Improving Patient Care and System Flow through Partnerships

The Hamilton Niagara Haldimand Brant (HNHB) Community Care Access Centre (CCAC) has been working closely with hospital partners, the Local Health Integration Network (LHIN), service providers, long-term care homes (LTCHs) and community support services to help patients return home, where they want to be, after their acute care needs have been met in hospital. Working together, the regional partners have been able to support patients and decrease Alternative Level of Care (ALC) patient days, helping to make beds available in hospital for patients who require acute care.

Situation:

The HNHB region ALC rate was 22.5 per cent as of April 2009. These ALC patients did not need hospital care, yet remained in acute care hospital beds. These patients were waiting to be discharged to another type of hospital care, a long-term care home or to a home. HNHB LHIN ALC Steering Committee, co-chaired by HNHB CCAC and hospitals’ representatives, was established to support consistent planning, monitoring and management of ALC reduction strategies.

Aims

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<th>Aims</th>
<th>Measures</th>
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<td>Decrease hospital utilization by alternate level of care patients</td>
<td>Percentage of ALC patients</td>
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Timeframe for improvement: April 2009 – March 2011

- Transition ALC patients out of hospital care to the appropriate care environment to meet their needs; and
- Prevent hospital admission of individuals at risk of becoming ALC patients by encouraging CCAC referral processes in emergency departments.

Change Ideas:

A number of initiatives were developed and implemented in ten hospitals across HNHB as part of the ALC reduction strategy:

- A "home first" philosophy was shared and embraced across the region;
- An ALC rate indicator was included in each partner’s Shared Accountability Agreement with HNHB LHIN;
- Development of a real-time ALC electronic data collection tool; and

Initiatives to improve the efficiency include:

- HNHB LHIN ALC Steering Committee in place (co-chaired by HNHB CCAC/hospital) to support consistent planning, monitoring and management of ALC reduction strategies;
- Education/information sessions offered for hospital staff and Medical Advisory Committees regarding "home first" philosophy;
• HNHB CCAC case manager in emergency room to assist with referrals to CCAC directly from ER;
• Joint (hospital/CCAC) intensive review of care plans by care team members;
• Implementation of Assess/Restore and Slow-Stream Rehab Programs with consistent assessment and admission process through HNHB CCAC;
• Enhanced home care supports provided to clients with greater care needs (regulation change for personal support services enabled higher intensity care plans);
• Real-time ALC data accessed through the LHIN ALC Information System is shared among hospitals; and
• HNHB CCAC and hospitals submit to the LHIN and share weekly and monthly data on system flow and capacity.

Results:

![HNHB Acute ALC Rates: 2009-10 & 2010-11](chart)

The following represents HNHB LHIN results of the alternative level of care reduction strategies over a two-year period (2009-10 – 2010-11):

• 44 per cent relative reduction in acute ALC rate (April 2009 ALC was 22.5 per cent; March 2011 ALC rate was 12.6 per cent);
• 5.3 per cent increase in HNHB hospital referrals to HNHB CCAC for in-home services since 2009-10; and
• 67.4 per cent reduction of hospital ALC patients who were waiting for admission to LTCHs (April 2009 – March 2011).

HNHB CCAC continues to work with its partners: HNHB LHIN, hospitals, service providers, long-term care homes and community support services. HNHB CCAC also continues its leadership role in ALC reduction strategies.