Volunteer 211. To provide a single point of access to coordinate the recruitment, selection and retention of volunteers in NSM LHIN. Volunteer 211 was created to connect health and human service organizations that need volunteers with people who are potential volunteers living in NSM.
Supportive Housing	Canadian Red Cross - Simcoe County Branch	To provide services and housing to maximize the functioning and autonomy of frail elderly persons and people with disabilities or chronic disease.
Supportive Housing Expansion	Helping Hands, Orillia	To provide on-site 24/7 supportive housing services for seniors in an existing apartment complex which houses a significant number of elderly tenants.
Mobile Seating and Mobility Clinic	County of Simcoe	To provide Assistive Devices Program (ADP) assessments using a clinic-based service delivery model.
Integrated Intensive Case Management	North Simcoe Muskoka Community Care Access Centre	Integrated Intensive Case Management - This is an innovative project building upon the successes of Resource Integration for Seniors in the Community (RISC), which was piloted in Ottawa. This program provides intensive case management for seniors living in independent settings in the Huntsville area, who are at risk of hospitalization or admission to long-term care homes.
Responding to the Health Needs of Our Seniors	North Simcoe Muskoka Community Care Access Centre	The unique geographical designation of Beausoleil First Nation (community is situated on Christian Island, accessible by ferry only, and ice-roads throughout the winter months) requires specific Assistive devices: Bathing assistive devices: 4

		Walkers, 2 Hydraulic Lifts, 4 Hospital beds.
Metis & Urban Aboriginal Holistic Home Care Program	Barrie Area Native Advisory Circle	This initiative will provide an increased basket of services to those currently available through the Georgian Bay Métis Council (GBMC) Long Term Care program by increasing the frequency and range of services provided. This project will be delivered in a manner that is culturally sensitive to the accustomed lifestyle of Aboriginal/Métis senior citizens that reside in this area of the province. The PSW transports clients to cultural and social events within the community. These outings help to decrease feelings of isolation while allowing them to connect with other seniors, community services and the community at large.
Comprehensive Transportation Program	Canadian Red Cross - Simcoe County Branch	This project will provide a comprehensive transportation program across North Simcoe Muskoka. NSM LHIN is experiencing an increase in demand for transportation to medical appointments. Transportation to medical appointments outside of the NSM LHIN remains a critical need. This project will integrate and coordinate the four funded Health Service Providers currently providing transportation services across all geographic boundaries in NSM.
Hospice Huntsville	North Simcoe Muskoka Community Care Access Centre	Development of a Residential Hospice in the Huntsville area
ALC Patient Flow Enhancement	Muskoka Algonquin Health Care	This is part of an Integrated Transitional Care Team. MAHC expanded ALC patient flow resources to enhance patient flow, system navigation and case management. This position will be seconded from the NSM CCAC.

		Standardized tools, processes and communication protocols will be developed. This position will primarily focus on the Bracebridge site however will also service Huntsville. The staff would become part of an Integrated Transitional Care Team. Members would include the ALC Patient Flow Coordinator as Team Lead, the Enhanced Case Manager, and the Geriatric Emergency Management Nurse.
Integrated Transitional Care Team: Enhanced Case Management	North Simcoe Muskoka Community Care Access Centre	This position will support the ALC Patient Flow Enhancement. NSM CCAC Case Management will establish service levels and develop and implement standards. This position will also be a member of the Integrated Transitional Care Team as noted above.
Wait at Home	North Simcoe Muskoka Community Care Access Centre	This program is designed to support patients who have been admitted to Muskoka Algonquin Health Care and designated as ALC for Long Term Care to return home able to await placement into a long term care home.

Urgent Priorities Fund

The North Simcoe Muskoka LHIN has received funding to help provide alternatives to hospital care. The focus of these funds is to provide 16 transitional care beds which will help to move ALC patients out of acute care beds to a more appropriate health care setting as quickly as possible.

Emergency Room Pay for Results

The Emergency Room Pay for Results program is an incentive plan to drive improvements in the patient flow, patient satisfaction and reducing ER length of stay. LHINs and participating hospitals are funded to meet ER Performance standards. Within the NSM LHIN, Royal Victoria Hospital and Orillia Soldier’s Memorial Hospital are participating.

Emergency Department Process Improvement Program (ED PIP)

ED PIP is a Ministry of Health and Long Term Care funded program designed to decrease ER Length of stay, improve patient satisfaction, improve staff work environment and build provincial capacity for quality improvements by sharing best practice across hospitals. Orillia Soldiers’ Memorial hospital is participating in Year 2 of ED PIP.

eHealth Strategy

As part of the Emergency Room (ER) and Alternate Level of Care (ALC) Wait Times Strategy, eHealth Ontario has made funds available from 2009-2012 to support ALC Resource Matching and Referral (RM&R) project activities that align with the Provincial Reference Model (PRM). RM&R automates the referral process using electronic documentation and facilitates matching of patients to the optimal care environment, based on clinical need and patient choice. Ultimately, patients will be transferred earlier. The electronic solution will enable the multidisciplinary team in the acute care setting to track a referral from initiation through to acceptance or denial.

The initial phase of the RM&R project aims to document the current state referral process between acute care inpatient units and post-acute destinations along four core pathways:

- Acute to Long Term Care (LTC) (referred via Community Care Access Centres [CCAC])
- Acute to Community Care (CCAC home care services)
- Acute to Rehabilitation
- Acute to Complex Continuing Care (CCC)

Later phases of the project will focus on the future state and on implementation of the online system. The client-centered online system will provide functionalities that the current paper-based referral system cannot, including simultaneous access to the referral form from any inpatient-unit computer; pre-selected match criteria to quickly allocate patients to the right program at the right time, and secure submission of referral applications to their appropriate destinations – all with the click of a button. Implementation of the online system and the accompanying data collection and tracking capabilities will also help identify some of the causes of bottlenecks and delays within the health care system.

In providing the funding, eHealth Ontario has indicated that LHINs may wish to work together to implement this in a way that reflects local referral patterns. To this end, 7 LHINs (Central, Central East, Central West, Mississauga Halton, North Simcoe Muskoka, South East and Toronto Central) have agreed to partner together on the first phase (Project Establishment and Current State Assessment) of the RM&R project.

The current state assessment will be used to understand referral processes beginning with the decision to discharge a patient from acute care areas to admission to a post-acute service. Working Group participants have been recruited from Acute Care, Rehabilitation, Complex Continuing Care, the NSM CCAC and Long Term Care homes who will document current referral volumes and map current state referral processes. Working Group participants will also take part in various workshops to validate current state workflows within their LHIN, and between LHINs, and also to explore opportunities for improvement in processes, practices, policies and communication, ultimately influencing the direction and overall success of the project. This phase of the project is anticipated to be complete by March 31, 2010. Objectives through to 2012 include implementation, deployment and adoption of the strategy.

Assumptions

When developing this strategy, assumptions were made in terms of funding and operations which helped to inform the goals, indicators, targets and action items.

The goals, indicators and targets for the 3 year NSM LHIN ER/ALC strategy are based on the assumption that funding will continue to flow for:

- Aging at Home – Year 3 (2010-2011)
- ED PIP – expansion to other hospitals
- ER Pay for Results – expansion to other hospitals
- Urgent Priorities Fund
- Diabetes Strategy
- New Long Term Care Home beds
- Nurse-Led Outreach Teams (Pro-Act)

The goals, indicators and targets for the 3 year NSM LHIN ER/ALC Strategy are based on the following operational assumptions:

- Changes to the LTCH Regulations
- A Health Human Resource Plan will be developed to support this initiative
- This strategy will align with the NSM LHIN Integrated Health System Design
- The E-Health and Resource Matching and Referral project will help to enable this strategy
- The ER/ALC Strategy will be supported by a project management approach
- Royal Victoria Hospital Redevelopment will occur with the addition of 101 new inpatient beds (2011/12)
- Hospice beds will be up and running – 13 to 15 beds
- Nurse Practitioner Led Clinics – Georgian and Huronia - will continue

Section 7 – ER/ALC Goals, Indicators and Targets

The ER/ALC Strategy is comprised of three major goals and ten indicators and targets which will be tracked and evaluated. A detailed action plan will also be developed for Year 1, 2 and 3 in order to move the strategy forward and achieve the targets.

Goal 1 – Reduce Emergency Room Demand

Why

To divert individuals from the ER who can be best served in other care settings using health promotion and prevention strategies so they do not need Emergency Room services.

Who

- Seniors at risk (e.g. frail, failure to cope, social isolation)
- Individuals who experience mental health challenge including addictions
- People with multiple and complex chronic diseases (with a focus on improved access to diabetes care)
- Falls including orthopedic trauma such as a hip fracture

What

	Indicators	Baseline	Current Performance	Year 1 LHIN Target 2010/11	Year 2 LHIN Target 2011/12	Year 3 LHIN Target 2012/13
1.1	Hospitalized Rate for Ambulatory Care Sensitive Conditions	343.23	343.34	300	250	200
1.2	Falls – related ER visits/100,000 population 65+ (Targets Under Development)	6145.6	TBD	TBD	TBD	TBD
1.3	Unscheduled ER visits/1000 population	534 visits per 1000 Annually	128/1000 (08/09 Q4) 534/1000 (08/09)	525/1000	500/1000	490/1000

How

- Integrated intensive case management teams in the community
- Tele-home care monitoring for individuals with chronic diseases (Re-Act)
- Nurse-led long term care outreach teams (including hospital-led teams and tele-home long term care home monitoring)
- Regional falls prevention programs
- Collaborative new partnerships with primary care and interdisciplinary teams to develop and/or improve chronic disease education and self-management programs in the community
- Health promotion and prevention strategies and enhanced referral processes
- Stronger partnerships with Emergency Medical Services (EMS) to develop innovative programs such as community referrals by EMS
- Behaviour intervention response team
- Diabetes Regional Coordination Centre and enhanced diabetes teams
- Home at Last

Goal 2 – Build Capacity and Improve Performance within Emergency Rooms

Why

To build capacity and improve performance within Emergency Rooms by designing and improving communication processes and flow from when a patient is assessed in the Emergency Room to admission in a hospital bed as well as fostering strong linkages with the CCAC and improved discharge planning upon leaving hospital.

Who

- Patients admitted to hospital
- Health system partners including: hospital staff, physicians, Community Care Access Centre, Emergency Medical Services, Community Support Services, Long Term Care Homes and other health service providers

What

	Indicators	Baseline	Current Performance	Year 1 LHIN Target 2010/11	Year 2 LHIN Target 2011/12	Year 3 LHIN Target 2012/13
2.1	Proportion of Admitted patients treated within the LOS target of ≤ 8 hours	40.00%	52.78% (09/10 Q1)	46% treated within ≤ 8 hrs.	50% treated within ≤ 8 hrs.	50% treated within ≤ 8 hrs.
2.2	Proportion of Non-admitted high acuity (CTAS I-III) patients treated within their respective targets of ≤ 8 hours for CTAS I-II and ≤ 6 hours for CTAS III	87.00%	90.48% (09/10 Q1)	92% treated within ≤ 4 hrs.	95% treated within ≤ 4 hrs.	95% treated within ≤ 4 hrs.
2.3	Proportion of Non-Admitted low acuity (CTAS IV & V) patients treated within the LOS target of ≤ 4 hours	88.00%	90.69% (09/10 Q1)	93% treated within ≤ 4 hrs.	95% treated within ≤ 4 hrs.	95% treated within ≤ 4 hrs.
2.4	Patient Satisfaction - ER Satisfaction	83% Positive/ 24% Excellent	83% Positive/ 24% Excellent (Q4 08/09)	85% Positive 25% Excellent	88% Positive 30% Excellent	90% Positive 35% Excellent

How

- Geriatric Emergency Medicine teams for the elderly
- Patient Flow Coordinators
- Nurses to help ambulance staff unload patients faster
- Rapid Assessment Areas within the Emergency Room
- Use of information technology such as bedside ultrasound
- Supporting technology such as: electronic referral, matching of resources and emergency room notification to community care providers
- Continued and better use of Mental Health Crisis Support teams in the Emergency Room
- Patient Flow Process Mapping

Goal 3 – Improve Bed Utilization – Allocate Patients to the Appropriate Levels of Care for their Conditions

Why

To improve bed utilization by allocating patients to the appropriate levels of care for their conditions such that individuals receive care in the setting that is the most appropriate to their need.

Who

- Seniors at risk (e.g. frail, failure to cope, social isolation)
- Long term care patients who require care at home or in an institutional setting
- Patients who require convalescent care, rehabilitation or restorative care
- End of life or palliative care patients

What

	Indicators	Baseline	Current Performance	Year 1 LHIN Target 2010/11	Year 2 LHIN Target 2011/12	Year 3 LHIN Target 2012/13
3.1	% ALC Days	20.67% (08/09)	18.9% (Q2 09/10) ¹	16% ALC days	13% ALC days	9.5% ALC days
3.2	ALC Length of Stay	52 days (08/09)	44 days (Q4 08/09)	45 days	40 days	30 days
3.3	Median wait time to LTCH placement	160 (08/09)	120 days (Q1 09/10)	120 days	90 days	60 days (provincial target 09/10 = 30 days)

How

- Assess the current list of individuals waiting for long-term care placement to determine if a LTCH or another setting could best meet their needs
- Wait at Home strategy to allow individuals to wait at home instead of a hospital bed
- Build capacity in the community through such initiatives as Balance of Care which are packages of services to meet an individual's needs
- Supportive housing options in the community
- Grouped care options and outreach models to support seniors to remain in the community

¹ Data Available only from active/undischarged patients as established by NSM Weekly ALC Reporting

- Hospital Teams to designate patients as ALC and the NSM CCAC to assess designated patients and determine the most appropriate destination in collaboration with the patient and the Hospital Team
- Additional bed capacity such as transitional, convalescent care, rehabilitation and hospice care with standard definitions and eligibility criteria including a common referral source
- Home at Last
- Regional repatriation agreements

Section 8 – Risk Assessment and Mitigation Strategies

There are several main risks which have the potential to impact the NSM LHIN's achievement of the ER/ALC Goals and Indicators and Targets.

1. One or more of the Assumptions listed in Section 7 are not realized in terms of funding or operations.
2. There is a significant and unexpected event which puts additional strain on the health care system, impacting hospital emergency departments or alternate level of care days.
3. The G8 Summit in June 2009 has the potential to impact emergency room wait times and alternate level of care days, depending on the demand on hospitals in the North Simcoe Muskoka LHIN.
4. The third wave of the H1N1 Influenza Pandemic potentially in the spring of 2010. The first and second wave demonstrated a significant burden on hospitals and has the potential to do so again, thus increasing ER wait times and ALC beds.

Mitigation Strategies will depend on the type of risk or event impacting the ER/ALC Goals, Indicators and Targets. They include:

1. Monitoring of ER/ALC goals, indicators and targets with regular reporting.
2. Monitoring of the initiatives impacting the ER/ALC goals, indicators and targets to determine their impact on ER/ALC. This includes Aging at Home, Urgent Priorities Fund, ER Pay for Results and Emergency Department Process Improvement Plan.
3. Realigning initiatives which do not meet their intended targets.
4. Assessing any significant or unexpected event which puts strain on the health care system and determining the appropriate response.
5. Developing and implementing G8 contingency plans in order to minimize impact on the hospitals in the NSM LHIN.
6. Implementing strategies in the Ontario Health Plan for an Influenza Pandemic and the Simcoe Muskoka Health Sector Emergency Plan Pandemic Plan such as the use of Flu Assessment Centres and Immunization Clinics to reduce the burden on hospitals.

Section 9 – Evaluation and Ongoing Monitoring

The ER/ALC Strategy will be monitored and evaluated based on the three goals, targets and indicators. Progress towards the indicators will be monitored and evaluated through the NSM LHIN's Performance Management team and the ER/ALC Performance Lead. Results will be reviewed by the NSM LHIN ER/ALC Steering Committee at the monthly meetings and shared quarterly with the NSM LHIN Leadership Council, the NSM LHIN Health Services Committee and the Board of Directors. Evaluation and monitoring will also be facilitated through the Weekly ALC reporting, the quarterly Stocktake report and meetings with the Ministry of Health and Long

Term Care. A project management approach will be used to coordinate all aspects of the strategy.

Section 10 – Communication Plan

The NSM LHIN ER/ALC Strategy is a major part of the NSM LHIN Integrated Health Service Plan (IHSP). As such, this document will be posted as a technical supporting document with the IHSP. A brief written summary of the work of the project and updates will be circulated quarterly by the NSM LHIN to participating agencies and through the NSM LHIN newsletter and website. Quarterly communication of activities and results will also be shared with the NSM LHIN Leadership Council, NSM LHIN Health Services Committee and the Board of Directors as well as through quarterly Stocktake meetings with the Ministry of Health and Long Term Care. As well, as initiatives are identified, developed or refined, key stakeholders will be engaged.

Section 11 – Summary

Impacting Emergency Room wait times and Alternate Level of Care is a complex issue that will involve strategies from across the health care system. Hospitals, CCAC, Long Term Care Homes, Community Support Agencies and other health care organizations will need to work together in order to make an impact on the indicators and increase client/patient satisfaction. Communication between partners and information technology will be key drivers in assisting us to meet these goals and targets. Detailed action plans for each of the 3 years will be developed including activities and indicators.

By focusing on reducing emergency room demand, building capacity and improving bed utilization we will provide the right care in the right place, make the best use of our health human resources and increase patient satisfaction with the delivery of health care services within the NSM LHIN.

