

**MOHLTC - HSAPD
ER/ALC Quarterly Stocktake Report**

LHIN: Central East LHIN

Report Date: July, 2009

SYSTEM FOCUS: Reduce time spent in the ER across Ontario

What is the problem?

Almost 50% of ER visits are made by patients with non-urgent or less urgent needs

Time spent in the ER is too long: 90% of patients are treated within 9.4 hours from triage to discharge

Time in the ER is five times longer for ER patients admitted to hospital (35 hrs); 75% of their total ER time (26 hrs) is spent waiting for an inpatient bed

GOALS

What are we striving to achieve?

1 Reduce ER demand
 Reducing the number of non-urgent cases that present at the ER will enable emergency clinicians to focus on patients with critical needs

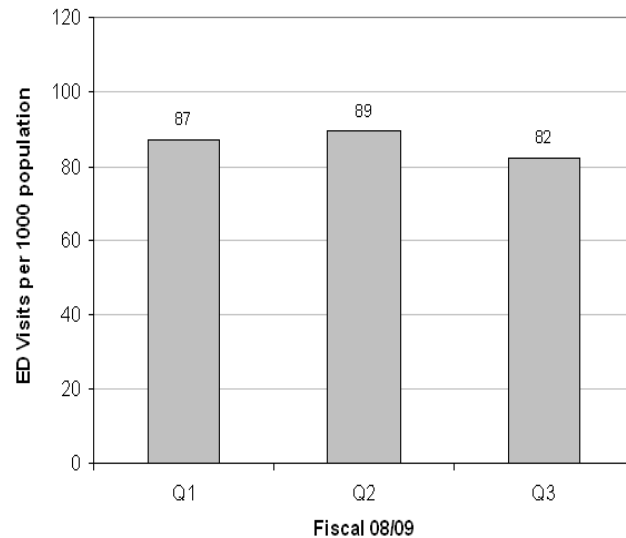
2 Increase ER capacity/performance
 Improving triage and admission processes and reducing ambulance offload times will enable emergency clinicians to provide more efficient care

3 Improve Bed Utilization
 Improving bed utilization expedites patient throughput and maximizes hospital capacity

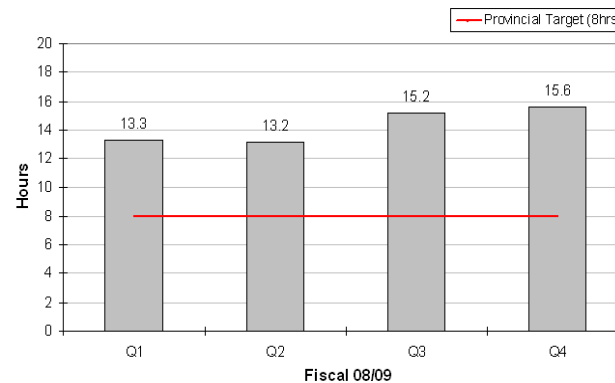
PROGRESS

Have we achieved our goals?

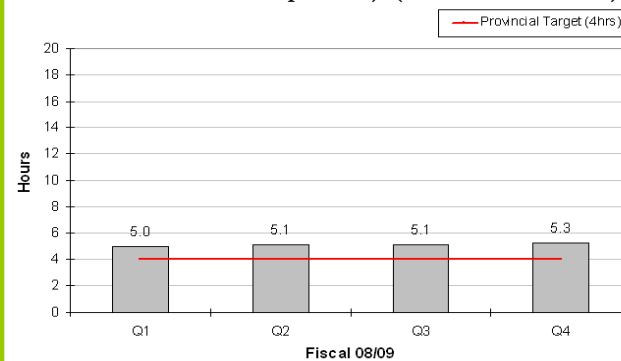
Number of ER Unscheduled Visits by quarter per 1000 population (Data Source: MoHLTC Provincial Health Planning Database & CIHI-NACRS)



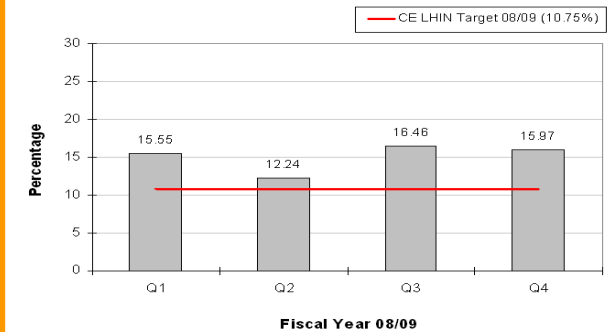
Time spent in the ER for high acuity patients (all admitted + non-admitted CTAS I, II, III patients). (Data Source: EDRS)



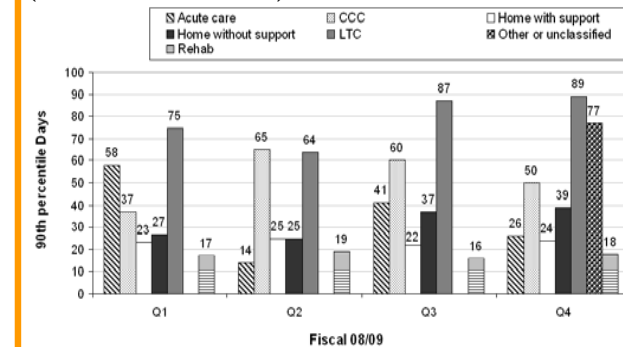
Time spent in the ER for low acuity patients (non-admitted CTAS IV & V patients). (Data Source: EDRS)



Percentage ALC Days (Data Source: CIHI-DAD)



Proposed Measure: Number of days from ALC designation to discharge by discharge destination (90th percentile Days) (Data Source: CIHI-DAD)



Note: Patients discharged against medical advice and those who died are excluded from analysis. Q1, Q2, Q3 and Q4 08/09 has not been finalized by CIHI. LHIN target TBD.

HIGHLIGHTS

Evidence of achievements and/or obstacles to progress

- The CE LHIN number of ER Unscheduled Visits by quarter per 1000 population decreased in Q3 FY2008 and was the lowest compared to Q1 and Q2. It is lower than the provincial number by 10 points.
- In Q3, the CE LHIN continued to have the 5th lowest number of ER Unscheduled Visits in the province.

- Time spent in the ER increased slightly for both high and low acuity patients from Q3 to Q4, consistent with the provincial trend.
- Time spent in the ER for both high and low acuity patients in the CE LHIN is higher than the provincial average.

- Percent ALC days increased from Q2 to Q3, but decreased slightly from Q3 to Q4. This measure remains above the provincial target, but has moved from being slightly above the provincial value in Q3 to substantially below it in Q4.
- CE LHIN ALC days is greatest for patients discharged to Long Term Care, consistent with provincial trends. The LTHC destination bars show a very similar pattern to the overall ALC summary graph.

	Interventions	Page
Reduce ER demand	➤ Aging at Home (AAH) and Urgent Priorities Fund (UPF)	Page 7
Increase ER capacity/performance	➤ Pay-for-Results (P4R) Y1 ➤ Pay-for-Results (P4R) Y2	Page 8 Page 9
Improve Bed Utilization	➤ Aging at Home (AAH) and Urgent Priorities Fund (UPF)	Page 10

LEGEND: Interpreting intervention performance

Supplementary Measures	Baseline	Target	Quarterly Performance	Key Considerations
<ul style="list-style-type: none"> A set of measures associated with a specific intervention/strategy that are indirectly linked to one or more overarching goals of the strategy 	The determined baseline will be inserted here and will remain the same each quarter	The determined target will be inserted here and will remain the same each quarter	<p>Illustrates current performance with respect to the supplementary measure against defined targets. Graphs/charts are inserted by Access to Care.</p> <p>The red, amber and green color coding of performance results is a visual guide that allows users to easily identify their performance relative to the specified target for a particular indicator; there will be a selected target for each supplementary measure associated with an intervention. Indicators included in the MLAA will be coloured accordingly to the LHIN corridors.</p> <div style="display: flex; flex-direction: column; gap: 5px;"> <div style="background-color: #008000; color: white; padding: 2px; text-align: center;">Doing Well – Below Corridors & LHIN Starting Point</div> <div style="background-color: #00b0f0; color: white; padding: 2px; text-align: center;">Improving – In Corridors & Equals or below LHIN Starting Point</div> <div style="background-color: #ffff00; color: black; padding: 2px; text-align: center;">Monitor – In Corridors & above LHIN Starting Point</div> <div style="background-color: #ff0000; color: white; padding: 2px; text-align: center;">Attention – Above Corridors, Reporting Required</div> </div> <p>Additional indicators will be coloured according to the following corridors.</p> <p>Green: performance result meets or exceeds the specified target</p> <p>Amber: performance result is less than or equal to 10% from the specified target</p> <p>Red: performance result is more than 10% from the specified target</p>	Explains current performance and what proposed changes could be put in place to improve performance. Information is inserted by LHIN. (These are guiding questions only)

CENTRAL EAST LHIN

Goal: Reduce ER Demand

Aging at Home (AAH)

- ◆ Caregiver supports – Respite program expansion; 2 Caregiver Support Centres
- ◆ Community support services – multiple program expansions
- ◆ Supportive Housing – 150 new units
- ◆ First Link program re: Alzheimer Disease
- ◆ Community Based Multi-Disciplinary Palliative Care Team in Scarborough
- ◆ 9 GEM Nurses

UPE

- ◆ Chronic Kidney Disease (CKD) Early Intervention and Outreach
- ◆ Self-Management Training for Consumers and Caregivers
- ◆ Comprehensive Vascular Disease Prevention and Management Initiative
- ◆ Unattached Patient Assessment Initiative
- ◆ Timely Discharge Information System

- ◆ Nurse Practitioner Outreach to Long-Term Care Homes
- ◆ WRAP (Wellness Recovery Action Plan) for patients with Mental Health conditions
- ◆ Community Mental Health Crisis Response Teams (P4R)
- ◆ CCAC Case Manager in the ED (P4R)



Supplementary Measures	Quarterly Performance	Key Considerations								
Number of ER Unscheduled Visits by quarter per 1000 population	<table border="1" style="margin: 10px auto; border-collapse: collapse;"> <caption>ED Visits per 1000 population - Fiscal 08/09</caption> <thead> <tr> <th>Quarter</th> <th>ED Visits per 1000 population</th> </tr> </thead> <tbody> <tr> <td>Q1</td> <td>87</td> </tr> <tr> <td>Q2</td> <td>89</td> </tr> <tr> <td>Q3</td> <td>82</td> </tr> </tbody> </table> <p>(Data Source: MoHLTC Provincial Health Planning Database & CIHI-NACRS)</p>	Quarter	ED Visits per 1000 population	Q1	87	Q2	89	Q3	82	<p>Past (pre-Q3 2008):</p> <ul style="list-style-type: none"> The number of ER Visits per Quarter per 1000 population decreased substantially in Q3 FY2008 compared to Q1 and Q2. However, there was not a corresponding lower average length of stay for ED patients. CE LHIN planned and implemented a number of initiatives funded through Aging at Home and Urgent Priority Funding to divert visits from the ED – primary among these was the Self-Management Training which has trained 450 consumers and caregivers in strategies to avoid visiting health care providers. Opened 4 new CHC's which were functioning in this period. There will be a ramp-up period to full capacity. Lags in implementation in multiple initiatives have led to inevitable lags in impact into FY2009 (e.g., CKD screening for Aboriginals (Q2); NP Outreach (Q3); CHC staffing (continuing)). <p>Current (Q3 2008):</p> <ul style="list-style-type: none"> CE LHIN numbers have followed the same trend as the province, but with overall lower numbers (provincial numbers were 100, 102, and 96 in the three quarters measured). CE LHIN continues to work with CCAC, the CE LHIN ED Task Group, and the ED Avoidance Coalition to implement initiatives to address ED demand. ED Avoidance Coalition focuses on Mental Health patients at LHO, the hospital with the highest frequency of visits from these patients (over 5000 visits in FY2007). CE LHIN plan is to spread coalition short-term impact and sustainable process methodology to other high user groups, such as frail seniors. There are an estimated 86,000 unattached patients in CE LHIN for FY2008 (highest in the province), and 1100 family physicians (5th lowest in the province for FTE's per 10,000 population). <p>Future (Q4 and beyond):</p> <ul style="list-style-type: none"> CE LHIN residents spent approximately 14,000 more hours in the ED from Q2 to Q3 FY2008. Our IHSP strategy is to save 1,000,000 hours of ED wait time by 2013 with a focus on simultaneous reduction of ED demand, improving ED capacity and performance, and improving bed utilization, while enhancing quality of care. Overlaying this goal is the Triple Aim framework—targeting, in equal measures, population health, patient experience, & per capita cost. CE LHIN will continue to work with the IHI ED Avoidance Coalition to address ED demand and LOS at all 14 CE LHIN hospitals. CCAC Deficit – fiscal pressure impacts staffing levels, creates wait lists, reduces ability of CCAC to provide timely support and creates accompanying ALC days for hospital based patients. NP Outreach Team – expected to divert up to 2000 clients on an annualized basis but long implementation process across 3 sub-LHIN planning areas. Expected impact in Q3 and Q4 of FY2009, but staffing is proving challenging—there are few NP's to recruit, and those available are inexperienced. P4R monthly reporting tool will be adopted for all LHIN initiatives and measure contribution of initiative outputs to system-level outcomes. CCAC Case Manager in the ED—has supported 257 additional clients in Q4 facilitating services and avoiding repeat ED visits and admissions at RVC. Expanded to LHB and LHO in Q1/Q2 FY2009.
Quarter	ED Visits per 1000 population									
Q1	87									
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CENTRAL EAST LHIN

Goal: Increase ER Capacity/Performance

Intervention: ER Pay for Results Year 1 –NOTE: TSH has been targeted for recovery of P4R funds by the Ministry. The CE LHIN has submitted an argument against recovery based on achievement of results post the performance measurement dates.

TSH:
 1. Rapid Assessment Zone (RAZ): Area within the Emergency Department to assess/diagnose and treat ambulating CTAS 3 patients in the ED.
 2. Rapid Admission Unit (RAU): 24 hour inpatient unit for patients who are admitted from ED or who are transferred from other inpatient units if there is less than 24 hours left in their stay
 (Increased Ancillary Support & LEAN methodology were necessary supportive measures to implement the RAZ and RAU)

RVHS:
 1. Rapid Assessment Zone. Dedicated area and staffing in the rapid assessment and treatment of ambulatory CTAS III, IV and V patients.
 2. Dedicated CECCAC Case Manager for the ED. To provide increased access for identified ED patients to CECCAC services.
 3. Nursing Staff Education. Support for nursing staff to obtain specialized training in formal academic institutions with a specific focus on critical care/emergency nursing.
 * LEAN methodology implementation (not funded by P4R)



Supplementary Measures	Baseline (Q3/Q4 07/08)	Target	Current Performance	Quarterly Performance (Data Source: EDRS)	Key Considerations															
Proportion of ED-LOS exceeding 24 hrs	4%	No more than 2% of total volume by end of FY 08/09	4%	<table border="1"> <caption>ED-LOS exceeding 24 hrs (Fiscal 08/09)</caption> <thead> <tr> <th>Quarter</th> <th>Rouge Valley Health System - Centenary (%)</th> <th>Scarborough Hospital (The)=Scar.Gen.Site (%)</th> </tr> </thead> <tbody> <tr> <td>Q1</td> <td>5%</td> <td>3%</td> </tr> <tr> <td>Q2</td> <td>4%</td> <td>4%</td> </tr> <tr> <td>Q3</td> <td>5%</td> <td>4%</td> </tr> <tr> <td>Q4</td> <td>5%</td> <td>3%</td> </tr> </tbody> </table>	Quarter	Rouge Valley Health System - Centenary (%)	Scarborough Hospital (The)=Scar.Gen.Site (%)	Q1	5%	3%	Q2	4%	4%	Q3	5%	4%	Q4	5%	3%	<p>Although neither CE LHIN hospital selected for Pay for Results Year 1 funding met the Ministry goal of 2% by the end of FY 08/09, The Scarborough Hospital showed improvement from Q3 to Q4, and has met the goal (1.7%) by Q1 of FY2009 (June). This success is attributed to the implementation of the Rapid Admission Unit (RAU) and the Rapid Assessment Zone (RAZ) implemented concurrently with relocation, renovation, and reopening of the Scarborough ED.</p> <p>At Rouge Valley Centenary, performance was affected by acute care bed reductions related to the Deficit Elimination Plan. The expectation based on current practices is that the negative trend will flatten and then gradually improve as the organization adjusts to the reduced bed base. Strategies in place to achieve this improvement include continuation of the Ambulatory Care Unit, as well as implementation of the dedicated CCAC Case Manager in the ED, continued development and implementation of orders sets, and LEAN methodology improvements throughout the organization. RVHS is also in the process of developing a new flow policy to manage overcapacity and surge volumes.</p>
Quarter	Rouge Valley Health System - Centenary (%)	Scarborough Hospital (The)=Scar.Gen.Site (%)																		
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Q2	4%	4%																		
Q3	5%	4%																		
Q4	5%	3%																		
Proportion of CTAS I & II patients treated within ≤8 hours and within ≤6 hours for CTAS III	63%	5% Improvement in Q3/Q4 07/08	62%	<table border="1"> <caption>CTAS I & II patients treated within 8 hours (Fiscal 08/09)</caption> <thead> <tr> <th>Quarter</th> <th>Rouge Valley Health System - Centenary (%)</th> <th>Scarborough Hospital (The)=Scar.Gen.Site (%)</th> </tr> </thead> <tbody> <tr> <td>Q1</td> <td>62%</td> <td>57%</td> </tr> <tr> <td>Q2</td> <td>65%</td> <td>58%</td> </tr> <tr> <td>Q3</td> <td>69%</td> <td>56%</td> </tr> <tr> <td>Q4</td> <td>68%</td> <td>57%</td> </tr> </tbody> </table>	Quarter	Rouge Valley Health System - Centenary (%)	Scarborough Hospital (The)=Scar.Gen.Site (%)	Q1	62%	57%	Q2	65%	58%	Q3	69%	56%	Q4	68%	57%	<p>The Scarborough Hospital's performance in reducing wait times or CTAS I-III patients were hampered by leadership disruptions, a downward trend that continued beyond the baseline period, staffing and fiscal issues, and an antiquated physical plant.</p> <ul style="list-style-type: none"> Since establishment of the RAU and RAZ, the negative trend has been reversed, and although Q3/Q4 FY2008 goals were not met, the hospital is on track to meet these goals in Q1 2009 (as indicated in the Pay for Results Performance Assessment submitted to the Ministry on 10 August). <p>Rouge Valley Centenary has experienced 3.7% absolute improvement from the Q3/Q4 2007 baseline of 64.7% to the Q3/Q4 FY2008 actual of 68.4%</p> <ul style="list-style-type: none"> Early improvements from October through March can be attributed to additional staffing added for the Ambulatory Care Area, increased physician coverage, and LEAN process improvements. In Dec 08, physician coverage increased from 24 to 29.5 hours daily. Physical geography of the ED reduced available bed space and limited flow—construction begun in March 2009 to solve this problem initially further reduced available space. Ambulatory care unit completed in May, 2009 has improved ED performance, and hospital is on track to achieve goals, although beyond the program timelines.
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Proportion of CTAS IV and V patients treated within ≤4 hours	69%	Stable or increasing by end of FY 08/09	70%	<table border="1"> <caption>CTAS IV and V patients treated within 4 hours (Fiscal 08/09)</caption> <thead> <tr> <th>Quarter</th> <th>Rouge Valley Health System - Centenary (%)</th> <th>Scarborough Hospital (The)=Scar.Gen.Site (%)</th> </tr> </thead> <tbody> <tr> <td>Q1</td> <td>61%</td> <td>76%</td> </tr> <tr> <td>Q2</td> <td>64%</td> <td>75%</td> </tr> <tr> <td>Q3</td> <td>69%</td> <td>74%</td> </tr> <tr> <td>Q4</td> <td>68%</td> <td>72%</td> </tr> </tbody> </table>	Quarter	Rouge Valley Health System - Centenary (%)	Scarborough Hospital (The)=Scar.Gen.Site (%)	Q1	61%	76%	Q2	64%	75%	Q3	69%	74%	Q4	68%	72%	<p>Both CE LHIN Pay for Results Year 1 hospitals showed slight improvement from their baseline performance for proportion of CTAS IV and V patients treated within ≤ 4 hours. Continuation of the RAZ and RAU at TSH, and the RAZ and CCAC Case Manager at RVHS established in year one are expected to improve this performance through year 2.</p> <ul style="list-style-type: none"> The Scarborough Hospital's performance remained steady, from the Q3/Q4 FY2007 baseline of 71.1% to the Q3/Q4 FY2008 actual of 72.4% Rouge Valley Centenary has experienced 1.9% absolute improvement from the Q3/Q4 FY2007 baseline of 66.2% to the Q3/Q4 FY2008 actual of 68.1%
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CENTRAL EAST LHIN

Goal: Increase ER Capacity/Performance

Intervention: ER Pay for Results Year 2 – Performance fund allocated Q3 FY 2008: \$525,000

<p><u>Community Based</u></p> <p>MH Crisis Response and Community Beds: \$742,500 (LHC/RVAP) Transition Beds: \$792,000 (LHC) Wrap Around: \$200,000 (Ross) NP-Urgent Transportation: \$65,000 (all sites) NP Outreach: \$100,000 (LHC/RVHS/TS/SH)</p>	<p><u>Hospital Based</u></p> <p>RVHS Centenary – \$686,000 TSH General – \$631,500 LHC Bowmanville – \$271,400 LHC Oshawa - \$1,443,300 Ross Memorial – \$560,000 RVHS Ajax/Pickering - \$752,000</p>
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Initiatives expected to affect these measures

◆ LEAN processes (Ross/RVHS)	◆ Corporate Patient Flow Improvement Team (LHC)
◆ Ambulatory Care Area (RVHS)	◆ CCAC Case Manager in ED (LHC/RVC)
◆ Inpatient Admission Unit (Ross)	◆ Patient Relations Representatives and Patient Navigators (TSH)
◆ Physician Assistant (Ross)	<u>Non P4R Initiatives</u>
◆ Nurse Practitioner (Ross)	◆ ED PIP (TSH)
◆ Rapid Assessment Clinic (LHC)	◆ FLO Spread (Ross/LHC)

General Notes

- ◆ Improvement guidelines make recovery almost inevitable for some hospitals performing at or above the provincial target of 90% for non-admitted patients at baseline. CE LHIN will be examining mid-year re-allocation possibilities for these hospitals



- ◆ CE LHIN, in collaboration with other LHINs, has developed a reporting template to track monthly performance and financial status of initiatives and to extrapolate the results of each program to a system-level outcome

Supplementary Measures	Baseline Fiscal 08/09	Target	Current Performance	Quarterly Performance (Data Source: EDRS)	Key Considerations																																			
<p>Proportion of admitted patients treated within the LOS target of ≤ 8 hours</p>	30%	10 point improvement in percentage	28%	<p style="text-align: center;">Fiscal 08/09</p>	<p>Tentative Goals for Designated Hospitals</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th>Hospital</th> <th>Baseline</th> <th>Goal</th> <th>Improvement</th> <th>Improvement Needed from Q4 Actual</th> </tr> </thead> <tbody> <tr> <td>RVHS Centenary</td> <td>31%</td> <td>41%</td> <td>10%</td> <td>14%</td> </tr> <tr> <td>TSH General</td> <td>31%</td> <td>41%</td> <td>10%</td> <td>10%</td> </tr> <tr> <td>LHC Bowmanville</td> <td>53%</td> <td>63%</td> <td>10%</td> <td>21%</td> </tr> <tr> <td>LHC Oshawa</td> <td>28%</td> <td>43%</td> <td>15% (targeted to improve <10% in non-admitted)</td> <td>18%</td> </tr> <tr> <td>Ross Memorial</td> <td>26%</td> <td>40%</td> <td>14% (targeted to improve <10% in non-admitted)</td> <td>13%</td> </tr> <tr> <td>RVHS Ajax/Pickering</td> <td>23%</td> <td>38%</td> <td>15% (targeted to improve < 10% in non-admitted)</td> <td>21%</td> </tr> </tbody> </table> <ul style="list-style-type: none"> • Baseline trends for all hospitals except Ross Memorial have been negative. • Q4 measures are below established baseline for LHO, LHB, RVC, and RVAP. • Baselines are relatively low compared to non-admitted for all hospitals, and especially low for RVAP (Q4 17%). There is room for significant improvement in this measure, and performance targets have been adjusted away from non-admitted categories for some hospitals to address this. • Bed closures at LHC and RVHS stemming from deficit elimination plans and the requirement not to decrease surgical volumes may hamper results for this measure. • Community Mental Health beds will save over 1000 admissions in Q3/Q4. 	Hospital	Baseline	Goal	Improvement	Improvement Needed from Q4 Actual	RVHS Centenary	31%	41%	10%	14%	TSH General	31%	41%	10%	10%	LHC Bowmanville	53%	63%	10%	21%	LHC Oshawa	28%	43%	15% (targeted to improve <10% in non-admitted)	18%	Ross Memorial	26%	40%	14% (targeted to improve <10% in non-admitted)	13%	RVHS Ajax/Pickering	23%	38%	15% (targeted to improve < 10% in non-admitted)	21%
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<p>Proportion of non-admitted high acuity patients treated within their respective targets of ≤ 8 hours for CTAS I-II and ≤ 6 hours for CTAS III</p>	83%	10 point improvement in percentage	84%	<p style="text-align: center;">Fiscal 08/09</p>	<p>Tentative Goals for Designated Hospitals</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th>Hospital</th> <th>Baseline</th> <th>Goal</th> <th>Improvement</th> </tr> </thead> <tbody> <tr> <td>RVHS Centenary</td> <td>75%</td> <td>85%</td> <td>10%</td> </tr> <tr> <td>TSH General</td> <td>66%</td> <td>76%</td> <td>10%</td> </tr> <tr> <td>LHC Bowmanville</td> <td>95%</td> <td>98%</td> <td>3% (10%)*</td> </tr> <tr> <td>LHC Oshawa</td> <td>90%</td> <td>95%</td> <td>5% (targeted to improve >10% in admitted)</td> </tr> <tr> <td>Ross Memorial</td> <td>82%</td> <td>90%</td> <td>8% (targeted to improve >10% in admitted)</td> </tr> <tr> <td>RVHS Ajax/Pickering</td> <td>88%</td> <td>95%</td> <td>7% (targeted to improve >10% in admitted)</td> </tr> </tbody> </table> <ul style="list-style-type: none"> • Baseline trends for all hospitals have been essentially flat except RVC, which showed consistent marginal improvement. • Increased ED volume at RVC Q1/Q2 is not defined by any particular group, but is broad-based. This increase may represent patient self-selection to RVC because of improvements caused by Ambulatory Care Unit (also true for low acuity non-admitted patients). • *Achievement of 98% in any category will be measured as having achieved 10% improvement. 	Hospital	Baseline	Goal	Improvement	RVHS Centenary	75%	85%	10%	TSH General	66%	76%	10%	LHC Bowmanville	95%	98%	3% (10%)*	LHC Oshawa	90%	95%	5% (targeted to improve >10% in admitted)	Ross Memorial	82%	90%	8% (targeted to improve >10% in admitted)	RVHS Ajax/Pickering	88%	95%	7% (targeted to improve >10% in admitted)							
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<p>Proportion of non-admitted low acuity patients treated within the LOS target of ≤ 4 hours</p>	81%	10 point improvement in percentage	80%	<p style="text-align: center;">Fiscal 08/09</p>	<p>Tentative Goals for Designated Hospitals</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th>Hospital</th> <th>Baseline</th> <th>Goal</th> <th>Improvement</th> </tr> </thead> <tbody> <tr> <td>RVHS Centenary</td> <td>67%</td> <td>77%</td> <td>10%</td> </tr> <tr> <td>TSH General</td> <td>76%</td> <td>86%</td> <td>10%</td> </tr> <tr> <td>LHC Bowmanville</td> <td>93%</td> <td>98%</td> <td>5% (10%)*</td> </tr> <tr> <td>LHC Oshawa</td> <td>87%</td> <td>97%</td> <td>10%</td> </tr> <tr> <td>Ross Memorial</td> <td>82%</td> <td>90%</td> <td>8% (targeted to improve >10% in admitted)</td> </tr> <tr> <td>RVHS Ajax/Pickering</td> <td>83%</td> <td>91%</td> <td>8% (targeted to improve >10% in admitted)</td> </tr> </tbody> </table> <ul style="list-style-type: none"> • Baseline trends for all hospitals have been essentially flat except RVC, which showed relatively consistent marginal improvement. • LHIN Physician Collaboration Incentive fund may also have an impact on this measure. • *Achievement of 98% in any category will be measured as having achieved 10% improvement. 	Hospital	Baseline	Goal	Improvement	RVHS Centenary	67%	77%	10%	TSH General	76%	86%	10%	LHC Bowmanville	93%	98%	5% (10%)*	LHC Oshawa	87%	97%	10%	Ross Memorial	82%	90%	8% (targeted to improve >10% in admitted)	RVHS Ajax/Pickering	83%	91%	8% (targeted to improve >10% in admitted)							
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CENTRAL EAST LHIN

Goal: Improved Bed Utilization

AAH Funding:

- ◆ LHIN-wide Home at Last program
- ◆ Supportive Housing
- ◆ Community Palliative Care Services
- ◆ 9 GEM Nurses
- ◆ Comprehensive Geriatric Assessment in the Community program (planned)

◆ Home at Last

UPF:

- ◆ ALC Client Activation (RMH)
- ◆ ALC Assessment and Coaching Team (PRHC)
- ◆ NP Outreach to Long-Term Care Homes (3)
- ◆ Transitional Care Unit (LHC)

Other

- ◆ FLO Spread Strategy
- ◆ Community Treatment Orders Program Expansion



Supplementary Measures	Baseline	Target	Current Performance	Quarterly Performance	Key Considerations
Percentage ALC Days	14.10% <small>Q4 FY06/07, Q1-Q3 FY07/08</small>	10.75%	15.97%	<p style="text-align: center;">Fiscal Year 08/09</p> <p style="text-align: center;">Data Source: CIHI-DAD</p>	<p>Past (pre-Q4 2008):</p> <ul style="list-style-type: none"> In June 2008, the ALC Task Group tabled their report with 56 recommendations. The profile of this report catalyzed a number of hospital based initiatives which may have improved patient flow and discharge of ALC patients. Initiatives in place during this period included GEM nurses (7), LEAN methodology, the FLO Collaborative, and ALC Client Activation. <hr/> <p>Current (Q4 2008):</p> <ul style="list-style-type: none"> This measure remains above the provincial target of 10.75%, but has moved from being slightly above the provincial value in Q3 to substantially below it in Q4. No new bed capacity had become available as of Q4 of FY2008. The number of CE LHIN ALC days for patients discharged to Long Term Care is the longest, and has followed the provincial trends. The number of days for patients discharged to "home without support" has also increased steadily. Throughout the year, a concurrent priority has been on surgical volumes and wait times. Even though the LTHC pattern has a correlation to the overall ALC summary, in Q4, LTHC went up while ALC went down, potentially reflecting an improved community response. Strategies underway to address this measure include NP Outreach Team, GEM nurses (increased to 9), and Home At Last (Durham & Scarborough implemented, additional sites to be implemented in Q1 FY2009). <hr/> <p>Future (Q1 2009 and beyond):</p> <ul style="list-style-type: none"> System Capacity: 20 Transitional Care Unit beds planned for Q1, 6 Community Mental Health Crisis beds (Q3), 7 (minimum) supportive housing dedicated ALC beds and 23 additional units for Q2-Q4. Wrap Around – project has supported early discharges from inpatient beds, including ALC and ER. There has been a lag in full impact which is anticipated for Q3. LHIN-wide implementation of Home at Last - 200 settlements – avoiding approximately 15.8 hours hospital stay per settlement. Transitional Care Unit – early success indicates avoidance of approximately 600 hospital patient days per month, primarily ALC days but also ED admitted patients FLO Spread Strategy – 3 hospitals participating in this initiative. Recommendations from ALC Assessment & Coaching Team expected to have Q2/Q3 impact. LEAN – large spread of Lean process improvements, especially RVHS, at which 41 of 44 departments and 442 volunteers/staff/physicians have participated in events. P4R monthly reporting tool will be adopted for all LHIN initiatives and measure contribution of initiative outputs to system-level outcomes. Mental Health Community Treatment Orders Program will improve bed utilization and influence admission length of stay for mental health patients.
Number of days from ALC designation to discharge by discharge destination	41 Days <small>Q1-Q4 FY 07/08</small>	TBD	43 Days	<p style="text-align: center;">Q4 08/09</p> <p style="text-align: center;">Data Source: CIHI-DAD</p>	