

Provincial Overview

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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



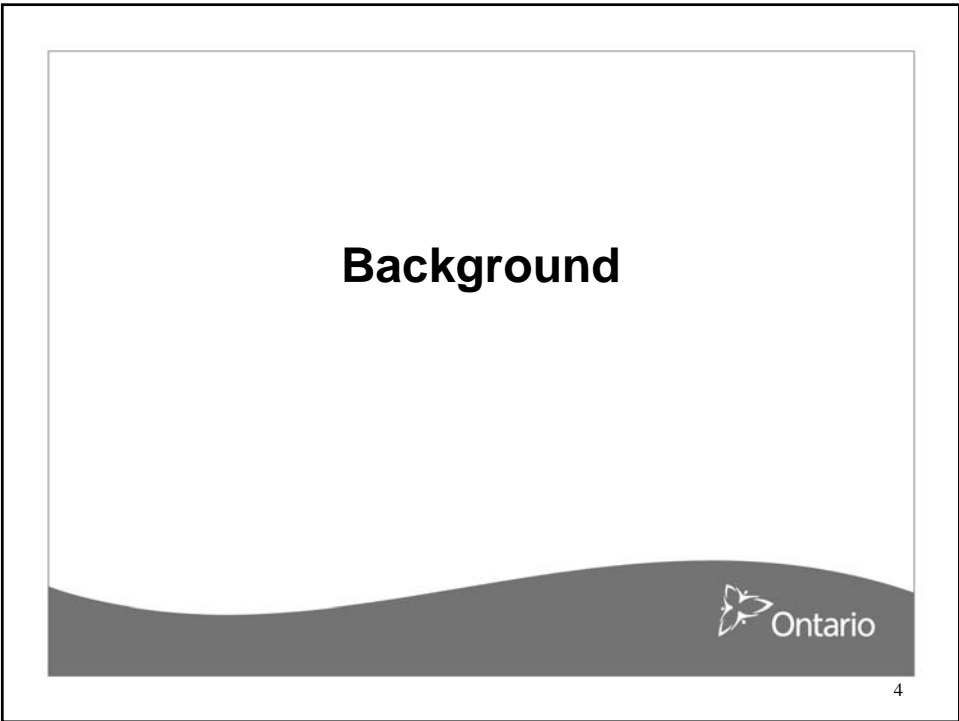
1

Overview

- Background
- Progress on Surgical and Diagnostic Imaging Wait Times: The Facts
- ER Wait Times: The Facts
- ALC: The Facts
- ER=ALC: Solutions
- IT Foundation: eHealthOntario
- Final Words



2



Looking Back ... Looking Forward

- The 1990s ... economic challenges
- Lessons learned
 - The value of good leadership especially in tough times
 - The importance of setting priorities



5

The Wait Time Strategy

November/04: Strategy Launched (Surgery, MRI/CT)

- **Adult waits from *decision to treat to treat* for cancer surgery, selected cardiac procedures, cataract surgery, hip and knee total joint replacements, MRI/CT scans**
 - By April/07, the Wait Time Information System (WTIS) captures waits in all wait time-funded hospitals
- **September/06: work begins to include general, orthopaedic and ophthalmologic surgery**
 - By March/08, WTIS reports these waits
- **December/06: work begins to include paediatric surgeries**
 - By Sept/07, WTIS reports waits from the 5 Paediatric Academic Health Science Centres
 - By April/09, WTIS to include paediatric surgeries in all Ontario hospitals
- **Spring/08: work begins to include all adult subspecialty surgery**
 - By Fall/09, WTIS to include these waits

October/07: Premier McGuinty Announces Strategy to Include ER Wait Times



6

ER Wait Times: A Top Government Priority

- April/08: Announcement that reducing wait times in ERs and improving access to family health care are the government's two most important health priorities over the next four years
- Premier McGuinty, Minister Caplan and Deputy Minister Sapsford:
 - Confirm these priorities as their own
 - Recognise the critical link between reducing ER wait times and reducing Alternate Level of Care patients and days in acute hospitals



7

ER Wait Times: A Top Government Priority

- July 25/08: Memo from Deputy Minister Sapsford to LHIN CEOs
 - Emphasized that a major factor contributing to ER wait times is the high number of ALC patients in acute hospitals
 - Highlighted initiatives to relieve ER/ALC pressures (e.g., ED Action Plan, ER Strategy activities, regulatory changes to increase CCAC service maximums, additional funds to enhance CCAC capacity to provide home care, and LHINs' Urgent Priorities Fund to be used to address ALC
 - Confirmed that in 2009/10, Aging at Home proposals must focus on strategies to address ER wait times and ALC



8

ER Wait Times: A Top Government Priority

Nov 14/08: Memo from ADM, Ken Dean to LHIN CEOs:

- Provided key recommendations of ALC Brainstorming Session (Kevin Smith chair, March/08) to help guide decisions about appropriate initiatives to support the ER/ALC Strategy (reduce ER length of stay and wait times for ALC patients)
- Stressed that success of the ER/ALC Strategy relies on aligning initiatives with the Strategy's objectives and having strong, effective local system management (effective governance and strong performance management)
- Confirmed that:
 - LHIN CEOs are responsible for effective performance management and making progress towards achieving the Strategy's objectives
 - Performance management will be a standing item at monthly MMC LHIN CEO meetings
 - 1+ dedicated LHIN Performance Leads for ER/ALC activities will be established in each LHIN to support LHIN coordination and implementation of the strategy, with monthly meetings held between the Ministry and LHINs to ensure alignment



9

ER Wait Times: A Top Government Priority

Levels of Accountability (ADM Ken Dean)

- | | |
|------------------|---|
| LHINS | <ul style="list-style-type: none">• Monitor and manage performance• Ensures appropriate supports are in place for ER/ALC agenda |
| Hospitals | <ul style="list-style-type: none">• Ensures appropriate utilization of hospital resources (i.e. beds)• Ensures appropriate capacity management including surgical flow• Commitment to overall operations improvement (ensuring ER and internal medicine units function and perform appropriately) |
| CCACs | <ul style="list-style-type: none">• Ensures that a comprehensive basket of services are available to enable patients, wherever possible, to stay at home |



10

Efforts to Reduce ER=ALC Waits Will Use the Same Elements as the Wait Time Strategy

- Create clear **accountabilities** for improving access
- Create a **pay for performance** model where hospitals are rewarded for doing more procedures
- Set targets to publicly track, monitor and **improve performance** through an **electronic reporting system**
- Increase system performance with **better use of resources**
- Incorporate **expert advice** of providers and local communities as well as lessons learned from other jurisdictions



11

Progress on Surgical and Diagnostic Imaging Wait Times: The Facts



12

Progress to Date – Province Surgical and DI Wait Times Sept 08

Service	Baseline (Days) ¹	90 Percent Completed Within			Current vs. Baseline	
		Current (Days) (Sep 08)	Access Target (Days)	Percentage Completed Within Target	Net change (Days)	Percentage change
General Surgery	121	127	182	96%	6	5.0
Cancer Surgery	81	73	84	93%	-8	-9.9
Angiography ²	56	26	—	—	-30	-53.6
Angioplasty ²	28	14	—	—	-14	-50
Bypass Surgery ²	49	62	182	100%	13	26.5
Ophthalmic Surgery ³	130	119	84-182	97%	-11	-8.5
Cataract Surgery	311	118	182	97%	-193	-62.1
Other ophthalmic surgery	114	132	84-182	91%	18	16.0
Orthopaedic surgery	190	186	182	90%	-4	-2.1
Hip replacement	351	180	182	90%	-171	-48.7
Knee replacement	440	205	182	88%	-235	-53.4
Other orthopaedic surgery	175	181	182	90%	6	3.4
MRI	120	100	28	45%	-20	-16.7
CT	81	41	28	83%	-40	-49.4
Paediatric surgery	273	223	182	86%	-50	-18.3

Notes:

1. Baseline Wait Times for Cancer Surgery, Cardiac, Cataract Surgery, Hip and Knee Replacements and MRI/CT are based on Aug/Sep 2005 data.
Baseline Wait Times for General Surgery, Ophthalmic and Other Ophthalmic Surgery, Orthopaedic and other Orthopaedic surgery are based on April 2008 data.
Paediatric baseline wait time based on April/May 2006 data.
2. Cardiac wait times include elective referrals only.
3. Ophthalmic surgery priority 4 access targets vary by service detail:
Cataract - 182, Glaucoma - 112, Corneal Transplant-182, Vitrectomy-84, Generic 182



Source: WTIS Sept 2008

13

Progress to Date – Central LHIN Surgical and DI Wait Times Sept 08

Service	90% completed within				Current vs. Baseline	
	Baseline ¹ (Aug/ Sept05)	Current (Sep 08)	Priority Level 4 (PL4) access target (days)	% completed within PL4 access target	Net change	% change
General surgery	103	125	182	97%	22	21.4
Cancer surgery	50	56	84	97%	6	12.0
Angiography ²	14	21	-	-	7	50.0
Angioplasty ²	13	12	-	-	-1	-7.7
Bypass surgery ²	46	68	182	100%	21	45.7
Ophthalmic surgery ³	75	78	84 - 182	100%	3	4.0
Cataract surgery	266	78	182	100%	-188	-70.7
Other ophthalmic ³	112	90	84 - 182	100%	-22	-19.6
Orthopaedic surgery	163	160	182	94%	-3	-1.8
Hip replacement	277	149	182	95%	-128	-46.6
Knee replacement	448	155	182	94%	-293	-65.4
Other orthopaedic	160	162	182	93%	2	1.3
MRI	151	108	28	32%	-43	-28.5
CT	69	24	28	93%	-45	-65.2

Notes:

1. Baseline Wait Times for Cancer Surgery, Cardiac, Cataract Surgery, Hip and Knee Replacements and MRI/CT are based on Aug/Sep 2005 data.
Baseline Wait Times for General Surgery, Ophthalmic and Other Ophthalmic Surgery, Orthopaedic and other Orthopaedic surgery are based on April 2008 data.
Paediatric baseline wait time based on April/May 2006 data.
2. Cardiac wait times include elective referrals only.
3. Ophthalmic surgery priority 4 access targets vary by service detail:
Cataract - 182, Glaucoma - 112, Corneal Transplant-182, Vitrectomy-84, Generic 182



Source: WTIS Sept 2008

14

Progress to Date – Central East LHIN Surgical and DI Wait Times Sept 08

Service	90% completed within				Current vs. Baseline	
	Baseline ¹ (Aug/ Sept05)	Current (Sep 08)	Priority Level 4 (PL4) access target (days)	% completed within PL4 access target	Net change	% change
General surgery	89	110	182	97%	21	23.6
Cancer surgery	90	55	84	97%	-35	-38.9
Angiography²	23	19	-	-	-4	-15.9
Angioplasty²	14	5	-	-	-9	-61.4
Ophthalmic surgery³	139	122	84 - 182	98%	-17	-12.2
Cataract surgery	323	124	182	98%	-199	-61.6
Other ophthalmic ³	60	82	84 - 182	99%	22	36.7
Orthopaedic surgery	171	170	182	91%	-1	-0.6
Hip replacement	399	173	182	91%	-226	-56.6
Knee replacement	307	194	182	88%	-113	-36.8
Other orthopaedic	139	164	182	92%	25	18.0
MRI	75	96	28	46%	21	28.0
CT	61	31	28	86%	-30	-49.2

Notes:

- Baseline Wait Times for Cancer Surgery, Cardiac, Cataract Surgery, Hip and Knee Replacements and MRI/CT are based on Aug/Sep 2005 data.
Baseline Wait Times for General Surgery, Ophthalmic and Other Ophthalmic Surgery, Orthopaedic and other Orthopaedic surgery are based on April 2008 data.
Paediatric baseline wait time based on April/May 2006 data.
- Cardiac wait times include elective referrals only.
- Ophthalmic surgery priority 4 access targets vary by service detail:
Cataract - 182, Glaucoma - 112, Corneal Transplant-182, Vitrectomy-84, Generic 182



15

Source:WTIS Sept 2008

Progress to Date – Central West LHIN Surgical and DI Wait Times Sept 08

Service	90% completed within				Current vs. Baseline	
	Baseline ¹ (Aug/ Sept05)	Current (Sep 08)	Priority Level 4 (PL4) access target (days)	% completed within PL4 access target	Net change	% change
General surgery	121	117	182	98%	-4	-3.3
Cancer surgery	85	83	84	90%	-2	-2.4
Angiography²	NA	10	-	-	NA	NA
Ophthalmic surgery³	155	227	84 - 182	82%	72	46.5
Cataract surgery	436	230	182	81%	-206	-47.5
Other ophthalmic ³	153	72	84 - 182	97%	-81	-52.9
Orthopaedic surgery	154	189	182	90%	35	22.7
Hip replacement	357	222	182	84%	-135	-37.8
Knee replacement	334	276	182	67%	-58	-17.4
Other orthopaedic	81	99	182	99%	18	22.2
MRI	74	39	28	48%	-35	-47.3
CT	97	25	28	92%	-72	-74.2

Notes:

- Baseline Wait Times for Cancer Surgery, Cardiac, Cataract Surgery, Hip and Knee Replacements and MRI/CT are based on Aug/Sep 2005 data.
Baseline Wait Times for General Surgery, Ophthalmic and Other Ophthalmic Surgery, Orthopaedic and other Orthopaedic surgery are based on April 2008 data.
Paediatric baseline wait time based on April/May 2006 data.
- Cardiac wait times include elective referrals only.
- Ophthalmic surgery priority 4 access targets vary by service detail:
Cataract - 182, Glaucoma - 112, Corneal Transplant-182, Vitrectomy-84, Generic 182



16

Source:WTIS Sept 2008

Progress to Date – North Simcoe Muskoka LHIN Surgical and DI Wait Times - Sept 08

Service	90% completed within				Current vs. Baseline	
	Baseline ¹ (Aug/ Sept05)	Current (Sep 08)	Priority Level 4 (PL4) access target (days)	% completed within PL4 access target	Net change	% change
General surgery	132	129	182	97%	-3	-2.3
Cancer surgery	109	62	84	98%	-47	-43.1
Ophthalmic surgery²	102	112	84 - 182	100%	10	9.8
Cataract surgery	168	112	182	100%	-56	-33.3
Other ophthalmic ³	57	NV	84 - 182	NV	NA	NA
Orthopaedic surgery	207	289	182	82%	82	39.6
Hip replacement	303	127	182	97%	-176	-58.1
Knee replacement	368	278	182	86%	-90	-24.5
Other orthopaedic	235	314	182	78%	79	33.6
MRI	325	101	28	36%	-224	-68.9
CT	115	24	28	93%	-91	-79.1

Notes:

- Baseline Wait Times for Cancer Surgery, Cardiac, Cataract Surgery, Hip and Knee Replacements and MRI/CT are based on Aug/Sep 2005 data.
Baseline Wait Times for General Surgery, Ophthalmic and Other Ophthalmic Surgery, Orthopaedic and other Orthopaedic surgery are based on April 2008 data.
Paediatric baseline wait time based on April/May 2006 data.
- Cardiac wait times include elective referrals only.
- Ophthalmic surgery priority 4 access targets vary by service detail:
Cataract - 182, Glaucoma - 112, Corneal Transplant-182, Vitrectomy-84, Generic 182



17

Source:WTIS Sept 2008

Progress to Date – Toronto Central LHIN Surgical and DI Wait Times - Sept 08

Service	90% completed within				Current vs. Baseline	
	Baseline ¹	Current (Sep 08)	Priority Level 4 (PL4) access target (days)	% completed within PL4 access target	Net change	% change
General surgery	83	125	182	96%	42	50.6
Cancer surgery	85	78	84	91%	-7	-8.2
Angiography²	33	29	-	-	-4	-13.0
Angioplasty²	22	15	-	-	-7	-31.8
Bypass surgery²	48	80	182	100%	32	67.5
Ophthalmic surgery³	120	119	84 - 182	96%	-1	-0.8
Cataract surgery	400	110	182	93%	-290	-72.5
Other ophthalmic ³	141	152	84 - 182	89%	11	7.8
Orthopaedic surgery	234	162	182	92%	-72	-30.8
Hip replacement	343	130	182	97%	-213	-62.1
Knee replacement	481	114	182	98%	-367	-76.3
Other orthopaedic	321	206	182	87%	-115	-35.8
MRI	85	87	28	55%	2	2.4
CT	88	49	28	81%	-39	-44.3

Notes:

- Baseline Wait Times for Cancer Surgery, Cardiac, Cataract Surgery, Hip and Knee Replacements and MRI/CT are based on Aug/Sep 2005 data.
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18

Source:WTIS Sept 2008

ER Wait Times: The Facts



19

Province and Central, Central East, Central West, North Simcoe Muskoka and Toronto Central LHINs ED Length of Stay (Hours) - June 2008. All ED Visits

	ALL ED Visits - ED LOS 90th Percentile (hours)			
	Baseline	Current Period	Current vs. Baseline	
	April 2008	June 2008	Net change	% change
Province	9.4	8.8	-0.6	-6%
Central West	11.1	10.0	-1.1	-10%
Toronto Central	17.9	14.9	-3.0	-17%
Central	10.4	9.8	-0.6	-6%
Central East	9.6	9.0	-0.6	-6%
North Simcoe Muskoka	7.7	7.4	-0.3	-4%

•To establish a baseline for ED Length of Stay: 9.4 hours in Ontario; range from 7.7 to 17.9 hours depending on the LHIN.

•Decrease in ED length of stay in all LHINs from April to June 2008.



20

Source: EDRS June 2008

Province ED Length of Stay (Hours): Admitted vs. Non-Admitted Patients June 08

	All ED Visits		Admitted Patients			Non-Admitted Patients*	
	Total Volume	ED LOS (June 2008)	% of Total ED Visits	ED LOS (June 2008)	Time to Inpatient Bed**	% of Total ED Visits	ED LOS (June 2008)
All ED Visits	376,763	8.8	10%	30.8	23.0	90%	6.7

- 10% of all ED visits are admitted patients; 90% are not admitted.
- The ED Length of Stay in Ontario for admitted patients is 30.8 hours compared to 6.7 hours for non-admitted patients (24 hours difference).
- 9 out of 10 patients admitted to hospital through the ED wait up to 23 hours for an inpatient bed.



Canadian Triage and Acuity Scale



CTAS I: requires resuscitation and includes conditions that are threats to life or imminent risk of deterioration, requiring immediate aggressive interventions (for example, cardiac arrest, major trauma, or shock states).

CTAS II: requires emergent care and includes conditions that are a potential threat to life or limb function requiring rapid medical intervention or delegated acts (for example, head injury, chest pain, gastrointestinal bleeding, abdominal pain with visceral symptoms, or neonates with hyperbilirubinemia).

CTAS III: requires urgent care and includes conditions that could potentially progress to a serious problem requiring emergency intervention, such as mild moderate asthma or dyspnea, moderate trauma, or vomiting and diarrhea in patients younger than 2 years.

CTAS IV: requires less-urgent care and includes conditions related to patient age, distress, or potential for deterioration or complications that would benefit from intervention or reassurance within one to two hours, such as urinary symptoms, mild abdominal pain, or earache.

CTAS V: requires non-urgent care and includes conditions in which investigations or interventions could be delayed or referred to other areas of the hospital or health care system, such as a sore throat, menses, conditions related to chronic problems, or psychiatric complaints with no suicidal ideation or attempts.



Province ED Length of Stay (Hours): CTAS Level June 08

CTAS Level	All ED Visits				Admitted Patients			
	Total Volume	ED LOS (June 2008)	CTAS Recommendation (hours)	% within CTAS Recommendation	% of Total ED Visits	ED LOS (June 2008)	Time to Inpatient Bed**	% within CTAS Recommendation
CTAS I	2,503	17.8	8	75%	57%	26.3	19.7	65%
CTAS II	52,588	16.6	8	72%	28%	30.1	23.0	42%
CTAS III	151,787	10.6	6	75%	12%	32.3	23.6	26%
CTAS IV	144,839	5.1	4	83%	2%	28.9	21.2	19%
CTAS V	23,794	4.2	4	89%	1%	28.2	15.9	27%

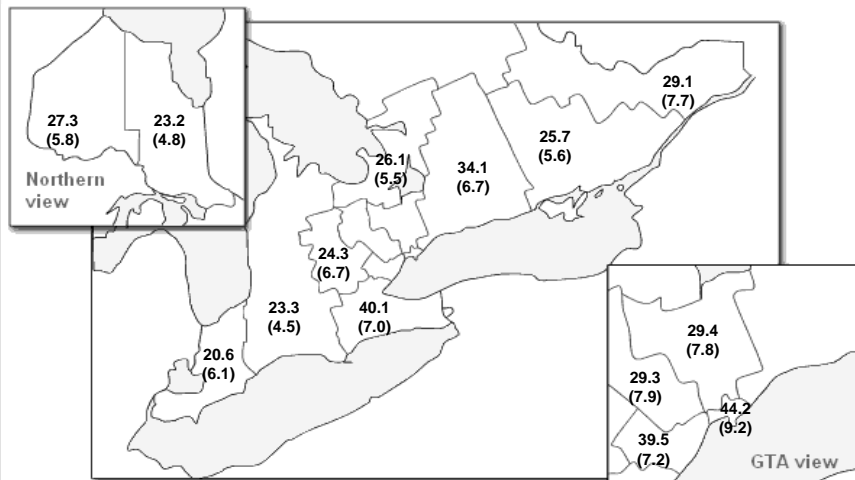
- More acute patients (CTAS I, II) have longer ED lengths of stay than less acute patients.
- Not all CTAS I and II ER patients are admitted to hospital: 57% of CTAS I and only 28% of CTAS II patients are admitted.
- 75% of CTAS I patients had an ED length of stay within 8 hours; 83% of CTAS IV and 89% of CTAS V patients had an ED LOS within 4 hours.



Source: EDRS June 2008

23

LHIN ED Length of Stay, Hours – Admitted and (Non-Admitted) - June 08



Province ED LOS : Admitted 30.8 hours; Non-Admitted 6.7 hours

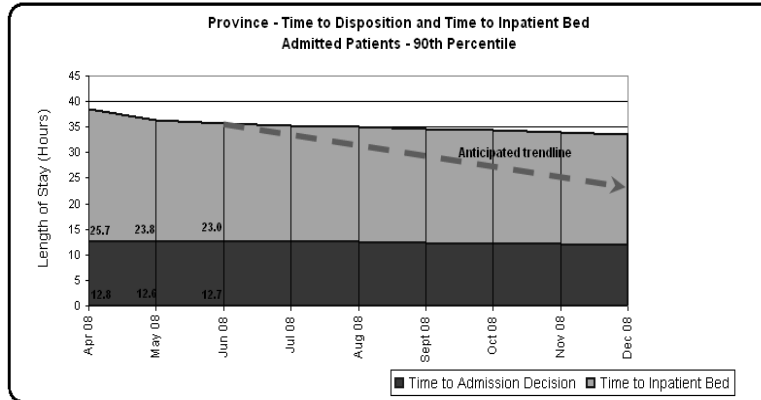
EDLOS Colour Legend: Green – LHIN (s) with shortest ED LOS;
Red – LHIN with longest ED LOS



Source: EDRS June 2008

24

Total Time Spent in ER - Breakdown for Admitted Patients



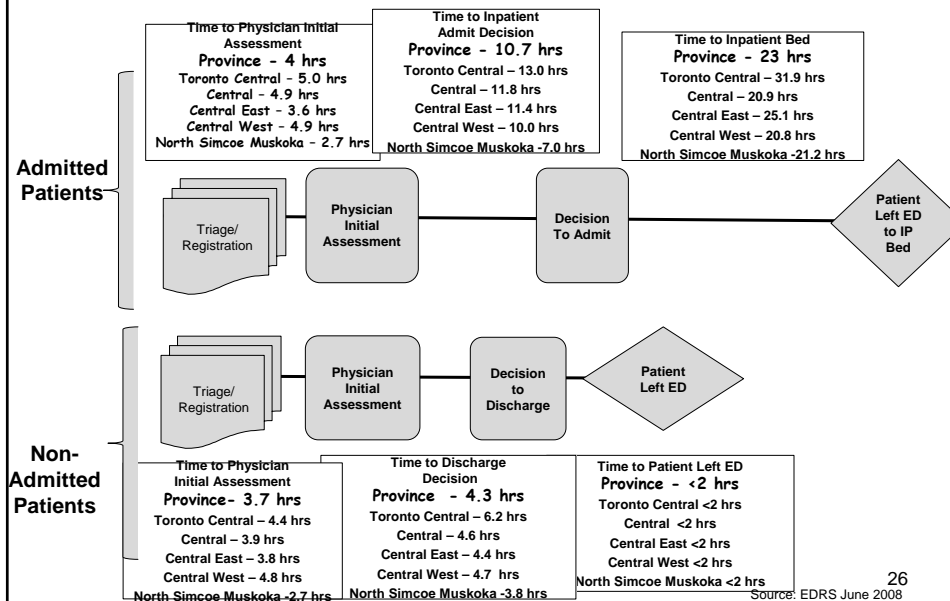
* Sum of Time to Disposition 90th percentile and Time to Inpatient Bed 90th Percentile is not equal to EDLOS 90th Percentile.
EDLOS 90th percentile is calculated from record level data.



Source: EDRS June 2008

25

ER Patient Flow: Length of Stay (Hours) – June 08 data



Source: EDRS June 2008

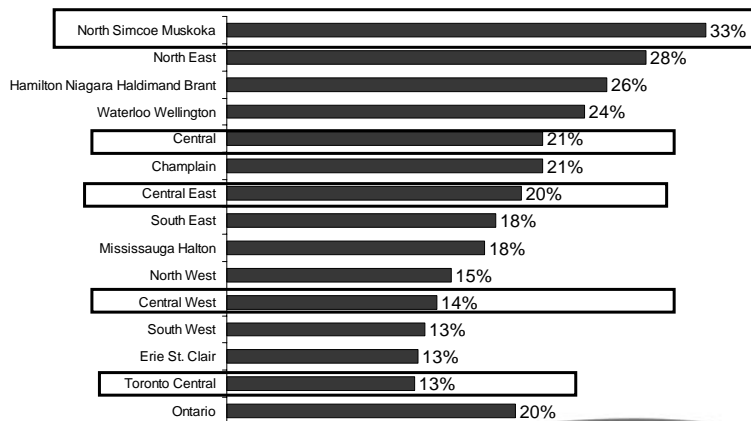
26

Alternate Level of Care: The Facts



27

Percent of Acute Care Beds Occupied by ALC Patients By LHIN

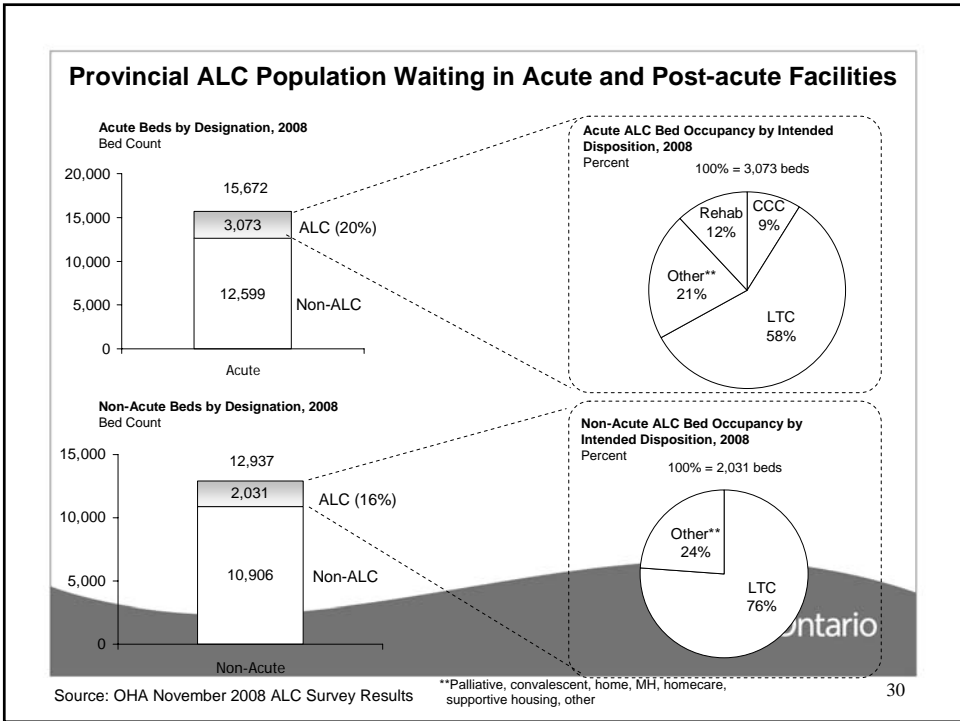
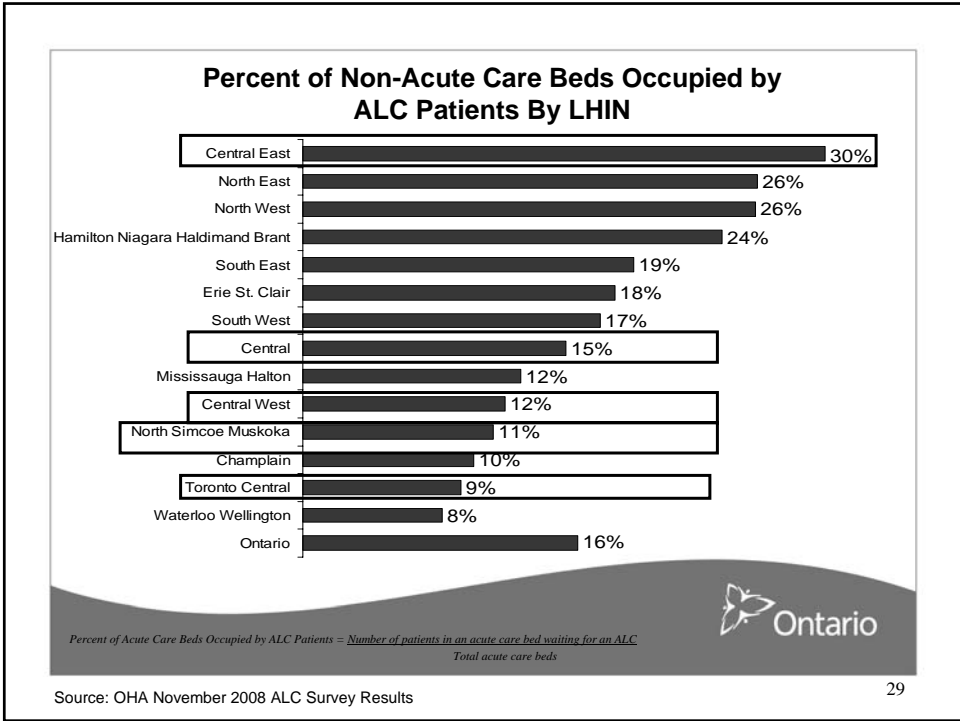


Percent of Acute Care Beds Occupied by ALC Patients = $\frac{\text{Number of patients in an acute care bed waiting for an ALC}}{\text{Total acute care beds}}$

Source: OHA November 2008 ALC Survey Results



28



Other ALC Reasons Patients in Acute Care Beds

Rehabilitation	377
Complex Continuing Care	274
Palliative Care	167
Convalescent Care	120
Home	64
Home Care	32
Assisted Living / Supportive Housing	29
Mental Health	11
Other	217



Source: OHA November 2008 ALC Survey Results

31

Number of Days Between Patient Designated as ALC and Discharge from Facility by Discharge Disposition PROVINCE Fiscal 2007/2008

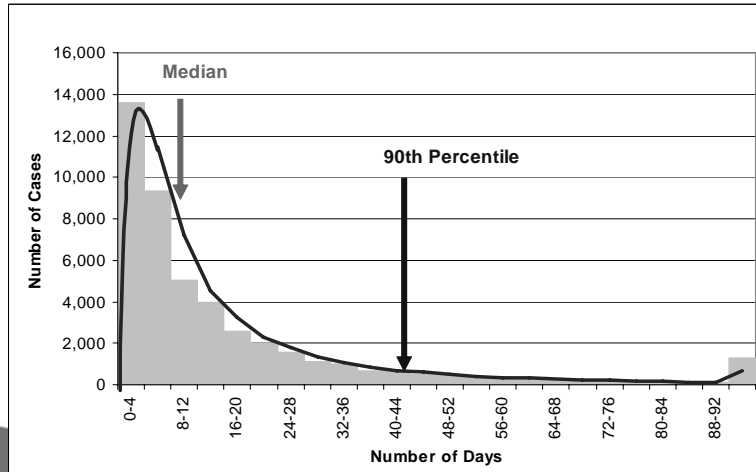
Disposition	Performance		
	Number of Discharges	Median (Days)	90th Percentile (Days)
Other hospital providing inpatient hospital care	1,412	7	35
LTC facility	24,756	10	50
Other (palliative, addiction)	969	9	44
Home with support	8,752	7	30
Home	4,768	6	27
Signed out Against Medical Advice	113	9	37
Died	5,299	11	45
Total	46,069	9	43



Source: Canadian Institute for Health Information (CIHI) Discharge Abstract Database (DAD)

32

Number of Days Between Patient Designated as ALC and Discharge from Facility PROVINCE Fiscal 2007/2008

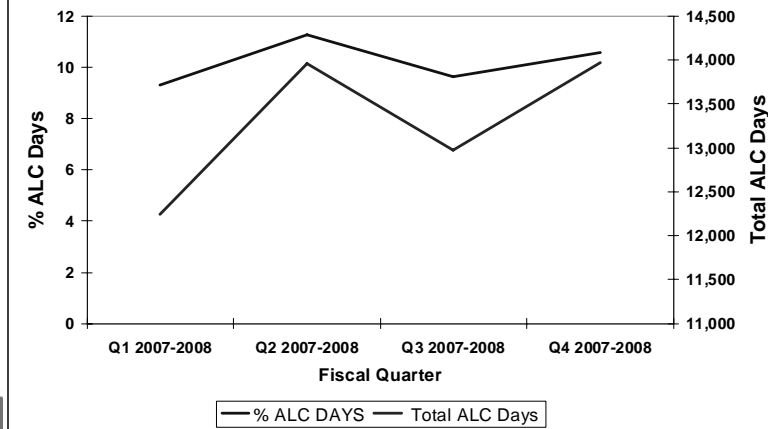


Source: Canadian Institute for Health Information (CIHI) Discharge Abstract Database (DAD)

33

Current State

Central LHIN ALC Days



Source: Canadian Institute for Health Information (CIHI) Discharge Abstract Database (DAD)

34

**Number of Days Between Patient Designated as ALC and Discharge from Facility by Discharge Disposition
CENTRAL LHIN Fiscal 2007/2008**

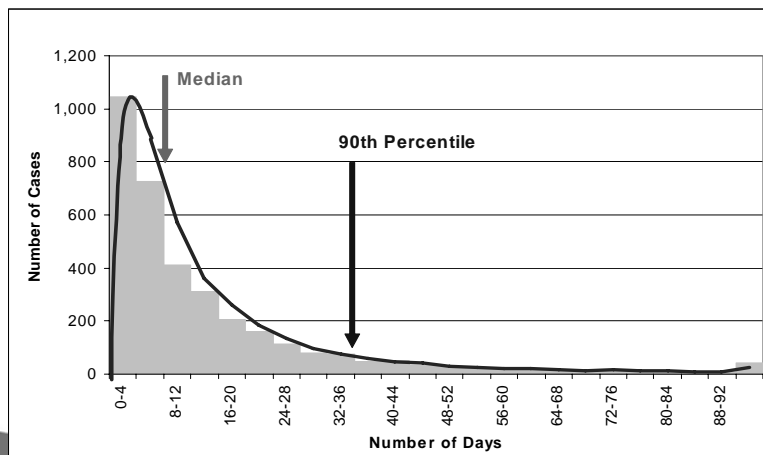
Disposition	Performance		
	Number of Discharges	Median (Days)	90th Percentile (Days)
Other hospital providing inpatient hospital care	19	12	23
LTC facility	2,149	9	37
Other (palliative, addiction)	39	14	40
Home with support	528	6	26
Home	397	7	35
Signed out Against Medical Advice	9	8	29
Died	326	12	44
Total	3,467	8	36
Province Total	46,069	9	43



Source: Canadian Institute for Health Information (CIHI) Discharge Abstract Database (DAD)

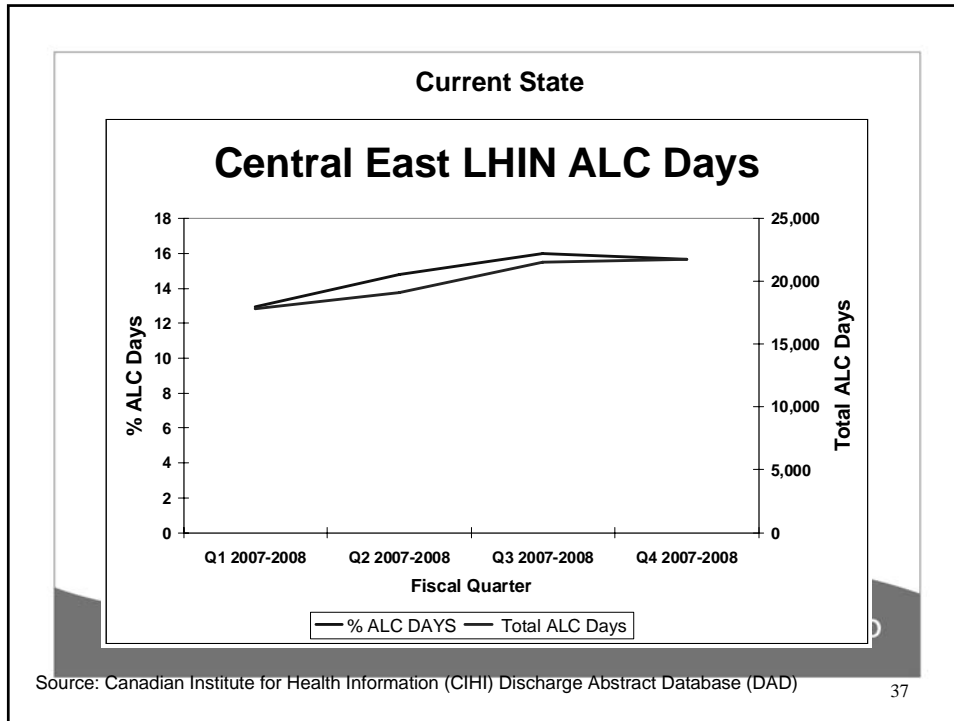
35

**Number of Days Between Patient Designated as ALC and Discharge from Facility
CENTRAL LHIN Fiscal 2007/2008**



Source: Canadian Institute for Health Information (CIHI) Discharge Abstract Database (DAD)

36

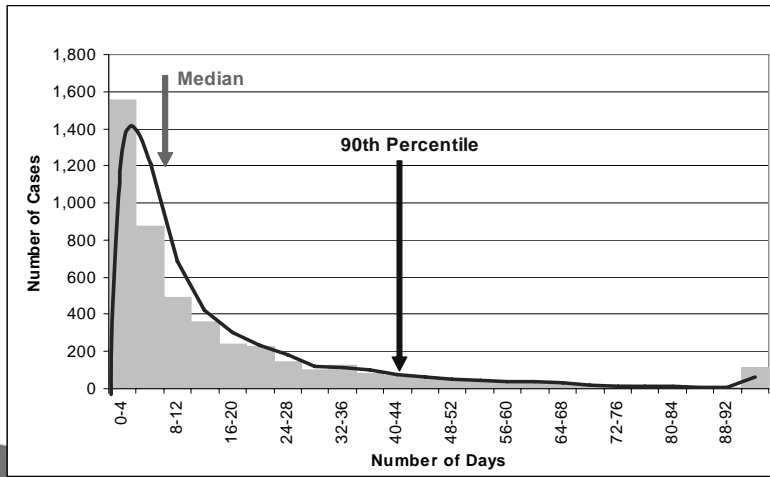


**Number of Days Between Patient Designated as ALC and Discharge from Facility by Discharge Disposition
CENTRAL EAST LHIN Fiscal 2007/2008**

Disposition	Performance		
	Volume	Median (Days)	90th Percentile (Days)
Other hospital providing inpatient hospital care	70	8	30
LTC facility	2,714	9	48
Other (palliative, addiction)	16	3	44
Home with support	1,026	7	28
Home	361	5	28
Signed out Against Medical Advice	11	6	71
Died	500	13	47
Total	4,698	8	42
Province Total	46,069	9	43

Source: Canadian Institute for Health Information (CIHI) Discharge Abstract Database (DAD)

**Number of Days Between Patient Designated as ALC and Discharge from Facility
CENTRAL EAST LHIN Fiscal 2007/2008**

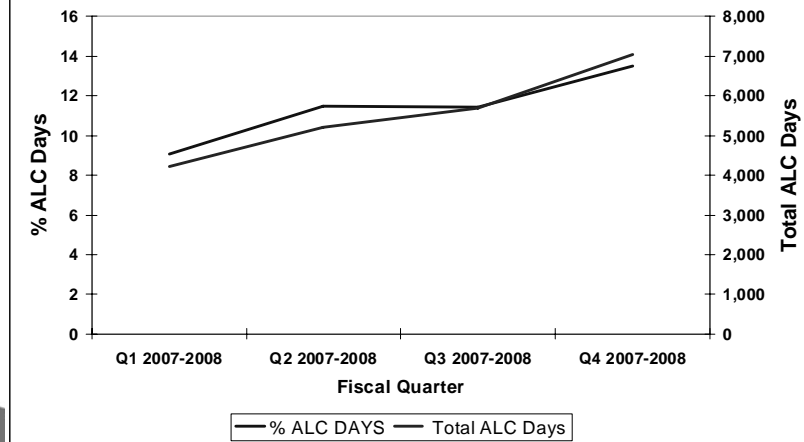


Source: Canadian Institute for Health Information (CIHI) Discharge Abstract Database (DAD)

39

Current State

Central West LHIN ALC Days



Source: Canadian Institute for Health Information (CIHI) Discharge Abstract Database (DAD)

40

**Number of Days Between Patient Designated as ALC and Discharge from Facility by Discharge Disposition
CENTRAL WEST LHIN Fiscal 2007/2008**

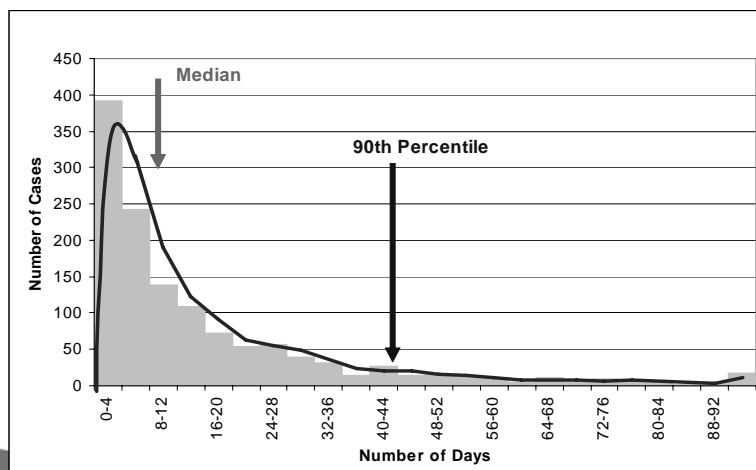
Disposition	Performance		
	Number of Discharges	Median (Days)	90th Percentile (Days)
Other hospital providing inpatient hospital care	41	6	26
LTC facility	742	11	55
Other (palliative, addiction)	14	10	41
Home with support	205	7	26
Home	216	5	25
Signed out AMA	4	3	5
Died	74	11	39
Total	1,296	9	43
Province Total	46,069	9	43



Source: Canadian Institute for Health Information (CIHI) Discharge Abstract Database (DAD)

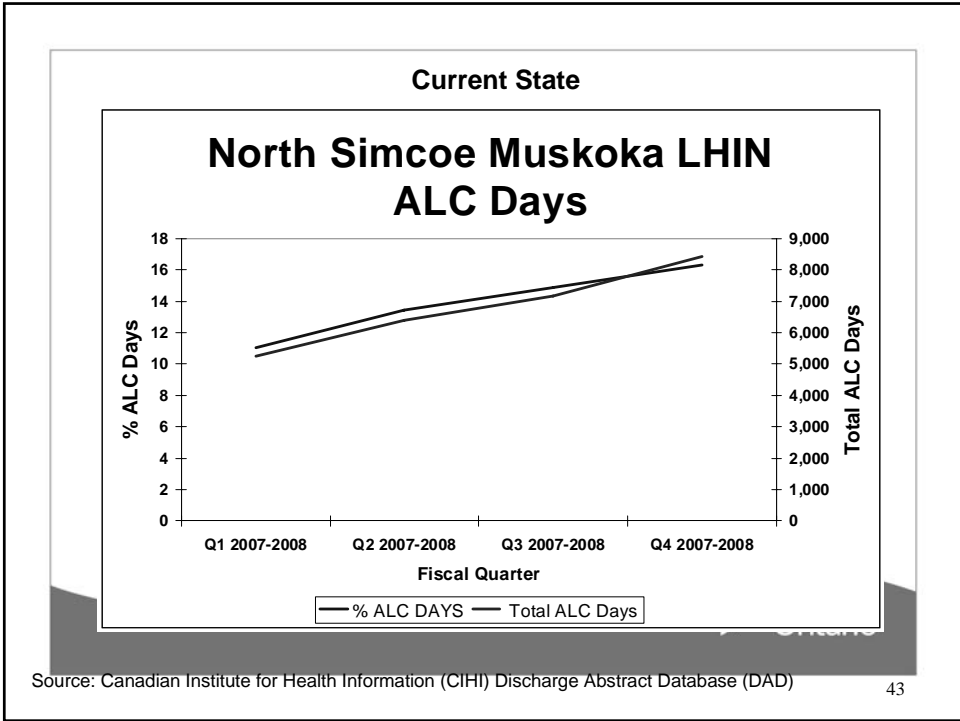
41

**Number of Days Between Patient Designated as ALC and Discharge from Facility
CENTRAL WEST LHIN Fiscal 2007/2008**



Source: Canadian Institute for Health Information (CIHI) Discharge Abstract Database (DAD)


42



43

**Number of Days Between Patient Designated as ALC and
Discharge from Facility by Discharge Disposition
NORTH SIMCOE MUSKOKA LHIN Fiscal 2007/2008**

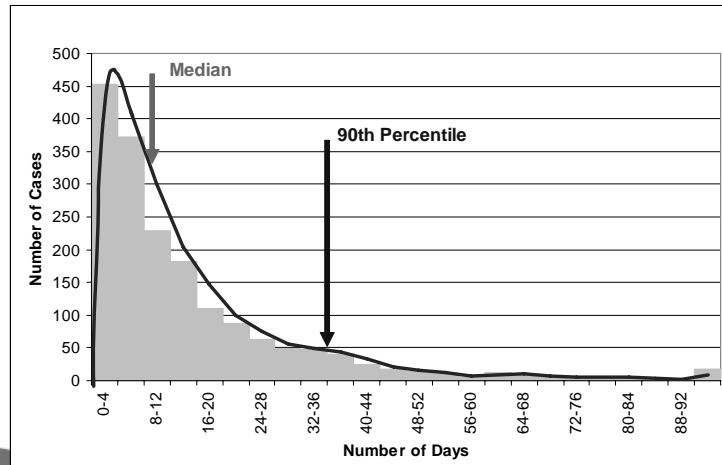
Disposition	Performance		
	Volume	Median (Days)	90th Percentile (Days)
Other hospital providing inpatient hospital care	25	11	56
LTC facility	891	10	39
Other (palliative, addiction)	25	22	39
Home with support	491	9	29
Home	96	6	24
Signed out Against Medical Advice	3	10	18
Died	235	9	35
Total	1,766	9	36
Province Total	46,069	9	43



Source: Canadian Institute for Health Information (CIHI) Discharge Abstract Database (DAD)

44

**Number of Days Between Patient Designated as ALC and Discharge from Facility
NORTH SIMCOE MUSKOKA LHIN Fiscal 2007/2008**

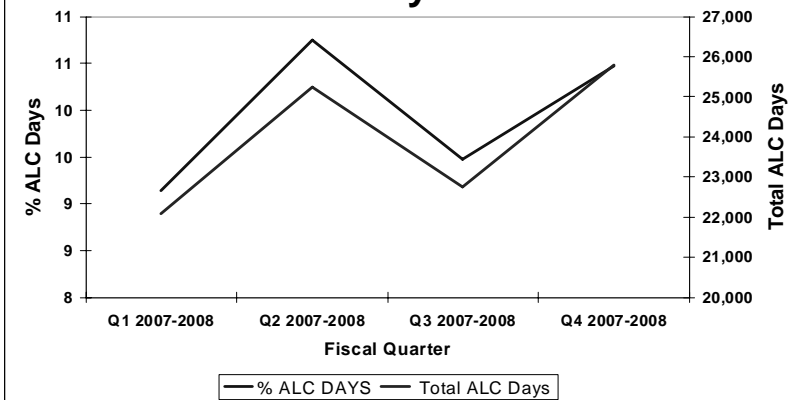


Source: Canadian Institute for Health Information (CIHI) Discharge Abstract Database (DAD)

45

Current State

Toronto Central LHIN ALC Days



Source: Canadian Institute for Health Information (CIHI) Discharge Abstract Database (DAD)

46

**Number of Days Between Patient Designated as ALC and Discharge from Facility by Discharge Disposition
TORONTO CENTRAL LHIN Fiscal 2007/2008**

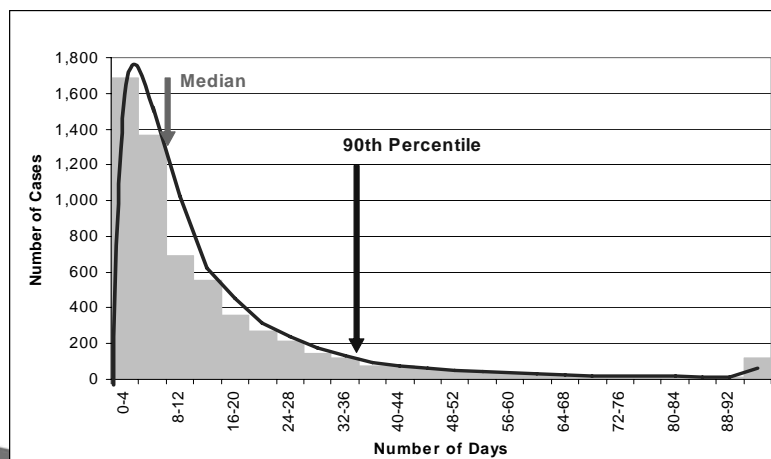
Disposition	Performance		
	Number of Discharges	Median (Days)	90th Percentile (Days)
Other hospital providing inpatient hospital care	115	7	30
LTC facility	3,648	8	36
Other (palliative, addiction)	393	14	56
Home with support	640	10	32
Home	640	7	27
Signed out Against Medical Advice	12	7	46
Died	541	9	37
Total	5,989	8	36
Province Total	46,069	9	43



Source: Canadian Institute for Health Information (CIHI) Discharge Abstract Database (DAD)

47

**Number of Days Between Patient Designated as ALC and Discharge from Facility
TORONTO CENTRAL LHIN Fiscal 2007/2008**



Source: Canadian Institute for Health Information (CIHI) Discharge Abstract Database (DAD)

48

ER=ALC Solutions



49

We Received a Lot of Excellent Advice

Key sources of advice

- *Action Steps to Improve Access and Reduce Wait Times in Ontario's ER* (July 2007). Advice from the ER Expert Panel, Chaired by Dr. Michael Schull.
- ALC Brainstorming session (March 28, 2008). Chaired by Dr. Kevin Smith.
- Discussions with the field.

Advice:

- We are acting on much of this advice.
- Hospitals, CCACs and LHINs also need to act.



50

ER Expert Panel (Schull) Had 11 Actions

Community (pre-emergency)

- 1. Fund community-based projects to manage selected chronic diseases (initial focus diabetes).**

Emergency Department

2. Expand patient distribution system from 15 Toronto hospitals to 30 hospitals in Ontario to improve information about off-loading and help “smooth out” the ambulance load on hospital EDs.
- 3. Fund the development of Ontario Physician Assistant training.**
4. Support common medical directive resource for Ontario EDs especially for conditions associated with ED quality and safety.
- 5. Support comprehensive training in the ED Patient Flow Toolkit and lean management techniques in up to 80 hospitals.**

Admission and In-Hospital Care

6. Increase number of hospital beds.



51

ER Expert Panel (Schull) Had 11 Actions ...

Discharge from ED and Hospital

7. Develop formal hospital-CCAC partnership agreements that integrate CCAC case managers in inpatient and ED, and support increased case management and home support workers.

Monitor and Improve Access, Quality and Performance

- 8. Establish Provincial Emergency Department Information System.**
9. Increase the number and type of ED indicators (monitoring, performance, developmental) in the HAPS agreements.
10. Conduct an ED chart review to evaluate quality of care.
- 11. Hire ED leads in each of the 14 LHINs and establish Emergency Services System Working Groups in each LHIN.**



52

ALC Brainstorming Session (Smith)

Main Messages

- If the province is to achieve the goal of reducing ER wait times, it must reduce the number of ALC patients across the system
- ALC is a multi-sectoral issue that spans the continuum of care, however, we must support the government's key priority which is to reduce ER Wait Times
- Immediate action is required



53

ALC Brainstorming Session (Smith) Had 15 Actions

Actions to Develop Provincial Policies that Align with Provincial Priorities

1. ***Change regulations to eliminate caps on maximum homemaking, personal support and nursing hours/services that CCACs can provide. (High Priority)***
2. Change regulations placing people in LTC homes to enable placement in the first available appropriate level of care setting. (High Priority)
3. ***Change LTC eligibility, placement and admission criteria so more complex and vulnerable residents are admitted to LTC, and less complex to more appropriate settings.***

Actions to Avoid Unnecessary Admissions and Support Discharge

4. ***Support community day programs/services to prevent LTC need.***
5. ***Create outreach teams that can complete home assessments 24 hours a day, 7 days a week.***



54

ALC Brainstorming Session (Smith) Had 15 Actions

Actions to Avoid Unnecessary Admissions and Support Discharge

- 6. Enhance timely access to 24/7 diagnostic tests in the community for residents of LTC homes, CCC facilities and convalescent care.**
7. Expand convalescent care to enable more patients to stabilise and transition from acute care to home care.
- 8. Support appropriate staffing standards for LTC homes and other settings such as supportive housing.**
9. Require hospitals to refer complex and vulnerable ER patients with no family physician to a FP or family health team upon discharge from the ER or hospital.
- 10. Support hospital ER care teams made of interdisciplinary staff with specialised skills in geriatric medicine, mental healthcare and other areas to prevent unnecessary admission of potential ALC patients.**



55

ALC Brainstorming Session (Smith) Had 15 Actions

Actions to Maximize Capacity

- 11. Identify and support physical plants capable of converting to temporary long-term care services. (High Priority)**
12. Require redeveloping LTC facilities to continue operating all beds while site is brought to current standards. Give priority to facilities in LHINs with the most severe ALC problems. (High Priority)
13. Dedicate funds to supplement retirement homes or preferred accommodation rates in LTC as an interim solution until appropriate services are obtained in LHINs with high ALC rates.

Actions to Support Continuous Performance Improvements

- 14. Develop provincial ER/ALC information strategy. (High Priority)**

Actions to Support Clear Accountabilities for Results

15. Identify clear accountabilities for improving access to ER services and reducing ER wait times by reducing the number of ALC patients and days in acute care hospitals.



56

IT Foundation: eHealthOntario



57

***eHealth Ontario* Supports the Government's Health Strategy Through Modernization and Clinical Impact**

- The Ontario government created a *new* agency, *eHealth Ontario*, to support its health strategy which is focused on diabetes and improved patient care and safety.
- It is critical to implement the Ontario government's health strategy, even in *challenging economic times*, in order to *modernize* the healthcare system to make it *sustainable* in the long run.
- *eHealth Ontario* is committed to delivering *clear, measurable, and transparent results*.
- *eHealth Ontario* is building a plan focused on achieving *excellence*. This means ensuring that priority initiatives yield results for patients and that the services to support new systems always meet customer needs.



58

If Patients Do Not Benefit From our Systems, Then Those Systems are Not Worth Pursuing

eHealth Ontario's major priorities are:

- Ensuring that people with diabetes receive top quality care by providing them with the electronic tools to manage their condition and receive the best care possible.
- Reducing medication errors through an e-prescribing system that eliminates hand-written prescriptions.
- Providing patients and providers with easy and secure access to information they need to receive and deliver care through an online portal.

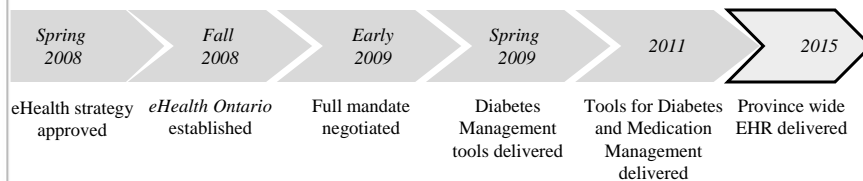
***eHealth Ontario* is not about technological achievement.
It is about clinical outcomes.**



59

eHealth Ontario Will Oversee the Development of a Province-Wide Electronic Health Record System by 2015

Major Milestones



The results *eHealth Ontario* delivers will improve patient care, quality and safety



60

By Working Together, We Will Realize Our Potential

- For the first time, Ontario has a *province-wide e-health strategy*.
- With *eHealth Ontario*, we now have a *single organization* responsible for executing that strategy.
- *eHealth Ontario* represents a new and critical phase in the province's e-health journey.
- This journey will require *tremendous effort by many people working together* for a united vision.
- We can transform and modernize the Ontario healthcare system by tapping into *locally proven e-health solutions* that may be developed and managed across the province.



61

Final Words



62

**Additional Information to be Provided in the Session
Moving Forward: Ontario's ER Wait Time Strategy**

- Pay-for-Results Program
- ED Process Improvement Program
- Patient Satisfaction Program
- Aging at Home
- ALC Information Management/Information Technology
- Transitional Capacity



63

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64