North East LHIN | RLISS du Nord-Est

Patient Flow Strategy: Improving Care Coordination and Alternate Level of Care (ALC) Performance

2016/17 TO 2018/19

Approved by the North East Health System Advisory Committee
January 19, 2016.

Ontario
Local Health Integration Network
Réseau local d'intégration des services de santé

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Introduction

The North East Local Health Integration Network's (NE LHIN) ***Patient Flow Strategy: Improving Care Coordination and Alternate Level of Care (ALC) Performance*, *2016/17 – 2018/19***, builds on previous and current work and experience within and outside of the NE LHIN to address patient flow across the continuum of health care needs and services.

Health service providers (HSPs) within the region have proven that they can successfully address ALC to ensure that, to the greatest extent possible, people receive the right care, at the right time and in the right place. The North East health system needs to continue to focus on optimizing patient flow as there is always room for improvement.

Northeastern Ontario has particular challenges related to demographics (in particular the aging population), health behaviours, health status, population distribution and geography that all affect demand for, and access to, necessary health services.

The patient flow strategy is an opportunity to apply the Triple Aim framework in the NE LHIN (i.e. improving the patient experience of care, improving the health of populations, and reducing the per capita cost of health care). In particular, improving patient flow and decreasing ALC supports a population management / risk stratification approach to most appropriately meet patient needs and address system pressures.

This strategy, effective April 1, 2016, outlines a framework to guide all patient flow partners across the health system. Improving access to services and optimizing care transitions require strategies and improvements that span the full continuum of the health system and that will result in high quality and sustainable services. Meaningful change, as measured through specific targets, requires performance monitoring, accountability and ownership by providers and communities.

Background

Patient flow refers to the movement and transition of patients between care settings, providers and organizations in order to accomplish the ultimate goal of the right care, in the right place, at the right time. Transitions might occur, for example:

- within organizations (e.g. from the ED to an inpatient bed, from a medical inpatient bed to a rehabilitation inpatient bed or outpatient service);
- between organizations of the same type (e.g. from one hospital to another hospital, from one LTCH to another LTCH, from one CSS provider to another CSS provider); or
- between sectors (e.g. from/to a hospital to/from primary care, CCAC, long-term care home or assisted living program).

When hospital-related patient flow is hindered, it can manifest as alternate level of care. The healthcare system strives to deliver care in a setting that is congruent with the clinical needs of a patient as defined by the patient's health status, treatment plan and goals. The following standardized provincial definition (developed in 2009) applies to all patient populations waiting in all patient care beds in an acute or post-acute care hospital in Ontario.

> *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 alternate level of care at that time by the physician or her/his delegate. The ALC wait period starts at the time of designation and ends at the time of discharge/transfer to a discharge destination (or when the patient's needs or condition changes and the designation of ALC no longer applies).*

ALC has been a significant challenge in Northeastern Ontario for a number of years. Hospitals, both large and small, struggle with moving patients to the most appropriate discharge destination due to a variety of reasons including capacity, absence of options and process issues.

Continued ALC challenges in the region coupled with the new aggressive province-wide target of 9.46% ALC in acute care, and 12.7% ALC in combined acute and post-acute settings per the 2016/17 Ministry-LHIN Accountability Agreement (MLAA), point to the need for renewed focus on ALC in the NE LHIN.

Desired Outcomes and Measures of Success

The desired outcomes of this strategy are: to enhance the patient experience through improved patient flow and care transitions; and to achieve the provincial ALC and community wait times targets.

This will be measured through a number of MLAA and related metrics as follows:

Hospital	Long-Term Care	Home and Community
Percentage of ALC days (in acute care) *	MAPLe scores upon admission to LTCHs	Home care patients with complex needs who received their first personal support visit within 5 days of the date that they were authorized for personal support services *
ALC rate (in acute and post-acute care) *	Long-stay waitlist by priority level	
Hospitalization rate for ambulatory care sensitive conditions (per 100,000 population) *	Time to placement by priority level	Home care patients who received their first nursing visit within 5 days of the date they were authorized for nursing services *
Number of ED admissions at 8 a.m.	Average length of stay in LTC	
	Annual Case Mix Index (CMI) scores	

Hospital	Long-Term Care	Home and Community
ED time to inpatient bed ED visits by CTAS score Actual acute length of stay (ALOS) Percentage of acute discharges that met expected LOS (ELOS) Conservable days at 0.9 ELOS Percentage of acute days used by patients with length of stay greater than 30 days Percentage of discharges before 11 a.m. Hospital occupancy rate Weekend discharges from acute care		90th percentile wait time from community for CCAC in-home services (application from community setting to first CCAC service (excluding case management) * Percent of acute care patients who have had a follow-up with a physician within 7 days of discharge *

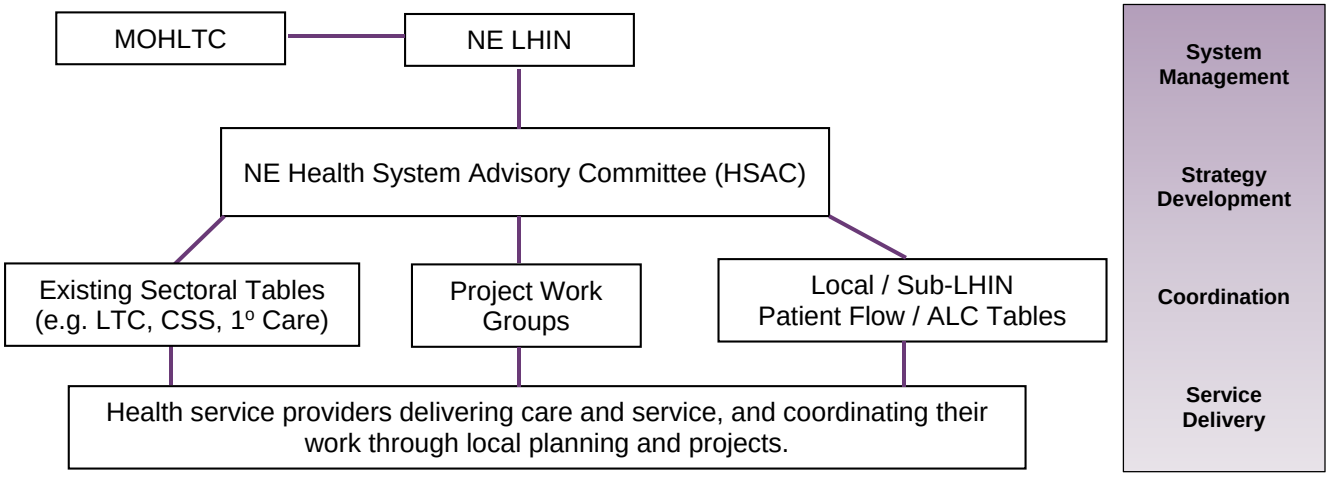
*** MLAA indicator**

Notes:

- Scorecards will be developed at the necessary geographic and organizational levels to support monitoring of the strategy.
- Metrics such as ALC days and rate will be broken down by specific target populations as appropriate (e.g. ALC – Long-Term Care, ALC – Rehabilitation, ALC – Home with CCAC Services)
- The regional focus at the North East Health System Advisory Committee (NE HSAC) will be predominantly on the MLAA indicators and changes thereto, while local / sub-LHIN tables will focus both on the MLAA indicators and the additional operational / process metrics related to patient flow.

Governance, Roles and Responsibilities

The following structure is premised on clear alignment, linkages and communications occurring between the various groups and levels.



Roles and Responsibilities			
MOHLTC	**NE LHIN**	**HSAC**	**Individual HSPs**
To set provincial targets, monitor and hold the 14 LHINs accountable for performance.	To set LHIN and sub-LHIN targets, monitor and hold health service providers (HSPs) accountable for performance. To facilitate and support regional strategy development. To invest in ALC related programming as resources become available.	To develop an overarching ALC strategy and workplan for the region. To make recommendations re. required investments. To identify linkages and synergies between cross-sectoral initiatives that can be leveraged. To support the analysis and interpretation of regular ALC performance measurement.	To incorporate and adopt the LHIN ALC targets as organizational goals (to be included in all SAAs starting in 16/17). To work towards the achievement of the LHIN target by participating in local and regional projects and strategies. To ensure that high quality ALC data is collected and reported in the pertinent monitoring tools.

NE LHIN Patient Flow Strategy: Improving Care Coordination and ALC Performance, 2016/17 to 2018/19

Regional and Local Governance and Accountability

Strategic Directions

Provincial Directions

Access	**Connect**	**Inform**	**Protect**
Improve System Integration and Accessibility	Modernize Home and Community Care	Increase the Health and Wellness of Ontarians	Ensure Sustainability and Quality

NE LHIN Priorities

Improve Access and Wait Times	**Increase Care Coordination**	**Strengthen System Sustainability**

North East Health System Advisory Committee Goal: To improve patient flow and care transitions, and achieve the provincial ALC and community wait times targets, through individual and collective action.

Annual Workplan

Regional Performance Targets

Strategic Areas of Focus

Process	**Capacity**	**Demand**	**Specific ALC Populations**

Regional Projects and Strategies

Local Performance Targets

Strategic Areas of Focus

Process	**Capacity**	**Demand**	**Specific ALC Populations**

Local Projects and Strategies

Performance Monitoring and Evaluation

Approach to Implementation

Addressing patient flow and ALC requires:

- concerted and coordinated efforts on a range of strategies and activities in-hospital and in-community … there is no one single solution; and

- a combination of process improvements, capacity management and demand management approaches. Care transitions and ALC are not simply hospital or LHIN problems, but rather are system-wide issues requiring system-wide strategies, partnerships and commitment.

Re-thinking ALC… key improvement levers.

Process	Capacity	Demand
Actions to ensure efficient patient centred flow	***Actions to plan and develop the right capacity in the system***	***Actions to stop the generation of new ALC patients***
What can we do to ensure patient-centred flow? ▪ Build more proactive integrated discharge planning practices. ▪ Advance elder-friendly hospital practices. ▪ Standardizing & streamlining discharge planning processes.	**What capacity is needed in the mid to long term to support?** ▪ Understanding the real downstream capacity (kind / amount) needed to support Northern Ontario residents. ▪ Plan for capacity conversion – from current to future state.	**What can we do to reduce demand?** ▪ Develop upstream approach to prevention. ▪ Strengthen primary care & chronic disease management approaches. ▪ Build capacity of home/ community care system. ▪ Advance elder-friendly hospital practices.

Considerations in developing the annual regional and local patient flow / ALC work plans and targets include:

Alignment

- Align with the overarching NE LHIN strategic plan as outlined in the IHSP.
- Do not duplicate projects that other groups are currently working on, or would be best led by others.
- There should be room in the workplans to address emerging HSP, LHIN and MOHLTC issues, and advise / act thereon.

Outcome-Focused

- Whenever possible, include activities that can be measured and that lead to measurable results.
- LHIN, HSAC and HSP work needs to support the achievement of pertinent Ministry-LHIN accountability agreement (MLAA) performance targets.
- Select priority activities that are based on evidence.

Work Smart

- Keep the workplans focused and simple to start. They will evolve and change over time.
- Work as a single virtual organization across the HUB hospitals and across sectors e.g. sharing and disseminating best practices, coordinating strategies and activities.
- LEAN and PDSA techniques must be incorporated into the work.
- Take advantage of opportunities to learn from the experiences of partners within and outside of the NE LHIN.

Leadership and Accountability

- Both regional and local executive sponsorship and leadership is required.
- Respectful relationships and attention to effective change management are critical.
- Shared accountability for ALC across HSPs and sectors will be in place through the refreshed service accountability agreements starting in 2016/17.

Conclusion

Patient flow is essential to effectively meet patient needs. In a complex system such as health care, many different strategies and many different partners are required to have a lasting and meaningful impact on the range of metrics to be addressed through this framework. No one sector or organization can do it alone.

This is a three-year strategy to collectively achieve patient flow targets in-hospital and in-community using the Triple Aim philosophy. The strategy will be implemented through process improvement, capacity management and demand management projects.

Annual workplans at the regional and local levels (with associated performance targets), in support of the overall strategy, will be developed and updated as required.

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