

Having Their Say and Choosing Their Way Project

Catch 22

Report 2: People's experience going to long-term care after being hospitalized.



THE CHANGE FOUNDATION
HEALTH CARE DESERVES OUR FINEST THOUGHT



Executive Summary

More and more Ontarians are struggling with the stress, confusion, and uncertainty of deciding on and finding the right accommodation for themselves - or a loved one - when leaving hospital. Patients are remaining in the hospital when they should be receiving care elsewhere. In the process of leaving to a long-term care home (LTCH), they are feeling unfairly treated by a system of access lacking in transparency.

The purpose of 'Having Their Say and Choosing Their Way' project is to help funders and providers of care more deeply understand the experience of the client during the 'hospital to home' transition. This transition takes place thousands of times each month in Ontario. If we understand the experience of some of these patients, we can think about the changes needed to make everyone's experience better.

Value from the Patient/ Family Caregiver Perspective

21 patients who were discharged from University Health Network (UHN)-Toronto Western (6) and Quinte Health Care (15), to long-term care homes, told investigators what helped and what was lacking in this journey. People have a common idea of what is important:

"I want help getting accurate information that I can understand at the right time and place, including viable options, so my family and I can make the right decision for us. I want to feel confident that people care and to be treated with fairness and respect."

In contrast, people also expressed what they didn't want to happen.

"I don't want to make a decision out of fear, inadequate care, or surprises"

Applying this value statement rigorously and throughout the entire process exposes areas where deficiencies occur:

Deficiency # 1 : Inaccurate and unavailable Information

Deficiency # 2 : The system of access is incomprehensible to families

Deficiency # 3 : Preplanning doesn't occur

Deficiency # 4 : Compromised care

Deficiency # 5 : Confusing financial messages

Deficiency # 6 : Insufficient help for the family

It should be noted that patients and caregivers spoke very highly of the *people* providing care, and acute care services, frequently praising their efforts. This underscores the need to focus on *process* improvement, engaging front-line workers in this effort.

Improving the experience of clients and families going from hospital to LTCH would involve:

- Proactively planning future care and accommodation options for the aging, before crises occur. Making life choices from a pressurized acute setting is best viewed as a system failure
- Improving the understanding of long-term care and supportive care options by all providers who come into contact with seniors and their families.
- Improving the information about long-term care Homes (LTCHs), including their features, quality, and wait times such that it can be clearly and helpfully presented to families.

- Systematically presenting other care options such as retirement homes, home care, other community services and private pay options in a service-oriented manner.
- Eliminating the over-processing of information by community care personnel, redirecting them towards a better client and family experience and less to the organizational or provincial administrative requirements. Focus on reducing over-processing of information in processes that span organizations to gain the greatest benefit.
- Simplifying access by overhauling regulations associated with LTCHs and changing regional long-term care home priority access policies. Current policies are contributing to prolonged hospital stays, compromised care and confusion for people who need long-term care.

Why the title ‘Catch 22?’ The novel Catch-22 involves bureaucratic regulations and circular reasoning, where administrative matters trump those affecting life and death. Bureaucratic rules, in the book, put people in the classic ‘no-win’ situation. When a family described the choices they made leaving hospital as a ‘Catch-22’ it was deemed an appropriate title for this report. Families encounter a very complex process requiring life-changing trade-offs with information that is often more meaningless than genuine.

If the hospital to LTCH process is an important process, then it requires awareness, alignment, and a client/ patient focus across organizations. With this, employees would feel a sense of mission in serving the needs of the final customer.

Report Organization

We studied two processes at two separate sites in Ontario. Each process has its own report:

Sites Involved	Report 1 ‘Hospital to Home Care’ Transition	Report 2 ‘Hospital to LTCH’ transition
<u>Toronto Central Region</u> Toronto Western Hospital + Toronto Central CCAC	√	√
<u>South East Region</u> Trenton Memorial Hospital + South East CCAC	X	√

In this document, **Report 2**, we examine the ‘hospital to long-term care home’ transition.

Site Acknowledgements

The leadership of Toronto Western Hospital (TWH), Quinte Health Care – Trenton Memorial, South East Community Care Access Centre and Toronto Central Community Care Access Center are to be congratulated. By opening their doors, and sharing access to the people they serve, and their staff, they are demonstrating leadership in quality improvement. This is not easy. However, this kind of courage will be what fuels the ongoing changes needed to transform and integrate health care in Ontario.

The project involved front line staff, management, and technical advisors at each site, from all related organizations with project management provided by Doleweerd Consulting.

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1. Introduction

Having Their Say and Choosing Their Way is a project funded by The Change Foundation in partnership with the Ontario Association of Community Care Access Centers (OACCAC).

Purpose of the project

The purpose of 'Having Their Say and Choosing Their Way' project is to help funders and providers of care more deeply understand the experience of the client during the 'hospital to home' transition. This transition takes place thousands of times each month in Ontario. If we understand the experience of some of these patients, we can think about the changes needed to make everyone's experience better.

The objective of this project is improvement. The way people feel while making transition from 'hospital to home' is a function of the design of the process which spans many organizations. The Community Care Access Centre (CCAC) Coordinators, Nurses, Personal Support Workers, Discharge Planners, and Therapists working within each individual organization are what make the process bearable for those going through it.

Two principal client experiences are explored: the transition from 'hospital to long-term care home (LTCH)' and from 'hospital back to home, with home care'. We interviewed patients who had left specific hospital inpatient units in Toronto and South East Ontario. Jeff Doleweerd and Tim Berezny are the authors of this report, having been involved in all stages of the initiative.

This report presents its findings using the following structure:

- Specifying what 'value' means to the client
- Identifying deficiencies in the process that were experienced by the client and family
- Determining how *capable* the process is of providing value
- Providing observations and suggestions for improvement for the hospital, CCAC, service provider agencies, vendors, Local Health Integration Network (LHIN) and Ministry of Health and Long-Term Care (MOHLTC). We call these 'Change Concepts'.

Scope of services being examined

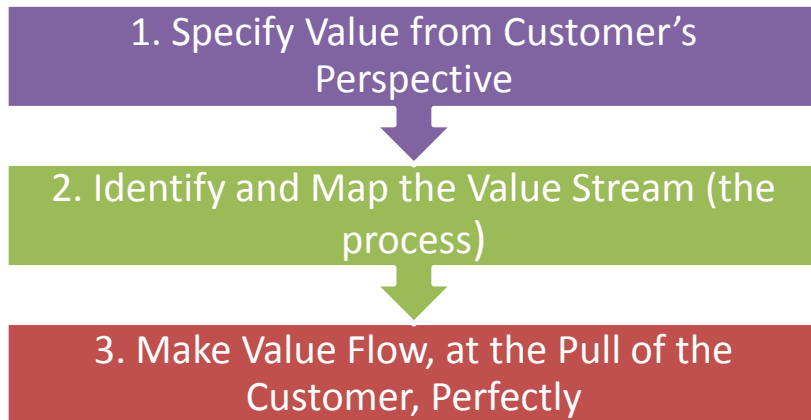
The scope of the 'hospital to LTCH' process begins with the patient identifying the need to go to the hospital, admission to the hospital, making long-term care home selections, usually includes an Alternate Level of Care (ALC) phase, and ends with the arrival at the long-term care home. The greatest emphasis is placed on the circumstances that brought the client to the ED, the client's experience while waiting for an ALC, the evaluation of post acute options (i.e. LTCHs), and the transition to the LTCH. There is less emphasis on the inpatient care experience and the actual stay in the LTCH. The 'hospital to LTCH' process was investigated in both the South East and Toronto Central regions.

This report discusses the 'hospital to LTCH' process. An accompanying report discusses the 'hospital to home care' process, which begins with the patient going to the hospital, and then follows them through a variety of other stages. This includes admission to the hospital, hospital discharge, and then receiving services at home. The 'hospital to home with home care' process was investigated only in the Toronto Central region, not in the South East region.

Methodology

The investigation is guided by quality improvement theory. The basic concepts popularized as ‘Lean’ quality improvement are relied upon to guide the investigation. The core idea of this report is to understand what clients and patients prefer (value), map how value is provided, and find ways to make value flow from beginning to end, by eliminating waste.

Figure 1 Lean Steps in Brief



We began to understand the experience of the client by seeking them out and listening to their story. We gathered their views, not for research, but as ‘expert advisors’ with opinions that matter. Then the process was examined to see how it works. Is the process designed to deliver what people want and value? We can then start to examine what parts of the process add value, what parts of the process represent waste and what can be done to create a better client experience.

Action 1 - Specify Value from the Client’s Perspective

The local CCAC and hospital recruited a sampling of people recently discharged from hospital for one-to-one interviews. This helped us understand the process from the patient’s perspective. We contacted caregivers or power of attorneys listed in the patient record for consent if the patient had dementia or cognitive challenges and difficulty recounting their experience fully. Our interviews were conducted in the caregiver’s home with the actual client present if possible. Occasionally, we held interviews over the phone. The majority of people who we interviewed in the ‘hospital to LTCH’ category were family members, and none required an interpreter. All interviews were recorded (where the client consented), transcribed professionally, and then subjected to a variety of qualitative analyses by the investigators. We arrived upon the main themes after multiple iterations and reviews of the transcripts.

The clients’ and caregivers’ insights were the primary source for generating the client value statement. Clients’ comments also helped to illustrate the shortcomings of the process. The defects, or ‘deficiencies’ as listed in the report, are process problems that do not get reversed before they get experienced by the client. We held a focus group with a sub-set of caregivers who helped validate and craft the Value statement.

All participants were provided with a small monetary reward as a ‘thank you’ for their participation.

Action 2 – Identify and Map the Value Stream (The Process)

Detailed process maps were created after directly observing the clinical and administrative staff activity. We observed and collected

information articles – brochures, forms, letters, checklists, and screenshots of applications- from start to finish. We created and validated a ‘Ben Graham Workflow’ map which shows task-level information. This detailed process map was then used to generate a modified value stream map - a more conceptual or abstracted diagram showing only key operations involved.

We overlaid the map with the issues identified through the client interview process. We also gathered ‘Change Concepts’ or improvement ideas informally suggested by staff, clients and families. We include in this report the change concepts which could improve the performance of the process, based on our preliminary analysis.

Action 3 – Make Value Flow, at the Pull of the Client, Perfectly

The process map was analyzed to determine if, in its design, it is *capable* of delivering value to the client. In so doing, we were able to better understand the root causes of both the positive and negative issues identified by the clients.

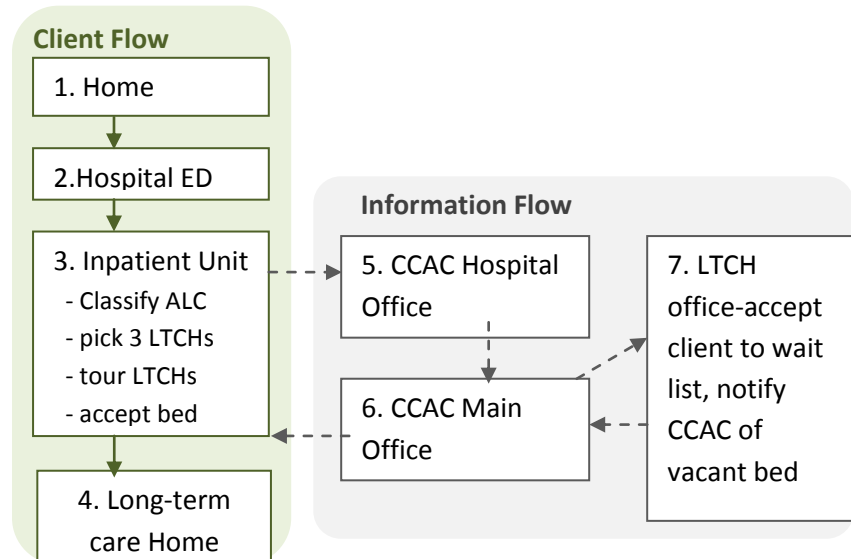
A note about language – ‘patient’ vs. ‘client’ vs. ‘customer’. For simplicity, we have chosen to describe people admitted to hospital as ‘patients’ and those in community as ‘clients’. ‘Customer’ is only used when discussing general quality improvement theory. ‘Caregivers’ refers to family or others who are informally caring for a patient or client.

Process Overview

The high-level steps for the ‘hospital to LTCH’ process are as follows: From 1) home, the client travels to the 2) hospital Emergency Department (ED) and eventually gets admitted to the 3) hospital

inpatient unit. Here, when deemed to require an Alternate Level of Care (ALC) the client and family select LTCH choices. The patient travels to 4) the long-term care home. This is the **client flow** portion of the process.

The **information flow** process begins with the hospital Social Worker (SW) (see staffing structure overview next) who provides information to the family. Then the patient is referred to CCAC (step 5). The CCAC Coordinator (CC) does an assessment of the client. The 5) Coordinator sends the information back to the 6) CCAC Main office to process the file and send the application package to the 7) LTCH office(s). The client is notified if they are accepted to the home’s waiting list. When a vacancy arises the 7) LTCH notifies the 6) CCAC Main office which then makes a bed offer to the chosen client.



Summary of Findings – ‘Hospital to Long-Term Care Home’

What is Value?

Through interviews with clients and caregivers that experienced the ‘hospital to long-term care home (LTCH)’ process, common themes emerged that were used to define what ‘value’ is, as desired by the client:

“I want help getting accurate information that I can understand at the right time and place, including viable options, so my family and I can make the right decision for us. I want to feel confident that people care and to be treated with fairness and respect.

In contrast, people also expressed what they didn’t want to happen.

I don’t want to make a decision out of fear, inadequate care, or surprises”

This ‘Value Statement’ represents what is important to the client and families experiencing this transition.

We found positive aspects to what people experienced. Most commonly, staff spoke highly of the acute care provided, the staff helpfulness in certain locations, and that health often improved after going to long-term care.

The *design* of the hospital to LTCH transition, however, yielded deficiencies identified by the clients. Most commonly, clients and families told us about the following deficiencies:

Deficiency # 1 : Inaccurate and unavailable Information

Deficiency # 2 : The system of access is incomprehensible to families

Deficiency # 3 : Preplanning doesn’t occur

Deficiency # 4 : Compromised care

Deficiency # 5 : Confusing financial messages

Deficiency # 6 : Insufficient help for the family

What is the Process for Delivering Value?

The detailed process investigation revealed many root causes of process deficiencies. From this investigation, 39 change concepts were generated. All of these change concepts are centered on the concept of *delivering better value to the client and reducing waste*. The client’s experience crosses a network of organizations, thus there are ideas for every organization involved in this journey - the hospital, CCAC, LTCHs, LHIN and MOHLTC - anchored on the value statement.

The change concepts are not intended as definitive recommendations, rather they are meant to provoke further reflection and feasibility investigation. They are not designed to optimize the functional performance of one organization or department, but rather to improve the process as a whole.

How Capable Is the Process?

The process was examined in relation to the value statement with the following question: “How capable is the process of providing value, as defined by the client?” It was found that the infancy of the process’ design, ownership, and the infrastructure around it are the major constraints to capably delivering value as sought by patients, family caregivers, and the public.

2. Study Statistics

Population Group

21 interviews were conducted. Candidates were identified and provided by Quinte Health Care Corporation (15), and Toronto Central CCAC (6). All clients were patients at either Trenton Memorial Hospital or Toronto Western Hospital.

The sample population had the following characteristics:

- Average Age: 82 (min 55, max 96)
- 8 people were receiving home care prior to admission (3 in Toronto)
- 6 people had LTCH application completed prior admission (0 in Toronto)
- 10 people were living with a family member prior to hospitalization (3 in Toronto)
- 76% female
- Average (Mean/Median) hospital stay : 128/66 days*
- Average (Mean/Median) Acute stay : 58/20 days*
- Average (Mean/Median) ALC stay: 70/47 days*

*data only available for SECCAC

19 people placed to LTCH: (14 SE/5 Toronto)

- LTCH 1st choice: 9 SE, 1 Toronto
- LTCH 2nd choice: 1 SE, 1 Toronto
- LTCH 3rd choice: 0 SE, 3 Toronto
- Interim bed: 2 SE, 0 Toronto
- Retirement home or home: 1 SE, 0 Toronto

Detailed Statistics can be found in "Appendix B : Detailed Interviewee Statistics."

A note about 'Avoidable' Hospitalization Statistics

10 of the 21 clients were admitted due to dementia or frailty of aging, while the remaining hospitalizations were due to a specific acute event (fall, stroke, other organ failure, etc). The frailty and dementia hospitalizations were often the result of the client's condition progressing to a point where the caregiver could no longer cope or something happened in the clients' surroundings that was avoidable (e.g., medication error). These can be classified as 'potentially avoidable' hospitalizations. Family caregivers themselves agreed with this assessment.

6 of the 10 'potentially avoidable' clients were receiving CCAC services, while only 2 of the 11 'acute' hospitalizations were receiving CCAC services before admission to the hospital. These hospitalizations may also represent opportunities to identify problems and direct clients to other appropriate sources of care.

In the Trenton site of Quinte Health Care, 'avoidable' hospitalizations comprised 40% of the total ALC days accumulated. (Data not available for TWH-UHN)

3. Specify Value from the Client/ Caregivers' Perspective

Positive Experiences

The investigators heard to different degrees, the following positive attributes. Unless indicated otherwise, the themes span both Toronto and South East sites. For the reader's interest, we indicate Toronto quotes with a (T). The remainder is for South East.

Positive Attribute # 1. The acute care was very good

Those interviewed often expressed that, were it not for the treatment their loved one received in hospital, they would not have survived. This was echoed throughout the group of clients where they presented with emergency issues.

"The intensive care unit was excellent. They saved my mom's life." (T)

"I was very impressed with the young doctor that was assigned to him. He was very thorough." (T)

"If it weren't for the treatment in the emergency department my mom would not be here."

Once the patient's acute needs were met, there were diverging views among the interviewees on the quality of the care, with some patients extolling the virtues of services such as nursing, while others were very negative. There may be a relationship between the length of time someone resided in hospital as an ALC patient and a diminishing satisfaction as the level of care no longer met their needs.

Positive Attribute # 2. The staff involved from CCAC and Quinte were helpful

Interviewees were delighted at times with the helpfulness of the CCAC Coordinator and Social Worker in South East site. At South East, the Coordinator gets involved early in the process, and many people noticed the benefit. This CCAC Coordinator not only does a full assessment, but counsels the family about LTC options.

"I would like to say that [CCAC Coordinator] was very, very helpful... I mean they have their policies they have to stick to, I guess, but very, very helpful."

"Oh yeah, oh yeah. No and it was very well done. Very well done. Oh no, no, I can't praise [them] enough."

"[CCAC Coordinator] was just a lovely person. And just so...very informative. And she talked to my mother which I liked. ...you know, because you're at that age, some people sort of dismiss you sort of thing. And I liked the way she...I was there, but she talked to my mother. "

Two people in Trenton commented on the collaboration of the CCAC and Hospital, such as:

"[CCAC Coordinator] and [Social Worker] work very close together all along. I had a lot of support from the [SW]. I mean he was on the phone a lot to me, giving me choices that [CCAC Coordinator] told him."

In Toronto, the Social Worker advises families of the hospital discharge policies and the requirements for three choices of long-

term care homes. Interviewees were not aware of any CCAC role present within Toronto Hospital site.

The Deficiencies

The investigators categorized the problems noted by families of loved ones going to long-term care in six main areas:

- 1) Inaccurate and unavailable Information;
- 2) The system of access is incomprehensible to families
- 3) Preplanning doesn't occur;
- 4) Compromised care;
- 5) Confusing financial messages and;
- 6) Insufficient help for the family.

Significant differences that exist between Toronto and South East are noted where they occur.

Deficiency # 1: Inaccurate and unavailable Information

The client/ caregiver repeatedly expressed frustration at being provided 'best guess' information that later turned out to be incorrect, causing a loss in trust.

Waiting time information is lacking. Hospitals need to use their acute care beds for people who need acute care. For ALC patients, families are required, or strongly encouraged, to select homes with 'short waiting lists'. However, such lists are not available for them to view. Further, it is unclear how being 'xth' on the list correlates to a shorter or longer waiting *time*. A person at the top of a list can wait a long time, and a person at the bottom of another list may get a surprise offer letter early on. This is due to the complexity of matching available beds to people (See Deficiency 2).

One caregiver noted that she was told it would take 6 months, and then was offered a bed in 1 week.

"What remains a big question mark in our experience was the fact that it looked so grim and yet so unexpectedly to have a very positive outcome"

We were told by another, waiting for the veterans LTCH beds:

"We said we want [x home] and that's it... the hospital said [x home] is long wait and you won't get in there. So you have to choose two other places. And he'll probably have to go to one of those other two. ... We succumbed to this idea. ...As it turned out, for some reason I don't know, I was very shocked. I got a phone call one day from the Social Worker saying I've got really good news for you.. A bed's come open at [x home] and your Dad's being transferred there." (T)

Another person got their 'information' about wait times from the long-term care home directly. This is common in both Toronto and South East.

"But he said ... and this is the middle of February 2008, he said the person who'd put their name in at [x home] for semi-private, that their name had been on the list (and waiting) since July of 2006. So I figured it would be, well, a while, so I was really surprised when they phoned just over two weeks later, and they offered a semi-private at [x home]."

A focus group of caregivers overwhelmingly stated that better knowledge of wait times would have improved their ability to make decisions and the overall experience significantly.

Page 20 of the CCAC Client Service Policy Manual says "The CCAC must inform the person about home waiting lists so he or she knows how long the wait may be for a specific home." This does not effectively occur.

Other important information about LTCHs is difficult to access. The primary decision criteria for selecting a LTCH for both study sites are:

1. Location (proximity to family caregiver's home)
2. Word of mouth experiences of others
3. Characteristics/ features of the home.

The cultural and/or religious attributes of long-term care homes is a specific characteristic sought out by 4 of 6 sample families in the Toronto site, and few if any in Trenton. Lists of homes given to families were differently arranged at each site, but both featured basic address, size and cultural features. The family caregivers were encouraged to gather other information and go on site visits to LTCHs.

Trusted endorsements in a small community are easily available as nearly everyone knows of someone with a connection to a nursing home, especially in Trenton where few homes exist. This is subject to bias if the individual spoken to had an unusually negative or positive experience at a particular site, or if the site had been subject to negative rumors or news reports.

"Yeah, it was location and word of mouth, because people we knew in the church community and stuff, they said, "Yeah, well my Mom's been there. It's a great spot".

In a location such as Toronto, with the large number of homes, such endorsements were less noticeable to the interviewers.

Site visits figure prominently into the process, with 18 of 21 interviewees booking tours of homes. Some families went on as many as 20 tours. Characteristics of the home (based on site visits) are also subject to bias. For example, bias may occur if an event occurred causing a bad odour just before a visit, or if a LTCH showed only the cleanest or newest areas of the home.

Arranging site visits was difficult.

*"Well, obviously you want to go look at these places. Which is sort of difficult because, to go look at the nursing home you got to phone the Social Worker there who coordinates a little tour. And that is usually only one period a week. Like maybe just maybe a Thursday at one o'clock and that's it. Oh, and if you are busy you can't go. So that's a little pain in the **** trying to get into these places to see them because you have to conform your schedule to theirs.... It becomes very stressful" (T)*

Despite being heavily relied upon by families, and encouraged by health professionals, **there is no consistency in approach to tours and other information shared about long-term care homes.** Families find it difficult to evaluate many attributes of a home that are

important to them. For example; staffing levels, how internal transfers occur and how roommates are assigned, how outbreaks are managed, extent of medical coverage, availability of a Nurse practitioner, other resident behaviours on the floor, what volunteer base there may be to take people to medical appointments etc. These are all difficult to ascertain but important to families, in retrospect:

“What kind of staff does the home have? That’s something that concerns me. What kind of training does the staff have? Are there real Nurses there or are they just kind of Nurse aids. I find that confusing....I never knew there were so many different levels of Nurses. So is there a real Nurse on duty?” (T)

Every person is unique, as is each of the province’s more than 600 long-term care homes. The paper-based lists of homes given to the 21 interviewees miss features important to so many families. Given the circumstances, families are capable of entirely missing the opportunity to go on site visits.

“After Mom was in, within the first month, we got a little survey from the home. And they were asking (how we thought) about a tour. And I had said on there, I didn't know a tour was possible, you know. And so...but that was maybe...maybe that was a communication thing that either we could have been told, or we should have asked, didn't think to ask”.

Further, families find there is not enough help for them when they are looking for options on where to take their loved one (see

Deficiency #6).

Note: only one family across the 21 interviews indicated they used the Ministry of Health complaints web site. <http://publicreporting.LTCHomes.net/en-ca/default.aspx>. This family mentioned relying on a daughter in the family who was a lawyer, to sort through the site, and gather anything important.

Deficiency # 2 : The system of access is incomprehensible to families

The LTCH matching process is complex, and that complexity is felt by clients. When matching a client to a bed, the following is a list of some of the factors that come into play: the priority level of the client (five possible levels), bed characteristics (private, gender, smoking, etc...), behavior considerations of room co-habitants, cost and ability to pay. Consequently, it is virtually impossible with today’s tools, to accurately predict when a bed will become free *for a specific person waiting*.

This complexity is felt by the clients. There is little understanding among patients about their relative position on a list, how much time they may have to wait, and what moves people higher on the waiting list for an available bed. A significant reason for this lack of understanding by clients is that even the health care workers helping the client do not have access to accurate information. Healthcare workers provide wait time information based largely on previous experience and observation, not on current accurate data. ***The lack of transparency about LTCH wait times is the first main source of wait list confusion and stress for clients.***

As one family caregiver commented concerning waitlist position:

"I would have liked to know where my mother had been on the placement list. I think I would have liked to know that because a lot of it seemed very arbitrary."

Another client was pleasantly surprised when the wait time information provided to her greatly over-estimated the wait:

"The Social Worker told me that the home that offers Peritoneal Dialysis has a really long wait, but I insisted on the home and it came up in less than six weeks".

The second main source of wait list confusion and stress for clients are the rules governing hospital discharge. The rules for applying to a LTCH ask the patient to choose homes with short waitlists, as per the following brochure excerpts:

Excerpts from Hospital Correspondence to Patients

Quinte Health Care: "It is suggested that you select three facilities, one that is your preferred choice and two alternative choices with short waiting times (usually three months or less). The choice selection is completely your decision. If a bed in a long-term care facility (not on your choice list) becomes available, and can meet your care needs, you will be discharged ... Should you choose to remain in hospital as an uninsured patient, you will be charged the full daily rate for hospital care. (Rate as of April 1, 2007 is \$847 per day)"

TWH- UHN Brochure: "If your health care team feels that you need care in a long-term care facility, your social worker will help you apply to the Community Care Access Centre (CCAC) for that service. You will be asked to choose three long-term care facilities. At least

two of your choices must have short waiting lists."

However, as previously discussed, despite being required to select homes with short wait lists (where 'short' is never defined), neither the client nor the health care worker has accurate information about which homes have short waitlists.

The following client expressed her confusion:

"In the beginning, the rules were that you'd...you had three choices of a nursing home. And if you turned one down, then you were taken off the list. And that was not a very good situation. So I guess they've changed the rules now, or seem to be anyway"

The rules led people to decisions that had unintended results. For example, the following client may have unnecessarily occupied a LTCH bed she didn't want when she could have been at home:

*"I asked them if I could have my mother stay **with me** until the private room at [x home] was ready and they said if I take her out of the system she won't get the private room. She will go to the bottom of the list. So, so long as I keep her at [y home] she's still on the list for the private room at [x home]. So that is a **catch 22** that I'm not particularly fond of, you know."*

Another complicated LTCH placement rule that confuses many clients relates to the **relative priority given to hospital patients on certain days**. Hospital clients may get priority over community clients, such as in Toronto when a facility is designated 'crisis', or in

South East when the hospital is given priority on three days of the week. The idea behind the priority rules is to relieve pressure on hospital beds, creating an outlet for ALC patients. Someone 'at the top of the list' for a long-term care home, living at home or another long-term care home, may be by-passed by someone recently admitted to hospital.

The perceived priority of hospital patients getting into long-term care homes was described by many people in both sites. One woman who volunteers at the LTCH that is her mother's top choice said:

*"They told me she was supposed to come and I phone CCAC and she says oh yes she was **the next one on the list**. But then CCAC says we had a crisis at the hospital so they had to clear them. I said to her very gently, I said, well you know my mother is supposed to be here, and you have a list, so you put mother in this home and you put the crisis people where my mother is. They didn't do that. They left her where she was and they used up her space. I was told that initially they didn't do anything like this behind my back, no no no." (T)*

Other people in South East shared similar feelings that the location of someone played a prominent role in how resources were distributed.

"I thought that once you're not putting pressure on the system by being in the priority (the hospital), although they told me that we would stay the same priority, I wasn't so sure or convinced that that is what would happen mainly because she would be at a place where

she was getting looked after. So I felt pretty determined to try my hardest to get Mom from hospital to the nursing home where she should stay..."

The hospital's aim of vacating beds is not well served when people want to remain in hospitals to get priority LTCH access. Overall, it increases confusion and causes behaviour at odds with ideal patient flow. Theoretically, the regulations could increase ALC issues as people discover that you can get into a LTCH faster by going through the ER to an inpatient bed than waiting at home.

Note: A change has reportedly occurred in South East Ontario. The practice of having all new LTCH bed vacancies arising on *Tuesdays, Wednesdays and Thursdays* offered to hospital patients before those clients with the same priority in the community has ended. Elsewhere, priority status continues to be granted to specific hospitals by their respective LHIN, continuing this state of confusion.

As a result of the confusing rules in place, **families turned to advocacy to find somebody to help with the confusing process.**

"If you don't have a family member like me or 'Mary' really pressuring [the hospital], I don't think you have a choice. I think you end up going wherever the first bed comes available. But I think that...because we said no, no we want [x] home we want [x] home I think maybe that's how we got [x] home..." (T)

A similar sentiment was echoed by another:

"We were forced to pick three homes and pay \$57 a day. It was always 'take it up with this person or that person'. Unfortunately, I have to work for a living so I haven't enough time to fight the system." (T)

Another person reported placing a complaint to her local MPP after she was informed that the wait for a LTCH may be six months. As it turned out, a bed offer was unexpectedly presented to them a week later. The resulting perception was that the 'squeaky wheel gets the grease', while the more probable scenario is that the information provided at the start was inaccurate.

A second outcome to the current rules was that *families try to 'game' the system to get the best outcome for their loved one.*

"I put the one we wanted first. And then I put the next two as the ones I knew we wouldn't get into for a couple of years. So I knew that I would get number one first. The other 2 choices were in new homes with a long waiting list."

Another couple discovered and exploited a loophole in the rules where spousal applicants get higher priority than single applicants. The couple submitted the patient's name along with her husband's name to qualify as spousal applicants. When the wife was admitted to the LTCH, the husband withdrew his name.

We asked families what advice they had for others in a similar situation. A common answer was to be an active and strong promoter of the individual's cause with the given system of rules.

Q. "So is there any advice you would give to people facing a similar situation....?"

A. "Get all the facts. Whatever facts there may be. Get all the facts and tell them that they have a mind of their own. They're not, like, prisoners".

Deficiency # 3 : Preplanning doesn't occur

Our investigation found 11 of 21 patients were previously CCAC clients (with 8 receiving home care). At least 5 of these had previously visited the Emergency Departments (ED) for problems for which they were later admitted. These 11 clients also spanned the specific people with dementia or other frailty of aging. Families were heavily involved in care decisions for this group.

The gradual decline in these clients' condition was often unnoticed until children or friends discovered the extent of the caregiver fatigue in the 'healthier' parent. That several of the people were hospitalized may represent *missed opportunities for providing information, education, and diversion.*

"As one caregiver reported, "dementia is so sneaky; I didn't realize how quickly it set in and how it affected her ability to cope".

For people interviewed receiving CCAC services and with dementia/frailty, the ED is used by many families as a place to go when they can no longer cope. The following specific reasons for ED admission were observed in this group:

- **Caregiver fatigue:** (e.g.) a woman came into the kitchen to find her husband standing over the stove with his oxygen

hose on the heated element. She could no longer handle this stress.

- **Providing a safer environment:** (e.g.,) a daughter received a call in the middle of the night from her mother's neighbour saying her mom was cutting the back of her couch looking for her grandson who lived 200 kilometers away.

These ED Admission cases typify the scenarios in which an alternate type of care *may* have been more appropriate (such as long-term care, interim nursing home, home care, respite, hospice, 24-hour care, medication, etc...). However, the families felt that there were no other viable alternatives available, leading them to the ED.

"I can't take him home, because I can't look after him. I couldn't. I couldn't. He was too confused and I don't have enough support and the healthcare system, there isn't enough support for people like him."

Hospitalization is not avoided in part ***because the preplanning discussion is readily delayed by families***. This was reported to be because the client does not wish to leave their home, children feel guilty about the options available to their parent, or there is disagreement among members of the family regarding the appropriate option.

"But she still insisted that she had to get up at night and then Dad would take her to the bathroom. That became a very, very long ordeal just for them to get her to the bathroom and back in bed because of the pain. And Dad came to the point where he could hardly sleep because he was always worried about Mom waking up."

A focus group involving family members of those with dementia/frailty stated that pre-planning to anticipate problems caused by diminishing health would have been beneficial. For some people, it is important that the trigger for pre-planning come from a neutral 3rd party (i.e. Physician) rather than a son/daughter who "just wants to put them away".

"She wouldn't hear it from me. But if her doctor mentioned moving to a nursing home – well then she'd think about it."

Many families of patients suffering a steady decline had the impression that the admission to the ER could have been avoided entirely if:

- diagnosis had been earlier (dementia in particular),
- there was assistance in medication and nutrition management,
- there was caregiver relief, or
- sufficient caregiver education about care alternatives that existed, and planning started.

These were confirmed in a focused group discussion.

Placement rules discourage preplanning when planning is equated with being put on a waitlist.

"I guess I did wonder if it would have been possible, or should be possible, to do some planning ahead without sort of committing to an application for a room. Because it seems like you have to, in order to get into the system, you have to say you're willing to take a room

on short notice, or pass on it and then maybe lose your place.”

The placement rules about accepting bed offers can end otherwise productive planning conversations among family members, perhaps prematurely.

Despite this, a common ‘advice to others’ that we heard from those interviewed was to ***try to plan for issues sooner among the family.*** Families consistently showed that they have complex dynamics to sort through, and that this planning was easy to delay.

“Well, my sister said ‘I’d like mom to go somewhere else besides home’. So I said, ‘Well, we’re gonna have...we gotta talk to Mom as well.’ And Mom said, ‘No way. I want to go home again.’ Which she did. And that was fine.... Then we left it.”

Some families were more complex than others:

Family: “But my parents insisted, for whatever reason, the boys had to make the decision. They had to be in agreement.”

Q: “All five?”

Family: “Yeah ... all five, which is very difficult. Because I said to them, that doesn’t work ... because what they wanted was us to have family meetings every single time. I said, ‘We can’t keep doing that. You have to have somebody responsible.’” (T)

Allowing hospitalization to be ***the*** event that causes discussions and decisions to occur within families is a failure to implement adequate, systematic methods of encouraging preplanning.

Deficiency # 4: Compromised care

Much has been written about the need for ALC days to be reduced so access can be given to others awaiting care in hospital. Based on interviewing people recently waiting for an ALC, such hospital days need to be reduced because families perceive inadequate care during this waiting period. They cite a lack of attention, discourtesy of hurried workers, or an actual decline in their health.

All interviewees understood that ***waiting in hospital for a long-term care home bed is detrimental to their health.***

“Like that was a delay there. Now my idea was if she had gone earlier to long-term care, maybe she be better off. She stayed in hospital too long...And that was what I think killed her mentally. Killed her like she...she was depressed.”(T)

The most common concerns about care in hospital that were expressed by waiting families were: 1. Inadequate feeding, 2. bed sores / lack of movement and 3. limited social stimulus. These were due in large part to the setting. The hospital unit is not equipped or easily configured to properly accommodate the typical needs of a patient requiring long-term care.

“And the other thing, and I know it’s the hospital...not the hospital’s fault but...unless we were there to feed my Mom, lots of times she didn’t eat. Because they told me

right out, 'We are not a nursing home, and we just don't have the staff to do it.'"

Another said:

"She got nothing for \$57 per day we gave to the hospital. If we didn't bring her the food, she wouldn't have eaten."(T)

As indicated in the positive experiences section, *acute care* offered in hospitals was virtually always lauded by the interviewees. "They saved her life", or "the treatment was excellent" were commonly heard. But when acute care facilities were faced with offering something more long term than acute, feelings changed:

"When he was still in emerg [...] one [Nurse] come up to me, and she wasn't very nice [...], she said, 'You know, you shouldn't have your husband come in here, he should be in a nursing home. This isn't the place for him.' Well, at the time I was stunned. I couldn't even answer. I just said, 'Well, I'm sorry, but his name is down for a nursing home, there's just none available.' Because he was really bad. He was confused and I was really upset. [...] I got thinking about it after and I thought, 'My goodness. I hope they don't treat all patients...or people like that.' [...]"

When in a hospital, patients and family are often in a vulnerable and anxious state. At the same time, an ED staff member may be stressed due to the high demands of their situation. It is a care mismatch felt by both the workers and the patients.

Perceptions of overmedication was evident in several interviewees. These may have involved the hospital itself during the ALC stage, community care Nurses, or the Family Physician:

"I was disappointed with her own doctor. She was on too much medication. One time when her doctor was in Greece and I took her to a walk-in clinic, this doctor, when he saw she was taking one pill four times a day he said no, no, no... One a day. Her cupboard are full of medication supplies. Enough for six months. She was taking whatever her doctor telling her. That doctor was her God..(T)"

One son was bitter about a community Nurse medication error that he says caused his mother's hospitalization in the first place:

"My mom never really recovered from getting the insulin overdose. The second time that she was given too much insulin by a Nurse at home was really bad. Her neighbour called the ambulance.... Some Nurses who came to my mom's house were in and out so fast, they aren't going to see any consequence."

By the time of the interview, many people had been resident of long-term care homes for weeks and months. Family members, sometimes surprised, would indicate that their loved one's health had improved.

"She picked up that C-dif in hospital. We found that out shortly after being in the nursing home ...it's pretty

standard I guess for people..... She picked it up at the hospital, yeah.... She is much better now."

While there was no mention of medication issues arising in the long-term care homes themselves, several people did state that their loved one improved after getting to the long-term care home.

"They got her off of all those...I mean she got well enough, she didn't need those narcotics. So that was a better thing for sure."

Another person summed up the connection between the care setting and the quality of care for many of the interviewees.

"Well, there is personal care at the long-term care home]. More people coming in and looking after her...the [long-term care home] has more staff. Oh yeah, so much better care. ...Oh yes. I mean I'm not faulting the hospital at all, but [the long-term care home] is just set up for more care all the time; So I think everybody if they...if they actually knew that, they...to me anyway, now that I know, what I saw, I wouldn't hesitate at all, to go from the hospital to a nursing home because you get more care there. I don't think there's any question about that".

Deficiency # 5 : Confusing financial messages

The investigators listened to story after story of people who were confused, surprised or angered by the real or threatened financial

impacts of staying in hospital. This was much more pronounced in South East Ontario, at Quinte Health Care, than at the Toronto site.

The decision by a hospital to charge a fee is based on an interpretation of regulation R.R.O. 1990, Reg. 965, s. 16 (2):

(2) Where an order has been made with respect to the discharge of a patient, the hospital shall discharge the patient and the patient shall leave the hospital on the date set out in the discharge order.

The rationale is that once a discharge order has been made, the patient is no longer insured by OHIP, and thus may be charged a fee. For both South East (Quinte) and Toronto (TWH), patients designated as ALC would face a co-payment equivalent to the basic rate charged at the facility type that they await (e.g., long-term care home).

At Quinte Health Care, there was the added written message that, should a patient turn down an available bed offered to them (not within their choices) the charge would become ~ \$820 per day. Both hospital sites employ a letter that asks families to sign their name indicating they read and understood the payment issues. For the people interviewed, the average wait time for a LTCH bed was four months post hospital admission. (*)With hundreds and thousands of dollars at stake, the fees were very significant issues to all interviewees. *South East data only.

At Quinte Health Care, people simply *did not understand the combination of written pamphlets and verbal messaging*. Interviewees said:

"Copayment has never been explained to us."

"They didn't tell her, they didn't tell anybody [about the co-payment], so when I got back ..., I was already three months behind in payments."

"And that co-payment thing is really the thing that bugged me the most, because I just couldn't get it. I just didn't understand."

"They gave me a letter about it, but it was couched in language in the letter that wasn't clear."

"They did tell me that. But when you're in a mix up like we were in, you don't think."

"I'm fairly intelligent. I went to university. ..but it was buried somewhere in the letter...it .should be like, "If you refuse this bed, you're gonna pay \$800 a day, like blinking, flashing."

The language in the written forms at Quinte Health Care is not simple nor is it geared to the lay person. Furthermore, the forms are presented at a time when patients and family are coming to terms with failing health and life changes. For example, following a stroke that left her father paralyzed on one side of his body and unable to speak, the daughter was pre-occupied with selling his house, looking for accommodations in a long-term care home and also dealing with the stress of seeing her father no longer able to cope on his own. She admitted to receiving the information, but absorbing it and internalizing the message did not take place, given the stress of the situation.

The \$820 fee was perceived by families as a pressure tactic used by Quinte Health Care. The purpose was to strongly encourage patients into a place they may not want to go in order to free up the hospital bed for a higher acuity patient.

"I felt very surprised and a little shocked that the Continuing Stay Coordinators would put so much pressure on you so early in the game. I think that was a bit of a disappointment for me especially because as a family you're very vulnerable. ..."

For the six individuals at Toronto Western Hospital, what would be paid was characterized as a matter negotiated between the individual and the hospital finance department. Interviewees expressed no mention of any larger bed refusal fee, should they not accept a long-term care bed presented. Beyond this, they were invited to apply for a *reduced* daily co-payment with language that says "you may qualify for a full or partial exemption from this fee."

Consequently, Toronto interviewees reported that with one phone call, the right explanation or complaint seemed to yield a lower, or no, payment.

Yeah, they phoned me. And the finance person said would cost like \$1,038 a month or something like that... "So I said, I sort of complained. I said 'why?'. The hospital said 'she's free of sickness'. And I said 'yeah but she's at the hospital, she has an apartment and pays rent'. The hospital said since she paying rent we don't pay for month of November and December. So we did not pay.(T)"

Similarly, another interviewee indicated that some negotiation led to good results.

"I didn't pay...no. She was in the hospital and I would have to pay the hospital co-payment only if she exceeded the two months limit and refused to go to a long-term care nursing home." (T)

For some families this feels **more obscure than fair**, particularly if they do not have the resources or capacity to complain.

"If my last name was different, or if I donated to the hospital or I was able to find a lawyer, I would find a loophole on paying the co-payment. Come on, don't take me for a fool." (T)

From this small study, there is little evidence that the even stronger threat of a higher payment at Quinte Health Care yields a quicker discharge from hospital. In fact, a greater proportion of people at Quinte Health Care-Trenton, remained in hospital until the patient's first choice presented (9 of 15) versus TWH (1 of 5 interviewees).

Deficiency # 6: Insufficient help for the family

Care options are not *systematically* offered in a service-oriented manner to people leaving hospital, in either site observed. There are no methods available to staff to systematically review what would be relevant private and public pay options, including retirement homes, home care or other community services. As the number of options grow, the current anecdotal and brochure based methods of information are showing their limitations.

Once made ALC, information to patients is heavily oriented to long-term care options, usually presented in paper list format. There were two observed examples of ALC patients destined for long-term care but who changed course to go to retirement homes or to home care at Quinte Health Care. These decisions were based on the threat of the fee for refusing a first available bed.

When asked what prompted the placement decision, most indicate that the choice was to go home or to long-term care. Further, that since their loved one required extensive nursing care, home was not an option. In Toronto, families indicate that going home with home care, private pay, or retirement home solutions were not offered. This is not to say that patients *should* have gone elsewhere, but only that the option was not entertained.

Three of six people in Toronto described, in detail, the steps they took to pursue other options, without any hospital or CCAC aid.

1. *"I wanted to find 24 hour-type care to help 'A' and get her back to her retirement home. I found out about meals on wheels from people I worked with. Then my son, who is a chiropractor, helped me find out that OHIP can pay for a person to go into A's home for one hour every day. One hour, Monday to Friday. That is all...". (T)*

2. *"I asked the Social Worker about this 'waiting at home' program I heard about just as my Mom was on her way out of hospital. I found out that you could get 56 hours of home care per week. So I asked if I could have taken my mom home and wait out her choice there. The*

Social Worker said 'I did not feel you needed to know because you don't live downtown.' But then I found out by calling around that where I live is where the program was first started. I was so mad." (T)

3. "A new retirement home is within walking distance of my house. So my daughter and I reserved a room to go in October for my mom. So when my Mom got the blood problem, they then told me they wouldn't take her. They don't have a Nurse there."

Q. "So what choices were you looking at instead?"

A. "The Social Worker.. her name has fallen from my head... I called her so many times. She gave me no options but that my Mom had to go to a long-term care. That's it." (T)

One person in South East identified how they found services on their own – hospice services – that could help with feeding their parent while still in the hospital.

We heard several people in the Toronto site mention that they really wanted someone to *help them and support them* with this very taxing process. Some expressed this with anger:

1. "She gave me only information she wanted to give me. I get a better understanding from talking to my cat." (T)

2. "The Social Worker or someone like that is supposed to help, are they not?" (T)

3. "But I did come up with three, and I came up with three based on my own research, and my own due diligence. CCAC did not help."(T)

When asked the question "what advice do you have for health care providers looking to improve the process of going from hospital to long-term care?", families in Toronto commented about an absence of direct involvement with the CCAC at the hospital. Where this was a relative strength at the South East location, in Toronto several people found this problematic:.

1. "They should make sure that the CCAC is involved from the beginning in the hospital and so that you keep up that relationship." (T)

2. "The main thing is CCAC placement communication directly to the family lead, right? Because that is the main missing link in the whole thing. Because then, a simple question I still don't know is how long are the waiting lists?" (T)

3. Q. "Do you have advice for the agencies involved that could improve the transition to long-term care?"

A. "Yeah, what about support for me?"

Q. "Tell me about that."

A. "Somebody to talk to. ...Just having somebody just a little bit knowledgeable about the whole medical system that we could talk to. Somebody who's not from the hospital and not from the nursing home that could maybe assist you through the whole process, who could be there for you. Who could answer questions and you could get advice from.... Who could validate some of our feelings about nursing homes. Some kind of helper we could consult with even about the financial stuff, and getting rid of all that furniture...Who doesn't have the nursing home's interest at heart and doesn't have the hospital's interest at heart. Has our interest."

Q. "Did you meet anybody at the hospital from the Community Care Access Centre?"

A. "Community care what? But I... like I said, I don't even know who that is..." (T)

Another gentleman expressed his hope for changes that may come with the statement:

"I fully understand, that specifically surveys like this are fairly important because I do believe that they will improve the process, because if you hear from enough people, then they connect the dots of, 'Hey, everybody's saying, you know, CCAC isn't talking to the family.' Then there's a consistent thread, that they need to fix."

Value Statement

As interviews progressed, the investigators developed a draft 'value statement'. This value statement is our best attempt to assemble the words of the clients, together, explaining what they desired in the process of going from hospital to living in a long-term care home. It was validated with interviewees and successively modified. For this study, caregivers were also consulted in a group setting where they could rank order the various statements in terms of priority. They said:

"I want help getting accurate information that I can understand at the right time and place, including viable options, so my family and I can make the right decision for us. I want to feel confident that people care and to be treated with respect."

Each component of this statement is a dimension of service value that may, or may not, be offered in the care process. Any step in the hospital-home process that does not contribute positively to the client experience is waste, in Lean theory. A step may be required by regulation or for administrative reasons. This does not necessarily make it valuable in the eyes of the client.

Caregivers also indicated what they didn't want:

"I don't want to make a decision out of fear, inadequate care, or surprises".

Delivering on the value statement implies negative experiences would diminish, yet caregivers were insistent this second statement be part of the report.

4. Identify and Map the Value Stream (The Process)

The consultants created a *workflow level* process map by observing the process step-by-step. The detailed map tracked most databases, forms, hand-offs, inspections, persons, and steps in the process, from end-to-end. This is done assuming a client arrives in hospital at emergency department, is admitted (unit 8a or 8b of TWH or inpatient unit of Quinte Health Care-Trenton) and is discharged to a long term care home.

The map is far too large and complex to include in this report. We instead include a *high level* process map describing the overall process, broken into 8 process blocks. The following section discusses the relevant activities observed in these 8 process blocks.

Blocks 1 – 4 represent the 'client pathway'. This is the process as the client experiences it. It is the interactions within these steps that the client experiences value.

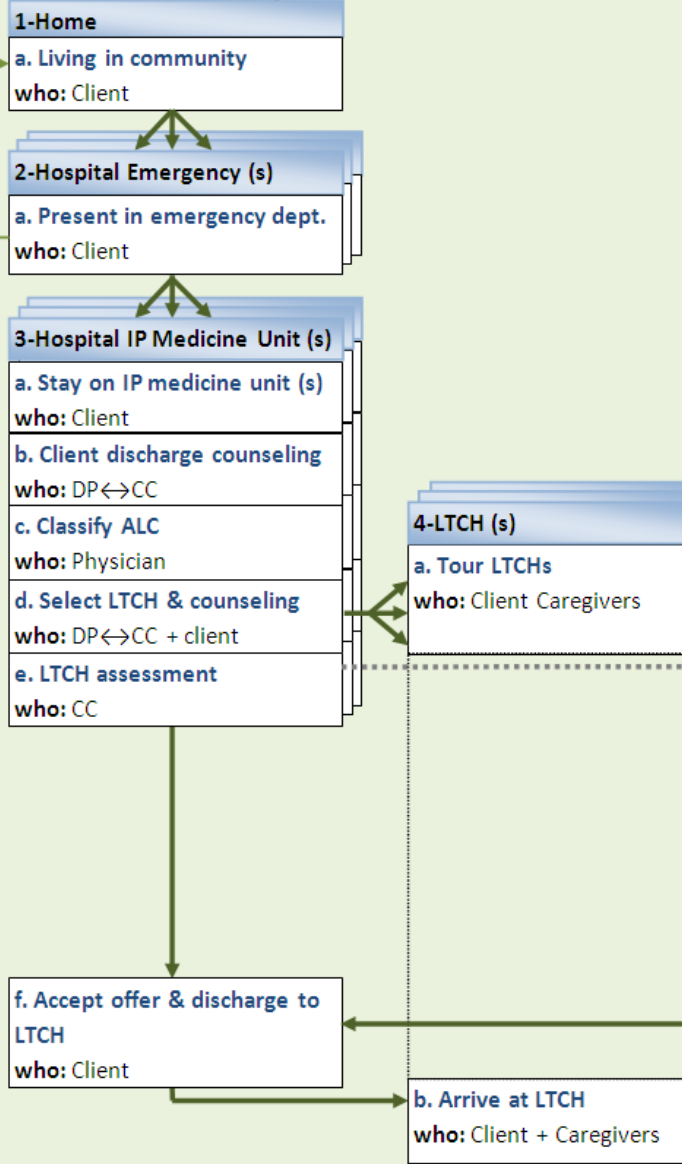
Blocks 5 – 8 represent the 'data processing pathway'. These steps are largely invisible to the client, and largely involve communication between organizations, filling out paperwork, and tracking information. These blocks exist to support the patient pathway.

There are 39 change concepts presented, listed with the organization that may be most interested in implementing the concept.

Process: Hospital to Long Term Care

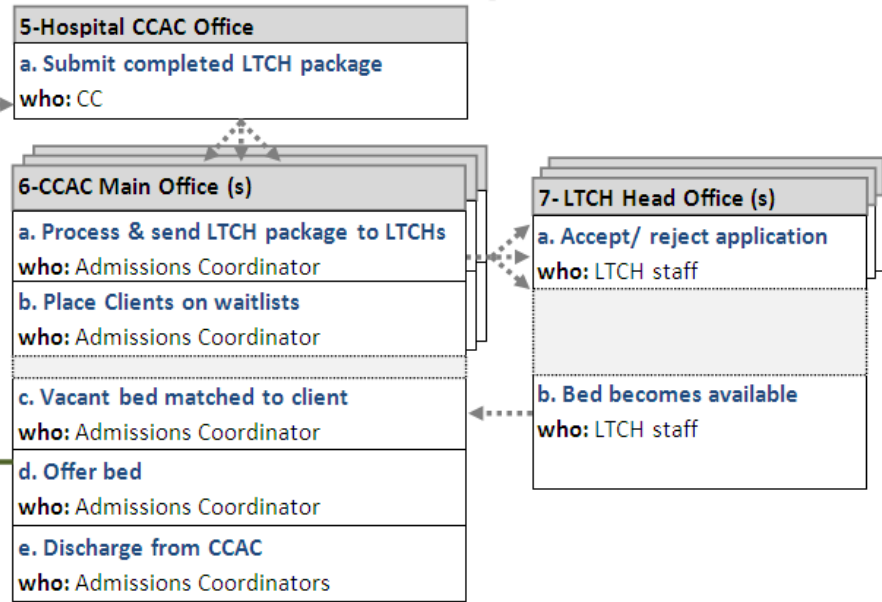
(High Level)

Client Journey Path



Abbreviations:
CC: Care Coordinator
CCAC: Community Care Access Center
IP: Inpatient
LTCH: Long Term Care Home
DP – Discharge Planner = Continuing Stay Coordinator or Social Worker

Information Processing Path



Process Metrics	
Hospital to LTCH Workflow	Observed estimate*
Number of unique information collection forms used	36
Number of instances of forms observed	84
Number of databases/ applications - unique	9
Number of unique staff involved in process	7
Total number of handoffs/ delays in process	15
Total observed of steps in process (includes 69 handling)	160

Vacant Bed Offer Process	
	Observed estimate**
Number of unique information collection forms	9
Number of databases+ tracking tools (spreadsheets)	2 (4)
Number of unique staff involved in process	5
Total number of handoffs/delays in process	6
Total observed of steps in process (includes 18 handling)	53

* based on SE site, variations for TCCCAC noted on Ben Graham Process Map **SECCAC and Toronto are very similar

At a glance description of process:

A patient presents to the emergency department with an acute issue or ‘caregiver burnout’ and becomes admitted to an inpatient unit. The Social Worker associated with the unit is triggered to visit the patient. Tracking tools are completed and charting done in hospital information system (HIS). The patient is given information about the hospital’s discharge policy. When patient is stable, an ALC order is written by the Physician indicating patient is ready for discharge.

The CCAC Coordinator is notified (timing varies) by hospital personnel. Coordinator schedules time to see client or family to complete RAI at a minimum. (Extent of involvement differs by site.) Background information is gathered from HIS. The patient is preregistered in CCAC system. Tracking tools are completed.

The application package for LTCHs is completed by the Coordinator, with components done by the hospital personnel such as medical information. The Coordinator completes a RAI assessment and the family submits their choice list of homes. The Coordinator forwards this to CCAC main office. The main office completes registration information and forwards to the relevant long-term care homes, who, in turn accept (or not) people to their waitlist within five days.

When a bed is available, the LTCH notifies CCAC by fax. CCAC locates candidate clients waiting for that home (~3). Contacts are made to determine readiness/ stability and to update assessments. A bed offer is made to one person by phone, by the CCAC Waitlist Coordinator, who notifies the LTCH of the result. The patient is expected to move to the home in a timely manner.

1 – Client Journey Location: Home

1a –Living in the Community

- Clients at home have various degrees of risk, most have chronic disease and failing health.
- All people had primary care Physicians and eight of 21 were receiving community care. Many interactions with each.
- Diffused ownership among health system of responsibility to encourage preplanning for care and accommodation issues among seniors and their families. Preplanning doesn't happen.
- Many instances of family frustration with primary and community care sector approach to seniors. Encounters often more transactional/ procedural than helpful.
- Lack of timely diagnosis, medication and nutrition management, and caregiver burnout among most common complaints at this stage.
- All families are unaware of cost issues of staying in hospital.

Databases/Forms/ Communications systems: not reviewed- many

Change Concepts

- # 1. **CCAC+HOSPITAL** - Collaborate with partners to improve preplanning of long-term care and crisis contingency planning in seniors.
- # 2. **CCAC**- Create consistent messages about importance of preplanning for staff to ensure that 'refusal of bed rule' does not encourage families to delay planning for the future.
- # 3. **HOSPITALS** - Create consistent messages and clear information that can be agreed upon and shared via primary care and CCACs, to those at risk of hospitalization. This includes what can be expected if admitted to hospital, including co-payment arrangements.
- # 4. **CCAC+HOSPITAL+LHIN**- Work together to create viable options for when crises do occur that can be accessed directly from community, via CCAC, with involvement of emergency medical services. This may redirect the current patient flow away from hospitalization. (note- family focus group gathered their thoughts on best design features for this.) Done effectively, this could result in significant ALC day reduction.
- # 5. **CCAC** - Develop a more 'retail' approach to services, assisting the public in understanding what a CCAC offers, the value of the service and how to access them.
- # 6. **CCAC+ Primary care**- Work together to build more meaning into the interactions with existing community care clients/ patients and their families who need help with chronic disease and aging, thus improving their experience. Share intelligence from both home visits (CCAC) and house calls (primary care).
- # 7. **CCAC** - Create 'triggers' in the community to assist families in initiating the care/ accommodation planning process. (e.g., when a patient is diagnosed with dementia, when somebody turns 70, when retirement planning, radio campaign, etc...)
- # 8. **CCAC** - Create more assertive outreach options for patient/Client groups, such as those with dementia or frailty of aging, who could benefit from better medication management, crises contingency planning, respite care and family education.
- # 9. **MOHLTC** -Demystify long-term care and promote positive image of this and other alternative settings for care outside hospital. Establish methods to convey the ways in which hospitals are excellent and what they are not suited for.

2 – Client Journey Location: Hospital Emergency (s)

2a. Present in Emergency Department

- 11 of 21 were brought by ambulance to hospital.
- Ten of 21 had caregiver fatigue, or an avoidable adverse event in community (medication management issue).
- ~five instances of patients admitted to emergency department due to lack of inpatient beds.
- Depending on where ambulance brings patient, hospital may or may not have acute care history available.
- Patient may receive nursing or medical care if presenting with acute (not social) issue.
- May be referred to other community services and/or be discharged.
- In Toronto, there is instant notification of CCAC with ED notification portal (clients who may need service and aid of existing CCAC clients presenting to ED. – CCAC office monitors portal).

Databases used: 2

Forms Observed: 2

Change Concepts

- # 10. **HOSPITALS** - Look for methods for making the hospital emergency department a senior-friendly environment, providing the most caring and considerate place possible as people move to other more appropriate settings.
- # 11. **HOSPITALS** - Make hospital admission process more robust to *trigger* notification to *all* relevant parties (i.e. CCAC Community Care Coordinators, home care agencies and supply vendors).

- # 12. **MOHLTC** - Re-evaluate the funding limitations on service that can be provided by home care (or other services) to determine if resources can be better re-allocated from ALC.
- # 13. **LHINS**- Integrate information systems so that no matter where a patient arrives, acute care history is available.
- # 14. **CCAC**-Extend concept of TCCCAC ED notification to other CCAC areas to ensure more triggered methods of follow-up exists across province.

3 – Client Journey Location: Hospital Inpatient Medicine Unit (s)

3a. Stay on IP medicine Unit(s)

- Patient may require stabilization by hospital care team.
- Rounds occur; unit Social Worker's involvement is triggered.
- Family is notified or contacted about the potential need to consider alternate care and accommodation.
- Several instances of movement of patient within hospital or across hospital sites. Communication with family regarding this was often problematic (e.g., surprised to find patient moved).
- Families report having to 'camp out' in hospital in order to know status of patient, as they rely of verbal messages from various parts of the hospital care team for status.
- May receive rehabilitation while in hospital.
- Ample charting in paper chart and/or Hospital Information system. Approach is highly variable across sites regarding what is/ isn't charted electronically in hospital. CCAC personnel must learn variations when dealing with multiple sites/ floors.

Databases used: 4

Forms Observed: 22

Tracking Tools: 4

Change Concepts:

- # 15. **HOSPITALS** - Methods to communicate inpatient medical patient status more visually, both with patients and families and among the care team. Use of bullet rounds among staff and whiteboards with patients has shown effectiveness in other areas.
- # 16. **HOSPITALS+CCAC**- Orientation vehicles made available to people in hospital plus other locations, to apprise them of how to start planning for the future.
- # 17. **CCAC** - Create a method for tracking that replaces manual 'Hospital ALC tracking tool' + Manual CCAC tracking tools + 'CMAL' that is drawn from CCAC's post acute service intake workflow *directly*.

3b. Client Discharge Counseling

- Client interacts primarily with the hospital Social Worker/ Continuing Stay Coordinator in partnership with the hospital team to plan the transition to home. When home care or placement is required CCAC is notified.
- Discharge counseling documentation may predispose people to planning for long-term care. Ability to pay for other options and other community services may or may not be discussed.
- No decision support tools at point of care or elsewhere to support systematic review of options with family.

Change Concepts:

- # 18. **HOSPITALS +CCAC** – Create a tool that supports the person doing discharge planning and family with information to examine all viable services available, public and private. (e.g., Care Concierge). Includes planning for home care and long-term care.
- # 19. **HOSPITALS+CCAC** – Design into the process a knowledgeable person who can spend *meaningful time* with patients and families, directly and early in process to explore all such options.
- # 20. **CCAC**- Reduce the burden of paperwork on families and make communication more senior friendly.

3c. Classify ALC

- Classification done by Physician, with advice of care team.
- Mismatch of care begins. See section Deficiency # 4 : Compromised care. Note that no interviewees in the 'hospital to home care' study expressed frustration with hospital care.
- Clients begin paying \$50 daily co-payment. See section Deficiency # 5 :Confusing financial messages.

Change Concepts:

- # 21. **LHIN** – Explore idea of a single organization taking responsibility for providing access to and/or paying for delivery of all care of the patient once they are classified as ALC, even while they remain in the hospital. This may include providing or paying for nursing, personal support, and other allied health services as well as collecting co-payment etc. (Requires home care process capability issues to be addressed. See Report 1).
- # 22. **Hospital +LHIN**- Make copayment information consistent across sites within region, reducing use of jargon. As this

aspect involves an assessment of ability to pay, this function may be combined with another role of someone able to offer private pay options requiring such knowledge of ability to pay.

3d. Select LTCH + Counseling

- Counseling knowledge is based on experience and information that may not be recent. Not able to provide accurate wait times, waiting list sizes for LTCHs.
- Over 600 homes in province, each with unique size, features, service etc. No consumer friendly and searchable knowledge bank available to public. Not possible for any person to provide comprehensive and timely counseling on what is available within this sector.

<p>Quinte HC- Trenton Variation Helping the client/ caregivers select homes and all related counseling is aided by the <u>CCAC Coordinator</u></p>	<p>Toronto Western Variation Helping the client/ caregivers select homes and all related counseling is performed by the <u>hospital Social Worker</u>.</p>
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Forms Observed: 20

Change Concepts:

- # 23. **CCAC** – Publish quantitative metrics on expected wait times LTCH waiting list sizes.
- # 24. **MOHLTC** – Give patients more opportunity to be matched with an appropriate home by allowing more than 3 LTCH options, especially important to those who may be hard to service.
- # 25. **CCAC** – Ensure that those helping in the selection of a LTCH are fully knowledgeable about the options. This may include training and certification for a given region, and potentially a

requirement that placement counselors do a tour themselves of all the homes in their region.

3e. LTCH Assessment

- Care Coordinator performs the RAI-HC assessment, a standardized assessment performed provincially. Done as designed, the RAI-HC takes approximately 1 hr to complete.
- See data processing path (RAI assessment itself seen to have marginal impact on client journey.)

<p>Quinte HC- Trenton Variation A hospital <u>Placement Case Manager</u> (a CCAC employee, dedicated to placement), performed detailed RAI-HC assessment and face-to-face counseling. Approx one hour to perform. Included laptop direct data entry. - Other information was provided in this exchange. - All families aware of CCAC involvement.</p>	<p>Toronto Western Variation A <u>hospital Care Coordinator</u>, (a CCAC employee arranging home care + placement). - performs a brief assessment, @ 10 minutes with the client. Collect other information from a review of hospital chart. -completes RAI data in CCAC office. - No families indicated any CCAC involvement within hospital.</p>
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Brochures: Some LTCH brochures may be distributed.

Forms Observed: 23: The LTCH application package is completed-previous forms that were originated on inpatient unit. Choice list may be provided by client at this stage. Five to six forms require signature of client or family. (therefore faxing etc. at a later time).

Databases: 3

Change Concepts:

26. **CCAC**- Review the Care Coordinator’s RAI assessment encounter. Work with staff to see how information collected and time spent can be maximized towards having a positive impact on the client experience.

3f. Accept & Discharge to LTCH

- The client received a bed offer for one of their 3 LTCH picks.
- The client has up to 5 days to prepare and move into the LTCH, otherwise the offer is withdrawn.
- The family/caregiver helps move belongings from previous home to LTCH, and arranges other details such as finances and termination of leases.

Quinte HC- Trenton Variation

The client may be offered an *interim bed* that is not on their choice list. Often this LTCH is over an hour from the caregiver/family. If they refuse this bed, they may be charged \$800 +day. This caused a great deal of fear in the interviewees.

Toronto Western Variation

No mention of an \$800/day charge was mentioned by the interviewees. As such, the stated theme of making a decision out of fear was less prevalent at site 2.

Change Concepts:

27. **LHIN** - Investigate more client-centric, realistic, and effective alternatives to encourage patients to take interim beds (such as making rule changes so as to *not lose* priority level on LTCH

wait list, placements nearer to family, assuring placement is temporary, etc.).

28. **CCAC**- Provide counsel to the client/caregiver with regard to issues such as changes in managing finances, moving logistics, and other value-added service.

4 – Client Journey Location: Long-term care Homes

4a. Tour Long-term care Homes

- Family caregivers usually tour LTCHs on behalf of patients waiting in the hospital.
- May visit many homes. Hospital provides paper based list of addresses of local long-term care homes. This is a small subset of 600 + homes in province.
- Limited times are made available for tours at homes (e.g., Thursdays at 1pm). Tours may be of homes distant from hospital, but closer proximity to a family member.
- Each home arranges their approach to tours- what is covered etc. Multiple phone calls with each home to arrange tours.
- Families search for ‘the right questions’ to ask.

Quinte HC- Trenton Variation

Less sites to visit in the region due to fewer long term care homes.

Toronto Western Variation

More long-term care sites to visit. More mentions of use of outside research (e.g., web, media) than at Quinte HC- Trenton.

- **Databases:** Internet research, media research, complaints site (highly variable)

Change Concepts:

- # 29. **CCAC + OACCAC** – Create a *provincial* ‘trusted source’ through which quality and characteristics about LTCHs can be shared. This could take a number of forms such as publications using a standard template, reviews by Social Workers or Placement Coordinators, reviews by an unbiased third party, DVDs, virtual tours, etc.
- # 30. **CCAC + OACCAC** - Support development of a less ‘controlled’ site that families can get easier access to ‘word of mouth’ feedback on long-term care homes.

b. Arrive at Long-term care Homes (Admit/ Move in)

- Travel to the home would be done either by the caregiver or arranged by the hospital through Ontario Patient Transfer (OPT). Sometimes done without family caregiver involvement.
- Medication orders and relevant medical history from hospital may be communicated to LTCH via fax (was not transferred for some interviewees).
- This is a time of great sensitivity for both the family of the resident who may have passed away (to create the vacancy) and the family moving in their relative. Families sometimes note the lack of sensitivity of each health system stakeholder to overall gravity of situation.

Change Concepts:

- # 31. **HOSPITAL/ LTCH-** Design a ‘discharge to LTCH process’ that ensures all medication and discharge instructions follow the patient, and that *personal* wishes of families are gathered and addressed in such important transitions. Assign a person to guide the transition, ensuring someone is attending to the

details, and that family and LTCH facility personnel are available to welcome the new resident.

5 – Data Processing Location: Hospital CCAC Office

5a. Submit Completed LTCH package

- This is done with some variations between sites as noted:

Quinte HC- Trenton Variation	Toronto Western Variation
After in RAI assessment, CCAC Coordinator returns to Main office of CCAC to complete minor component of RAI assessment remaining and physical handoff to team assistant for remainder of processing.	After gathering information on floor, CCAC Coordinator goes to the Hospital CCAC office where she completes all of electronic RAI assessment and transmits to Team Assistant at main office by a method not observed.

Databases: 2

Forms Observed: ~ 20

Change Concepts

- # 32. **CCAC** - Minimize and automate the data capture requirements for CCAC personnel in the hospital. There is currently significant overproduction and overprocessing of information. Some goals may include; that any piece of information should be only entered once; that any data captured must inform care delivery decisions by front line staff; that a CCAC Coordinator should be able to reasonably follow the same process in any hospital in the LHIN, replace faxes with electronic transmission, maintain visibility of the state/process of a client to all relevant stakeholders without added ‘tracking’ tools.

6 – Data Processing Location: CCAC Main Office

6a. Process and send LTCH package to LTCHs

- The information from the RAI assessment and the placement application package is copied 3 times, once for each long-term care home the client has indicated on their choice list. This is couriered or faxed.
- Homes have five days to accept or 'withhold acceptance' to their long-term care home, and associated waiting list.

Databases: 3

Forms Observed: 21

Tracking forms: bed availability form

Change Concepts:

- # 33. **LHIN** – Eliminate the fax/courier step by creating a shared repository with applications and RAI-HC assessments that allow the CCAC and LTCHs to be able to look up the relevant information.
- # 34. **CCAC+ LTCH**- examine what is most valuable to the LTCH from within the application and assessment package, and for how long the information remains useful. Information collected and whose usefulness expires before being viewed should no longer be collected.

6b. Place Clients on Waitlists

- LTCH indicates acceptance to CCAC which then creates an 'acceptance' letter. Letter is sent to client or power of attorney.

- CCAC adds client to wait list for this home, noting relevant client features (gender, accommodation type, care level, etc) within software system.
- Where client acceptance is 'withheld' (~10% of time), process returns back to hospital for family to make another choice.

Change Concepts:

- # 35. **CCAC** – Reduce time to acceptance (5 days) by long-term care home by providing relevant information from CCAC Coordinator electronically.
- # 36. **MOHLTC**- Allow expanded number of choices immediately, particularly for those who are hard to serve, thereby expediting the process of locating homes willing to offer residence.

c. Vacant bed matched to client

- LTCH notifies CCAC of vacant bed by fax, within 24 hours of vacancy.
- Specific details of what type of bed is available ('light care, medium care, male, female, semi-private, etc.) may be lacking as long-term care home undertakes its own internal 'bed offer' process. Other families internally may want the bed in question.
- Final details of vacant bed may come days later.
- CCAC locates ~3 potential clients from list for consideration to place. A process begins, that may last days, of gathering today's medical and other status of the clients being considered. For hospital patients on the list, this will include calls to Social Worker or other CCAC personnel at the hospital.

Change Concepts:

- # 37. **MOHLTC+LTCH + CCAC**– Create a provincial LTCH bed registry that can be shared across all CCACs and LTCHs. This would outline the specific details of each bed within each home, and an overview of the high level clinical status of the resident occupying this bed. From this data there would be greater visibility on the resources and residents, thereby illuminating what may be coming available. (e.g., wait times). Specific details of the vacant bed, particularly the nature of roommate, which dictates if room is male/female occupied, and behavioural issues would be more transparent.
- # 38. **MOHLTC**- consider an overhaul of long-term care home regulations with goal of simplification of rules of access (see conclusion of report).
- # 39. **LHIN**- Consider discontinuing practice of changing priority level of person waiting due to a change of location (i.e. Both practices of gaining 1a status while hospital is in a crisis, and a patient losing community crisis 1a status when person in community becomes hospitalized.)

6d. Offer Bed

- Placement Coordinator communicates with the client/caregiver via phone.
- Family has a day to accept or reject the bed offer.

6e. Discharge from CCAC

- Client status in CCAC system is changed to 'discharged' if client is accepted to a long-term care home that is their first choice.
- Follow up phone call (~6 weeks) to determine if person placed in 2nd or 3rd choice wants to remain on waitlist for their 1st choice. If not, discharge.

7 -Data Processing Location: LTCH Head Office (s)

Not observed.

5. Conclusion: Is the Process *Capable* of delivering value to the client?

Thus far, this report has answered the following questions:

- What does the client define as value?
- What is the process used to deliver value to the client?

Recall the value statement:

"I want help getting accurate information that I can understand at the right time and place, including viable options, so my family and I can make the right decision for us. I want to feel confident that people care and to be treated with fairness and respect."

Now, we can ask '*How capable* is the process of delivering value?' Currently, the process is not very capable of meeting patient and family expectation for at least three reasons: the design, ownership and infrastructure are lacking.

Design

The process has not been designed on an end-to-end basis. There are few if any mutual performance expectations across organizations anchored on what families need. Functional managers use the legacy departmental processes to manage their functional area's performance improvement. As such, information about, for example, bed availability or new community services is slow or unable to arrive to the destination where it is required.

Further, the documentation of the process has been primarily functional, with few interconnections, electronic or otherwise, to support performance. The placement process needs inter-enterprise redesign to optimize its performance. Specific examples of design

flaws include conducting assessments that may not be used later, wait list information that is unavailable despite patient requirement to choose 'short wait list' homes, regulations that dissuade preplanning and others that encourage long-term care homes to always be fully occupied.

Infrastructure

Almost every software currently used in the 'hospital to LTCH' process is designed to serve the functional needs of a single organization or department. Such fragmented legacy IT systems lacks the architecture to allow for inter-enterprise communication so essential to support the process.

Additionally, human resources systems are arranged functionally, with functional managers (e.g., discharge planning, hospital intake, organizational placement, long-term care management, etc) rewarding the attainment of functional excellence. (e.g., # of assessments completed, % of occupancy of LTCH etc.). The ideal inter-enterprise process, designed to deliver value by helping people with this transition, would be used to drive role definition.

The result is staff that are left to manage the hybrid of 'stovepipe' applications that do not move information to where it needs to go, and that takes their time away from helping people.

Ownership

The ownership of the 'hospital to LTCH' process is not an individual effort. It is a group of people diffused across several organizations who devote some part of their mindshare to the end-to-end process's performance. This diffused operational ownership means that the process has not been well documented end to end, that

improvements have been historically small scale and slow to arrive. If the authority to change the process comes by lobbying other functional managers to make change, the changes will be tiring and time consuming for all involved.

The infancy of the process design, ownership and infrastructure around it are the major constraints to capably delivering value as sought by patients, family caregivers and the public.

6. Moving forward

Challenging the way we think about long-term care access

Through these two sites, a number of questions were generated about access to LTC. While they are not easily answered, they do challenge some of the working assumptions underlying today's system design:

- Does the '97% LTCH occupancy funding incentive' *decrease* ALC days (by ensuring high utilization), or *increase* ALC days (by forcing hospitals to be the 'buffer' that holds ALC patients until a spot opens in the LTCH)?
- Which method would be more effective for providing appropriate care for patients and reducing ALC days –continuing to expand capacity by creating permanent long-term care beds, or expanding the 'buffer' by creating dedicated interim care beds?
- Who should occupy a LTCH bed? The level of 'need' of people going to long-term care homes differs. For example, when vacancy rates go up, a new home is built, or a new wing is created, CCACs go further down the waitlist. Why is the level of

need required to access such a bed not kept at a fixed level? Would setting a required 'high' needs level reduce confusion? By doing so, how much system capacity would be freed?

- Why do some LTCHs have long wait lists while others have empty beds? What can be changed about the sites that are not in demand to make them more attractive than staying as an ALC patient in the hospital?
- Does granting 'priority access' to the hospital for LTCHs decrease or increase days spent in hospital? Could this restriction on community access to LTCH increase patient flow to hospital? Does the patient's fear of losing 'hospital' priority status prolong hospital stays?
- Why can no more than three LTC homes be put on a choice list?
- Can the available supply of LTCH beds be changed to enable easier matching? Might having uniformly available private room options streamline access, improve care in homes, and reduce cost to the system?

Future areas of inquiry

The following is a running list of questions participants raised in South East and Toronto that may be explored in future sites:

1. What can be learned from crisis community placements where the patient never entered the hospital? Can these learnings be applied to improve the ALC process?
2. How does the experience of people in the 'waiting at home' program differ than waiting in hospital?

Current status of improvement actions

Toronto Central

During the past year, Toronto Central CCAC has initiated a redesign of its current service delivery model. The focus of change is on improving value to clients, more effectively supporting transitions, and helping hospitals address short and long term wait time and capacity issues.

This project has had a significant influence on CCAC planning and has helped to set priorities for transformation. Key building blocks of the approach are outlined below.

A Population Focused Model of Care Coordination

TCCCAC is transitioning from a geographic focus to a population focused case management model, where case managers specialize in caring for certain client types. This will enable case managers to gain a better understanding of client and caregivers, tailor processes and communications to meet their needs, and strengthen partnerships with stakeholders including physicians, hospitals, psycho geriatric resources and others. Given their vulnerability and the results of this project, frail seniors at risk of losing independence will be the first in a series of population-focused teams in the future.

Intensive, Continuum-Focused Case Management for Targeted High Risk Populations

The population-based model will introduce a more intensive case management model for targeted high-risk populations. Intensive case management has the potential to reduce avoidable admissions to hospital, improve pre-planning and more proactively identify and respond to issues of caregiver fatigue. In this model, care

coordinators will follow their clients through the continuum of care. Seniors receiving home care who are admitted to hospital will be followed by their existing community care coordinator, who can help them prepare to return to the community and support them in making decisions about their next care destination.

Organizational Focus on the Client Experience

Toronto Central CCAC has committed to deepening its understanding of the experience of clients. A promise of care and service commitments are being established across all areas of client service. Specialized training and orientation has been developed and the provincial client satisfaction survey has been adjusted to capture more feedback from clients. Other client experience initiatives underway include:

- **Introduction of Client Quality Check Points** – Toronto Central CCAC now performs check-in calls to all newly admitted clients 1-2 days post-discharge from the hospital. This is intended to provide support to the client in their transition and to proactively address any issues or concerns that they may have with their service.
- **Communication Redesign** - Toronto Central CCAC has redesigned all client brochures based on feedback from this report and client focus groups and input. The message is simple – Help is a phone call away. Call centre staff have been retrained to provide a warm embracing experience for all callers and further work is underway to take the call centre response to a new level.

Waiting at Home & Seniors Independence Project

These two projects have allowed Toronto Central CCAC to test very different approaches to supporting seniors and their caregivers. One is community based, with a goal to help seniors remain independent in the community safely with more integrated support. The other is a hospital 'in-reach' program where community care coordinators work with CCAC staff in hospitals to support clients to get back home. TCCCAC has seen significant diversions from long-term care as well as vastly improved results in measures of client experience and satisfaction. Evaluations of these programs are available from Toronto Central CCAC.

Together We Care

In March 2009, Toronto Central CCAC co-authored "Together We Care", a white paper exploring innovative ways to support patient flow across the continuum during times of growing demand and reduced capacity. The focus is on transforming system culture and behaviours related to clients – particularly when it comes to traditional assumptions about long term care. The mantra is keeping people home and getting people back home. This paper was tabled at the hospital leadership (CEOs) in the Toronto Central LHIN, who recognized that we need a change in approach across the continuum at every level of the organizations that serve clients. The next step includes a round table on the subject and research into an integrated model of care for seniors.

Hospital Transformation

Toronto Central CCAC has committed to transforming how it works in hospitals with a goal to improve the value that it brings to clients, rethinking key processes, and building stronger relationships with hospital partners at all levels of the organization. A number of

significant changes are planned for the coming year, including a new approach to working in the emergency department, redesigned processes and workflows, and improved information and support for clients as they transition home or to other care destinations. Other initiatives include:

- **Home First** – The "Home First" approach is about creating an environment where life-altering decisions are not made in an acute care bed. It has the potential to transform the current referral process to long term care by refocusing everyone, including discharge planners, physicians and the CCAC, on the idea that patients should go home first if they are able. Patients are assessed for their ability to go home with CCAC support; decisions about long term care are made once a client has returned to the community. *Home First* has shown dramatic improvement in other jurisdictions, both in terms of client experience and in reduced ALC to long term care. Toronto Central CCAC is planning to phase in a Home First approach with all of its hospital teams beginning in Summer 2009.
- **Early Notification and Involvement of CCAC in Hospital** - A new automated referral system is being implemented in the Toronto Central LHIN. Fundamental to this system is an early notification to the CCAC of a hospitalization to improve the timeliness and opportunity for their involvement. In early tests, this has been critical to getting people back home (as opposed to long term care) and providing improved support to clients and families.

Crisis Placements

1A crisis placement designation gives priority to hospital patients in

the LTCH placement processes, causing a ripple effect across the system that has real impact on the client experience. This report verifies that A1 Crisis Placement causes confusion and may cause further hospitalizations. Toronto Central CCAC and Toronto Central LHIN have a steadfast commitment to avoiding the assignment of 1A status to hospitals. However, Toronto Central CCAC continues to feel the impact of other LHIN areas when they use this priority method, and has therefore escalated this issue to a provincial review table.

Commitment and Focus from Board to Front Line

Toronto Central CCAC has committed to three major aims for 2009/10 that demonstrate wide spread commitment to transformational change. Overall transformation will occur over two to three years as we fundamentally drive a 'client experience' focused culture through the new organization. These aims included

- Transforming Our Clients Experience;
- Transforming Our Work and Role in the Hospital;
- Building Our Quality and Safety Capacity Across the Organization.

"This project, combined with others... was pivotal for the Toronto Central CCAC in challenging our thinking and behaviours. It significantly informed our path forward. We have chosen to radically change the way we are structured, organized as well as how we approach care for our clients as a result."

South East

Placement Notification

Families of people hospitalized and looking for LTCH advice needed to make a call to the CCAC to get assistance from the CCAC

coordinator. This involved some phone tag between the family and the CCCAC coordinator. The process is now more streamlined so that patients can get easy access to the coordinator at predefined, scheduled times on site in the hospital.

Staffing modifications

People who are waiting for long term care in hospital may not require acute care, but they continue to have personal care needs. Without adequate attention, their health status can actually decline while they wait. This was a problem for Quinte Health Care, who addresses it by adding personal support workers to help people with needs such as feeding and ambulation.

Removal of Hospital Priority Access Days

There was a practice in South East Ontario of having all new LTCH bed vacancies arising on *Tuesdays, Wednesdays and Thursdays* offered to hospital patients before those clients with the same priority in the community. This caused confusion to those waiting for LTCHs and may have been counterproductive to the goal of reducing unnecessary hospitalizations. This practice was discontinued recently. Results are being monitored

The South East CCAC and Quinte Health Care have established a senior- level ongoing liaison process to action findings of the project.

Appendix A : Staffing Structure

Social Workers and Continuing Stay Coordinators

The staffing structures differ at TWH- UHN and Quinte Health Care-Trenton. At TWH, Social Workers employed by the hospital counsel patients *through the entire process* of selecting choices, steering the family to complete most of the application package for LTCHs. In Toronto, the CCAC Coordinator completes the final assessment for eligibility.

At Quinte Health Care, the CCAC Coordinator is involved sooner in the process, triggered by the hospital's Continuing Stay Coordinator (who may be a Nurse). Both the Continuing Stay Coordinator in Trenton and the Social Worker in Toronto take responsibility for communicating to the client the hospital's discharge policies, including any requirements to select LTCH's with shorter wait lists.

For convenience, we will refer to the Social Worker and the Continuing Stay Coordinator by the title 'Social Worker' (SW), even though this is technically incorrect.

The client's main contact in the hospital for discharge issues is the SW. The SW is a hospital employee. The SW uses a number of approaches to identify clients who may be a high risk of exceeding the hospital's expected length of stay due to their more complicated situation (e.g. frailty, co-morbidities, living arrangements, etc), or who may need home care services.

Once the patient has been identified, the Social Worker works with the patient, family and care team to find a post-acute care option to enable discharge. The SW then implements the discharge plan. This may include a transfer to another inpatient unit in the hospital, a

referral to the CCAC, or a linkage to other community resources to maintain the patient's independence in the community (e.g. retirement homes, Hospice, Meals on Wheels, Alzheimer Day Programs, etc.).

CCAC Coordinator

The staffing structures of Toronto Central CCAC and South East CCAC also differ within the respective hospital scenarios. At the South East site, hospital patients come into contact with the CCAC Coordinator with the encouragement of the hospital SW when *the potential* for placement is noticed. The SECCAC Coordinator is involved in educating the families about placement, the rules, the expected wait times etc. In Toronto, the Social Worker for the Hospital does much of this counseling. The CCAC Coordinator in Toronto is involved only once the client is stable, the application is complete, and most of the paperwork compiled. Both CCAC's Coordinators complete a RAI assessment, and forward the completed application to the CCAC Main Office. There were observed differences in the mechanics and time taken to complete the RAI assessment across sites.

In Toronto, the CCAC Coordinator is on-site given the high volume of patients going to LTCH. In South East, the CCAC Coordinator is part time on site at Trenton, with the hospital scheduling family meetings with the Coordinator on predetermined days.

Waitlist Coordinator

This role performs similarly in both sites. Waitlist Coordinators are located within the CCAC office, and manage the communication involved matching available LTCH beds with all people on the home's waitlist. Once a LTCH vacancy is communicated via fax to CCAC Waitlist Coordinator, the bed is matched with potential residents by

reviewing the wait list. The potential resident is then investigated for their medical stability/ readiness etc.. This involves multiple phone calls and could involve reassessments of the client in some situations. Once a match is determined, the Waitlist Coordinator communicates the bed offer, often to the patient or caregiver directly. Regulations specify that patients may take up to 24 hours to make a decision on a bed offer.

Appendix B : Detailed Interviewee Statistics

Detailed interviewee Statistics

Figure 2: Overview of People Interviewed

Location	Reason for admission or CCAC diagnosis	Placement location/ choice
QHC-TMH	Fall & CHF	1st
QHC	Prostate surgery & dementia	1st
QHC	seizures/ frail	1st
QHC	Fall & CVA	Home after first available offer
QHC	Frail/old/ dementia	2nd
QHC	Fall – Osteo	1st
QHC	CVA	To first available bed
QHC	Frail & Osteo related	Retirement home
QHC	Fall & Blind	1st
QHC	Dementia & O2	3rd
QHC	CVA	1st
QHC	Dementia	1st
QHC	Dementia	1st
QHC	Pain – frail/old	1st
QHC	Dementia	To first available bed
UHN-TWH	Kidney failure/ frailty	waiting
UHN-TWH	Colon failure	2nd
UHN-TWH	CAD	1st
UHN-TWH	Failure to cope	3rd
UHN-TWH	Delirium	3rd
UHN-TWH	CHF	3rd

Appendix C : Detailed Process Map Illustration.

This is a scaled down version of the detailed 'hospital to home care' workflow process created for this report. This image is for illustration purposes only. A full map may be made available upon request from Doleweerd Consulting (www.doleweerd.com).

