Success study:
Managing alternate level of care at Trillium Health Centre in partnership with the CCAC and LHIN

Situation:

Trillium Health Centre is a large academic-affiliated hospital within the Mississauga Halton LHIN that serves a catchment area of over one million residents and is a regional centre for advanced cardiac and neuroscience including stroke and vascular care, as well as sexual assault and domestic violence. Trillium was struggling to flow admitted patients out of the emergency department as its alternate level of care (ALC)† cases increased. The number of ALC cases peaked at 131 in March 2009, representing about 18% of the hospital's beds.

Aim:

Reduce ALC cases from March 2009 onwards.

Measures:

- Number of ALC patients per day
- Number of ALC patient days

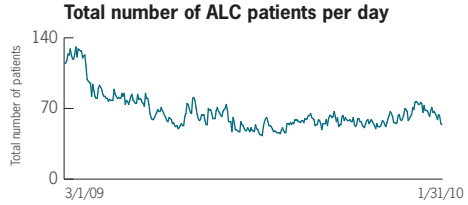
Changes:

- Established a Joint Discharge Operations group where Trillium's discharge planning staff and CCAC case managers work together as one team, reviewing all ALC patients awaiting placement on a daily basis and assigning them to streams such as home first, chronic, chronic palliative and rehabilitation. The daily reviews ensured that any new information about a patient was communicated and acted upon immediately
- Coordinated a three-day Kaizen event with the CCAC and LHIN, which used Lean methods to complete a value stream analysis of the current state. This analysis showed that only 20% to 27% of the steps and time taken for discharge planning added value to the patient. A future value stream analysis identified opportunities for eliminating steps and standardizing discharge practices
- Developed key protocols for implementing "Home First," an initiative in Mississauga Halton LHIN that aims to have patients who are admitted to hospital return home after discharge from acute care. The goal of the program was to leverage supports from CCAC and Aging at Home investments to ensure patients were able to return to the appropriate environment with necessary supports, thereby deferring the decision or process to place patients into LTC inappropriately
- Ensured patients received full assessment and review by Trillium and the CCAC to ensure that all necessary supports were implemented in the right care environment to support safe care post discharge. Successful implementation depended on getting physicians on board with a consistent message about going home first before LTC placement
- Implemented utilization software (Medworxx) to determine more accurately when a patient should be deemed ALC
- Tightened the approval process for placement on the ALC LTC list, to reflect the philosophy that LTC should only be considered after all other alternatives had been exhausted
- Introduced the role of Patient Navigator to assist with discharge planning
- Discussed the challenges associated with hard-to-serve/hard-to-place patients and created protocols and documents to assist Trillium and CCAC staff in handling these cases
- Developed tools for staff, patients and families to facilitate a safe and timely discharge to the most appropriate destination

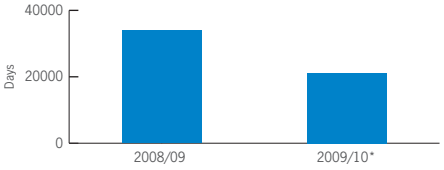
Results:

Trillium reduced its ALC beds to fewer than 55 (7% of beds) in March 2010 from 131 (representing 18% of the hospital's beds) in March 2009. This represents a 67% reduction in ALC cases. This initiative has also strengthened the partnership between Trillium and the CCAC, streamlined transitions for patients from acute care to an appropriate community setting and reduced the average discharge time.

Total number of ALC patients per day



Total ALC patient days per year



Next steps:

Trillium Health Centre continues to refine protocols, roles and procedures related to discharge practice to improve the transition from acute care and spread improvements, such as the Patient Navigator role, across the entire organization. The hospital continues to work closely with the CCAC to improve its discharge processes and its opportunities for enhancing partnership with the LHIN.

†An ALC bed is occupied by a patient who does not require the intensity of resources or services provided in that specific care setting.
*Mar 09 is an estimate based upon past 3 months