Moving Forward: Ontario's Emergency Room Wait Time Strategy

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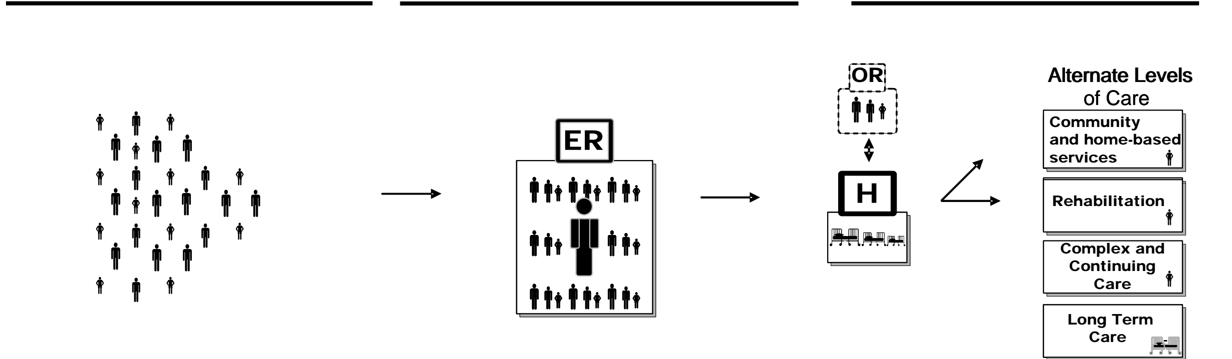
Central, Central East, Central West, North Simcoe Muskoka, and Toronto Central Local Health Integration Networks – November 21, 2008

Invitational Regional "ER=ALC" Discussion Group"
Working Together Towards Sustainable Solutions

The ER/ALC Strategy calls for System-wide Improvements

Actions to reduce ER Wait Times must be applied across the entire system

Community: Reduce ER Demand | ***Improving Processes within the ER*** | ***Faster Discharge for ALC Patients***



ER/ALC Strategy Initiatives
- LTC Nurse Outreach Teams
- Urgent Care Centres
- Initiatives to reduce demand from palliative cancer, heart failure, respiratory disease and mental health & addictions patient groups

ER/ALC Strategy Initiatives
- Pay-for-Results hospital incentives
- ER Process Improvements
- Expand Health Human Resource capacity, including nurses to reduce ambulance offload delays, Physician Assistants and New Nurses

ER/ALC Strategy Initiatives
- Targeted increases in LTC and transitional bed capacity
- Aging at Home (ALC)
- Expanded homecare/community support
- Align LTC eligibility to ER/ALC Strategy

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Pay-for-Results introduces LHIN accountability for patient wait times

Pay-for-Results Program

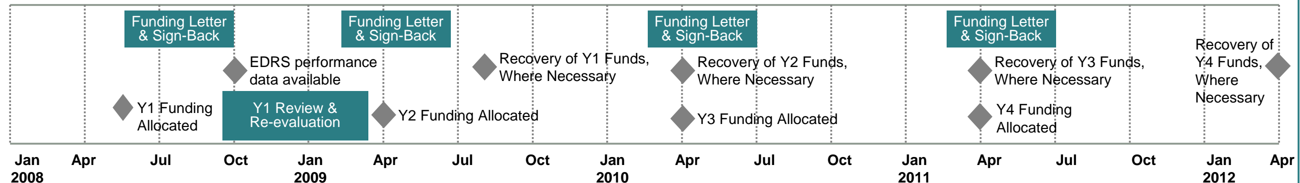
- The Emergency Room Pay-for-Results program is an incentive plan to drive improvements in the ER patient experience. It recognizes hospitals that are improving patient flow, improving patient satisfaction and reducing Length-of-Stay (LOS) for ER patients.
- LHINs will be funded to meet ER performance and data compliance conditions in 35-50 designated hospitals. Failure to meet funding conditions will result in financial penalties and put future eligibility at risk
- The program's Year One assumptions and structures will continue in Year Two with adjustments to expand eligibility, tighten funding conditions and improve accountability for observed performance. MOHLTC will continue to enhance Pay-for-Results as evaluation data become available.
- The funding mechanism and eligibility criteria will take into account: performance against CTAS I/II/III goals; patient volume; admitted patient LOS; and growth pressures.
- Like other aspects of the Wait Time Strategy, LHINs will coordinate with local HSPs to decide how earned funding will be invested toward further ER performance improvements. For example, hospitals may put the money toward fast track models, waiting room enhancements, bed management systems, etc.

Measurable Objectives (Data Source)

- Reduce ER length-of-stay (EDRS)
- Improve satisfaction (NRC Picker Patient Satisfaction Survey)

Accountable Parties

- LHIN CEOs
- Hospital CEOs



ED Process Improvement Program will improve ED efficiency and capacity

ED Process Improvement Program

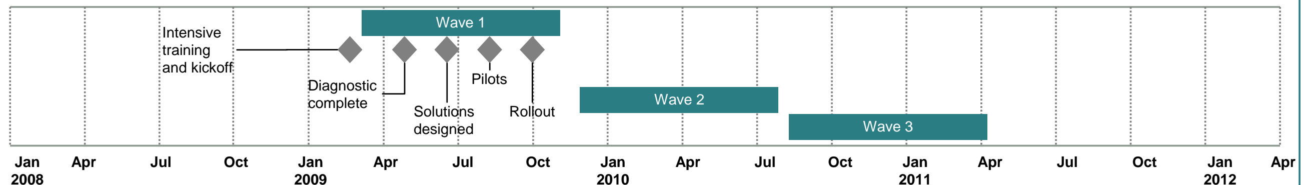
- ED PIP's four main objectives are to decrease ED LOS for all CTAS levels, improve patient satisfaction with the ED experience, provide a better working environment for ED staff and build provincial capacity for quality improvement.
- ED PIP will guide and support up to 90 participating hospitals through a structured Lean operations transformation improvement approach (based on 4 pilot sites). Hospitals may participate in one of the three, 8 month transformation waves of work.
  - Support will be structured into three streams of activity within each 8 month wave: LHIN and local hospital leadership stream, hospital working team leader(s) stream, and onsite team support stream
- Resources required for success will be provided from the ED PIP, participating LHINs, and participating hospitals, specifically:
  - ED PIP: provide overall program structure, content, leadership training, and onsite support
  - LHIN: ensure local accountability and champion program regionally
  - Hospital: provide local leadership, team resources, and enabling data tools
- ED PIP offers a structured and supported improvement approach that LHINs and hospital leaders can leverage to achieve ED wait times improvement objectives, while simultaneously building local capacity and performance management systems to enable ongoing sustainability and scale of impact.

Measurable Objectives

- ED LOS for all CTAS levels (daily reporting tool)
- Patient satisfaction (NRC Picker Survey)
- Provincial capacity for QI (# people trained in QI tools)

Accountable Parties

Hospital CEOs | LHIN CEOs



Measuring and improving patient satisfaction with their Emergency Room (ER) experience is a key goal of the ER/ALC strategy

Patient Satisfaction Program

- The objective of the ER/ALC strategy is to increase public satisfaction and confidence in the health care system by providing:
  - ✓ Timely access
  - ✓ Quality care
  - ✓ Improved patient experience
- Measuring patient satisfaction with emergency care will be mandatory. An enhanced version of the current National Research Corporation (NRC) – Picker will be used in 2009/10 for this purpose. An alternate, improved tool may be introduced in the future.
- The patient satisfaction scores will be reported publicly on a quarterly basis starting in August 2009.
- Survey sampling details and associated costs are underdevelopment. Hospitals will be notified soon of the process, including data requirements in preparation for public reporting.

Measurable Objectives (Data Source)

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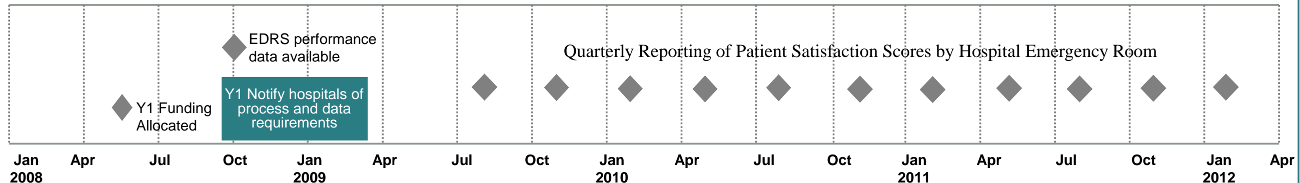


Supporting seniors to remain in their homes

Aging at Home (AAH)

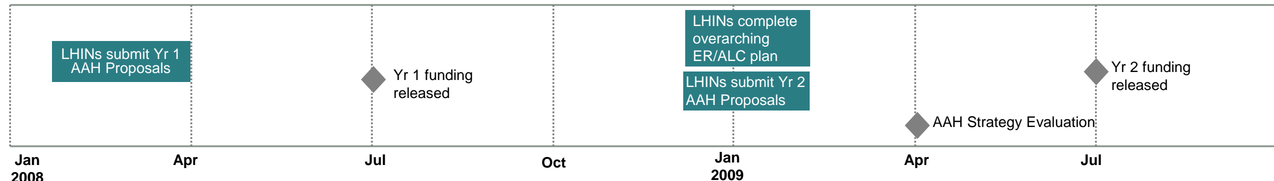
- In 2007/08, the Minister announced the Aging at Home Strategy, an multi-year $700M investment to provide support to seniors and their caregivers to stay healthy and live with dignity and independence
- ALC was identified as a priority as part of the 2007/08 AAH announcement.
- AAH will relieve pressures on hospitals and long-term care homes by ensuring the right services in the right places at the right time:
  - transition supports from hospitals to community services
  - home care and community supports when seniors' needs create high risk of ER visits and institutionalization
  - community supports to keep seniors healthy and active in their homes and communities
- 290 proposals are being implemented by the LHINs in 2008/09; many of these proposals work to address ALC
- Recent regulatory changes were made to increase CCAC service maximums and additional funds were allocated to enhance CCAC capacity to provide home-based care
- The MOHLTC and LHINs are meeting with Kevin Smith (Provincial ALC Lead) to align AAH with Ontario's ER/ALC Strategy
- LHINs are developing an ER/ALC Overarching Plan by December 2008,and Year 2 Aging at Home Detailed Service Plan by January 30, 2009.

Measurable Objectives (Data Source)

- Percentage of Alternate Level of Care Days Among Seniors, Age 65+ (Inpatient DAD)
- Median Wait Time for Seniors Age 65+ in Days to Long-Term Care Placement (Client Profile Database)

Accountable Parties

- LHIN CEOs



The ER/ALC Information Strategy will give ER professionals the business process tools and accurate timely data they need to improve ER and ALC wait times

ALC Information Management/Information Technology

The ALC IM/IT initiative will improve performance measurement:

- enhance **Emergency Department Reporting System** to provide more timely data and links to other indicators of system performance
- expand the provincial **Wait Time Information System** to capture near real-time ALC wait time data in acute care and post-acute care hospitals
- Leverage data from the MOHLTC **Client Profile Database** to analyze and report on people waiting in the community for long-term care

The ALC IM/IT initiative will also provide new business process tools:

- expand the **ED/CCAC Notification** system to high volume ERs across the province to reduce unnecessary inpatient admissions through the ER
- create provincial data and business process standards for **e-Referral and Resource Matching** solutions and provide funding to LHINs to implement local solutions that meet provincial standards

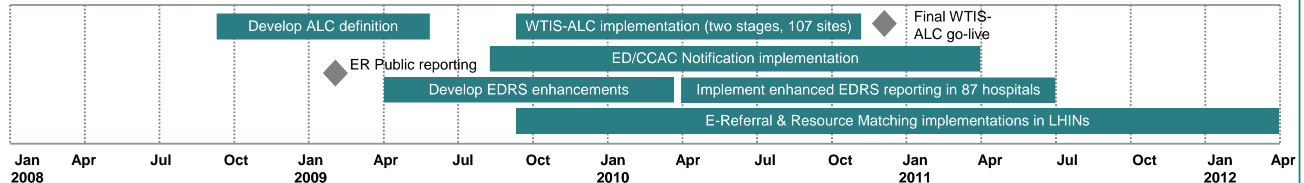
A working group will develop and champion a comprehensive, provincial **ALC Definition.**

Measurable Objectives

- Timely roll-out of system

Accountable Parties

- MOHLTC



Reviewing Transitional Capacity Needs

Transitional Capacity

- As part of a comprehensive strategy to address ALC challenges, some LHINs/hospitals have implemented short term transitional capacity to alleviate immediate pressures.
- The ministry is reviewing this issue provincially.
- There are 40 communities with hospitals above 10% ALC in acute beds. This totals 1,305 ALC patients above 10% (excluding small hospitals; October 2008 OHA ALC Survey).
- 80% of the 1,305 ALC patients are in 20 communities.
- In these communities, the amount over 10% acute can inform short-term transitional capacity.

80% of 1,305 in 20 communities

Community	# above 10% acute	Avg # waiting in ER for bed
North York	98	49
York (Region)	60	42
Toronto East and West	57	33
Ottawa	85	22
Sarnia	42	6
Hamilton	151	55
Burlington	29	15
Niagara	96	35
Mississauga	35	21
Oakville	35	19
Sudbury	66	14
Sault Ste Marie	66	10
North Bay	29	
Barrie	39	10
Thunder Bay	30	20
Belleville/Trenton	37	9
Kitchener/Waterloo	43	20
Cambridge	29	3
Guelph	21	8

Note: information based strictly on responses from hospitals October08

20% of 1,305 in 20 communities

Community	# above 10% acute	Avg # waiting in ER for bed
Lindsay	21	6
Peterborough	19	12
Cobourg	14	4
Oshawa	19	15
Scarborough/Ajax/Pickering	18	20
Brampton	13	25
Pembroke	13	3
Cornwall	9	7
Brantford	11	9
Timmins	12	
Collingwood	9	8
Midland/Penetanguishene	15	
Orillia	12	14
Bracebridge/Huntsville	15	2
Brockville	10	
Kingston	17	15
Perth and Smith Falls	6	2
Stratford	4	3
Woodstock	10	
Owen Sound	10	1

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