Appropriate level of care:
a patient flow, system integration and capacity solution

Report by the expert panel on alternate level of care
December 2006

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1.0 Executive summary

The term alternate level of care (ALC) is used by the health care system to describe patients waiting for an appropriate level of care to meet their needs.[1] The Canadian Institute for Health Information (CIHI) uses the term to describe and collect information concerning acute hospital patients who have finished the acute care phase of treatment but remain in an acute care bed.

The extent of ALC days in Ontario's hospitals is a serious, system-wide issue that challenges the health care system. It will continue to grow in scope unless effective action is taken. Long waits for appropriate levels of care are a symptom of significant issues related to patient flow, access to care, system integration, availability of care and service options, system capacity and resources.

The rate of ALC days as a percentage of total hospital days has been described as an important indicator of health system performance.[2] However, patients also wait for appropriate levels of care in other health care sectors, such as complex continuing care (CCC), rehabilitation, long-term care (LTC) homes and in some community services.

Acute care data reveals:

- Between eight and 10 percent of all acute hospital days in Ontario and Canada respectively are attributed to patients designated ALC.[3]
- Every day in Ontario, more than 1,600 acute hospital beds are occupied by patients waiting for a more appropriate level of care. Most often, these patients are waiting for LTC home, rehabilitation and CCC beds, and home-based services.[4]

Excessive waits for appropriate or alternate levels of care in hospitals create a domino effect across the system. When both ALC days and demands for acute care services are at high levels, patients wait in emergency rooms for an inpatient bed to become available, paramedics wait to offload ambulance patients to an emergency stretcher, and elective surgical patients experience cancellations waiting for a post-operative bed.

As hospitals attempt to reduce ALC days to accommodate people requiring acute care, patients and families can experience added pressure and anxiety while making important decisions about future care. Hospitals and health care providers are committed to working with patients and families to achieve the best possible post-acute plan of care. If care in a LTC home has been determined to be the most appropriate level of care and wait lists are long, as they are in many communities, hospitals often request that patients accept an available LTC bed as a place to wait for a bed in the LTC home of their choice.

The high level of ALC days in hospitals must be addressed quickly and effectively. With baby boomers expected to increase the numbers of seniors, and improved

[1] CIHI, Waiting for Health Care in Canada: What we know and what we don't know, Chapter 4, Beyond Acute Care.
[2] Ontario Health Quality Council, 2006 First Annual Report.
[3] CIHI and Provincial Health Planning Database (PHPDB) 2005-2006.
[4] Inpatient Discharges Data, PHPDB 2005-2006.

treatments and technology promising to prolong life, the number of patients requiring ongoing care can be expected to grow significantly in the future. Healthier lifestyles, effective prevention of illness and disability and improved chronic disease management contribute to the ALC solution but they alone cannot keep ALC days from increasing in the immediate term.

We can expect to see a reduction in ALC days when individuals find it easier to move from one level or type of care to another. This requires an effective continuum of providers and provider organizations that is transparent to those receiving care, a comprehensive range of care and service options to meet community need and a supply of services that reflects demand. To achieve this state, significant system-level commitment to action is required.

Panel recommendations and priorities for implementation
The panel's recommendations are aimed at creating a comprehensive system of care to meet ongoing care needs, through prevention of disability, improved flow, innovative care approaches, a focus on care in the community and a balance of supply and demand for services.

Of the 22 recommendations listed, the following were determined to be priorities by the panel as those with the greatest short to medium-term (one to five years) potential to improve ALC performance:

- Define and expand (where appropriate) the role and capacity of the health system to provide care in the community, in complex continuing care and rehabilitation programs, and in long-term care homes.

- Increase and balance the availability of supportive housing for seniors across the province.

- Increase home care for services such as personal support and homemaking.

- Review hospital discharge policies and practices and Community Care Access Centres' (CCAC) placement policies with the intention of getting hospitalized long-term care home eligible patients to select three homes appropriate to their care needs. Homes should be selected in order of preference, including at least two from a regularly-updated CCAC list of homes with vacancies or shorter waiting lists. When an appropriate bed is offered in one of the selected homes, it is expected that it will be accepted as either a permanent placement or a place to wait for a first choice of home.

- Implement demonstration community-based high intensity needs programs for seniors in areas with high rates of ALC.

- Develop education and awareness programs to inform patients, families and providers about: ALC designation; the effective use of each level of care; and the value of planning for future care needs.

- Improve the co-ordination of services to provide a smooth transition of care across the continuum of services, by defining accountabilities for timely and effective client flow.

Recommendations have been organized under eight themes: meeting specialized needs in LTC homes, CCC and rehabilitation beds; supporting independence through care in the community; improving system access, integration and patient flow; provider, patient and family education; predicting long-term care service demands; best practices within and across health care organizations; enablers; and data, benchmarks and accountability.

While the panel has underscored priority recommendations, it urges the implementation of all 22 recommendations:

4.1 Meeting specialized needs in LTC homes, CCC and rehabilitation beds

R1 Define and expand (where appropriate) the role and capacity of the health system to provide care in the community, in complex continuing care and rehabilitation programs, and long-term care homes.

4.2 Supporting independence through care in the community

R2 Increase home care for services such as personal support and homemaking, to enable appropriate frail elderly and people with disabilities to remain independent at home, and to provide cost-effective care in the community.

R3 Establish a core set of community support services upon which all local communities can build.

R4 Implement demonstration community-based high intensity needs programs for seniors in areas with high rates of ALC.

R5 Develop a mechanism for funding to meet the care needs of individual, hard-to-serve clients.

R6 Make assisted living a provincial priority for investment over the next five years to increase and balance the availability of supportive housing for seniors across the province.

4.3 Improving system access, integration and patient flow

R7 Under the leadership of the Local Health Integration Networks (LHINs) improve the co-ordination of services to provide a smooth transition across the continuum of care by clearly defining accountabilities for timely and effective client flow.

R8 Review hospital discharge policies and practices and Community Care Access Centres' (CCAC) placement policies with the intention of getting hospitalized long-term care home eligible patients to select three homes appropriate to their care needs. Homes should be selected in order of preference, including at least two from a regularly-updated CCAC list of homes with vacancies or shorter waiting lists. When an appropriate bed is offered in one of the selected homes, it is expected that it will be accepted as either a permanent placement or a place to wait for a first choice of home. Where waiting lists are long at all homes, a fourth option should be offered, in which the individual gives the CCAC permission to scan all appropriate available beds to seek a potential match for their consideration.

4.4 Provider, patient and family education

R9 Develop education and awareness programs to inform patients, families and providers about: ALC designation; the effective use of each level of care; and the value of planning for future care needs.

4.5 Predicting long-term care service demands

R10 Approve long-term care home beds in response to the demand resulting from demographic changes over the next 10 years and to address present demand in underserved communities. Replacement of physical plants in older homes should also be a priority.

R11 Continue to use short-term interim strategies in communities experiencing severe hospital pressures as a result of excessive waits for long-term care home beds.

R12 Develop a demand projection model for all pre- and post-acute care services.

4.6 Best practices within and across health care organizations

R13 Implement toolkits and performance improvement coaching teams to provide assistance to hospitals, Community Care Access Centres and long-term care homes that have identified a need to improve discharge planning and patient flow practices, and to community support services that have identified a need to improve assessment and service access processes.

R14 Implement a risk assessment tool for early identification of hospital, primary care and community patients at risk of requiring ongoing longer-term care.

R15 Use consistent tools to objectively measure care requirements to select and provide the most appropriate care level available in a community.

4.7 Enablers

R16 Support access to primary care, chronic disease management, e-health initiatives and health human resource strategies, as critical enablers in addressing ALC issues.

4.8 Data, benchmarks and accountability

R17 Develop rules and criteria for the application of ALC in Ontario, to improve the quality of hospital ALC data.

R18 Report ALC days in complex continuing care and rehabilitation.

R19 Identify existing and/or new data sources and reporting mechanisms to capture standardized client wait times and disposition data for people awaiting appropriate levels of care in non-hospital settings.

R20 Establish evidence-based wait times as benchmarks for access to long-term care homes, complex continuing care, rehabilitation, home care and community services.

R21 Study local patient flow in each Local Health Integration Network (LHIN) to improve and monitor ALC performance.

R22 Set a provincial target for a 10% reduction in ALC days per year, over the next five years, for patients waiting in acute care hospitals for alternate levels of care.

Implementation of panel recommendations
The recommendations of the ALC expert panel cover a broad range of issues that affect hospitals, CCACs, LTC homes, mental health, supportive housing, community support agencies and primary care providers. For this reason, the panel recommends responsibility for implementation be assigned to respected leaders from across the acute and community health care sectors who are actively engaged in care delivery and/or management. The LHIN and primary care perspectives should also be reflected, and a mechanism to ensure input by consumers should be developed.

An existing provincial working group, such as the one responsible for improving access to emergency services, may be well positioned to assume responsibility for implementing the panel's recommendations, particularly with an expanded mandate and membership.

The timing is right for change. There is a convergence of ideas and broad agreement about what needs to be done to address the issues. This report provides a system-wide overview of ALC, followed by recommendations to improve patient flow, access, system integration, care and service options, and system capacity.

2.0 Overview of the issue

2.1 Background

The extent of ALC days in Ontario's hospitals is a serious, system-wide issue that challenges the health care system. It will continue to grow in scope unless effective action is taken. Long waits for appropriate levels of care are a symptom of significant issues related to patient flow, access to care, system integration, availability of care and service options, system capacity and resources.

The term ALC is used by the health care system to describe patients waiting for an appropriate level of care to meet their needs.[5] The Canadian Institute for Health Information (CIHI) uses the term to describe and collect information concerning acute hospital patients who have finished the acute care phase of treatment but remain in an acute care bed. While CIHI data does not yield a complete picture of ALC, it is used to track trends in ALC patient numbers and hospital days and length of stay for individuals awaiting LTC home, rehabilitation and CCC beds and other health care services such as home care.

A recent CIHI publication shows that ALC patient days currently account for a significant percentage (8.7%) of hospital days in Canada.[6] In Ontario, ALC days accounted for 9.32% of hospital days in 2005/6.[7] Further, there is evidence that patients and clients wait in other non-acute health care settings for an appropriate level of care. However, data is not systematically collected or shared on these waits.

The Ontario Health Quality Council and provincial expert panels on Emergency Care, Critical Care and Wait Times identify ALC as an important indicator of system performance.[8, 9] A Collaborative Position Paper by the provincial associations representing hospitals, long-term care homes and community care access centres, released in May 2006, provides important analysis and recommendations to address ALC in hospitals.[10] It is suggested that improving ALC performance would result in a significant improvement in emergency department overcrowding, ambulance offloading times, elective surgical cancellations, acute care bed availability, surge capacity and other system challenges. In this context, it is easy to understand the sense of urgency associated with ALC.

While viewed as an important indicator of health system performance, ALC is first and foremost an issue that affects people. Hospital patients designated ALC, through no fault of their own, find themselves waiting in the system. Having experienced an

[5] CIHI, Waiting for Health Care in Canada: What we know and what we don't know, Chapter 4, Beyond Acute Care.
[6] Ibid.
[7] Inpatient Discharges Data, Ministry of Health and Long-Term Care (MOHLTC), Provincial Health Planning Database (PHPDB) 2005-2006.
[8] Ontario Health Quality Council, 2006 First Yearly Report.
[9] "Improving Access to Emergency Services: "A System Commitment" Schwartz, Dr. Brian, Chair "Final Report of the Hospital Emergency Department and Ambulance Effectiveness Working Group: to MOHLTC", Toronto, Government of Ontario, 2005.
[10] "Alternate Level of Care – Challenges and Opportunities," A collaborative position paper. Ontario Hospital Association (OHA), Ontario Long Term Care Association (OLTCA), Ontario Association of Non-Profit Homes and Services for Seniors (OANHSS) and Ontario Association of Community Care Access Centres (OACCAC). Ontario, May 2006."

acute illness requiring hospitalization, the often elderly person is faced with important decisions regarding future care that affect independence and quality of life. These difficult decisions are compounded by significant periods of waiting to access an appropriate level of care. Anxiety and distress are experienced not only by the patient, but by caring family and friends.

ALC is a system challenge with important implications for people requiring health care. Use of the term 'appropriate' rather than 'alternate' more accurately reflects the care patients wait for and is a less value laden term. The expert panel felt that the term 'appropriate level of care' would be better terminology.

Evidence does not exist to determine the optimal 'wait time' for access to an alternate level of care. While hospitals provide safe, high-quality care, patients waiting for alternate level of care may be at risk of hospital-acquired illness and deterioration in physical, mental and social functioning.

2.2 Panel deliberation process and approach to information gathering

Following publication of the Collaborative Position Paper, an expert panel on ALC was established in May, 2006.[11] The use of expert panels in Ontario has proven to be a valuable tool in the process of improving health care. This approach supports 'the system helping the system' principle and strengthens the relationship between government and health care providers. It is encouraging that both providers and government are listening to, and acting upon, many recommendations made by expert panels.

The mandate of the ALC expert panel was broad and included:[12]

- Building on the multi-stakeholder Collaborative Position Paper *Alternate Level of Care-Challenges and Opportunities*;
- Ensuring that all ALC issues were identified;
- Using a system-wide approach;
- Identifying strategies and priorities likely to reduce ALC days and improve health system integration and accountability; and,
- A focus on access, accountability, innovation, shared learning and best practices.

In establishing the expert panel, a decision was made by the Ministry of Health and Long-Term Care (MOHLTC) to expand the membership beyond hospitals, LTC homes, and CCACs to include community support agency representation from both mental health and other community services, discharge planning and leadership from the newly formed LHINs.[13] This broad range of perspectives was highly valued, and at the same time, presented some challenges in building consensus.

Further, the panel's work plan included the use of focus groups to comment on early findings and direction. A total of 92 people participated in eight focus groups, with representation from across the province.[14] The focus groups provided perspectives from seniors, mental health clients and their advocates, LHINs and those working in

[11] "Alternate Level of Care – Challenges and Opportunities," A collaborative position paper. OHA, OLTCA, OANHSS and OACCAC. Ontario, May 2006.
[12] Full terms of reference for ALC expert panel is listed in Appendix C.
[13] A list of panel membership is provided in Appendix D.
[14] Focus group participants are listed in Appendix E.

hospitals, LTC homes and their advocates, CCC, rehabilitation, supportive housing and the community. The dialogue and ideas generated by the focus groups contributed significantly to this report.

The panel worked with the following guiding principles in the development of solutions to improve ALC performance and deliver the appropriate level of care. Effective solutions will:

- Provide optimum, timely, cost-effective care in the most appropriate setting;
- Consider care in the home/community as a first option, if appropriate;
- Balance improved policy and standards for care with flexibility to meet unique local challenges;
- Recognize the responsibilities of all stakeholders and the leadership role of LHINs in improving system integration, patient access and patient flow;
- Be both strategic (longer term) and tactical (more immediate), with tactical solutions supporting longer-term strategies;
- Support patient/client choice, and;
- Reflect best practice and evidence.

Site visits to Capital Health's CHOICE program in Edmonton and to Peel Senior Link in Mississauga/Brampton and a series of presentations assisted the panel with its work.[15]

[15] Presentations made to the panel are included in Appendix F.

3.0 Profile of ALC in Ontario

3.1 The ALC challenge

ALC is a long-standing, significant and persistent issue across Canada and in many other countries. It is a symptom of larger system issues related to patient flow, access, system integration, capacity and resources.

When both ALC days and demands for acute care services are at high levels, the length of time patients wait for other acute care services increases. For example, patients wait longer in emergency rooms for an inpatient bed to become available, paramedics wait longer to offload their patients to an emergency stretcher, and elective surgical patients experience cancellations waiting for a post-operative bed.

The high level of ALC days in hospitals be must addressed quickly and effectively. With baby boomers expected to increase the numbers of seniors, and improved treatments and technology promising to prolong life, the number of patients requiring ongoing care can be expected to grow significantly in the future. Healthier lifestyles, effective prevention of illness and disability and improved chronic disease management are important but alone they will not be enough to keep ALC days from increasing in the immediate term.

A recent survey of hospital executives from five countries identified limited availability of post-acute care as one of the key factors leading to discharge delays from acute care facilities.[16]

ALC days in Ontario as a percentage of total acute inpatient days in 2005/6 were 9.32% according to the MOHLTC. There are significant variations in the ALC rates from one LHIN to another, as well as large variations among hospitals within individual LHINs. The Mississauga Halton LHIN has the lowest rate of ALC in acute hospitals (6.15%) while the North East LHIN reports the highest rate (15.93%). Six LHINs have ALC rates above the provincial average.

[16] CIHI, Waiting for Health Care in Canada: What we know and what we don't know, Chapter 4, Beyond Acute Care.

Figure A: ALC days in Ontario in 2005/2006 per LHIN

LHIN	Number of ALC separations*	ALC days as a % of total patient days in 2005/2006†	Hospital Range‡	Number of hospitals that report ALC days per LHIN
North East	3,469	15.93	0.00 – 53.38	23
South East	2,004	14.98	3.65 – 35.64	6
North West	1,658	10.94	4.09 – 42.14	12
Champlain	3,595	10.85	0.60 – 26.96	17
Hamilton Niagara Haldimand Brant	6,820	11.07	3.07 – 51.99	11
Toronto Central	5,734	7.84	0.00 – 17.24	7
Erie St Clair	2,382	7.79	0.21- 13.92	7
Central East	3,168	7.72	3.89 – 30.63	8
North Simcoe Muskoka	1,581	7.39	0.89 – 22.78	6
Central	2,952	6.75	0.00 – 12.64	6
Central West	1,089	6.61	5.50 – 8.34	2
Waterloo Wellington	1,598	6.36	1.23 – 12.20	6
South West	3,645	9.36	0.00 – 31.09	19
Mississauga Halton	1,850	6.15	1.04 – 18.45	3
Total	41,545	9.32	0.00 – 53.38	

Source: Inpatient Discharges Data, Ontario MOHLTC, Provincial Health Planning Database (PHPDB) 2005-2006.

* Includes hospitals with and without psychiatric beds, private and federally administered hospitals, children's hospitals, hospitals with palliative-care units and a hospice. Information is provided for each acute site of the hospital and the assignment to a LHIN is based on postal code of the hospital site.

† ALC days as a % of total patient days is calculated as: % ALC days = [(ALC days) / (Total Length of Stay)] *100%, based on the same data element names appearing in the source data. All numbers used for calculations are as reported by hospitals. Newborns and stillborns have been excluded from all calculations.

‡ Some hospitals did not report ALC days; this has led to the 0 appearing as lower range and should not be interpreted as hospitals without ALC days.

Note: The methodology used to calculate ALC days is subject to ongoing refinement, evaluation and modification.

3.2 ALC profile

With patient days waiting for transfer to an appropriate level of care accounting for approximately 9.32% of total acute days in Ontario, approximately 1,600 acute care beds are unavailable on any given day for acute care. In Canada, the average length of stay for ALC designated hospital patients is 36.1 days - five times greater than the overall acute average length of stay of 6.5 days. [17]

CIHI data shows ALC designated patients are female (58.1%) and over the age of 65 (82%) with a mean age of 75.4 years. They have a mix of health problems that

[17] CIHI Survey: Alternatives to Acute Care? Healthcare Quarterly Vol. 9 No. 2 2006

require follow-up or ongoing services from a variety of non-acute service providers. In urban areas, ALC patients are evenly distributed across income groups. Approximately half of all ALC designated patients are hospitalized for treatment of trauma, neurological and mental illnesses and disorders, and cardiovascular and respiratory diseases.[18]

Upon leaving hospital, 39% of Canadian patients designated ALC are transferred to LTC homes; another 10% go to inpatient rehabilitation; 33% are discharged home with or without home care services; and 10% pass away during their ALC wait.[19] In Ontario, upon leaving hospital, 24% of patients designated ALC go to LTC homes; 24% go to CCC; 20% go to rehabilitation; 13% go home with home care; and, 14% go home without home care.[20]

An August 2006 'snapshot' survey of ALC designated patients waiting for LTC home placement in Hamilton hospitals showed that of the 102 patients designated ALC, 50% were previously unknown to the CCAC and 51% of those known were experiencing some cognitive impairment and/or behavioral issues including aggression, agitation or wandering.[21]

Figure B: Summary of Ontario ALC separations and days by discharge disposition

Transfer & Discharge Disposition	**ALC separations**	**% of total ALC separations**	**Total ALC days**	**% ALC days**
1. Home (excluding home care)	5,350	14.1	64,253	12.2
2. Home care	4,905	13.0	51,274	9.7
3. Long-term care home	9,056	23.9	206,068	39.0
4. Complex continuing care	8,978	23.7	109,478	20.7
5. Rehabilitation	7,632	20.2	64,511	12.2
6. Other	1,929	5.1	32,700	6.2
Total	37,850*	100	528,284†	100

Source: Inpatient Discharges Data, Ontario MOHLTC, Provincial Health Planning Database (PHPDB) 2005-2006

* Calculated by subtracting number of patients who died (N=3,695) from all ALC separations (N = 41,545).

† Calculated by subtracting number of days for patients who died (N = 64,687) from all ALC days (N = 592,971).

[18] CIHI Survey: Alternatives to Acute Care? Healthcare Quarterly Vol. 9 No. 2 2006.
[19] Ibid
[20] Inpatient Discharges Data. Provincial Health Planning Database (PHPDB) 2005-2006.
[21] "ALC to LTC: The Challenge Continues", Hamilton Emergency Services Network, August 2006.

While ALC specifically occurs in acute care, clients and patients also wait for appropriate care in other parts of the system. Many patients wait at home for LTC home and other residential placements such as supportive housing. Patients wait in complex continuing care and rehabilitation for transfer to other levels of care.[22] Mental health clients wait in tertiary mental health beds and in the community for transfer to other levels of care. Forensic clients often wait in the justice system for the specialized beds and programs they require. Figure C lists the broad range of services for which clients and patients wait.

Figure C: Non-acute care services for which ALC designated patients wait

ALC designated patients wait for many services:

- Long-term care home (basic and preferred level beds, specialized programs and high-intensity, needs-supported care)
- Complex continuing care (chronic, rehabilitation, palliative and other specialized care, such as respiratory care and dialysis)
- General or specialized rehabilitation
- Convalescent care
- Specialized acute care (e.g., forensic beds)
- Palliative care
- Inter-hospital transfer (between community and tertiary)
- Retirement home
- Group home
- Assisted living/supportive housing
- Home care (CCAC and other)
- Recovery of an ill informal caregiver
- Adapted living services or changes to home
- An appropriate level of care to meet complex specialized needs, such as a bed with a ventilator or a safe environment
- Addiction services
- Supportive housing
- Intensive case management (mental health)

3.3 ALC data quality and consistency

While available ALC data for acute hospital patients is useful in determining the magnitude of the issue, it is not as useful as it could be in the search for solutions.

[22] Rehabilitation is defined as a progressive, dynamic, goal-oriented and often time-limited process, which enables an individual with an impairment to identify and reach his/her optimal mental, physical, cognitive and /or social functional level. Rehabilitation is provided in a variety of settings, including acute care hospitals, CCC programs, rehabilitation hospitals, outpatient clinics, long-term care homes and private clinics. While long-term care emphasizes residential care with a social model, complex continuing care typically involves goal-oriented inpatient services, which may or may not be time-limited, emphasizing regaining functional levels, often with a goal of discharging the individual to the community or to long-term care. The patient's medical conditions are often more complex of those in long-term care homes and require about twice the level of care received by patients in long-term care settings. (Source: "Optimizing the Role of Complex Continuing Care and Rehabilitation in the Transformation of the Health Care Delivery System – A discussion paper", Ontario Hospital Association, May 2006.)

The ALC definition is known to be inconsistently applied across hospitals. Timing of ALC designation varies, as does the process for determining ALC. The quality and availability of the discharge destination data is particularly inconsistent. This problem has been widely recognized by experts who have tried to work with the data.[23] [24] [25] The lack of comparable information about patients/clients waiting in locations other than acute care makes it difficult to fully understand waits for appropriate levels of care across the system.

Consistent, comprehensive, high-quality data is essential if ALC performance is to be measured and targets set as part of accountability and other agreements between health care partners. This requires standardized data elements for patients waiting for an appropriate level of care within the system. Acute hospitals, CCACs, CCC and rehabilitation hospitals, LTC homes, mental health and addiction, and community support providers should regularly report information to LHINs and to one another. Patient-specific, real-time data is necessary to efficiently and effectively manage patient care on a day-to-day basis across organizations. Monitoring trends and planning and delivering services to meet future care needs requires aggregate data.

[23] CIHI, Waiting for Health Care in Canada: What we know and what we don't know, Chapter 4, Beyond Acute Care.
[24] Ontario Health Quality Council, 2006 First Yearly Report.
[25] "Alternate Level of Care – Challenges and Opportunities," A collaborative position paper. OHA, OLTCA, OANHSS and OACCAC. Ontario, May 2006.

4.0 Key findings and panel recommendations

To a large extent the work of the expert panel corroborates information that is already known about delays in accessing appropriate levels of care and the impact of underlying patient flow, system integration, capacity and resource issues and challenges. There has been significant consensus on what needs to be done. Despite this consensus, action has been slow and at the margins.[26]

The significant rate at which chronic conditions affect the population, not just in Ontario but around the world, has been identified as a key challenge facing health care and has the potential to significantly impact wait times for appropriate ongoing care.

Today, the majority of health care services are used by individuals with chronic conditions and the cost of treatment is significant. In Canada, it has been estimated that 67% of direct health care costs can be attributed to chronic disease. Chronic conditions have been defined as those expected to persist or to recur, beyond one year.[27] They are associated with age, gender and socio-economic status. There is a range of chronic conditions common to patients currently designated ALC in our hospitals, from recurrent psychosocial conditions such as serious and persistent mental illness to diseases such as diabetes, chronic respiratory and cardiovascular diseases and disabilities associated with conditions like post-stroke impairment.

While public health measures aimed at preventing chronic disease must be a health care priority, care demands by those with chronic conditions will continue to significantly impact the system. Without responsive services and adequate capacity we can expect to see increasing numbers of patients queuing in hospitals and across the system for appropriate levels of care.

Hollander's national study, *Analysis of Interfaces Along the Continuum of Care, "The Third Way": A Framework for Organizing Health Related Services for Individuals with Ongoing Care Needs and Their Families,* provides important information on the continuum of home and community care required to meet the ongoing care needs of four population groups: frail seniors, adults with physical disabilities, persons requiring mental health services and children with special needs. The first three of these population groups represent the majority of our current ALC population in hospitals. The study identifies significant gaps and insufficient service capacity that present barriers to coordinated ongoing care. The negative impact of turf protection amongst services and the relative power base of services were found to inhibit the flow of clients across health sectors.[28] A lack of information and information technology across services, differing eligibility criteria, admission processes and the need for re-assessment at multiple points were identified as factors that affect timeliness of access to service. Nowhere in Canada did the study find flexibility for 'funding to follow the client.'

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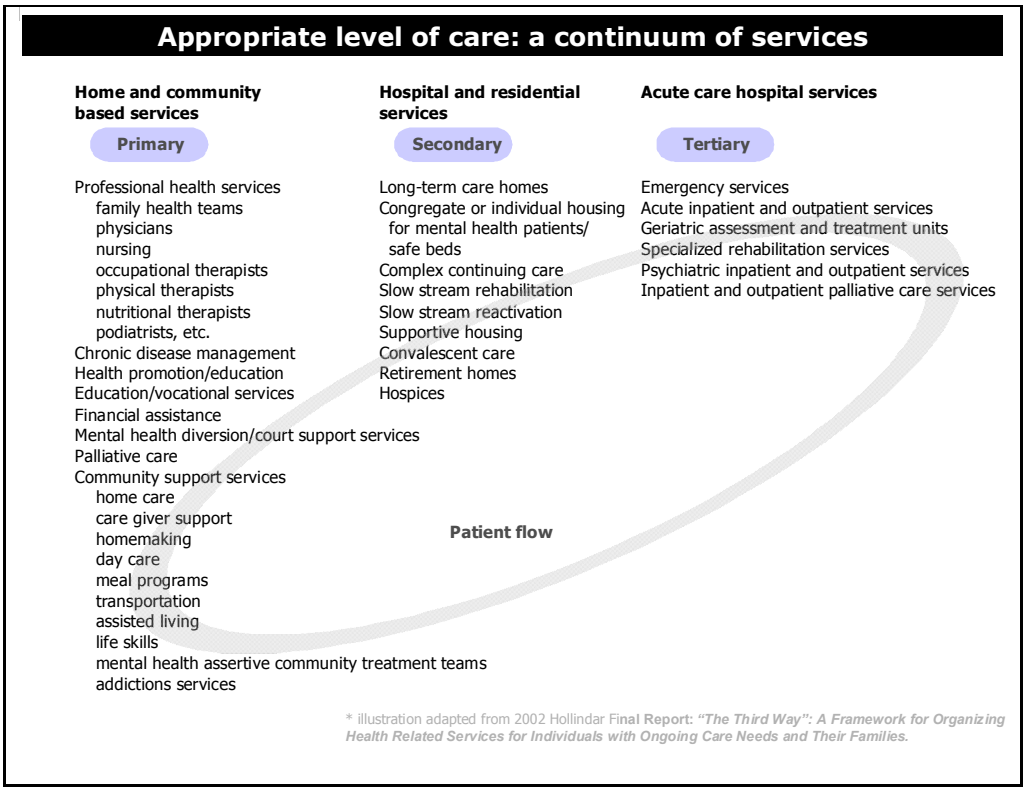
[26] Hollander, Marcus J. (February, 2003) "The Third Way": A Framework for Organizing Health Related Services for Individuals with Ongoing Care Needs and Their Families.

[27] "Chronic conditions and co-morbidity among residents of British Columbia," Broemeling, Anne-Marie, Watson, Diane, Black, Marilyn, Center for Health Services and Policy Research, University of British Columbia, February, 2005.

[28] OCCAC, OANHSS, OHA and OLTCA, "Alternate Level of Care – Challenges and Opportunities: A Collaborative Position Paper", Ontario, May 2006.

Implementation of common classification systems to determine level of care needs and a common assessment tool are cited in the Hollander report as key in the planning and management of our complex systems of care. Also raised are the rural issues of fewer types of services, transportation barriers in accessing services and proximity of residential care to families.

Figure D: Appropriate level of care: a continuum of services



Many local ALC studies have been conducted across the province in an effort to improve ALC performance in their hospitals and build relationships across organizations. The panel recognizes this important work and the resulting efficiency improvements across the province. The factors identified by local groups as contributing to waits show many similarities. Commonly noted challenges include:[29] [30] [31] [32]

- Accessibility to primary care physician services;
- The need for process improvements in assessment and referral processes for some services;

[29] "Alternate Level of Care (ALC) Report". Kingston General Hospital ALC Task Force. February 2006

[30] "From Alternative To Appropriate Levels of Care". Ottawa ALC Strategic Committee Report of Recommendations. August 2006.

[31] "A Study of Alternate Level of Care in the City of Thunder Bay". North-western Ontario District Health Council. September 2004.

[32] "A Southwest Regional Office Perspective on the Alternate Level of Care Issue". Presentation to the Long-Term Care/Hospital Program Management Team. June 2003.

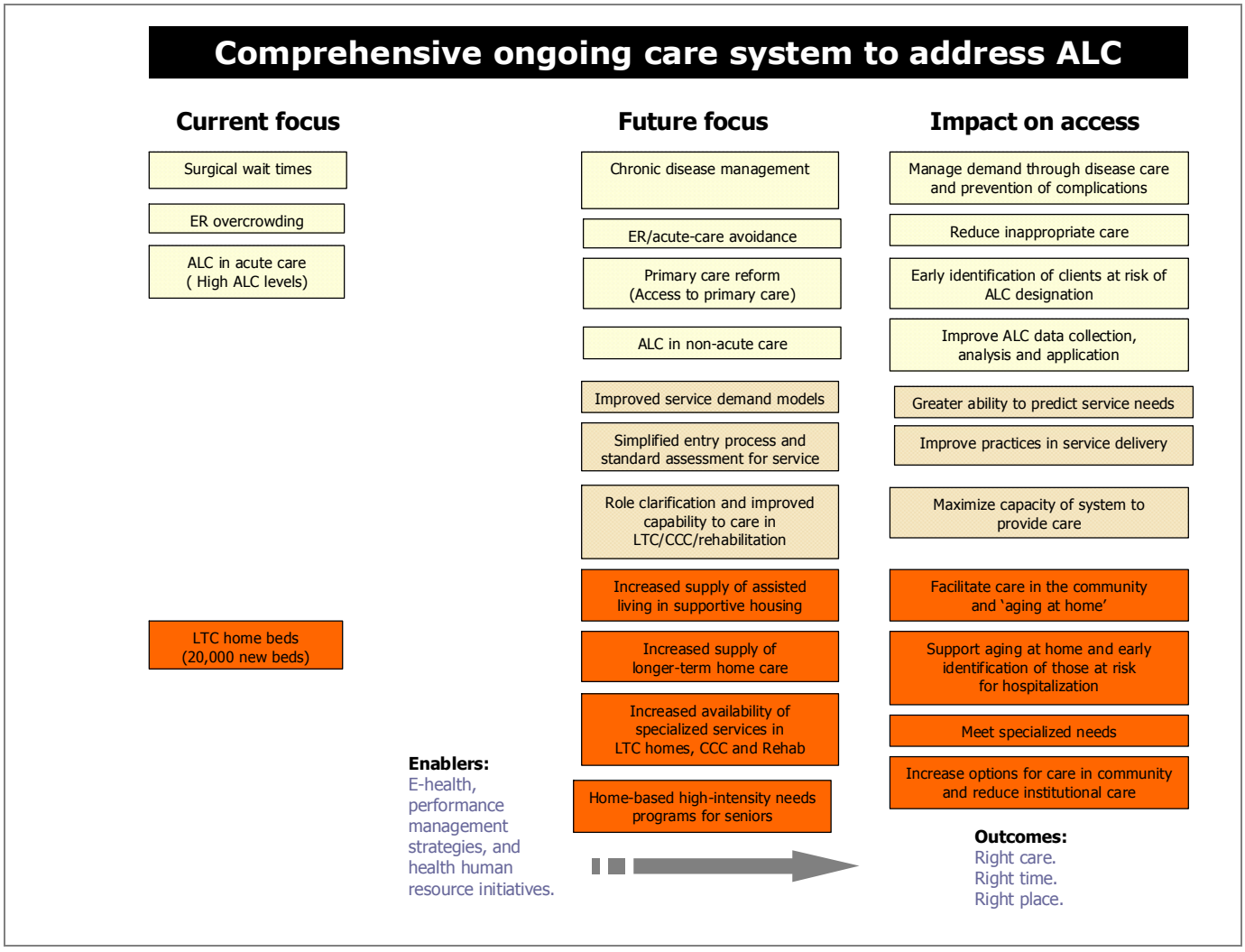
- The limited supply of community support services;
- Communication and coordination challenges among health care providers;
- Variable utilization rates in post-acute services;
- The need for process improvements in hospital discharge and utilization management protocols;
- Lack of availability of post-acute options for special needs populations, including people requiring respiratory care or dialysis, those with mental health conditions, acquired brain injury and difficult behaviours, and the homeless; and,
- The limited supply of LTC home beds and supportive housing options.

There is no magic bullet to resolve the ALC challenge and while there are many actions that can be taken by individual organizations, system level actions and a shared commitment by all stakeholders to improve patient flow, system integration, capacity and resources are required to achieve lasting results.

Key findings and recommendations of the expert panel have been grouped under the following themes:

The panel's recommendations are aimed at creating a comprehensive system of care to meet ongoing care needs through prevention of disability, improved flow, innovative care approaches, a focus on care in the community and a balancing of supply and demand for services. Figure E summarizes the key recommendations and their impact on access.

Figure E: Comprehensive ongoing care system to address ALC



4.1 Meeting specialized needs in LTC homes, CCC and rehabilitation beds

The scope of specialized needs

Local ALC studies underline the importance of services to meet specialized needs of post-acute patients.[33] Chronic respiratory care, dialysis, mental health care, slow stream rehabilitation, reactivation and transitional care are identified as unmet needs in many communities. Diversity needs, including food, language and spiritual considerations, are important areas to address. Other key areas are care needs of people with co-existing mental health conditions, challenging behaviours and infection control issues.

Existing services for specialized needs

At present, services to meet specialized needs are provided in some LTC homes, CCC and rehabilitation facilities. Gaps in service and unclear responsibility by each level of care for the provision of these services often result in referrals to the facility that offers a service, rather than to the most appropriate level of care. Clarifying services and programs to be offered by LTC homes, CCC and rehabilitation is essential to address gaps in service and to create a continuum of care.[34]

Over time, LTC homes have been asked to care for residents with increasingly specialized needs and many homes have risen to the challenge. However, considerable variation continues to exist in services offered across homes and communities. Support to meet specialized needs has been offered to residents through the MOHLTC high intensity needs fund (HINF), a tool used to assist homes to care for individual patient needs, particularly equipment required for wound care. The potential exists to support the delivery of more specialized care through the use of such funds.

Nurse practitioners have been employed in LTC homes in some communities, with good results, assisting with the development of clinical and procedural skills in homes, prevention of unnecessary visits to the emergency room and admissions to hospital, and improved integration of care between long-term care homes and hospitals.[35] Geriatric emergency management (GEM) nurses have also been useful in bridging care between the emergency room and the LTC home and helping to avoid unnecessary hospitalizations.

CCC, once regarded as a long-term residential placement, is increasingly utilized for shorter-term treatment from which patients move to other levels of care or home. Patients often transfer from complex continuing care and rehabilitation to LTC homes. However, there are few mechanisms for patients to transfer directly from LTC homes to these other settings.

Acute hospitals with CCC beds often give patients in their hospital priority access to CCC beds as a strategy to manage ALC issues. As a result, access to CCC beds by patients from the community or other hospitals may not be available.

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[33] Local ALC studies listed in footnotes on page 17.

[34] OCCAC, OANHSS, OHA and OLTCA, "Alternate Level of Care – Challenges and Opportunities: A Collaborative Position Paper", Ontario, May 2006.

[35] Aestima, "The Ontario Nurse Practitioner in Long-Term Care Facilities Pilot Project: Interim evaluation, final report. " February 23, 2002.

A recent Ontario Hospital Association discussion paper, *Optimizing the Role of Complex Continuing Care and Rehabilitation in the Transformation of the Health Care Delivery System* details the changes in the CCC sector over the past 15 years. Beds have decreased by 44% and length of stay by two-thirds, while discharges have increased by close to 60%. Based on the Minimum Data Set (MDS) 2.0 and resource utilization groups (RUGS) that comprise it, close to 65% of patients fall into the specialized and extensive care groups.[36]

The access and assessment processes for CCC and rehabilitation differ widely across organizations. In most communities access is determined by the organization providing the care. Some organizations and communities have begun to see the value in standardizing this process and there are good examples of progress being made. In Sudbury, the CCC placement process is carried out by the CCAC, and in Hamilton there is discussion on moving in this direction. In some communities there is also discussion about creating a single process and point of entry for rehabilitation services.

New directions for meeting specialized needs

Significant opportunity exists for LTC homes, CCC and rehabilitation to assist in the specialized ongoing care of patients suffering from chronic disease and disability, many of whom are currently designated ALC in hospitals.

Recommendation 1

> **Define and expand (where appropriate) the role and capacity of the health system to provide care in the community, in complex continuing care and rehabilitation programs, and long-term care homes.**

The following steps will support the achievement of this recommendation:

a. Based on community need, providers should develop programs to meet the needs of specialized patient populations including:
    - slow-stream rehabilitation and reactivation services for complex patients;
    - longer-term respiratory care;
    - transitional care to provide graduated support for individuals being discharged from acute care following significant stays;
    - specialized rehabilitation for patients who have, for instance, an acquired brain injury, musculoskeletal injury, spinal cord injury or stroke, and;
    - programs for patients with mental health or behavioural issues.

[36] Specialized and extensive care are two RUGS classification levels requiring higher levels of care.

b. Reassess skilled nursing and other professional services required in LTC homes, CCC and rehabilitation based on patient care needs.[37]

c. Review use of the HINF as a mechanism to increase care capacity in LTC homes. Consider funding nurse practitioners to allow homes to care for higher intensity patients and to prevent unnecessary transfers to emergency rooms for care.

d. Evaluate the recently implemented convalescent care programs in LTC homes to determine if this is an appropriate and cost-effective use of LTC home capacity.

e. Develop and implement standard assessment and level of care classification tools to improve efficiency and to provide information upon which future services can be planned.

f. Review the resources required to provide each level of care and determine the impact of any changes on health human resources.

g. Optimize the use of CCC and rehabilitation beds and ensure they are a resource to the system.

4.2 Supporting independence through care in the community

Community-based care options

Community support services and supportive housing play an essential role in facilitating independence in the community and are key components of the continuum of care for the frail elderly, people with disabilities and people suffering from serious mental illness who are able and wish to remain in the community.

The panel and its focus groups confirm that frail elderly and adults with disabilities who want to remain independent have important and often unmet needs for the following services: assisted living/supportive housing, chronic home care (home making and personal care) and other community support services such as attendant care, transportation, meal services and friendly visiting.

There are excellent examples of community support services working with hospitals and others to meet the home care needs of patients and to assist with discharge from acute care. For example, Downsview Services for Seniors has bundled a number of services including home making/home help, meals on wheels, transportation and security checks to provide support to seniors discharged from hospital following an acute admission. The agency works directly with hospital discharge planners to arrange access to these services for clients not eligible for CCAC home care services.

[37] This would include skilled nursing services such as tracheostomy care, dialysis, enteral feeding (providing nutrition through a tube into the gastroenteral system), total parenteral nutrition (delivering nutrition directly into the blood system), intravenous therapy, chest tube care, traction, medication titration, bi level positive airway pressure/continuous positive airway pressure (a special form of ventilation), and long-term mechanical ventilation in medically stable patients.

Client Intervention and Assistance (CIA) is another community support service which is available to hospital discharge planners and others in some communities. It focuses on marginalized, isolated individuals at high risk of poor health outcomes. The goal is to prevent and resolve crisis situations and support individuals through appropriate referral and monitoring to achieve better health outcomes and reduce the use of more costly and scarce health care resources, such as emergency rooms.

CCACs, community support services and longer-term home care

CCACs provide a simplified service access point to community-based care services. Accountabilities of CCACs include:

- determining eligibility for, and buying on behalf of the consumer, highest-quality best-priced visiting professional and homemaking services provided at home and in publicly-funded schools;
- determining eligibility for, and authorizing admissions to, all long-term care homes;
- service planning and case management for clients, and;
- providing information on, and referral to, all other long-term home or community-based care services, including volunteer-based community services.

By providing longer-term home care services, many frail elderly and clients with disabilities will be supported to meet their daily living activities and will maintain a greater level of independence in the community. These services can assist in the client's safe return to the community after hospitalization, and help prevent unnecessary hospital admissions.

If these services are to be provided by CCACs, home care - especially for non-professional services such as homemaking and personal support - will need to be increased.

Recommendation 2

> **Increase home care for services such as personal support and homemaking, to enable appropriate frail elderly and people with disabilities to remain independent at home, and to provide cost-effective care in the community.**

Consideration must be given to the role that community support services play, and could play, in the delivery of longer-term homemaking and personal care services. Within each LHIN there is a need to assess the current continuum of community support services for duplication and gaps, and to ensure services are well-integrated and have adequate links to one another and to CCACs, hospitals and primary care providers. The goal is to determine an optimal mix of community services to support the longer-term, non-acute care needs of frail seniors, people with disabilities, and people with chronic mental conditions in each community.

With this information LHINs and their community support agencies can identify priorities for reallocation or investment, should new resources become available to meet local needs. Opportunities to improve the level of integration of community services through strategies such as common referral, assessment, intake and discharge processes should be identified and supported.

Recommendation 3

Establish a core set of community support services upon which all local communities can build.

Community-based high intensity needs program

As part of a continuum of services to support individuals with complex ongoing needs there is a place for high intensity needs programs that offer an alternative to residential care.

In mental health, there has been considerable success in supporting clients suffering from serious and persistent mental illness through programs such as the Assertive Community Treatment Team (ACTT).[38] ACTT teams offer intensive case management and treatment services over extended periods of time on a 24/7 basis in the community. Clients live in a variety of community settings, including supportive housing. The client has frequent contact with the team and the program provides psychiatric care, the support of a multi-disciplinary team and links to other services in the community. Clients are followed during in-hospital stays and every step is taken to prevent and resolve crises.[39] Many of these clients would face multiple acute inpatient admissions and or require institutional care without this program. Addiction treatment options such as home detoxification and withdrawal is an example of a successful high intensity home-based program.

Based on a U.S. program known as PACE, Alberta introduced a Comprehensive Home Option of Integrated Care for the Elderly (CHOICE) program to provide intensive services to selected medically complex and/or frail seniors. The Capital Health CHOICE program, in operation for 10 years and currently serving close to 400 clients, including those aged 60 plus with chronic mental health issues, has demonstrated success through improved health outcomes, client and family satisfaction and a significant reduction in use of acute and emergency care.[40]

Clients accepted into the CHOICE program are at high or moderate risk for institutionalization, have one or more chronic medical conditions requiring ongoing medical monitoring and treatment, and are frequent users of health care services including emergency, primary care, specialist care and acute in-patient care. As part of the program, clients attend a specialized day care centre where they receive medical monitoring and treatment by program physicians and nurses, medication administration, physical and occupational therapy, recreation therapy and social activities, health education and meals and snacks. The need for in-home services is assessed and arranged and transportation to and from the program is provided. In addition, medications are provided through a program pharmacy. Twenty-four hour respite care for informal caregivers and in-patient treatment beds when close medical monitoring for a short duration is required is also available. Clients must want to be a part of the program and informal caregivers are required to be active partners. Program staff are available for contact 24-hours a day in case of an

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[38] "Impact on Alternate Levels of Care, Mental Health and Addiction Branch, Ministry of Health and Long-Term Care, June 2006", Hayward, Carrie, Ontario's Mental Health System: Presentation to the ALC Expert Panel.

[39] Ibid

[40] "Comprehensive Home Option of Integrated Care for the Elderly – CHOICE." Edmonton Capital Health Authority, 2006 and a site visit to the program in Edmonton.

emergency. In 2005, the average length of stay in the program was just over one and a half years.

A program evaluation was conducted in 2003 comparing the utilization of health services by 137 clients during a one-year period prior to admission to the program with utilization in the first year of care in the CHOICE program. The average age of the clients was 78 years and the average number of medical conditions was nine. Compared year over year, acute inpatient admissions decreased by 67% and inpatient days by 70%. Emergency visits fell by 63% and ambulance transfers decreased by 50%.

In Alberta, caring for a client in this program costs about $2,000-$2,500 per month. Clients contribute up to $120 per month for their care, based on individual financial ability.

In Ontario, programs exist that have many of the elements of a high intensity needs home-based program for the elderly and there is the potential to build upon what is presently available in our province.

At present a study is being conducted by the Ontario Seniors Secretariat that looks at alternatives to LTC home placement for veterans. While results are not yet available this work should contribute further to the discussion.

Recommendation 4

> **Implement demonstration community-based high intensity needs programs for seniors in areas with high rates of ALC.**

If the demonstration programs achieve established goals and prove cost-effective and successful, Ontario community-based high intensity needs programs for the elderly should become part of the overall provincial strategy to meet long-term care needs. Program goals should include improved client outcomes, effective integration with other services, reduced hospital admissions and emergency visits and high levels of client/patient satisfaction.

Flexible funding

At present certain medications and necessary medical supplies can be accessed only through acute care or home care. This results in avoidable admissions to hospital and home care to access these services. There are also a very small number of complex, hard-to-serve clients whose care needs do not fit well into available service options. To access these services, hard-to-serve clients may be unnecessarily admitted to hospital or home care. In such cases, it would be helpful to have the funding 'follow' the individual patient, versus the current model in which funding follows specific services. This would allow for the movement of resources across service components to meet these clients' needs.[41]

[41] Hollander, Marcus J. (February, 2003) "The Third Way": A Framework for Organizing Health Related Services for Individuals with Ongoing Care Needs and Their Families.

Recommendation 5

Develop a mechanism for funding to meet the care needs of individual, hard-to-serve clients.

Supportive housing

Supportive housing has been a success in Ontario since it was introduced in the late 1980s. Currently there are 100,000 rent geared-to-income seniors apartments in the province, and only 8,000 clients receive MOHLTC funded 'assisted living' services. In addition, there are approximately 6,500 MOHLTC funded supportive housing units for mental health clients. Demand for these services significantly exceeds supply.[42] Supportive housing is required to meet the needs of many frail elderly, people with physical disabilities, and people with acquired brain injury, HIV/AIDS, mental health issues and addictions. Current wait lists for assisted living and supportive housing in many communities are years long.

Supportive housing is a combination of subsidized accommodation funded through federal and provincial programs and operated through a variety of local housing agencies, and supportive on-site services funded by the MOHLTC and provided by community support service agencies. Professional services are also provided to home care eligible clients in supportive housing by the CCAC. This combination creates community alternatives to institutional care and homelessness, maximizes client security, independence and control and supports client participation in the community.

In Ontario, assisted living services in supportive housing (ALSSH) for seniors provides support services in permanent, often not-for-profit, congregate living settings. The frail or cognitively-impaired seniors who receive these services must require the availability of minimal 24-hour on-site assistance. Services are provided in either dedicated supportive housing where all units are designated ALSSH or in integrated supportive housing where some units are occupied by ALSSH clients. Usually the accommodation and the services are 'delinked'; that is the landlord and the service provider are not the same. Support services can include attendant services, personal support, essential homemaking and an emergency response system. In addition, CCACs provide professional services to eligible residents and clients may access other community support services such as transportation and visiting meal programs.

The number of clients served by ALSSH for seniors in Ontario varies significantly from one LHIN to another (Figure F). Within LHINs, the distribution of assisted living in supportive housing varies greatly.

[42] "Assisted Living Services in Supportive Housing", Home and Community Support Services Branch, Ministry of Health and Long-Term Care, June 2006. Presentation to the Panel.

Figure F: Seniors assisted living services in supportive housing by LHIN

LHIN	# of seniors served *	Population 65 years and older (2006 forecast projection)	Rate of assisted living in supportive housing per thousand population 65 years and older
Erie St. Clair	29	90,110	0.3
South West	128	137,915	0.9
Waterloo Wellington	0	83,132	0.0
Hamilton Niagara Haldimand Brant	582	208,209	2.8
Central West	1,138	69,610	16.3
Mississauga Halton	841	107,527	7.8
Toronto Central	2,638	154,319	17.1
Central	977	182,170	5.3
Central East	1,029	197,164	5.2
South East	0	80,271	0.0
Champlain	56	151,399	0.4
North Simcoe Muskoka	247	64,615	3.8
North East	895	89,968	9.9
North West	344	32,389	10.7
Provincial Total	**8,904**	**1,648,797**	**5.4**

Source: Health Care Programs Community Services System 2005-2006.
* Budgeted service levels as reported by MOHLTC Regions in Form 2A (budgets). Assignment of clients to LHINs is based on the address of the organization providing the service. Services many be provided across LHIN boundaries.

Ontario has many excellent providers of assisted living, of which Peel Senior Link is one. It offers coordinated personal care and homemaking services for over 1,000 seniors in designated buildings in Mississauga and Brampton.

Peel Senior Link also offers a program of day services available to many seniors who require less assistance. This support can include chiropody, language interpretation, assistance with completing forms, crisis intervention, referral and advocacy, grocery shopping, transportation to medical appointments and counselling.

It is both the quality of supportive services provided and the level of collaboration and integration with housing providers (both regional and private), MOHLTC, local government, CCACs, local health care providers including the hospitals, LTC homes, public health, mental health and addictions services, and primary care practitioners upon which successful programs are built.

The value of supportive care in congregate settings has been recognized by residents and health providers as an essential service in the continuum of care.[43] It is encouraging that in Alberta recent increases in supportive housing capacity have positively impacted the demand for LTC home beds.

Supportive housing has the potential to provide increased options for more independent living leading to improved quality of life, prevention or delay of health status deterioration, and a reduction in unnecessary hospital admissions that may lead to ALC designation and waits in hospital for an appropriate level of care. If supportive housing is to play a larger role in the system there may need to be more focused admission criteria and increased flexibility in the assisted living rules, particularly the requirement of 24-hour on-site assistance to facilitate service to the maximum number of residents and improve responsiveness to changing resident needs. It is also essential that provincial and federal governments work collaboratively to ensure that the supply of supportive housing is appropriate to the needs of the communities being served.

Recommendation 6

> **Make assisted living a provincial priority for investment over the next five years to increase and balance the availability of supportive housing for seniors across the province.**

Assisted-living spaces required to meet the needs in each community will be determined through the work of LHINs and supported by the ministry's planning for long-term care which is under development. The impact of increases in the availability of supportive housing for seniors on the demand for CCAC and other community support service should be monitored, and where appropriate, resourced.

4.3 Improving system access, integration and patient flow

Recognizing that people prefer to be treated outside of hospitals and other institutional settings has led to the development of cost-effective community-based alternatives.[44] These efforts, along with successful developments in technology, health promotion, illness prevention and management of chronic disease, have the potential to reduce unnecessary emergency visits, hospital admissions and institutionalization.

As care continues to move into the community, it is increasingly important to ensure the system of ongoing community care is effectively coordinated. It is the transition from one service to another and the coordination of multiple services where the health system often falters. Shared accountability and/or integrated networks of services among community support services, primary care, CCACs, hospitals, LTC

[43] Lum, Janet M. Ruff, S. and Williams, P.A., "When Home is Community: Community Support Services and the Well-Being of Seniors in Supportive and Social Housing". A Research Initiative of Ryerson University, Neighbourhood Link/Senior Link and the University of Toronto Funded by United Way of Greater Toronto, April 2005.

[44] "Future Demand for Long-Term Care, 2002 to 2041: Projections of Demand For Long-Term Care for Older People in England". Wittenberg, R, Adelina Comas-Herrera, Derek King et al. Personal Social Services Research Unit Discussion Paper 2330 for the Department of Health, England, March 2006.

homes, and other social and human services are essential to deliver an efficient, effective and simplified system of care to providers and clients. The goal is to provide the right care at the right time in the right place.

Recent best practice literature (Hollander) suggests that beyond acute care, service delivery best practices for organizing community care services should include:[45]

- fewer points of entry to service allowing for more consistent client screening mechanisms and system ease of use by consumers and providers;
- standardized client assessment and authorization of care to determine needs appropriately and ensure use of the full range of services available;
- a consistent client classification system to assist in determining the level of care required, system efficiency and ongoing planning for an efficient and effective mix of services on a system-wide basis;
- system level case management to provide for regular monitoring, reassessment and review of client needs and changes in care through flexible case management models that remain in place as long the client is in care, and;
- regular and effective communication with clients and families.

There are Canadian examples of evolving systems of care. Capital Health in Edmonton has a single 'one number to call' point of entry for access to an array of community and residential care services (Figure G). Case management is provided and individual service needs are determined using standardized assessment and service classification tools. While still early in its evolution, there is an ongoing commitment by system leaders to continue working within this new model of service access.

Figure G: Edmonton's Capital Health Program

Edmonton's Capital Health Program
One point of call leads to:

- home care
- palliative care
- childrens' services
- day programs
- CHOICE
- supportive living for seniors, people with disabilities and mental health illnesses
- facility living, which includes nursing homes/continuing care and other residential care for care needs such as dialysis, tracheostomy, mental health and special care dementia.

[45] Hollander, Marcus J. (February, 2003) "The Third Way": A Framework for Organizing Health Related Services for Individuals with Ongoing Care Needs and Their Families.

There was considerable discussion and debate at panel meetings and full consensus was not reached on the need or advisability of a single point of entry, standardized assessment tools, care authorization and case management. One school of thought suggested that all doors should lead to service and that all providers should take on the role of system navigator. Others saw the value in moving in the directions of the suggested practices but expressed concerns regarding organizational control and who would take accountability for these functions.

There was agreement that system navigation strategies should be developed within each LHIN and implemented over the next one to two years. Further, there was recognition that some LHINs, in collaboration with provider organizations and with input from users, may wish to consider simplified access, referral and assessment processes for complex continuing care, rehabilitation, assisted living and potentially other services required by individuals with complex and disabling chronic diseases.

Recommendation 7

> **Under the leadership of Local Health Integration Networks (LHINs) improve the co-ordination of services to provide a smooth transition across the continuum of care by clearly defining accountabilities for timely and effective client flow.**

Improving patient flow

Hospitals have identified that while 24% of ALC patient discharges are to LTC homes, they account for 39% of ALC days. These waits have a significant impact on the availability of acute care beds in hospital.

Panel members felt very strongly that a clear and coherent hospital discharge policy for LTC home eligible patients should be developed and consistently applied. This will help facilitate a smoother transfer of patients from hospital to LTC homes and ensure that seniors are placed more quickly into care settings appropriate to their needs. What is required is a process in which seniors maintain choice of residence *and* patient access to acute care is preserved. In our current system, this may require a hospitalized senior to wait for their home of choice from their second or third choice of home, rather than from an acute care bed.

The panel recognized the need to protect seniors' rights to choose their place of residence. Clear guidance, support of provincial placement policies, and effective communication with patients and families are required.

Recommendation 8

> **Review hospital discharge policies and practices and Community Care Access Centres' (CCAC) placement policies with the intention of getting hospitalized long-term care home eligible patients to select three homes appropriate to their care needs. Homes should be selected in order of preference, including at least two from a regularly-updated CCAC list of homes with vacancies or shorter waiting lists. When an appropriate bed is offered in one of the selected homes, it is expected that it will be accepted as either a permanent placement or a place to wait for a first choice of home. Where waiting lists are long at all homes, a fourth option should be**

offered, in which the individual gives the CCAC permission to scan all appropriate available beds to seek a potential match for their consideration.

This approach facilitates the patient's need for care being met in an appropriate setting, and improves the availability of hospital beds to meet the acute care needs of the community.

In many communities the demand for preferred and basic accommodation in homes is not consistent with the current practice of a 60/40 split.[46] This issue is complex and often results in long waits for basic accommodation. Further, despite regulated care standards in all Ontario LTC homes, some homes are preferred by residents and their families over others. This seems to relate mostly to the physical facilities in older homes and some funding or rate disincentives. The panel believes patient flow to LTC homes would be improved if these issues could be addressed.

4.4 Provider, patient and family education

The need for patient, family and provider education to assist in understanding the ALC designation and hospital discharge options has been identified by the panel as significant. Information provided to patients and families at the time of ALC designation should be clear and consistent across organizations. Much like the proactive province-wide education program encouraging families to discuss organ donation at the time of signing their driver's licence, families should be educated about the value of discussing future care options before health fails. Further, the awareness campaign is an opportunity to address common misperceptions and build confidence in the important role that LTC homes play in the continuum of care. Input by seniors and other users of the system in the development and evaluation of educational materials should be part of the process.

Recommendation 9

Develop education and awareness programs to inform patients, families and providers about: ALC designation; the effective use of each level of care; and; the value of planning for future care needs.

4.5 Predicting LTC service demands

It has been the practice in Ontario to project the demand for LTC home beds based on beds per thousand population aged 75 and over. Although an investment by the province in 20,000 new beds addressed some of the demand, the distribution methodology requires continual refinement. More recently, consideration has been given to using the ratio of individuals waiting for a LTC bed per number of permanent available beds, and to balancing the availability of LTC home beds with other LTC services. This promises to be a more effective way to determine the capacity required for all LTC services, including LTC beds.

[46] The regulations under the current LTC homes legislation require that no more than 60 percent of the licensed (or approved) bed capacity of the home can be set aside as preferred accommodation.

Another important consideration in selecting locations for LTC homes relates to the travel time for family and friends of LTC home residents. There are examples of communities where the location of LTC home beds requires their families to travel long distances to visit loved ones.

Figure H shows, by LHIN, the number of LTC home beds; the number of LTC home beds per thousand population over the age of 75, and; the supply of, and demand for, LTC beds and the demand/supply ratio.

Figure H: LTC home beds by LHIN at July 31, 2006

LHIN	**# of LTC beds (LS)**	**Population 75 years and older**	**Supply of LTC beds per thousand population 75 years and older**	**Demand for LTC beds per thousand population 75 years and older**	**Demand/ supply ratio***
Erie St. Clair	4,166	43,546	95.7	111.9	1.17
South West	6,744	66,920	100.8	123.5	1.23
Waterloo Wellington	3,645	40,253	90.6	112.1	1.24
Hamilton Niagara Haldimand Brant	10,326	102,840	100.4	117.3	1.17
Central West	3,239	29,679	109.1	107.1	0.98
Mississauga Halton	4,099	47,243	86.8	95.8	1.10
Toronto Central	5,978	76,866	77.8	93.4	1.20
Central	7,001	83,771	83.6	96.2	1.15
Central East	9,401	94,296	99.7	120.3	1.21
South East	3,683	36,921	99.8	136.2	1.37
Champlain	7,339	71,798	102.2	127.7	1.25
North Simcoe Muskoka	2,535	28,489	89.0	122.7	1.38
North East	4,729	39,210	120.6	143.2	1.19
North West	1,700	15,471	109.9	137.2	1.25
Provincial Total	**74,585**	**777,305**	**96.0**	**115.1**	**1.20**

Source: MOHLTC Occupancy Monitoring database and Client Profile databases.
Note: Long-term care beds do not include those short-stay beds used for respite, or convalescent care beds used by people recovering strength and functionality after acute episodes before returning home.

The current bed distribution issues, and the anticipated increase in the number of seniors in Ontario, will require future growth in the number of LTC beds.
A concurrent increase in the availability of assisted-living, community support services and new programs to assist the frail elderly to stay in their homes, have the potential to moderate the need for growth in comparatively more expensive LTC home beds.

Recommendation 10

> **Approve long-term care home beds in response to the demand resulting from demographic changes over the next 10 years and to address present demand in underserved communities. Replacement of physical plants in older homes should also be a priority.**

Interim strategies
While decisions are being made about allocation of permanent LTC home beds and other strategies to address gaps in service, there may be a need for interim solutions in areas facing major ALC pressures now. It is understood that these are reactive measures and that an overall system improvement approach is recommended by the ALC expert panel.

Recommendation 11

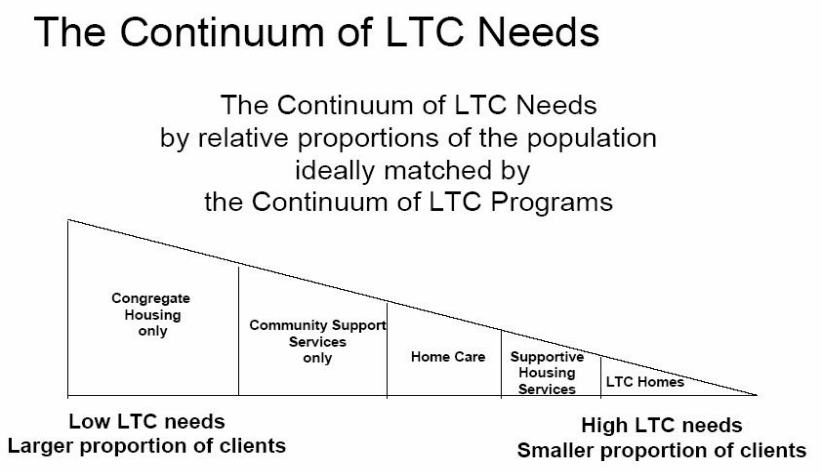
> **Continue to use short-term interim strategies in communities experiencing severe hospital pressures as a result of excessive waits for long-term care home beds.**

Strategies may include:

1. Designating interim LTC beds in existing homes, if available.
2. Short-term use of retirement home beds for some clients waiting in hospital for LTC home beds. The CCAC would provide the additional services required by these clients.
3. Fund the CCAC to provide short-term enhanced home care services to support some patients who have been discharged from hospital while they wait for a bed.

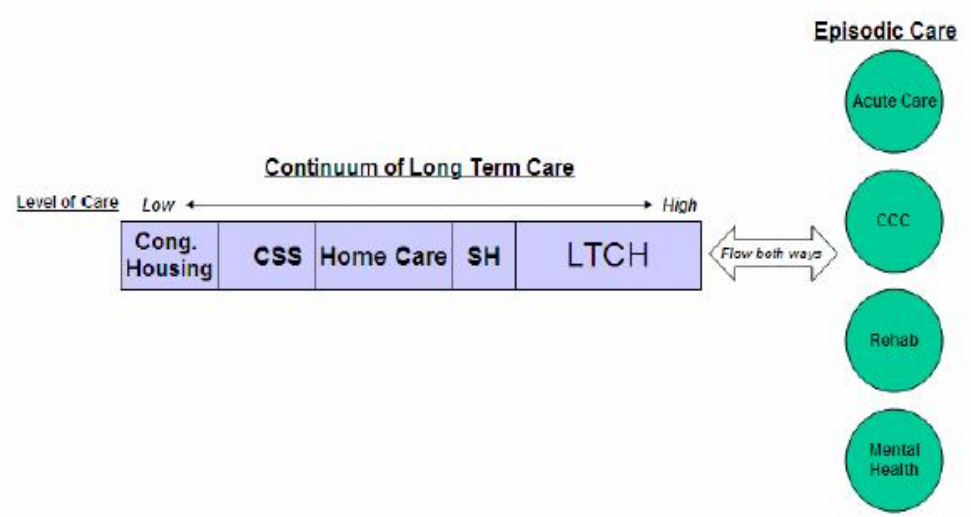
Improved demand projection models
Recent work by the Long-Term Care Planning and Renewal Branch of the MOHLTC to develop a planning algorithm for continuing care (PACC) looks at an 'ideal' continuum of long-term care programs to meet the needs of the population requiring these services. The continuum of services include congregate housing, community support services, home care, supportive housing services and LTC homes. Figure H shows the relative need for each level of care within the population when services are ideally matched to client need.

Figure I: The continuum of LTC needs[47]



At present, each of these services is planned for in isolation. The case has been made that in the future these services should be viewed as a continuum where the supply of each is seen as interdependent. The result would be services provided in proportion to the normal or community-specific distribution required to cost-effectively meet client needs. The continuum of LTC programs and the relationships with other parts of the system in the PACC model are illustrated as follows:

Figure J: Continuum of LTC programs and the relationships with other parts of the system in the PACC model[48]



[47] Report on the Development of Version 1 of the Planning Algorithm for Continuing Care (PACC 1.0) – Michael Stones PhD, Peter Brink PhD Candidate, Trevor Smith PhD, Barbara Nytko MSc. June 29, 2006. In preparation for submission for publication.

[48] "Management of Demand for the Continuum of LTC Services, V.1", Barbara Nytko MSc, Long-Term Care Planning & Renewal Branch, Ministry of Health & Long-Term Care, Government of Ontario, 2005. Information distributed to the panel.

Implementation of the PACC model will be an important step forward in policy, planning and funding decisions for the full range of LTC services in Ontario.

The British Personal Social Services Research Unit (PSSRU) published a discussion paper in March 2006 describing a LTC demand projection model for in-home and residential care.[49] This model was developed to make projections for four key variables: the future numbers of older people with disabilities; the likely level of demand for LTC services and benefits; the costs associated with meeting the demand; and, the workforce required.

The model divides the elderly population according to a number of characteristics relevant to the use of services. These include the level of functional disability, measured in terms of activities of daily living, marital status, whether living alone, with a partner or children, type of housing, and receipt of informal care. Disability rather than age has been shown to be a key factor in determining the need for long term care. The six disability categories used in the model are:

- able to perform activities of daily living (ADL), such as personal care and instrumental activities of daily living (IADL), such as domestic care, without difficulty or help;
- have difficulty performing IADL but not ADL tasks;
- difficulty bathing;
- difficulty with other ADL tasks;
- cannot perform at least one ADL task without help, and;
- live in the community and cannot perform two or more ADL tasks without help or live in a care home or long-stay hospital.

This approach allows for modeling based on assumptions about each of the variables or characteristics, such as the impact of future changes in the rate of disability, informal care giver trends and specific policy changes. Further projections can be made on the costs associated with changing needs and policies. Given that affordability of service is and will continue to be a significant issue this capability would be useful. Demand projection models for other services such as transitional care, CCC and rehabilitation would also be useful.

Recommendation 12

Develop a demand projection model for all pre- and post-acute care services.

The model will assist in understanding and predicting current and future demand for care. It could also support the development of improved provincial policy. Research to develop a model could be undertaken on a provincial or national basis.

[49] "Future Demand for Long-Term Care, 2002 to 2041: Projections of Demand For Long-Term Care for Older People in England". Wittenberg, R, Adelina Comas-Herrera, Derek King et al. Personal Social Services Research Unit Discussion Paper 2330 for the Department of Health, England, March 2006.

4.6 Best practices within and across health care organizations

Toolkits and coaching teams

There are many examples of best practices in areas such as discharge planning, care integration, patient flow and care provider partnerships. However, they are not well-documented or shared across the system.[50] The ALC expert panel made similar observations, taking note of many innovative practices within individual communities and across the care continuum, from CCACs, hospitals, LTC homes and community support agencies, to collaborative initiatives involving both acute and non-acute care providers.

Examples include the use of nurse practitioners in LTC homes, quick response program, geriatric emergency management (GEM), CCAC case managers and extended social work coverage in the emergency room and direct referral from ambulance to CCAC. This work has improved care and will continue to improve system efficiencies. Appendix B provides further information on some innovative practices.

The coaching team, a technique recommended in recent expert panel reports, is currently in use supporting improved practices in peri-operative care and critical care. Teams of clinical and administrative coaches recognized by their peers as experts in the subject area, work with health care organizations that voluntarily request the assistance of a coaching team. Based on early reports, coaching teams appear to be well received and helpful to the field. The expert panel on ALC believes that coaching teams working with hospitals, CCACs and other health care organizations, could be useful in improving discharge planning, patient flow and assessment of care practices. Increasing referrals, for example, from hospitals and CCACs to community support service agencies may help to promote access and address diversity needs.

Improved and integrated information systems can also leverage the scope and speed with which the sharing of best practices can occur. For example, through one electronic portal, acute and non-acute services could have access to best practices and support.

Recommendation 13

> **Implement toolkits and performance improvement coaching teams to provide assistance to hospitals, Community Care Access Centres (CCACs) and long-term care homes that have identified a need to improve discharge planning and patient flow practices, and to community support services that have identified a need to improve assessment and service access processes.**

To prevent unnecessary or prolonged hospitalization, it is important to identify individuals at risk for being designated ALC, as early as possible. However, our present system lacks a standard screening approach in hospitals, primary care and the community, to assess an individual's risk of being designated ALC. Such a tool

[50] Hollander, Marcus J. (February, 2003) "The Third Way": A Framework for Organizing Health Related Services for Individuals with Ongoing Care Needs and Their Families.

could help ensure planning for a potentially complex discharge begins soon after a patient at high risk is admitted to hospital. This type of screening in the community could help identify clients whose condition is deteriorating, facilitate an appropriate intervention, and prevent unnecessary emergency visits and hospitalization.

Recommendation 14

> **Implement a risk assessment tool for early identification of hospital, primary care and patients in the community at risk of requiring ongoing longer-term care.**

In hospital, these screening tools should be used on admission and at frequent intervals thereafter (e.g., at 7, 14 and 21 days).

Recommendation 15

> **Use consistent tools to objectively measure care requirements to select and provide the most appropriate care level available in a community.**

This information is also needed to effectively plan services. The data could be collected through standardized client assessment tools, where they exist.
Clear definition of the care provided in acute care, CCC, LTC homes, rehabilitation and other care settings will assist in this process of matching care needs to services.

4.7 Enablers

There are many initiatives underway in Ontario with the potential to positively impact waits for appropriate level of care, improve patient flow and system integration. These include primary care, chronic disease management, e-health initiatives and health human resource strategies.

Primary care
The availability of primary care has been identified as a significant discharge planning issue by hospitals and community providers. Progress on improved access through current initiatives including the new Family Health Teams (FHTs) and the upcoming report by the expert panel on wait times for primary care is important. Effective working relationships between FHTs and emergency rooms, CCACs, CCC, rehabilitation and community support services are essential to improve patient flow. FHTs have an important role to play in chronic disease management and system navigation. The importance of access to primary care, especially for seniors with complex conditions and others at risk for hospitalization and ALC, cannot be overstated. Availability of primary care physician services in long- term care and community palliative care have also been raised as important system issues.

Chronic disease management
Progress in preventing and managing chronic diseases must be a priority. Without significant improvements in our system capability to deliver effective and efficient chronic disease management services we can expect the demand for acute and post-acute services and ALC days to increase. An upcoming expert panel report on Diabetes Management is an important early step in setting a chronic disease management strategy for Ontario.

E-health initiatives
Successful e-health initiatives, including electronic health records and e-referral, which improve the availability and accessibility of patient and management information across health and community service organizations is a key enabler to achieving system integration and patient flow.

Health human resource strategies
The majority of the recommendations by the panel involve relatively low technology solutions. However, with the clearer definition of levels of care in LTC homes, complex continuing care and rehabilitation, as well as the increasing demand for community services, there will be a need to review the health human resource implications.

Meeting new program and service volume requirements requires the development of relevant health professional and service worker programs. It will be particularly important to focus on nurses, rehabilitation workers, mental health and addiction workers, personal support workers and homemakers. It is becoming increasingly important to educate and train all health professionals in the care of the frail elderly and those living with chronic disease.

Recommendation 16

> **Support access to primary care, chronic disease management, e-health initiatives and health human resource strategies, as critical enablers in addressing ALC issues.**

4.8 Data, benchmarks and accountability

Data
Consistent high-quality data is required to effectively measure system performance using key indicators, targets and benchmarks. Quality improvements are required in the ALC patient data abstracted from acute patient records for reporting to CIHI. Further, new consistent high-quality data sources on clients waiting for appropriate levels of care in other areas of the system, such as complex continuing care, rehabilitation, LTC homes, mental health and addictions services, home care and other community support services, are required.

There are a number of examples of common assessment tools, particularly interRAI tools being implemented by CCACs, inpatient mental health and others. If shared with system partners, standardized data from these sources has the potential to assist with understanding care needs, levels of care and planning for future service and capacity needs.

Recommendation 17

> **Develop rules and criteria for the application of ALC in Ontario, to improve hospital ALC data quality issues.**

The data consistency working group of the Ontario health information management advisory committee must be engaged in the development of these rules or criteria. Once established, the rules or criteria must be rolled out to hospital care providers, discharge planners and coders, using a strategic communications and education plan. Ongoing evaluation of the effectiveness of the new criteria and education strategy should be conducted through compliance audits and, where necessary, enforcement of data reporting standards.

Criteria or rules must be developed outlining: on what basis and by whom a patient is designated ALC; at what point in the hospital stay ALC is to be applied and removed; and, what information is to be documented and coded on discharge disposition. The panel recommends that both physicians and designated discharge planners/case managers in hospitals have responsibility to apply an ALC designation.

Recommendation 18

> **Report ALC days in complex continuing care and rehabilitation.**

A request from the data consistency working group should be made to CIHI to create ALC data fields for coders to complete in complex continuing care and rehabilitation settings.

Patient data on complex continuing care, rehabilitation and tertiary mental health is currently reported to CIHI so this should be possible. It does, however, represent a significant change to existing reporting systems. CIHI is a national data base, and a request would have to be submitted to CIHI for consideration. If this did move ahead, appropriate criteria, rules, education and audits would be necessary to ensure data quality and consistency, as for acute care ALC designation.

Recommendation 19

> **Identify existing and/or new data sources and reporting mechanisms to capture standardized client wait times and disposition data for people awaiting appropriate levels of care in non-hospital settings.**

The data consistency working group should be requested to assist in this process. Non-hospital settings would include LTC homes, supportive housing, home care, mental health and other community support services. Once reliable ALC day information becomes available in settings beyond acute care, ALC performance targets must be set out in these service areas.

CCACs are working toward a common information system and standard assessment tools for LTC home and for home care service eligibility. This has the potential to provide consistent quality information about the characteristics of these specific client populations and their wait times for services. This information can also be shared across organizations to assist in the provision of care.

Most community support agencies do not have the infrastructure in place to electronically collect and report this level of data on client wait times, and standards need to be developed. Progress is being made, however, and there is interest through the Ontario Community Support Association (OCSA) to work on determining those data elements which are common across agency service assessment tools. This would assist with data collection and provide common data sets that could be shared for those clients accessing multiple services.

Benchmarks, indicators and access targets

The 2006 First Yearly Report of the Ontario Health Quality Council identifies that "the performance indicators we have today are not good enough for the job that will become more difficult as Ontario's growing and aging population demands more health services." The ALC panel shares these concerns and further recognizes the importance of research evidence to support the establishment of benchmarks that set out 'optimum wait times' for access to an appropriate level of care.

The federal wait times report defines benchmarks, indicators and targets as follows:[51]

- benchmarks are evidenced-based goals;
- indicators measure how well a system is performing in relation to a benchmark, and;
- targets are discretionary interim performance goals based on practical capacity to achieve them.

Without benchmarks, reliable indicators can not be established to measure organizational or system performance. This leaves discretionary interim performance goals or targets as the tool currently available for use.

Recommendation 20

> **Establish evidence-based wait times as benchmarks for access to long-term care homes, complex continuing care, rehabilitation, home care and community services.**

Evidence-based wait times will require clinical and administrative research to determine the impact of waiting for an appropriate level of care on health outcomes.

While waits for an appropriate level of care should be days, not weeks, wait-time reduction targets need to be modest to be realistic, given the magnitude of the existing problem in acute care and elsewhere in the system and the significant service gaps that exist in our current continuum of care.

Accountability

Over time, health care providers must commit to achieving a level of patient/client flow and system integration that does not exist today. In this new state, with sufficient capacity and resources there will continue to be short, but acceptable, wait times as individuals transition from one level of care to another.

[51] "Final Report of the Federal Advisor on Wait Times", Postl, Brian D. for Health Canada, Ottawa, ON, 2006.

LHINs will have responsibility for patient flow and accessibility. In carrying out this role, a review of structures and processes to manage appropriate level of care issues will be required. Through patient flow committees, each LHIN should work to identify ALC days associated with process inefficiencies and those related to gaps in service and capacity in each level of care. Patient Flow Committees should build on existing ALC Committees and have representation from acute care, CCACs, LTC homes, complex continuing care, rehabilitation, mental health and addictions and community support services. An early focus should be on establishing useful ALC reports to monitor trends and ALC performance targets.

Recommendation 21

> **Study local patient flow in each Local Health Integration Network (LHIN) to improve and monitor ALC performance.**

Patient Flow Committees should be established to take responsibility for recommending and monitoring local ALC reduction targets, taking into account process improvement opportunities and the anticipated impact of new and planned local service capacity. It is important to recognize that process improvements may not reduce ALC days if the care required is not available.

Recommendation 22

> **Set a provincial target for a 10% reduction in ALC days per year, over the next five years, for patients waiting in acute care hospitals for alternate levels of care.**

The sum of all LHIN targets should support the successful realization of the provincial target.[52] Agreed upon local targets should be incorporated into relevant accountability and partnership agreements.

[52] The provincial target of 10% has been arbitrarily set as reasonable and achievable goal.

5.0 Priority and implementation planning

In developing and evaluating its recommendations, the panel asked the following questions:

- What is the expected impact of the recommendation on reducing ALC days?
- Does this recommendation support improved access to appropriate levels of care by patients/clients?
- What is the impact of the recommendation on improving patient flow and a more integrated and comprehensive approach to patient assessment, discharge planning and case management?
- Are the costs of implementing the recommendation high, medium or low and is there a more cost effective alternative to the same outcomes?
- What are system barriers or supports impacting the implementation of this recommendation?
- Does this recommendation incorporate best practice?
- Is this primarily a short term tactical action or a longer term strategy?

Although the panel believes that significantly reducing waits for appropriate levels of care in hospitals and other parts of the system will require significant investments and improved integration of health care services it is recognized that not all recommendations can be considered for implementation in the short and medium-term.

Priorities

Based on this knowledge the following recommendations have been prioritized as those most likely to meet the goals of improved patient flow, system integration and reduced ALC days in hospitals and elsewhere in the system in the short to medium-term (one to five years):

- Define and expand (where appropriate) the role and capacity of the health system to provide care in the community, in complex continuing care and rehabilitation programs, and long-term care homes.

- Make assisted living a provincial priority for investment over the next five years to significantly increase and balance the availability of supportive housing for seniors across the province.

- Increase home care for services such as personal support and homemaking, to enable appropriate frail elderly and people with disabilities to remain independent at home and to provide cost-effective care in the community.

- Review hospital discharge policies and practices and Community Care Access Centres' (CCAC) placement policies with the intention of getting hospitalized long-term care home eligible patients to select three homes appropriate to their care needs. Homes should be selected in order of preference, including at least two from a regularly-updated CCAC list of homes with vacancies or shorter waiting lists. When an appropriate bed is offered in one of the selected homes, it is expected that it will be accepted

as either a permanent placement or a place to wait for a first choice of home.

- Implement demonstration community-based high intensity needs programs for seniors in areas with high rates of ALC.

- Develop education and awareness programs to inform patients, families and providers about: ALC designation; the effective use of each level of care; and, the value of planning for future care needs.

- Under the leadership of Local Health Integration Networks (LHINs) improve the co-ordination of services to provide a smooth transition across the continuum of care by clearly defining accountabilities for timely and effective client flow.

Implementation structure

The recommendations of the expert panel will require an effective implementation structure. As with the work of other expert panels, it is recommended that implementation leadership come from the field in partnership with MOHLTC and LHINs. The recommendations of the ALC expert panel cover a broad range of issues that affect hospitals, CCACs, LTC homes, mental health, supportive housing, community support agencies and primary care providers. For this reason, the panel recommends responsibility for implementation be assigned to respected leaders from across the acute and community health care sectors who are actively engaged in care delivery and/or management. LHINs and primary care should also be represented, and a mechanism to ensure input by consumers should be developed.

An existing provincial working group, such as the one responsible for improving access to emergency services, may be well positioned to assume responsibility for implementing the panel's recommendations, particularly with an expanded mandate and membership.

Initiatives selected for implementation will require work or task groups with specific expertise. Appendix A sets out the panel's recommendations, accountabilities and timeframe.

Appendix A: Recommendations, accountabilities, impact and timeframe

4.1 Meeting specialized needs in LTC homes, CCC and rehabilitation

Recommendation	Accountability	Impact on ALC	Timeframe
R1 Define and expand (where appropriate) the role and capacity of the health system to provide care in the community, in complex continuing care and rehabilitation programs, and long-term care sectors to provide care.	Implementation Steering Committee (ISC) and MOHLTC.	High.	One year for development. One to three years of implementation.

4.2 Supporting independence through care in the community

Recommendation	Accountability	Impact on ALC	Timeframe
R2 Increase home care for services such as personal support and homemaking, to enable appropriate frail elderly and people with disabilities to remain independent at home, and to provide cost-effective care in the community.	MOHLTC.	High in preventing and reducing ALC.	Up to six months.
R3 Establish a core set of community support services upon which all local communities can build.	MOHLTC.	High in the long-term.	One year for development. Three to five years for implementation.
R4 Implement demonstration community-based high intensity needs programs for seniors in areas with high rates of ALC.	ISC, LHINs and MOHLTC.	High impact in reducing ALC, preventing unnecessary ER visits and hospitalization.	Six months planning and 18 months to build a program to a capacity of 100-120 clients.
R5 Develop a mechanism for funding to meet the care needs of individual, hard-to-serve clients.	MOHLTC.	Medium.	One year.
R6 Make assisted living a provincial priority for investment over the next five years to increase and balance the availability of supportive housing for seniors across the province.	MOHLTC.	High.	One to five years.

4.3 Improving system access, integration and patient flow

Recommendation	Accountability	Impact on ALC	Timeframe
R7 Under the leadership of Local Health Integration Networks (LHINs), improve the co-ordination of services to provide a smooth transition of care across the continuum of services, by clearly defining accountabilities for timely and effective client flow.	LHINs.	High impact on patient flow and ALC over time.	One to two years for planning, implementation and evaluation.
R8 Review hospital discharge policies and practices and Community Care Access Centres' (CCAC) placement policies with the intention of getting hospitalized long-term care home eligible patients to select three homes appropriate to their care needs. Homes should be selected in order of preference, including at least two from a regularly-updated CCAC list of homes with vacancies or shorter waiting lists. When an appropriate bed is offered in one of the selected homes, it is expected that it will be accepted as either a permanent placement or a place to wait for a first choice of home. Where waiting lists are long at all homes, a fourth option should be offered, in which the individual gives the CCAC permission to scan all appropriate available beds to seek a potential match for their consideration.	MOHLTC, LTC homes and hospitals.	Moderate.	Up to six months.

4.4 Provider, patient and family education

Recommendation	Accountability	Impact on ALC	Timeframe
R9 Develop education and awareness programs to inform patients, families and providers about: ALC designation; the effective use of each level of care; and; the value of planning for future care needs.	ISC, LHINs, MOHLTC, hospitals, mental health homes and community support agencies.	Moderate over time.	Six months for development. One year for implementation.

4.5 Predicting long-term care service demands

Recommendation	Accountability	Impact on ALC	Timeframe
R10 Approve long-term care home beds in response to the demand resulting from demographic changes over the next 10 years and to address present demand in underserved communities. Replacement of physical plants in older homes should also be a priority.	LHINs and MOHLTC.	High.	Six months to plan and one to 10 years to implement.
R11 Continue to use short-term interim strategies in communities experiencing severe hospital pressures as a result of excessive waits for long-term care home beds.	LHINs and MOHLTC.	Short-term impact.	Immediate, based on need.
R12 Develop a demand projection model for all pre- and post-acute care services.	LHINS and MOHLTC.	High, over time.	One to three years for research and integration of findings in planning for services and policy.

4.6 Best practices within and across health care organizations

Recommendation	Accountability	Impact on ALC	Timeframe
R13 Implement toolkits and performance improvement coaching teams to provide assistance to hospitals, Community Care Access Centres (CCACs) and long-term care homes that have identified a need to improve discharge planning and patient flow practices, and to community support services that have identified a need to improve assessment and service access processes.	ISC, MOHLTC and stakeholder organizations.	Medium.	Six months to one year.
R14 Implement a risk assessment tool for early identification of hospital, primary care and community patients at risk of requiring ongoing longer-term care.	ISC and stakeholder organizations.	Medium.	Up to one year.
R15 Use consistent tools to objectively measure care requirements to select and provide the most appropriate care level available in a community.	All stakeholders.	Medium.	One to two years.

4.7 Enablers

Recommendation	Accountability	Impact on ALC	Timeframe
R17 Support access to primary care, chronic disease management, e-health initiatives and health human resource strategies, as critical enablers in addressing ALC issues.	MOHLTC.	High over time.	Three to five years.

4.8 Data, benchmarks and accountability

Recommendation	Accountability	Impact on ALC	Timeframe
R17 Develop rules and criteria for the application of ALC in Ontario, to improve hospital ALC data quality issues.	Data consistency working group of the Ontario health information management advisory committee.	High over time.	Six months.
R18 Report ALC days in complex continuing care and rehabilitation.	Same as 17.	Medium.	One year.
R19 Identify existing and/or new data sources and reporting mechanisms to capture standardized client wait times and disposition data for people awaiting appropriate levels of care in non-hospital settings.	Ontario health information management advisory committee.	Medium.	One to two years.
R20 Establish evidence-based wait times as benchmarks for access to long-term care homes, complex continuing care, rehabilitation, home care and community services.	LHINs and MOHLTC.	High.	One to three years.
R21 Study local patient flow in each Local Health Integration Networks (LHINs) to improve and monitor ALC performance.	LHINs.	Medium.	Six months.
R22 Set a provincial target for a 10% reduction in ALC days per year, over the next five years, for patients waiting in acute care hospitals for alternate levels of care.	MOHLTC.	Medium.	Six months to one year.

Appendix B: Patient flow practices addressing ALC

Arundel and Glouberman investigated discharge practices from a broad, system perspective by examining how roles, relationships and structural boundaries between the home care and hospital sectors impact on patient discharge. The study identified six main types of system barriers:[53]

1. System barriers to working together;
2. Family/caregiver/patient barriers;
3. Geographic barriers;
4. System management and control barriers;
5. Constant system change, and;
6. Resource barriers.

The authors proposed a set of eleven factors important to best practice discharge that were grouped into three categories; formal systems (e.g. legitimization of the relationship between acute care and home care), relationships and informal networks (e.g. boundary spanning positions) and system capacity (e.g. availability of referral and assessment service). No jurisdiction reviewed demonstrated best practice in all factors; instead, some focused on one of three areas while others attempted to make progress in all three. Their findings also emphasize the need to recognize unique characteristics of each community, and to capitalize on strengthening relationships between sectors in order to develop a common focus.

Examples of selected initiatives to address ALC demonstrate elements of these strategies.

Achieving timely "simple" discharge from hospital - A toolkit for the multi-disciplinary team produced by the National Health Service, Department of Health, UK, focuses on practical steps that health and social service care professionals can take to improve discharge. It supports members of a multi-disciplinary team by providing practical advice, fact sheets and case studies. Designed and tested with practitioners in the field, the toolkit reflects daily practice. Available at: http://www.nhs.uk/england/searchResults.aspx?site=england&q=Achieving+timely+simple+discharge

One Point of Call, Capital Health in Edmonton, offers a single "one number to call" point of entry for access, assessment and case management leading to an array of community care services, including home care, palliative care, children's services, day programs, CHOICE, supportive living for seniors, mental health clients and people with disabilities, and facility living (nursing homes/continuing care and other residential care for special needs that include dialysis, tracheostomy, mental health, and special care dementia).

Discharge Planning Standards & Guidelines, produced by the Association of Discharge Planning Coordinators of Ontario (ADPCO) and the Canadian Association of Discharge Planning & Continuity of Care (CADPACC) and revised in June 2005

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[53] Substudy 15: An Analysis of Blockage to the Effective Transfer of Clients from Acute Care to Home Care". Arundel Caryl & Glouberman, S., for the Health Transition Fund, Health Canada, Ottawa, ON, January 2001. Taken from: www.homecarestudy.com/reports/summaries/ss15-es.html

provides standardized definitions of the discharge planning process and the role of discharge planners, as well as a set of common goals and core functions that include early identification of clients requiring discharge planning intervention, assessment, planning in partnership with an interdisciplinary team, ongoing collaborative implementation, and outcome measurement.

ALC Strategy in Waterloo Region, a collaborative pilot project between Cambridge Memorial, Grand River and St. Mary's General Hospitals, CCAC of Waterloo Region and the MOHLTC resulted in a centralized discharge planning process. Common discharge policies and patient information was developed for all three hospitals. Estimated length of stay was identified on admission and consistent criteria were established for ALC designation. Other outcomes included implementation in the emergency department of the *Identification of Seniors Assessment of Risk* assessment tool, identification of learning needs in LTC homes and a number of other collaborative strategies to improve the discharge planning process, including regional clinical pathways and development of geriatric specialists to support the unique needs of the ALC population.

ALC Placement Tool Kit, a collaborative hospital and CCAC project developed in Grey Bruce County, helped strengthen relationships by identifying previously held perceptions of each other, and developing joint strategies to address three P's; people, paper tools and processes. Work continues on performance management indicators and other improvement indicators.

A Conjoint Project of Halton Healthcare and the Halton CCAC established a clear process and increased collaboration to improve access and patient satisfaction. A mapping exercise, beginning with a patient's ALC designation through to a bed offer and placement into long-term care, clearly depicts the patient's journey, and outlines in detail the process, accountabilities and performance indicators.

The Ottawa Regional Geriatric Assessment Program has identified several hospital diversion strategies. Investing in enhanced risk-screening and assessment in hospitals and the community has reduced the demand for LTC beds. Integrated primary care, community support, home care and geriatrics, combined with flexible service-maximums for high-risk seniors to effect service substitution and intensive case management reflect new models of community-based care.

Advanced Home Care Teams (AHCT) help acutely-ill patients get the help they need at home. Through an innovative partnership between Community Care Access Centre of London and Middlesex, together with London Health Sciences Centre and London InterCommunity Health Centre, AHCT is designed to provide an alternative to in-hospital care for people with short-term acute or complex illness. The team is comprised of nurse practitioners, the patient's family physician and other community care professionals. AHCT is based on a very successful pilot project conducted in London between 1999 and 2001, Integrating Physician Services in the Home (IPSITH). The project showed that patients receiving care through AHCTs were one-third less likely to have an emergency room visit than those patients not being treated through AHCTs. Patients were more satisfied with their care and their family caregivers reported greater knowledge about in-home services and managing illness than those patients and their caregivers who were not involved with AHCTs. In addition, care received through these teams was

less costly than hospital care.

The Transitional Care Program, the Niagara Health System's innovative program that offers an ALC option for seniors, is based on strategic partnerships and a collaborative culture between Niagara Health System, Community Care Access Niagara and Residence Retirement Group. In this model, a retirement home setting provides continued opportunity for clients to maintain function and quality of life following acute hospitalization, while awaiting LTC home placement. Clients may find that their overall health and function improves, and that a retirement home setting accommodates their needs. They may choose to remain in a retirement home instead of transferring to a LTC home when the bed offer becomes available.

The GTA Rehab Network identified improved service delivery and access as a strategic priority. Their recent ALC survey of patients in three hospitals resulted in a better understanding of rehabilitation referral patterns and referral inefficiencies, due to a combination of factors that included inappropriate application of the ALC rehabilitation designation, referral process inefficiencies, lack of clarity around differentiating geriatric rehab programs and wait times to access services. Standardization of programming and key components of rehabilitation across geriatric rehabilitation programs will be addressed as part of the Network's follow-up, in addition to developing an alternate model for streamlining the referral process.

Bridgepoint Health PatientNET Program is a multidisciplinary academic teaching service designed to effectively match medically stable ALC patients in acute care to the most appropriate program. This occurs by systematically evaluating patient capabilities and performance trajectory, and by leveraging the team's understanding of available health care linkages and resources in the community. The program is comprised of two teams, ALC Connect and PatientHUB. ALC Connect acts as a network facilitator for patients in partner acute care organizations. The second team PatientHUB, is a 46-bed intensive assessment unit at Bridgepoint Hospital that helps to delineate the needs of patients with high disease burdens and ultimately links them with the most appropriate care program in the health care system.

Appendix C: Terms of reference for the expert panel on ALC

EXPERT PANEL ON ALTERNATE LEVEL OF CARE
Terms of Reference

PREAMBLE:

In its 2006 First Yearly Report, the Ontario Health Quality Council identified that patients in acute care hospitals waiting to move to other services and levels of patient care represent a significant barrier to a high performing health system. The Council estimated that almost 10% of Ontario acute care beds are taken up with these Alternate Level of Care (ALC) patients. This results in an inefficient use of our most expensive health care resources and reflects a lack of integration within the health system.

The recent Collaborative Position Paper entitled *Alternate Levels of Care – Challenges and Opportunities* produced by a multi-stakeholder Alternate Level of Care Working Group (with representation from the Ontario Hospital Association, Ontario Association of Non-Profit Homes and Services for Seniors, Ontario Association of Community Care Access Centres and Ontario LongTerm Care Association) provides a comprehensive review of ALC issues and challenges as well as recommendations for practical solutions and system strategies to improve patient care and hospital ALC performance.

Under the leadership of both the Assistant Deputy Minister of Acute Services Division, Ministry of Health and Long-Term Care and the Chief Executive Officer of Champlain Local Health Integration Network, an Expert Panel on Alternate Level of Care has been established to address this important health system issue.

MANDATE & OBJECTIVES:

The Expert Panel will be responsible for recommending an action plan to improve system performance through effective and achievable strategies to reduce ALC patient days in Ontario. The Panel will rely on the work of the multi-stakeholder Alternative Level of Care Working Group and the work of other provincial working groups who have identified ALC as a significant issue. The primary goal is to ensure that all aspects of the issue have been identified and to prioritize those strategies most likely to achieve a significant reduction of ALC days across the system and improve health system integration and accountability.

The Expect Panel will:

- Develop a system-wide approach to ALC patients that emphasizes a variety of approaches aimed at achieving the most appropriate and cost effective mix of institutional and community resources to meet the care needs of the aging (and other special needs) population. This will include a focus on access, accountability, innovation and an overall systems perspective for shared learning and best practices.

- Recommend a standard ALC definition for all inpatient settings and mechanisms for the collection and reporting of ALC information. Develop ALC indicators and a recommended process for setting ALC targets and for monitoring ALC performance.

- Assess, prioritize and make recommendations on the highest impact strategies to reduce ALC days across the system, in both the short and longer term. This will include a range of strategies developed and implemented by the field within existing resources; potential legislative changes to support best practice as well as potential new approaches/models of care/service to efficiently and effectively address the needs of ALC patients for quality care. Current new strategies, including convalescent care and interim long-term care beds will also be considered.

- Recommend timelines, assign responsibilities, and identify funding/resource requirements to achieve targeted results.

PANEL CO-CHAIRS:

The Panel will be co-chaired by Mary Kardos Burton, ADM, Acute Services Division, Ministry of Health and Long-Term Care, and Dr. Robert Cushman, CEO, Champlain Local Health Integration Network.

PANEL MEMBERSHIP:

See Appendix D.

ROLES & RESPONSIBILITIES OF MEMBERS:

The secretariat function will be coordinated through the ADM, Acute Services Division. This function will include the scheduling, preparation and distribution of materials for meetings. Staff resources will include Darlene Barnes and Doug Gowans, ADM's office.

Panel members are responsible for attending meetings, advising on items presented for discussion, reviewing and providing feedback on materials as drafted.

A contracted professional writer will aid in the writing and preparation of the final report.

Appendix D: Members of the ALC expert panel

Mary Kardos Burton, Co-Chair
Dr. Robert Cushman, Co-Chair

Darlene Barnes, ALC Project Lead
Enza Ferro, Ontario Hospital Association
Cathy Danbrook, Ontario Hospital Association
Doug Gowans, Ministry of Health and Long-Term Care
Susan Thorning, Ontario Community Support Association
David Kelly, Ontario Federation of Community Mental Health and Addiction Programs
Nancy Mongeon, Ontario Association of Community Care Access Centres
Astrida Plorins, Ontario Long Term Care Association
Krista Robinson-Holt, Ontario Long Term Care Association
Wendy Kirkpatrick, Ontario Association of Non-Profit Homes and Services for Seniors
Wendy Robb, Association of Discharge Planners
Donna Rubin, Ontario Association of Non-Profit Homes and Services for Seniors
Marian Walsh, Ontario Hospital Association
Barb MacKinnon, Ontario Association of Community Care Access Centres
Mohamed Badsha, Canadian Mental Health Association
Tim Burns, Ministry of Health and Long-Term Care

Appendix E: Focus group participants

Jane Adams, Manager Social Work, Queensway-Carleton Hospital
Mary Alberti, Executive Director, Schizophrenia Society of Ontario
Mohamed Badsha, ALC Expert Panel Member, Director – Community Support, Canadian Mental Health Association – Toronto Branch
Raymond Applebaum, Executive Director, Peel Senior Link
Darlene Barnes, ALC Project Lead, Ministry of Health & Long-Term Care
Edna Beange, Council on Aging Network
Carolyn Beatty, Hospital Consultant East Region, Ministry of Health & Long-Term Care
Marilyn Benn, Administrator, Extendicare
Rosslyn Bentley, Director of Client Services, Wellington Dufferin Community Care Access Centre
Nancy Bradley, Executive Director, Jean Tweed Treatment Centre
Judy Brown, Director Communications, Ottawa-Carleton Hospital
Stasia Bradshaw, Discharge Planning Coordinator, Woodstock General Hospital
Dr. Stephen Buchman, President Elect, The Ontario College of Family Physicians
Mieke Busman, Vice President and Chief Nursing Officer, St. Josephs' Care Group
Terry Codling, Administrator, Grove Park Home for Senior Citizens
Lois Cormac, VP Specialty Care Incorporated
Mary Jane Cripps, Executive Director, Reconnect
Dr. Robert Cushman, ALC Expert Panel Co-Chair, Chief Executive Officer, Champlain Local Health Integration Network
Lois Dent, President, Concerned Friends
Donna Derouchie, Administrator, Glen Stor Dun Lodge Home for the Aged
Helen Ferley, Administrator, Seniors' Health Centre (North York General Hospital)
Joyce Firlotte, Administrator, Perth Community Care Centre
Greg Fougère, Executive Director & Chief Executive Officer, The Perley and Rideau Veterans' Health Centre
Myrna Forsyth, Executive Director, Downsview Services To Seniors Inc.
Bill Gleberzon, Associate Executive Director, Canadian Association of Retired Persons
Doug Gowans, Senior Policy Analyst, Acute Services & Community Health Divisions, Ministry of Health & Long-Term Care
Sue Hillis, Executive Director, Dale Brain Injury Services
Greg Howse, Executive Director, Simcoe Outreach Services
Diane Hupe, Chief Nursing Officer, Sisters of Charity of Ottawa Health Service
Paul Huras, Chief Executive Officer, Southeast Local Health Integration Network
Kate Jackson, (A) East Regional Director, Ministry of Health & Long-Term Care
Andre Jean, Manager Client Services, Ottawa Community Care Access Centre
Neil Johnson, Integrated VP for Medicine Services, London Health Sciences Centre
Richard Joly, Senior Director, Performance, Contracts and Allocations, North East Local Health Integration Network
Mary Kardos Burton, ALC Expert Panel Co-Chair, Assistant Deputy Minister, Acute Services Division, Ministry of Health & Long-Term Care
Janet Kasperski, Chief Executive Officer, The Ontario College of Family Physicians
Donna Laevens-Van West, Coordinator, Halton-Peel Emergency Services, Credit Valley Hospital
Steve Lurrie, Executive Director, Canadian Mental Health Association - Toronto
Lorna Macdonald, Coordinator, Waterloo Wellington Emergency Services Network
Donna MacDonald, Executive Director, Community Care Haliburton County

Debbie MacDonald Moynes, Executive Director, Prince Edward County Community Care for Seniors Association
Charlotte Maher, Executive Member of the Board, Carewatch Toronto
Terry McCullum, Executive Director, Loft Community Services
Karen McGrath, Executive Director, Canadian Mental Health Association - Ontario Division
Scott McLeod, Senior Director, Planning Integration & Community Engagement, Mississauga Halton Local Health Integration Network
Elaine McNaughton, Executive Director, Personal Choice Independent Living / Choix Personnel Vie Autonome
David McNeil, Vice President of Nursing Administration, Sudbury Regional Hospital, Laurentian Site
Ethyl Meade, Co-Chair, Ontario Coalition of Senior Citizens' Organizations
Jane Meadus, Barrister & Solicitor, Institutional Advocate, Advocacy Centre for the Elderly
Dr. Nancy Merrow, Chief of Staff, Southlake Regional Health Centre
Shanaz Meghji, Multicultural Council for Ontario Seniors
Michael Meyette, Director of Decision Support, Quinte Healthcare Corporation
Malcolm Moffat, President & Chief Executive Officer, St. John's Rehabilitation Hospital
Nancy Mongeon, ALC Expert Panel Member, Executive Director, Manitoulin-Sudbury Community Care Access Centres
Mary Beth Montcalm, President & Chief Executive Officer, Providence Healthcare
Lisa Mudie, Care Manager, Richview Residence Supportive Housing Corporation
Sheila Neuberger, Vice President Clinical Services, Whitby Mental Health Centre
Dr. Mark Nowaczynski, Member, The Ontario College of Family Physicians
John Oliver, President & Chief Executive Officer, Halton Healthcare Services Corporation
MaryAnn Oshukany, Discharge Planner, Grand River Hospital
Eric Partington, (A) Program Manager East Region, Ministry of Health & Long-Term Care
Marlene Pink, Executive Director, Tillsonburg and District Multi-Service Centre
Eleanor Plain, Director, Corporate Services, Kingston, Frontenac Lennox & Addington Community Care Access Centre
Astrida Plorins, ALC Expert Panel Member & Vice-President of Operations, Leisureworld Caregiving Centres
Joanne Pomerleau, Director of Clinical Services, Montfort Hospital
Laura Pisko-Bezruchko, Senior Director, Planning, Integration & Community Engagement Toronto Central Local Health Integration Network
Pat Prentice, Executive Director, Ontario Association of Resident Councils
Allen Prowse, VP, Mental Health & Administrator, Providence Continuing Care Centre
Cathy Raiskums, Manager, Discharge Planning and Social Work, Halton Healthcare Services
Jackie Redmond, Executive Director, Hastings and Prince Edward Counties Community Care Access Centre
Wendy Robb, ALC Expert Expert Panel Member, Regional Manager Utilization/Social Work, Niagara Health System
Krista Robinson-Holt, ALC Expert Panel Member, Director of Health Planning and Research, Ontario Long Term Care Association
Eilyn Rodriguez, Director, Project Management, Ontario College of Family Physicians
Donna Rubin, ALC Expert Panel Member, Chief Executive Officer, Ontario Association of Non-Profit Homes and Services for Seniors
Angela Shaw, Executive Director, St. Jude Community House
Donna Shea, Case Coordinator and Discharge Planner, Lakeridge Health Oshawa

Karen Slater, (A) Program Manager East Region, Ministry of Health & Long-Term Care
Norman Slatter, Administrator, Granite Ridge
Colleen Small, Program Director of Mental Health Programs, Kingston General Hospital
Pat Stoddart, Senior Director, Central West Local Health Integration Network
Jill Tettmann, Senior Director, Planning, Integration and Community Engagement, North Simcoe Muskoka Local Health Integration Network
Susan Thorning, ALC Expert Panel Member, A/Chief Executive Officer, Ontario Community Support Association
Marg Toni, Director of Resident Services, Regency Care
Judith Wahl, Executive Director, Advocacy Centre for the Elderly
Mark Warden, Director of Client Services, Hastings Prince Edward Community Care Access Centre
Marian Walsh, ALC Expert Panel Member, President & Chief Executive Officer, Bridgepoint Health
Patty Welychka, Health Program Director Transitional Care / Utilization Management Niagara Healthcare
Lexan Wheaton, Case Coordinator, In-patient Rehabilitation Unit, Lakeridge Health Oshawa
Carol Williams, Executive Director, Peel Halton Acquired Brain Injury Services
Brigitte Witkowski, Executive Director, Mainstay Housing
Vida Vaitonis, Director Home and Community Support Services Branch, Ministry of Health & Long-Term Care

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