



**Having their say and choosing
their way:
Helping patients and
caregivers move from hospital
to 'home'**



**Executive Summary: Site One in South East
LHIN Area**

**Based on report created by Doleweerd
Consulting Inc.**

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Background

Having their say & choosing their way: helping patients and caregivers move from hospital to 'home' is a joint project of The Change Foundation and the Ontario Association of Community Care Access Centres (OACCAC). Launched in January of 2008, the project will map out and improve the myriad interactions and decisions that patients and their caregivers must make during the transition from hospital to 'home.' The project has the potential to improve patient experience, decrease unnecessary hospital stays, reduce community-based adverse events and eliminate confusion about provider roles and responsibilities.

Selected CCACs, hospitals and interested Local Health Integration Networks will work together to identify and improve patient/caregiver experiences and decision-making throughout the move from hospital to 'home' – be that personal residence, retirement home, long-term care home, supportive housing, etc. The project will be rolled out in three sites over several years and phases, starting with Quinte Health Care's Trenton Memorial and the South East CCAC. As part of this project, patients and their caregivers will be surveyed about their needs, perspectives and placement preferences to help inform recommendations for changes to process, policy or practice.

Why do we need this project?

Despite much focus on the importance of providing Ontarians with an integrated health-care system, where "the right people get the right treatment in the right place at the right time", many patients still fall between the cracks. One of the causes of this disconnect is the lack of good transition planning from one health-care sector to another. With the demand for home-care/community services on the rise and hospital cost constraints, the need for good discharge

planning from acute care hospital to home/community setting is more pressing than ever.

Every year over 1 million patients are discharged from acute care hospitals in Ontario. Effective transition processes would help ensure that patients are transferred to the most appropriate subsequent care destination in a timely manner. There is compelling evidence that in some parts of the province that is not always happening today:

- Patients often stay in hospitals long after their acute-care requirements have been met (ALC -Alternative Levels of Care).
- In 2005/6, Ontario had 600,000 ALC days (equivalent to six 270-bed hospitals);
- 58% of ALC days are spent preparing to return home or relocate to a Long-Term Care Home (Provincial Health Planning Database, 2005).

What's the problem?

Delays are often caused by slow processes, complex or inadequate communication, and lack of timely information, resulting in increased number of ALCs. The challenge of effective communication is that it involves a great number of stakeholders – for instance, patients, family and caregivers, clinicians, administration, long-term care homes, hospitals, and Community Care Access Centres (CCACs).

Site 1 Project: SE CCAC and QHC Trenton Memorial

What was done?

To understand the hospital-to-home process from the patient's perspective, 15 recently discharged individuals from QHC Trenton Memorial were recruited for one-on-one interviews conducted by project management consultants with Doleweerd Consulting. All of the patients had spent some time in hospital when they no longer needed that level of care (ALC). Process maps examining the hospital-to-home transition were generated through direct observation of clinical staff activity and interactions with clients. Local project team members identified opportunities to create value for the patient with each step in the process. Caregivers were also involved. Ideas for changes to improve the process were developed and the two organizations are working on implementing them.

What did patients and families say they wanted and needed?

"I want 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."

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

What did we find out about the process moving from hospital to home?

Moving from hospital to long-term care home took:

- 160 steps: 69 handling steps; 36 forms; 4 (often long-distance) family trips to the hospital (many more calls required); 15 delays at hospital and CCAC levels.

Making a bed offer took:

- 53 steps: 18 handling steps; 5 staff involved; 5 phone calls (not including LTCH interim bed offer process); 5 times client is entered into a tracking pool; 9 forms originated; six delays.

Background on ALC at Quinte Health Care

High ALC rates can lead to high hospital occupancy, which can lead to emergency department crowding, delays offloading ambulances, cancelled elective surgeries, unnecessary patient exposure to risk and inefficient use of resources. Furthermore, it is excessively costly to the system to inappropriately keep patients in the hospital.

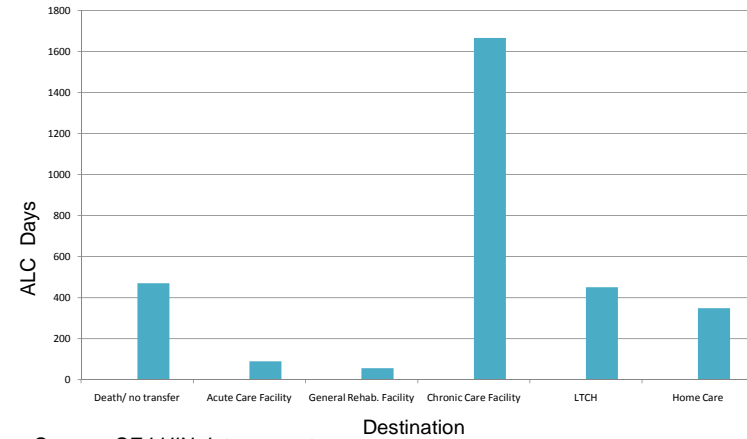
For Quinte Health Care Corporation (QHC), 68% of ALC days are accumulated by patients who go to continuing care facilities.

	Belleville	Bancroft	Picton	Trenton	All Sites
Transferred To Continuing Care Facility (Nursing Home,HFA, DVA Homes)	65%	78%	72%	69%	68%
Deceased	15%	12%	13%	12%	14%
Discharged Home With Support Services (Home Care)	14%	8%	9%	13%	12%
Discharged Home With No Support Services	3%	2%	3%	4%	3%
Transferred To An Acute Inpatient Facility (Incl. Acute Rehab., Acute Psych.)	3%	1%	2%	3%	2%
Transferred To Other Type Of Facility (Incl. Ambulatory Care, Palliative Care, Addiction Treatment, Jail)	0%	0%	1%	0%	0%
Left Against Medical Advice (With/Without Signout, Awol)	0%	0%	0%	0%	0%
Total ALC Days	7,456	1,709	2,460	3,087	14,712

Source: South East Local Health Integration Network

The distribution of destinations for ALC cases in Trenton is similar to QHC as a whole. ALC patients in Trenton are frequently located on the Complex Continuing Care (CCC) Unit prior to discharge to another setting as indicated by the ALC chart below. Definitional challenges associated with ALC have been described fully in other reports and are not tackled herein.

Where do ALC patients go? Fiscal 2006-07: QHC - Trenton



Source : SE LHIN data request

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For the purpose of this study, identified patients who are located on the CCC unit and considered 'operationally' by the hospital to be awaiting other care are included as participants.

All patients involved relied heavily on their informal caregiver to help arrange post acute care services, thereby enabling hospital discharge.

Methodology

For the South East site in question, nearly all patient participants in the study were destined for Long-Term Care Homes. The local project sponsors were most interested in this specific pathway, and at the time there were coincidentally high numbers being

discharged to this location type. Future project sites may look to expand upon participants going to other destinations, such as home with/without home care.

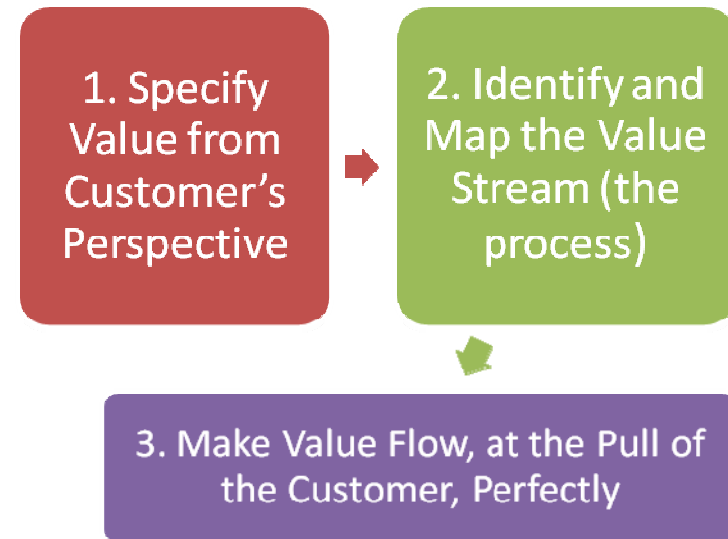
The type of patients, from a diagnostic perspective, was reflective of the ALC population as a whole— a mix of cognitively impaired, people suffering frailty, those recovering from stroke or fractures.

The investigation was primarily guided by applying quality improvement theory, with the most relevant being those popularized as Lean quality improvement concepts. The core idea of Lean involves specifying value of any given process, mapping how value is provided, and then working to make value flow from beginning to end by eliminating waste.

This investigation will be conducted at three sites in geographically distinct regions of Ontario. Each site includes a hospital, a related CCAC, and other organizations as needed. This report includes findings from the first site, Trenton Memorial Hospital (TMH) of Quinte Healthcare Corporation in the South East LHIN.

A Local Project Team composed of front line staff, management, and technical advisors from representative organizations was established. This team engaged in the investigation with project management provided by Doleweerd Consulting. This report was written by the consulting group and vetted with the project team.

Figure 1 Lean Steps in Brief



Action 1 - Specify Value from the Client's perspective

To understand the hospital-to-home process from the patient's perspective, a sample of recently discharged individuals from the participating hospital was recruited for one-on-one interviews. Because many of the patients in this study had dementia or cognitive challenges brought on by age and had difficulty recounting their experience fully, caregivers or power of attorneys listed in the patient record were contacted for consent.

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

Process maps examining the hospital-to-home transition were generated through direct observation of clinical staff activity and interactions with the client. A Ben Graham Workflow map was completed and then validated with the Local Project Team, comprised of front-line workers. This very detailed and elemental

map was then used to generate a modified Value Stream Map- a more conceptual diagram showing the key operations involved.

The map was overlaid with the deficiencies identified through the client interview process to help understand how they occurred.

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

Local project team members identified opportunities to create value for the client – change concepts during a design session. The client value statement, a list of process deficiencies and process maps were used as the foundation for the brainstorming session. Caregivers were also involved via focused group discussions.

The change concepts developed have been shared in a preliminary fashion with components of the senior management teams of both QHC and SECCAC. Several actions of a quick win nature are being investigated across the two organizations.

Client Statistics

15 interviews were conducted. Candidates were identified and provided by Quinte Health Care Corporation. All clients were patients at Trenton Memorial Hospital and had an ALC portion to their stay.

Basic Population Statistics

The sample population had the following characteristics:

- Average Age: 81 (min 55, max 96)

- 33% receiving homecare prior to admission
- 40% LTCH application completed prior admission
- 47% living with a family member
- 73% 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

Clients were discharged from the hospital as follows:

- LTCH 1st choice: 60%
- LTCH 2nd choice: 7%
- LTCH 3rd choice: 7%
- Interim bed: 13%
- Retirement home or home: 13%

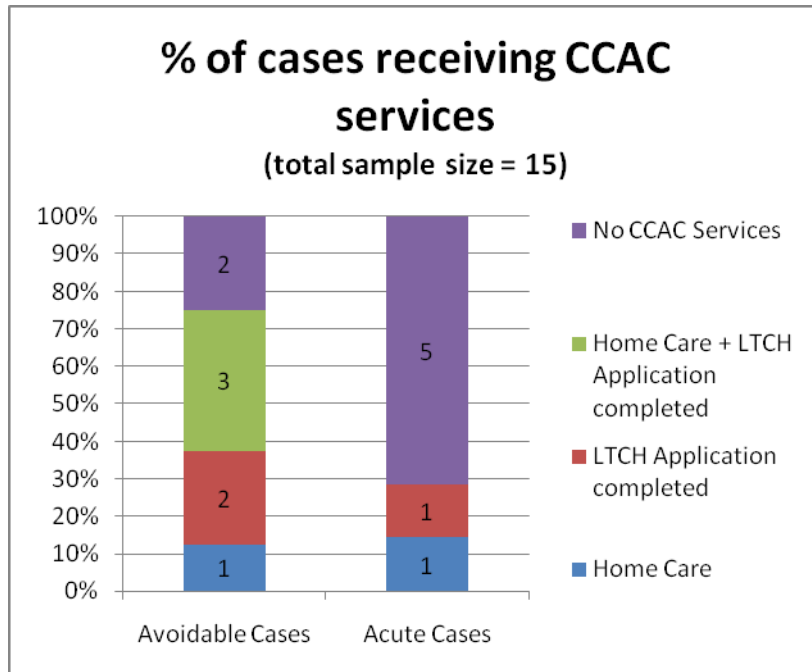
“Avoidable” Case Statistics

8 of the 15 clients were admitted due to dementia or frailty of aging, while the remaining cases were due to a specific acute event (fall, stroke, surgery). The frailty & dementia cases were often the result of the client’s condition progressing to a point where the caregiver could no longer cope. Since there are options other than the ER for these types of cases, they have been classified as “potentially avoidable” cases. Caregivers themselves agreed with this assessment.

Of the “potentially avoidable” cases, 75% were already receiving CCAC services, while only 28% of the “acute” cases were receiving CCAC services before admission to the hospital. That these clients arrived at the ER while receiving CCAC services represents a missed

opportunity to identify problems and direct clients to the appropriate source of care.

For this sample population, these “potentially avoidable” cases comprised 40% of the total ALC days accumulated.



For both the “potentially avoidable” and “acute” hospital admissions, the length of ALC stay was similar. The “potentially avoidable” clients had a much shorter acute stay.

Hospital Admission Type	Median Length of Stay	
	Acute Days	ALC Days

Acute	77	46
Potentially Avoidable	10	50

For the “potentially avoidable” patients, the hospital is acting primarily as a waiting area for their next setting.

Note that all of the statistics in this section are based on a sample size of 15 clients from a single community.

Client/Staff Interactions at Trenton Memorial Hospital

Patients and caregivers come in contact with three primary roles in the hospital environment who facilitate their transition from hospital to “home” (other members of the health-care team also assist but they are not described here because it is not their main responsibility – for example, the GP and the unit Team Leader).

Continuing Stay Coordinator (CSC)

The client would first meet the CSC, a QHC employee responsible for identifying patients 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). Once the patient has been identified, the CSC then assesses their needs and develops a plan for facilitating their discharge. This assessment may include counseling for the patient and caregivers on their options for post acute care services. The CSC 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 (e.g. retirement homes, Hospice, etc).

Hospital Case Manager (HCM)

Following a referral from hospital personnel the patient may meet the Hospital [Home Care] Case Manager. This person works for the South East CCAC and is responsible for determining the patient's eligibility for receiving in-home services from the CCAC (e.g. personal support service, rehab, nursing, etc). The hospital case manager sees the patient in their hospital room and completes an assessment to identify services and equipment required to facilitate a safe discharge back to their personal residence. The HCM works closely with the patient's family and the CSC to coordinate the plan of action for achieving the expected discharge from hospital. In addition to government funded home care services, the Hospital Case Manager may also link the patient to community support service agencies for additional support to maintain the patient's independence in the community. This may include Meals on Wheels, Hospice, Alzheimer Day Programs, etc, etc.

Hospital Placement Case Manager (HPCM)

For patients who are deemed at risk to live on their own in the community by the CSC, the patient and their caregivers are referred to the Hospital Placement Case Manager. This person works for the South East CCAC and is responsible for completing the application for placement into a Long Term Care Home (LTCH). The Hospital Placement Case Manager meets with the patient and their caregivers at the same time if possible (for patients with dementia – the Power of Attorney is required to be present) to conduct a comprehensive assessment to determine their eligibility for placement. The HPCM counsels the patient/caregivers on the

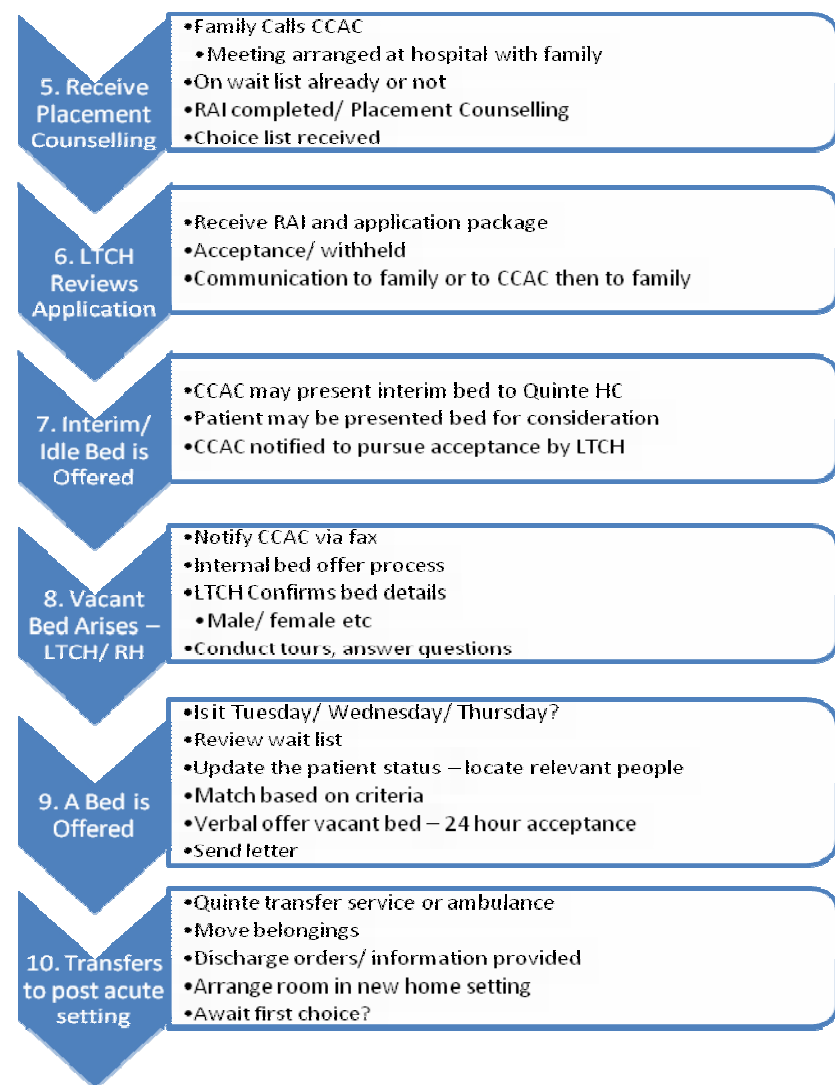
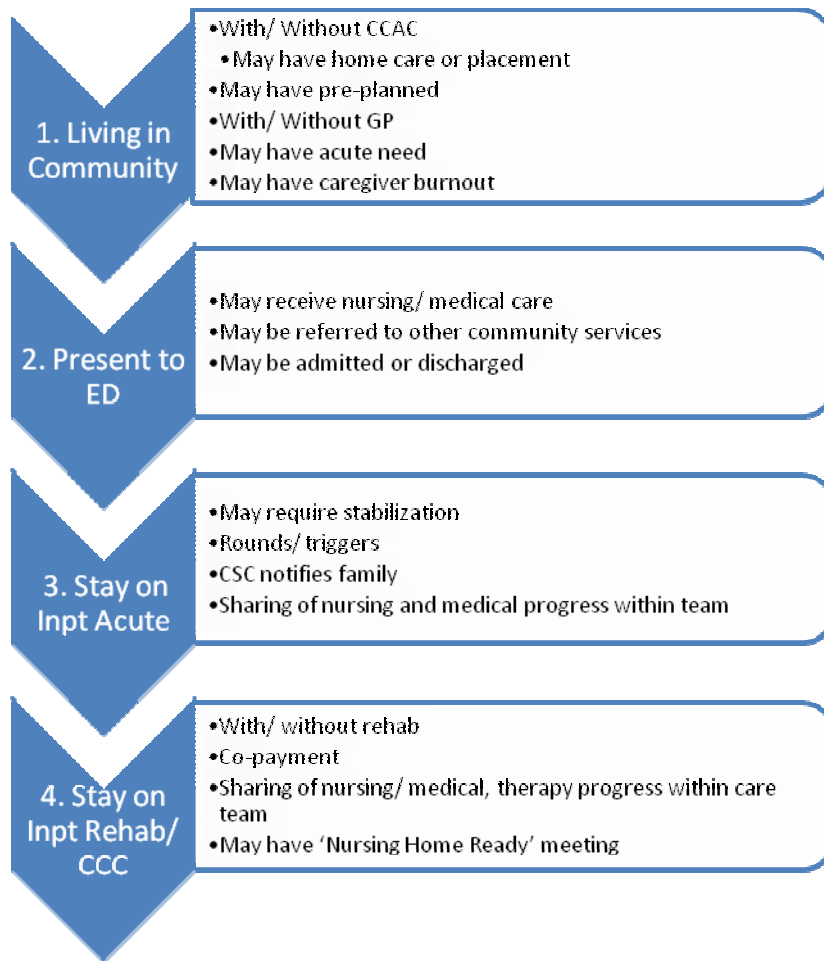
process for being placed into a LTCH. This includes touring LTCHs to submit their top three choices on the application. Once the HPCM determines a patient is eligible for placement, they complete all the necessary documents and obtain signatures to complete the application package. The HPCM works closely with the family, the CSC, and the chosen LTCHs to facilitate the patient's placement.

Waitlist Coordinator

The Waitlist Coordinator manages the communication involved with matching available LTCH beds with all people on the home's waitlist. Once a LTCH vacancy is communicated via fax to CCAC, the bed is matched with potential residents by reviewing the wait list. The potential resident is then investigated for their medical stability/readiness. 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. Waitlist coordinators are located within the CCAC office.

Identify and Map the Value Stream (The Process)

With value specified from the patient/ caregiver's perspective, the next step was to map the process through which value is generated. The Hospital → Home process is composed of 10 stages:



Eliminating Waste

A detailed process map was also generated to isolate specific value-added activities (something that contributes directly to what a

patient needs) from non value-added activities, which can be viewed as waste. The key forms of waste from within the hospital to LTCH process are from waiting, overproducing something that is not yet needed, and over-processing of information. The following are some examples receiving attention from the local project team:

Waiting:

- There are many waits within the hospital to long term care home process. Some of the avoidable waits include: waiting for a family to contact the placement coordinator, waiting for the family to visit long term care homes at predefined times, waiting up to (sometimes more) than 5 days to find out if a patient is accepted to a LTCH wait list, waiting to send the RAI to the LTCH via fax or courier, waiting for the LTCH to indicate which bed is truly available after the home’s internal bed offer is complete, waiting for information from people who know the client and whether their status has changed and their readiness for placement.

Overproduction

When clients are aiming to be put on a waitlist to, as they put it, accrue seniority, the RAI-HC is created. It was not observed to be used effectively by any party in this circumstance. This may be due to the fact the RAI will be repeated when the patient becomes a higher need. The RAI-HC reportedly duplicates many parts of other functional assessments that are being completed.

Over- processing:

- RAI assessments are filled out electronically. Then, instead of transmitting them electronically they are printed out. This

amounts to over 20 pages. They are then couriered or faxed to the long term care home. Furthermore, long term care homes report they only typically review a small part of the RAI, if any.

- When there is a change to the RAI, a paper copy of the entire package is sent to the long term care home, with no obvious indication of what has changed.
- 3 different hospital-based roles (2 CCAC Case Managers and 1 Hospital Continuing Stay Coordinator) doing different aspects of post-acute care planning for ALC patients contributes to repetitive information collection.
- Chasing down people to get an updated client status before doing a bed offer (duplicating effort because information is not available at fingertips)
- Documentation required by the placement coordinator/

Key Metrics-- Hospital to LTCH Workflow

- ~160 total steps
- 69 handling steps
- 36 forms originated
- 4 family trips to hospital to meet- minimum (many more phone calls)
- 15 delays
Includes both hospital and CCAC- *from Ben Graham workflow maps*

Key Metrics—Vacant Bed Offer Process

- ~53 total steps
- 18 handling steps
- 5 staff involved
- 5 phone calls (not including LTCH internal bed offer process)
- 5 times client is entered into a tracking tool
- 9 forms originated
- 6 delays

waitlist coordinator and hospital case manager is excessively cumbersome. The CCAC's hospital case manager alone had approximately 15 forms observed to complete for a home care referral, up from a reported 3 several years ago.

- Hospital staff must contact CCAC staff to receive information about waitlist status for their patients, rather than being able to look the information up directly.
- The requirement of the CCAC hospital case manager to seek management/ committee approval to authorize personal support. Leads to unclear or untimely communication to patient re: what can be expected.

Value from the Patient/Family Caregiver Perspective

More and more Ontarians are struggling with the stress, confusion, and uncertainty of deciding on and finding the right care and accommodation for themselves -- or a loved one – before leaving hospital. There is a lack of clear and complete information provided at the right time to patients and their families for decision making purposes. Furthermore, patients are remaining in the hospital when they should be receiving care elsewhere.

Hospital patients requiring alternate levels of care (and their families) stated:

“I want 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.”

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.

Process Findings

1. Failures are occurring in efforts to proactively plan future care and accommodation options for the aging, before a crisis occurs. Planning failures are also occurring even after crises have happened. This leads to avoidable encounters with hospital ERs and inpatient units.
2. Breakdowns in preplanning and disease management processes cause vulnerable families to make life-changing decisions while in a pressurized hospital setting. Many of the post-acute options presented while in hospital are misunderstood and not viable.
3. Information about Long Term Care Homes, including their quality and wait times, does not exist in a way that can be clearly and helpfully presented to families.
4. Other care options such as retirement homes, home care, other community services and private pay options are not *systematically* offered in a service-oriented manner.
5. Front line community care employees are over-processing information, expressing frustration at a perceived requirement to work less for the patient, and more for provincial or organizational administrative requirements. Resources to create value for clients can be harvested from an emphasis on reducing waste in processes spanning organizations.
6. The complexity of the regulatory environment associated with LTCHs and other local bed management policies are contributing to prolonged hospital stays. Consequently, patients are not getting necessary care and support during this time.

Subsequent reports will explore these issues in greater detail, presenting more ideas for improvement to this process.

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

Challenging the Way We Think about LTC Access

Through this first site, 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:

1. 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)?
2. 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?
3. Who should occupy a LTCH bed? 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 create an adequate system buffer to serve people in crisis awaiting permanent placement?
4. 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?
 5. Does granting "priority access" days to the hospital for LTCHs (i.e. all open beds go to the hospital on Tuesday, Wednesday, Thursday) actually decrease 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 in Quinte?
 6. Why can no more than 3 LTC homes be put on a choice list?
 7. Can the available supply of LTCH beds be changed to enable easier matching? Would having uniformly affordable private options streamline and reduce cost to the system?

Future areas of inquiry

The process used in South East will be repeated with modifications in two more regions of the province. The following is a running list of questions participants raised in South East that may be able to be explored in the future sites:

1. How does what's valuable to the patient/ caregiver differ between regions of the province (i.e. rural/small town vs. urban)

2. How does a differing set of communication methods in a hospital with shorter ALC length of stay impact the experience of the patient and family?
3. How does what's valuable to the patient differ depending on their reason for admission (i.e. acute event vs. dementia vs. caregiver fatigue, etc...)?
4. 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?
5. How does having a more integrated CCAC/ hospital role affect the experience of the patient and process performance?
6. Discontinuing the practice of requiring Hospital Case Managers to seek management approval for authorizing personal support. This reduces waiting time and resources required to process referral.
7. Establishing ongoing senior hospital-CCAC liaisons to discuss findings of project.

Current status of actions in South East

Local stakeholders have currently reported taking action in:

1. Modifying the method of notifying the placement coordinator to make it timelier and simpler for patients in hospital. Meetings with CCAC case manager for placement will be prebooked.
2. Trigger a meeting with the CCAC case manager for those patients who have been identified as "TRST" positive. This involves utilizing a tool in ER to identify high risk elderly.
3. Trigger CCAC even if patients are returning home, to ensure that there is an opportunity to present long term care/ accommodation planning options at an earlier stage.
4. Eliminate approval steps for in-home authorizations
5. Adding staff, such as personal support workers, in hospital sites to help with requirements of ALC patients.
