Ministerial Directives
*Immediate Results, Long-Term Sustainability*

Summary Report

*November 8, 2012*
In February 2012 Health Minister Fred Horne issued three Directives related to hospital capacity and wait time reductions.

Alberta Health Services’ response was a far-reaching and ongoing examination of hospital utilization and sustainability across the province. AHS allocated $76 million for the initiative in addition to related projects already funded and underway.

Results were measureable and significant.

The actions and the report that follows address the following:

- What actions were taken?
- What actions have had and will have the greatest immediate impact on patient care, including wait times?
- What was the immediate impact on wait times across the entire health delivery system – both hospital and continuing care?
- How will they be expanded and sustained going forward?

The actions are divided into three groups:

1. **Immediate, short-term action to reduce wait times**
   - New hospital and continuing care capacity.

2. **Medium and longer-term impact and sustainability**
   - Integrated Health Home: integration and support with Family Care Centres, Primary Care Networks and Path to Home.

3. **The Future**
   - Local and provincewide care integration, Strategic Clinical Networks, system modelling and Decision Support Centre of Excellence.

Minister Horne requested “all reasonable efforts to meet (these) goals by October 31, 2012.”

Each Zone developed an *Action Plan to Address Ministerial Directives*. AHS also has a role in fulfilling several of the other recommendations. These will be addressed in a future report.

AHS is two years into a five-year plan to improve performance and sustainability of the system. In many cases, the Ministerial directives reiterated the importance of these strategies. AHS will continue to deliver on the five-year plan and measure and report progress.
The Directives

1. Reduce average weekly inpatient bed utilization rates to 95 per cent at each of seven Alberta hospitals: Foothills Medical Centre, Peter Lougheed Centre, Rockyview General Hospital, University of Alberta Hospital, Royal Alexandra Hospital, Grey Nuns Community Hospital and Misericordia Community Hospital.

2. Reduce by half the number of patients assessed and waiting in acute and sub-acute facilities for continuing care from January 31, 2012, baseline.

3. Implement standardized processes across Alberta to discharge patients from acute patient beds and arrange for followup community supports, if needed, on a seven-day-a-week basis.

Immediate, short-term action to reduce wait times

New capacity to reduce wait times in hospitals, continuing care and mental health.

Results:

High priority was placed on implementing action plans by October 31, 2012, and planning, operational and frontline staff have been recognized for their commitment and hard work. Although challenging due to the short time period, significant progress was made.

- Capacity was added in acute care, continuing care and mental health. Six of the seven facilities have seen a substantial reduction in patients assessed and waiting. This reduction ranged between 15 and 40 per cent. Three of seven facilities achieved the target for occupancy.

- 174 additional acute care beds were made available; 52 acute care beds were added; 10 sub-acute care beds were converted to full acute care use and the operation of 112 temporary beds were converted from part-time to permanent full-time use. (In total, this is the equivalent of the number of beds in a medium-sized hospital.)

- 415 continuing care beds were added to the Calgary and Edmonton Zones as part of this effort.

- 49 mental health spaces have opened in the community.

- Hiring was very successful with more than 400 front-line health workers added to the system specific to these initiatives.

- Pilot projects to standardize provincial discharge are underway, with full implementation planned across the province. Initial plans on ways to utilize Primary Care Networks (PCNs) and Family Care Centres (FCCs) to greater advantage to reduce demand, over the longer term, are being developed.
• Although delays were encountered opening continuing care beds at the rate we had planned, we expect all of the planned beds to be opened over the next three to six months and as capacity continues to come on stream, the impact will be seen on continued reduction in occupancy rates and in the number of patients assessed and waiting for placement.

• In Calgary, the South Health Campus is opening inpatient beds in spring 2013 and when these open, there will be a significant impact on hospital capacity in the Calgary area.

Although the full mandate of the Ministerial directives was not fully achieved by October 31, 2012, AHS short-term and long-term improvement will continue. Capacity and improvement initiatives per 2012/2013 plans will continue beyond October 31, 2012, to reach all three Directive targets.

Projections suggest that the Directive 1 and 2 targets could be achieved by March 31, 2013. However, many factors — in particular, the availability of continuing care services — have an impact on time spent patients assessed and waiting in acute care.

In the short term, timing for new continuing care capacity cannot be precisely predicted. Uncertainties include difficulty securing partner operators and confirming service timelines; construction schedules; licensing and development permitting issues; and hiring and labour actions.

The longer-term view indicates substantial progress has already been made in continuing care. Between April 2010 and September 2012, we saw the following reductions related to patients awaiting appropriate placement:

• 41 per cent reduction in the average number of days clients spent waiting in acute or sub-acute beds for placement.

• 21 per cent reduction in the number of patients waiting in acute and sub-acute for placement.

• 10 per cent reduction in the number of patients waiting in community for appropriate placement.

Between March 2011 and March 2012, more than 1,000 continuing care spaces were added across Alberta. As well, by March 2012, more than 104,700 home care clients were being served, which is an increase of 4.5 per cent over the previous year (100,300). Each year, more than 7,000 clients are placed in continuing care from acute and sub-acute beds.

Appendices 1 and 2 detail initiatives and results.
Urgency:

The urgency around both short- and long-term initiatives is captured in the graph below. Pressure on our Emergency Departments is increasing. The increased demand on Emergency Departments has a direct impact on the demand for acute care inpatient beds. This pressure makes medium- and longer-term strategies essential.

Figure 1: Number of Emergency Department visits in Calgary Zone and Edmonton Zone over time
The outcomes of our short-term efforts to open acute care and continuing care capacity are shown in the charts below.

*Occupancy rates*

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Figure 2: Weekly average occupancy rates at the seven specified for weeks beginning Sept. 9 through Oct. 28, 2012. Note: Data is subject to minor retroactive fluctuation as information systems are reconciled.

*Assessed and Waiting*

<table>
<thead>
<tr>
<th>Location</th>
<th>Number Waiting Jan 2012</th>
<th>Ministerial Target</th>
<th>Usual Number Waiting (12-month average)</th>
<th>Number Waiting October 2012</th>
<th>Increase or Reduction from # Waiting in January</th>
<th>Increase or Reduction from Usual # Waiting</th>
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<td>-31%</td>
<td>-36%</td>
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Figure 3: Number of patients assessed and waiting in acute/sub-acute care for continuing care placement

The full impact of these actions will be realized after October 31, 2012, with additional improvements being seen in the coming months. However, it is evident that adding capacity alone is not sufficient to meet the needs of Albertans in a sustainable manner. The next section outlines how these actions need to be expanded and sustained going forward.
Medium- and longer-term impact and sustainability

Integrated Health Home: Primary Care Networks, Family Care Clinics and Path to Home

☐ Plan for November 1, 2012, to March 2013

Given expected population growth and aging, wait time improvement cannot rely solely on annual additions to acute care and long-term care facilities. Ongoing increases in demand continue to burden capacity and result in unsustainable cost increases.

Annual population growth and higher rates of growth in the seniors demographic suggest that to maintain equilibrium at 95 per cent occupancy (e.g. assuming a current acute bed total of 8,000 and a 2.5 per cent population growth) 200 additional beds/year would be required. This is equivalent to adding a medium-sized hospital every year.

Medium- and long-term concerted efforts to reduce the number of people needing to be admitted to hospital to ensure services are sustainable are essential.

☐ Integrated Health Home

Integrated Health Home is one of four medium-term strategies. Essentially, this is a model where our expanding Primary Care Networks (PCNs), Family Care Centres (FCCs) and Home Care can be leveraged to both reduce demand on our Emergency Departments and have the resources and capabilities to maintain patients in their home. This model is in its very early developmental stages but is a far better alternative than ever-increasing investment in facility-based care for both the quality of life for our patients and the sustainability of the health system.

For 2013/2014, AHS is continuing to refine strategies to improve Albertans’ health status and provide clinically acceptable alternatives for acute care to lower acute care occupancy and ensure patients are treated in appropriate settings. Strategies to move forward are focused on sustainability and the means to maintain equilibrium.

☐ Four medium-term strategies

1. **Focus on early intervention and community-based care for the small subset of the population who require a greatly disproportionate portion of health system resources (Integrated Home Health).**

   AHS is developing strategies to improve health status and provide clinically acceptable alternatives for acute care. The most productive approach with the highest likelihood of impact would focus on those patients who, in the current design of service delivery, require a much greater proportion of health care services but who could be treated and managed more successfully with higher intensity of integrated community and home care services. From an acute hospital perspective, the occupancy challenges are predominantly in medicine and psychiatry units. A significant proportion of these patients could and should be served in a specialized and more effective way in the community, living at home with aligned supports, including Home Care, and services through a PCN or FCC.
2. **Continue to improve service mix and performance across the system.**

A number of strategies and initiatives are underway to make optimal use of capacity and enable a model delivering health care closer to home and with less dependency on facility-based care. These strategies will provide better care and start to reduce demand for acute care. Several initiatives are in flight for this fiscal year and initiatives are being prioritized as part of the 2013/2014 budget planning cycle.

   a. Provide high-quality community care as an alternative to facility-based care.
   b. Manage acute care admissions, inpatient flow and discharge effectively.
   c. Optimize transitions and continuing care decisions.

3. **Implement Path to Home, the provincial discharge model to improve transitions to community care and reduce assessed and waiting times.**

The Path to Home program will improve patient experience, reduce length of stay in acute care, provide the ability to manage capacity in real time and improve the continuity of care from acute to community. Implementation has started in Edmonton and Calgary and will continue across the province. Current efforts have yielded significant results in Edmonton. This approach needs to be expanded. In Edmonton, from February 2012 to the end of August 2012, the Expected Length of Stay/ Average Length of Stay (ELOS/ALOS) has been reduced from .974 to .928. At 95 per cent occupancy, this equates to 70 beds (67 beds at 100 per cent occupancy). Similar improvement initiatives are underway across the province.

4. **Continue to add capacity according to existing capacity plan.**

Capacity will be required to meet demands of population growth and aging. Currently, there are gaps in capacity in some parts of the province and certain services. There are plans in place to add acute care capacity in Calgary at the South Health Campus and continuing care capacity across the province. In planning new capacity, there is ongoing tension between identified needs, the need to realize improvements in system performance and the need to allocate budgets effectively.

Consistent with HQCA recommendations, AHS is developing a more focused approach to forecasting, planning and managing capacity. This type of forecasting will be a function for the System Modelling and Decision Support Centre of Excellence (COE) outlined for consideration in the next section.
The future: Local action and provincewide integration

*Strategic Clinical Networks, System Modelling and Decision Support Centre of Excellence*

- **Leverage Strategic Clinical Networks (SCNs)**

Strategic Clinical Networks are developing evidence-based pathways for patient care that are improving the patient experience. These pathways start and end in primary care and PCNs are a vital element of these pathways. SCNs are leading and supporting evidence-informed improvements in team-delivered prevention and in clinical performance to achieve the highest quality and best outcomes at the lowest reasonable costs.

- **Create a System Modelling and Decision Support Centre of Excellence (COE)**

Transformation in the health care system requires an organizational capability to analyze and monitor complex scenarios and support planning and decision-making. There are already pockets of excellent work across the organization in forecasting, modelling, capacity management, monitoring and evaluation. An enterprise-wide strategy that co-ordinates clinical, operational, financial and human resources information is required.

Example: Where these techniques have been used, the benefits are substantial as in the REPAC (Real Time Emergency Patient Access and Co-ordination) application that provides Emergency Department flow information internally and to the approach to long-term service planning that is occurring in several key portfolios. This is already being used to provide public information on wait times on the AHS website.

AHS requires a more comprehensive and co-ordinated approach to develop and use analytical information to support key decisions. There are several recommendations and required actions within the HQCA February 2012 recommendations that point to the need for increased capacity in this area. AHS is considering these developments in information management as foundational to moving forward on the five-year plan and to continue to evolve our capacity for real-time information and forecasting.

The COE would include:

- Forecasting to look out into the future to estimate health system demands, model various potential service delivery changes on demand, and forecast utilization impacts from health system redesign.

- A sustainability lens on the planning models that deal with cost drivers, workforce and capital constraints, and analyzes impacts of health system redesign from a sustainability perspective. Sustainability is modelled from the perspective of the health of populations, the utilization of services, delivery costs from changes due to inflation, more efficient health service input mix, and an optimized mix of service offerings.

- Implementation of Path to Home across the province.
• System flow or operations management to provide insight into the here and now, detailing the information required to manage capacity on a real-time basis, designing care processes that optimize patient flow and estimating impact of redesign in the near term.

Next Steps: Create and review a proposal for the creation of the COE. The proposal should identify the objectives, scope, responsibilities, operating model, resources and budget.

Conclusion

A focused effort to achieve the targets set by the Directives has led to organization-wide development of a stronger, sustainable health system.

We will fulfill all of the Directives and expand the targets provincewide.

Going forward, the innovative approach of working with PCNs and FCCs will be the most important factor in achieving a patient focused, quality-driven health care system.

The HQCA recommendations and Directives will be major drivers of this work.
Appendix 1

Initiatives in the Past Six Months to Achieve the Ministerial Directives

To address the directive targets by October 31, 2012, a number of current initiatives were accelerated or introduced. AHS has been successful in delivering on action plans for over 45 major initiatives delivered in the past six months. In summary:

1. Capacity in acute care has increased by 52 beds and there was an additional conversion of 10 beds to full acute care use.
2. Capacity of 112 temporary transition beds was maintained.
3. 49 mental health spaces have opened in the community.
4. Capacity in continuing care has increased by 415 beds and additional spaces will be opened over the coming months.
5. Hiring has been very successful with over 400 front-line health workers added to the system specific to these initiatives.
6. Real time occupancy measurement began June 2012 and is closely monitored.
7. Transformation initiatives have realized substantial reductions in length of stay.
8. Implementation is underway for primary and community-based programs to enable patients to remain at home to receive health care services.
9. Path to Home, a standardized process to proactively manage discharge and transition of patients to an appropriate level of care, is being piloted. Full implementation is planned over the next two-and-a-half years.

☐ Summary of results in the past six months

Goal of Directive 1:
Reduce average weekly inpatient bed utilization rates to 95 per cent at each of seven Alberta hospitals: Foothills Medical Centre, Peter Lougheed Centre, Rockyview General Hospital, University of Alberta Hospital, Royal Alexandra Hospital, Grey Nuns Community Hospital and Misericordia Community Hospital.

Results for Directive 1:
Achieving occupancy targets requires a careful balance of the right level and optimal utilization of capacity. In many cases, changes are planned and implemented over a multi-year horizon and are part of a five-year strategy.

- Edmonton is realizing the benefit of improvement initiatives within acute care and in the community to improve occupancy rates. Royal Alexandra Hospital, Misericordia Community Hospital and University of Alberta Hospital have achieved the target.
• Grey Nuns Community Hospital continues to face growing demand and limited capacity.

In Calgary, the South Health Campus (SHC), scheduled for opening inpatient beds in 2013, will increase acute capacity. In the interim and where reasonable, available acute spaces in Calgary were opened with SHC funding. Because of the imminent opening of SHC, building other temporary facilities in the short-term was not a reasonable option.

• All Calgary facilities continue to see occupancy above 95 per cent.

Using real-time information to monitor key indicators is the most effective way to determine means to achieve the greatest benefit. Measuring and monitoring occupancy across the province in a standardized way has improved substantially over the past six months. Seasonal increases in demand for acute care services have driven occupancy numbers up in the past two weeks by two to four per cent.

There is a strong correlation between Directive 1 and Directive 2. If the number of patients assessed and waiting for continuing care can be minimized within the acute care facilities, it frees up much needed capacity.

**Goal of Directive 2:**
Reduce by half the number of patients assessed and waiting in acute and sub-acute facilities for continuing care from January 31, 2012, baseline.

**Results for Directive 2:**
Substantial momentum has been built in expanding continuing care capacity, addressing gaps in the housing continuum for complex and mental health patients, implementing alternative strategies to enable patients to be assessed at home rather than in acute care facilities, and augmenting Home Care services.

The number of patients assessed and waiting has been reduced in six of the seven facilities with reductions ranging from 15 to 40 per cent from the January 31, 2012, baseline.

In Edmonton, existing, standard long-term care beds were converted into 60 complex care spaces to address a gap in the housing continuum, 40 community mental health beds were opened and an additional 57 continuing care spaces were added. Edmonton is on the verge of achieving the 50 per cent reduction targets.

In Calgary, 358 continuing care spaces were added with 156 spaces open but not yet occupied as staff work to safely move patients into these newly opened facilities. Calgary has reduced the number of patients assessed and waiting in acute care and expects further improvements in the short term as this capacity is put into service.

AHS continues to accelerate these strategies where feasible given construction timelines and other external factors and anticipates the target could be achieved by March 31, 2013.
Goal of Directive 3:
Implement standardized processes across Alberta to discharge patients from acute patient beds and arrange for followup community supports, if needed, on a seven-day-a-week basis.

Results for Directive 3
AHS has delivered on our action plan responding to Directive 3. The design, information architecture and implementation plan for Path to Home, a provincial discharge and capacity management model, was completed by October 31, 2012. This is the first phase of a large-scale transformation project to be implemented across the organization. Path to Home is a new standardized discharge planning model that will improve patient transitions to the community and reduce the time patients wait in acute care for placement in the community by partnering with the health care team, patients and their families to complete all steps for a successful discharge. It is a systematic and collaborative approach to facilitate transitions to community supports, reduce length of stay and manage capacity.

Community support and acute care providers have participated in designing Path to Home, which will provide both anticipated discharge timing and a standardized discharge summary to help facilitate the continuity of care from acute care to the community. The Path to Home program will be implemented at all seven hospitals identified in the Ministerial directive and across the province over the next two-and-a-half years.
Appendix 2

Results and short-term initiatives to achieve Ministerial Directives

Directive 1 Plan November 2012 to March 2013

In Calgary, the South Health Campus (SHC), scheduled to open inpatient beds in 2013, will increase acute care capacity. In the interim and where reasonable, available acute spaces in Calgary were opened with SHC funding. Because of the imminent opening of SHC, building other temporary facilities in the short-term was not a reasonable option.

With capacity at SHC, occupancy in Calgary is anticipated to fall below 95 per cent at all Calgary urban hospitals. A carefully orchestrated commissioning is planned for SHC and other community capacity to ensure capacity levels and occupancy reductions are maintained while shifting care to appropriate settings.

Edmonton will be reviewing the need for additional acute care beds in planning for 2013/2014, based on population growth and aging. The focus in Edmonton is on reducing length of stay, allocating beds optimally across services, focused rehabilitation and community initiatives.

Directive 2 Plan November 2012 to March 2013

Forecasting the “Number of Patients Assessed and Waiting in Acute/Sub acute care for Continuing Care” is a complex undertaking. Experience has shown that timing for new continuing care capacity in the short term cannot be accurately predicted. Factors inherent in expanding continuing care facilities create uncertainty:

1. Lack of predictability of the timing of new continuing care capacity opening. AHS has seen delays in anticipated commissioning dates within and prior to HQCA Response initiatives for the following reasons:
   - Funding approvals.
   - Difficulty securing operators and confirming services and timelines.
   - Managing construction schedules.
   - Licensing and development permitting issues.
   - Hiring and labour actions.

2. There are many variables that impact the number of patients requiring placement, the type of service that is required and the opening of spaces.

AHS is monitoring the short-term forecast as the 2013/2014 continuing care plans are solidified. On a long-term basis, timing fluctuations of a few weeks or months are not as significant.

Moving beyond October 31, 2012, AHS will continue to work on reducing Alternate Level of Care (ALC) patients waiting in acute facilities. AHS proposes that the objective be measured as a percentage of ALC patients in acute care beds, consistent with Recommendation 3 in the HQCA February 2012 Report, as this measure reflects more accurately the scope of the problem in both volume and duration of beds occupied inappropriately. Emphasis will be placed on reducing the time patients wait for appropriate care placements and reducing ALC length of stay through initiatives such as Destination Home and other community based supports and the Path to Home program.
Directive 3 Plan November 2012 to March 2013

The Path to Home program is following a five-phase plan for the seven-site implementation, listed below. The first phase is complete and the second will complete by March 2013. The final three phases will be completed across the province over the next 30 months.

1. Provincial Design Standards and Implementation Strategy
2. Cornerstone: Detailed Design and Configuration
3. Implementation: Process implementations in acute care and community supports
4. Capstone: Care Traffic Control Centre implementation
5. Shield: Sustainability and Continuous Improvement

In addition to the provincial standards, the output of the Cornerstone Phase will be eLearning modules, tools and templates to support implementations of the standards within the seven sites and provincially. Through the seven site implementations, AHS will build a small, specialized team to support the formal implementations of the Path to Home model across the organization.

Meeting challenges

With a growing and aging population, the approach of adding commensurate capacity in acute care and facility-based continuing care at the same rate will result in unsustainable cost increases. It has been determined that even with the addition of spaces, the measures do not always move linearly as there are many factors that influence occupancy and continuing care placements, including changes in demand, assessment variations, clinical decision-making and system flow and performance.

Over the past six months AHS has delivered a large suite of capacity increase and improvement projects. Challenges in ED, acute care occupancy or continuing care cannot be looked at in isolation; the impact from one domain to the next needs to be carefully considered. Stronger linkages, collaboration and transition between these domains and PCNs/FCCs are required to optimize care.

AHS has developed a multi-faceted approach to improve overall access, quality and sustainability for the future. Given expected population growth and aging, improvement cannot rely solely on annual additions to acute care and long-term care facilities. Ongoing increases in demand continue to burden capacity and result in unsustainable cost increases. Fundamentally, consideration is being given to redesigning the health care system to focus on primary care, appropriate utilization of system resources and optimal care pathways being defined through the Strategic Clinical Networks.

AHS will:

Focus on primary care and community-based services for the population that requires ongoing high levels of support to maintain their health (Integrated Health Home).

Appropriate utilization of system resources through the eyes of the patient is a primary consideration. The focus on acute care occupancy and alternative levels of care can be viewed as a forcing function of demand versus supply. A means to manage demand through strategies to improve health status and provide clinically acceptable alternatives for acute care is being explored.
Strategies to improve health status and provide clinically acceptable alternatives for acute care are being developed. The most productive approach with the highest likelihood of impact would focus on those patients who currently consume a greater proportion of health care services but could be treated and managed more successfully with a higher intensity of integrated community and home care services. From an acute hospital perspective, the occupancy challenges are predominantly in medicine and psychiatry units. A significant proportion of these patients could and should be served in a specialized and more effective way.

To do this requires significant change. To do this the small subset of the population who require a greatly disproportionate portion of health system resources needs much more targeted, integrated, and specialized care. A truly patient-centred model is not always consistent with traditional care provider boundaries and current specializations of facility, function, and program. Effective specialized services for these patients would reduce the demand on acute and long-term care capacity.

These changes span the spectrum of practices, policies, accountability and funding. An Integrated Health Home project is being considered as a pilot project.

AHS is examining ways to leverage the full potential of PCNs and FCCs and community resources and improve integration of local service delivery within a broader health system (i.e. Zone). Many of the services are in place in Alberta, and co-ordination and gaps in capacity and service mix are being explored.

This type of change is transformational and requires significant commitment and thoughtful investment. AHS is considering a prototype for a home health model focused on patients with access to services through PCNs and FCCs who could avoid being admitted to hospital and have equal or better outcomes (e.g. approximately 3,500 patients within a community of 70,000). This initiative could bring together many of the existing capabilities and improvements in the health system as appropriate to serve the needs of this population.

Design principles include key differentiators:

- Services designed around the patient.
- Special measures taken to manage this high needs population in their homes, funded at the patient level.
- Clear accountabilities required for defining and managing the care plan with each patient. These accountabilities would be underwritten with the appropriate health and community supports.

To be successful, it would be important to direct initial actions and be prepared to phase and scale the prototype appropriately. Additionally, there are a number of policy issues and structures to be addressed for successful implementation of this initiative. AHS and Alberta Health could work with other system stakeholders to address some of these barriers. Many have previously been identified in the work that was done regarding the development of an Alberta Health Act. As this initiative proceeds, additional barriers may be identified. Consideration could be given to the following enablers:
1. Funding model that enables discretion at the patient level to allocate dollars to address service requirements.

2. A physician compensation model that accounts for the time required with individuals who have complex medical problems, often complicated by social issues, for adequate communication and co-ordination with care partners and for participating in the design of the work. This model must incent physicians to improve the health status of their patients and reduce acute care utilization.

3. Funding for system navigation proposals to provide the resources for integrating across services.

4. A continuum of housing options in the community to meet the needs of all patients including those with mental health or complex needs (e.g. Persons with Developmental Disabilities, Mental Health, or Complex Care).

5. A streamlined guardianship process.

6. Creative solutions to address coverage issues (e.g. uninsured services or citizenship) that are causing patients to make choices that are not medically optimal.

7. Information sharing policies to facilitate population-based research across sectors and full collaboration between organizations (e.g. Freedom of Information and Protection of Privacy Act and Health Information Act).

Next steps:

Determine funding and approval to launch a prototype focused on a complex/high-cost patient population.

Conduct data analysis, engagement and planning work to define the patient population, needs and set of projects that are required to implement the prototype. A more detailed initiative outline would be needed once analysis and planning work is complete.

Create a governance structure to focus on the transformation objectives for this patient population and maintain alignment at a community level.

AHS will:

**Continue to improve service mix and performance across the system.**

A number of strategies and initiatives are underway to make optimal use of capacity and enable the delivery of health care closer to home with reduced dependency on facility-based care.
These strategies will provide better care and start to reduce demand for acute care. Several initiatives are in flight for this fiscal year and detailed actions for the improvements identified are part of the 2013/2014 budget planning cycle. These improvements all contribute to three main themes:

1. Provide high-quality community care as an alternative to facility-based care.
   - Strengthen Primary Care
   - Shift to home-based care and home care redesign

2. Manage acute care admissions and flow effectively.
   - Enable admission decision-making
   - Improve Emergency Department flow
   - Balance capacity by clinical service
   - Reduce length of stay
   - Implement Path to Home

3. Optimize transitions and continuing care decisions
   - Improve transition decisions
   - Balance the service mix of continuing care facilities
   - Address gaps in Mental Health

Next steps:

Continue to implement initiatives that are underway and review the impact of each of the initiatives as part of the yearly budgeting cycle to determine which actions are most effective.

☐ Ministerial Directive descriptions and results

Below is a description of the initiatives and results for each Ministerial directive.

Directive 1 Initiatives to October 31, 2012

Goal of Directive 1:

Reduce average weekly inpatient bed utilization rates to 95 per cent at each of seven Alberta hospitals: Foothills Medical Centre, Peter Lougheed Centre, Rockyview General Hospital, University of Alberta Hospital, Royal Alexandra Hospital, Grey Nuns Community Hospital and Misericordia Community Hospital.

1. Acute Care Capacity

To support the Ministerial directives, 52 acute care beds were added, 10 sub-acute care beds were converted to full acute care use and the operation of 112 temporary beds was extended (total acute care bed impacts 174).
Prior to the HQCA review, efforts were in place to shift care to the community to more appropriately care for those requiring continuing care services and reduce reliance on the acute care system. In addition to being important to move patients to continuing care so they are in a more comfortable and more home-like environment, it is also less expensive from a health system perspective. Sustainability of the system in the face of rising costs has been a key priority for AHS.

Patients awaiting appropriate placement were often placed in transition units which were established on a temporary basis within acute care sites. As such, as new continuing care capacity was scheduled to be opened, plans were made to reduce the number of transition beds in acute care facilities. Upon receiving the Ministerial directives, action plans were put in place to maintain these transition beds until more sufficient capacity was available in the community.

The following table outlines the net new beds that were opened as well as the number of transition beds that remained open in response to Directive 1.

<table>
<thead>
<tr>
<th>Acute Capacity</th>
<th>Calgary Zone</th>
<th>Edmonton Zone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Added acute beds (net new – opened minus closed)</td>
<td>36</td>
<td>16</td>
</tr>
<tr>
<td>Extended temporary beds</td>
<td>43</td>
<td>69</td>
</tr>
<tr>
<td>Converted transition beds to acute care medicine beds at UAH</td>
<td>-</td>
<td>10</td>
</tr>
<tr>
<td>Total Capacity Improvement</td>
<td>79</td>
<td>95</td>
</tr>
</tbody>
</table>

Going forward, rather than attempting to manage capacity simply by increasing supply, AHS intends to leverage innovative care delivery strategies outlined in Section 5 that will reduce demand for hospital-based care. Redesign of primary health care to focus on wellness, prevention and chronic disease management are critical to managing the health of the population in a fiscally responsible and sustainable manner.

2. Mental Health Capacity

<table>
<thead>
<tr>
<th>Mental Health Capacity</th>
<th>Calgary Zone</th>
<th>Edmonton Zone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Health Capacity has been increased by adding net new mental health beds to improve capacity of community housing and care for clients with addictions, mental health and developmental delays.</td>
<td>Roberts House</td>
<td>Alberta Hospital</td>
</tr>
<tr>
<td>Added mental health beds</td>
<td>Nine net new beds with 20 more planned to open in December 2012</td>
<td>40 net new beds</td>
</tr>
</tbody>
</table>
3. Services Allocation

A review was conducted to better understand the alignment of need and capacity by service within the facilities. This review resulted in the reallocation of beds between services, focusing on Medicine and Mental Health.

4. Reduced Length of Stay

In Edmonton, from February 2012 to the end of August 2012, the Estimated Length of Stay/Average Length of Stay (ELOS/ALOS) has been reduced from .974 to .928. At 95 per cent occupancy, this equates to 70 beds (67 beds at 100 per cent occupancy). Similar improvement initiatives are underway across the province.

Directive 1 Results as of October 31, 2012*

* The last full week available for reporting is October 28 – November 3, 2012, at time of report preparation. AHS will continue to monitor occupancy.

Measure Definition:

Occupancy is measured as ‘patients registered’ as a percentage of ‘Registered Inpatient Beds Staffed and in Operation’.

Official real-time occupancy measurement began in June 2012 and weekly occupancy rates at the seven specified hospitals have been closely monitored from that point forward in order to track progress toward achieving the directives. Occupancy measurement will be expanded to regional sites outside Edmonton and Calgary by December 31, 2012. Measuring and monitoring occupancy across the province in real time in a standardized way has been important to reaching the HQCA targets.

The following table provides a view of the weekly occupancy results as a percentage.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>FMC</td>
<td>98</td>
<td>99</td>
<td>100</td>
<td>98</td>
<td>97</td>
<td>102</td>
<td>102</td>
<td>100</td>
</tr>
<tr>
<td>PLC</td>
<td>98</td>
<td>99</td>
<td>101</td>
<td>99</td>
<td>98</td>
<td>102</td>
<td>103</td>
<td>98</td>
</tr>
<tr>
<td>RGH</td>
<td>101</td>
<td>100</td>
<td>100</td>
<td>99</td>
<td>99</td>
<td>102</td>
<td>100</td>
<td>98</td>
</tr>
<tr>
<td>Grey Nuns</td>
<td>104</td>
<td>103</td>
<td>104</td>
<td>101</td>
<td>99</td>
<td>104</td>
<td>104</td>
<td>103</td>
</tr>
<tr>
<td>Misericordia</td>
<td>96</td>
<td>96</td>
<td>95</td>
<td>99</td>
<td>92</td>
<td>95</td>
<td>91</td>
<td>92</td>
</tr>
<tr>
<td>RAH</td>
<td>93</td>
<td>92</td>
<td>94</td>
<td>92</td>
<td>92</td>
<td>92</td>
<td>90</td>
<td>90</td>
</tr>
<tr>
<td>UAH</td>
<td>99</td>
<td>99</td>
<td>97</td>
<td>97</td>
<td>93</td>
<td>96</td>
<td>95</td>
<td>94</td>
</tr>
</tbody>
</table>

Figure 1: Weekly average occupancy rates at the seven specified for weeks beginning Sept 9 through Oct 28, 2012. Note: Data is subject to minor retroactive fluctuation as information systems are reconciled.
Occupancy at the Edmonton hospitals has been declining as acute capacity has been added, bed closures delayed, length of stay decreased and allocation of beds adjusted. In Edmonton three of the four hospitals met the 95 per cent target: Royal Alexandra Hospital, Misericordia Community Hospital and University of Alberta Hospital. Grey Nuns Community Hospital continues to face growing demand and limited capacity.

In Calgary, occupancy levels continue to be above the target. Over the majority of the summer/early fall, Calgary facilities were approximately two to five per cent above target. All facilities are currently over 100 per cent with increases in seasonal demand over the past two weeks. October is one of the highest months of the year for acute care demand. The opening of inpatient beds at the South Health Campus in 2013 is expected to provide significant additional capacity and reduce occupancy. With the added capacity, the focus will shift to improve utilization by reducing length of stay and caring for patients in the appropriate setting.
Directive 2 Initiatives to October 31, 2012

Goal of Directive 2:
Reduce by half the number of patients waiting in acute and sub-acute beds for continuing care placement as of January 31, 2012, at each of the seven Alberta hospitals: Foothills Medical Centre, Peter Lougheed Centre, Rockyview General Hospital, University of Alberta Hospital, Royal Alexandra Hospital, Grey Nuns Community Hospital and Misericordia Community Hospital.

1. Continuing care capacity has been increased to provide the right level of care in the community setting and enable more timely discharge when facility-based continuing care is required.

<table>
<thead>
<tr>
<th>Number of Net New Continuing Care Beds</th>
<th>Calgary Zone</th>
<th>Edmonton Zone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Net New Beds by October 31, 2012</td>
<td>358</td>
<td>57</td>
</tr>
<tr>
<td>% of Planned New Continuing Care Beds for 2012/2013</td>
<td>97%</td>
<td>31%</td>
</tr>
</tbody>
</table>

Factors inherent in expanding continuing care facilities have caused significant delays: funding approval; difficulty securing operators and confirming service timelines; construction schedules; licensing and development permitting issues; and hiring and labour actions. As a result, Calgary has recently opened the targeted capacity and work is ongoing to place patients in those spaces as quickly as is safely possible and Edmonton will realize much of their capacity after October 31, 2012.

2. Adult day support spaces have been increased to provide support for seniors who continue to live in their home and require rehabilitation and regular assessment by physicians, nurses and rehabilitation professionals.

<table>
<thead>
<tr>
<th>Total Adult Day Spaces Added</th>
<th>Calgary Zone</th>
<th>Edmonton Zone</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Intake of patients for 90 net new day spaces begins November 2012</td>
<td>60 net new</td>
</tr>
</tbody>
</table>

3. A program underway in Edmonton and Calgary, Destination Home, targets community-based clients at risk for institutionalization to maximize their potential in the familiar surroundings of their home if safely able to do so. The goal is to facilitate safe discharge of patients – with comprehensive home care and community supports – while awaiting assessment for continuing care.

4. In Edmonton, Advanced Ambulatory Care Services - Specialized Rehabilitation Outpatient Program (SROP) at the Glenrose Rehabilitation Hospital provides an interprofessional rehabilitation service for patients requiring specialized tertiary rehabilitation services. The service began accepting referrals on October 1, 2012, and received approximately 20 referrals in the first month. Once the program is fully operational, the target is treatment of 390 patients/year or 32/month.
5. In Calgary, the Comprehensive Community Care (C3) program will implement 90 net new spaces in urban Calgary as an alternative to continuing care capacity. Admissions to an interim C3 program are scheduled to begin November 2012, and ease of transition of care to C3 from Home Care will be ensured.

6. In Calgary and Edmonton, Emergency Medical Services have an increasing role in reducing assessed and waiting times in acute facilities. In Edmonton, the Community Health and Pre-hospital Support Program (CHAPs) has been expanded. CHAPs allows Emergency Medical Services crews to refer patients for community- and home-based care services. There were 561 referrals in 2011/2012. The target is for 1,122 referrals for 2012/2013 or 93/month. There have been 996 referrals year to date.

7. In Calgary, the Community Paramedic Program is extending the existing nurse practitioner program in selected facilities to provide longer program hours and access to additional assessment and treatment equipment and supplies. Community paramedics were recruited, trained and in place by October 31, 2012.

**Directive 2 Results as of October 31, 2012**

Measure Definition:

‘People waiting in acute/sub-acute (hospital) beds for continuing care placement’ is a count of the number of persons who have been assessed and approved for placement in continuing care, who are waiting in a hospital acute care or sub-acute bed. The counts taken are a snapshot (point in time) on the last day of each reporting period.

Since the counts are a snapshot at one point in time, they are prone to variability. The Ministerial Directive target was based on the count taken on January 31, 2012. An analysis of prior assessed and waiting numbers indicates that the January count was not representative of the usual assessed and waiting patient count at all sites. For example, over 12 months, an average of 51 patients were waiting at FMC compared to only 33 on January 31. The difference between this “usual number” (51) and the Ministerial Target (17) makes achieving this directive extremely challenging. The usual number waiting is shown in Figure 4 for comparison purposes.

Calgary:

From March 2012 to present, there has been a steady reduction in the number of patients assessed and waiting in acute and sub-acute settings. However the baseline number of assessed and waiting of January 31, 2012 was one of the lowest in the last several years, especially at the Foothills Medical Centre. Over the past six months, 358 continuing care spaces were added with 156 spaces open but not yet occupied as staff work to safely move patients into these newly opened facilities. Calgary has reduced the number of patients assessed and waiting in acute care and expects further improvements in the short term as this capacity is put into service.
Edmonton:

There has been significant progress towards attaining the 50 per cent reduction targets. Edmonton had a spike in the number of patients assessed and waiting in acute and sub-acute care over summer 2012. The increase can be attributed to the temporary unavailability of beds resulting from labour action, floods, and construction delays and temporarily relocating residents to create complex long-term care beds, which will fill a gap that has existed in the continuing care continuum. Operational teams have demonstrated tremendous focus in planning and delivering to overcome these challenges and move patients into the appropriate level of care.

<table>
<thead>
<tr>
<th>Location</th>
<th>Number Waiting Jan 2012</th>
<th>Ministerial Target</th>
<th>Usual Number Waiting (12 month average)</th>
<th>Number Waiting October 2012</th>
<th>Increase or Reduction from # Waiting in January</th>
<th>Increase or Reduction from Usual # Waiting</th>
</tr>
</thead>
<tbody>
<tr>
<td>FMC</td>
<td>33</td>
<td>17</td>
<td>51</td>
<td>28</td>
<td>-15%</td>
<td>-45%</td>
</tr>
<tr>
<td>PLC</td>
<td>46</td>
<td>23</td>
<td>48</td>
<td>38</td>
<td>-17%</td>
<td>-21%</td>
</tr>
<tr>
<td>RGH</td>
<td>51</td>
<td>26</td>
<td>62</td>
<td>61</td>
<td>20%</td>
<td>-2%</td>
</tr>
<tr>
<td>UAH</td>
<td>25</td>
<td>13</td>
<td>23</td>
<td>16</td>
<td>-36%</td>
<td>-30%</td>
</tr>
<tr>
<td>RAH</td>
<td>35</td>
<td>18</td>
<td>41</td>
<td>21</td>
<td>-40%</td>
<td>-49%</td>
</tr>
<tr>
<td>Grey Nuns</td>
<td>17</td>
<td>9</td>
<td>15</td>
<td>14</td>
<td>-18%</td>
<td>-7%</td>
</tr>
<tr>
<td>Misericordia</td>
<td>13</td>
<td>7</td>
<td>14</td>
<td>9</td>
<td>-31%</td>
<td>-36%</td>
</tr>
</tbody>
</table>

Figure 4: Number of patients assessed and waiting in acute/sub-acute care for continuing care placement
Figure 5a: Number of Patients Assessed and Waiting in Edmonton Zone Acute and Sub-Acute
Note: See paragraph above charts for context regarding Edmonton

Figure 5b: Number of Patients Assessed and Waiting in Calgary Zone Acute and Sub-Acute care
Other relevant measures:

The Ministerial directives centered on measures of occupancy and the number of patients waiting in acute and sub-acute beds for continuing care placement. Additional measures demonstrate substantial improvement in areas related to the Ministerial Directives.

Continuing care measures:

Services delivered to seniors over the past two years have increased substantially. For example, between March 2011 and March 2012, more than 1,000 continuing care spaces were added across Alberta. As well, by March 2012, more than 104,700 home care clients were being served, which is an increase of 4.5% over the previous year (100,300). Each year, more than 7,000 clients are placed in continuing care from acute and sub-acute beds.
Coinciding with added service capacity is a downward trend in Emergency Department visits among seniors when compared to the overall population. Furthermore, between April 2010 and September 2012, there were the following reductions related to patients awaiting appropriate placement:

- 41 per cent reduction in the average number of days clients spent waiting in acute or sub-acute beds for placement.
- 21 per cent reduction in the number of patients waiting in acute and sub-acute for placement.
- 10 per cent reduction in the number of patients waiting in community for appropriate placement.

The percent of clients placed within 30 days increased from 55 per cent to 69 per cent between April 2011 and September 2012. The length of time that patients are waiting is important. There has been substantial improvement in this measure over the past year as patients are being placed more quickly. The AHS quarterly report documents steady progress on the per cent of patients admitted to a continuing care facility (SL or LTC) within 30 days (see Figure 7).

![Percent Admitted to Continuing Care within 30 Days](image)

Figure 7: Percent of patients admitted to a continuing care space within 30 days.
Emergency Department measures:

The initial purpose of the HQCA February 2012 Report was to review the quality of care and safety of patients requiring access to Emergency Department (ED) care. Progress has been made in improving the number of patients that are admitted within the eight-hour target, even with a steady rise in the number of ED visits in both Calgary and Edmonton. Ongoing improvement activities will continue to propagate this trend and improve performance against target. This has been an improvement and is indicative of the efforts in ED and the acute hospitals to improve occupancy rates and flow.

AHS has established performance targets for ED admissions and discharges. Over the past two years, the demands placed on EDs in the Calgary and Edmonton Zones have risen as shown in Figure 1 (See Page 5). Although demand is rising, both Calgary and Edmonton are managing admissions and discharges in a timely manner. Both Zones are trending toward the target for admissions within 8 hours, as shown in Figure 8.

![Improving Performance - Admissions from ED](image)

Figure 8: Percent of Emergency Department patients admitted within eight-hour target
Directive 3 Initiatives and Results to October 31, 2012

Goal of Directive 3:

Implement standardized processes across Alberta to discharge patients from acute patient beds and arrange for followup community supports, if needed, on a seven-day-a-week basis.

The directive to establish standardized processes for discharge across Alberta is one that does not have a ‘quick fix’ and is linked to sustainable capacity management for acute care. In the HQCA Response Updated Plan, produced in June 2012, AHS outlined the program of work to deliver on this directive and established commitments for October 31, 2012. As planned, the design, information architecture and an implementation plan for Path to Home, the provincial discharge model, was complete by October 31, 2012.

In order to facilitate an improved discharge/transition from acute care to community health care, care teams need to be proactive in their planning for this discharge/transition. To address this, seven of Alberta’s metropolitan hospitals have developed and are preparing to implement a Provincial Discharge Model for Alberta.

Under this model, hospital staff and professionals will meet at predefined times to review patient discharge results and proactively manage patient care and flow. They will partner with patients and their families to complete all steps for a successful discharge which will improve the patient experience as they transition to the community and ensure they are placed appropriately to meet their needs in a timely way. Roles and responsibilities for a well-planned discharge are outlined for each step of the patient journey while in hospital and for ongoing supports to successfully go home or to a community facility. Clearly outlining each step in the process anticipates patient needs throughout their journey and allows for successful communication between the health care team, patients and their families; improving both staff and patient satisfaction. It is a systematic and collaborative approach to facilitate transitions to community supports, reduce length of stay and manage capacity.

Community support and acute care providers have participated in designing Path to Home, which will provide both anticipated discharge timing and a standardized discharge summary. The objective is to facilitate a seamless patient transition from acute care to the community by ensuring a plan for discharge/transition is determined upon patient admission. To achieve the desired Path to Home plan for the patient, the program will work to deliver hospital patient care services in a predictable manner based on several target performance indicators.

Based on the current state analysis of the seven AHS sites, and past experience of other North American hospitals that have implemented standardized discharge practices similar to those in Alberta’s Path to Home, it is expected that the average hospital LOS will be reduced by approximately 0.5 day with variability on an individual patient basis. This LOS reduction implies two benefits.

1. Reduced patient waits and delays: In 2011/2012, patients stayed in the seven participating hospitals for an average of 8.19 days. It is expected that, with the implementation of more formalized, repeatable work processes in hospitals, the average hospital stay will decrease by 0.5 day, to 7.69 days – meaning that, on average, patients will spend 6.10% less time in hospital.
2. Increased hospital capacity: Assuming that patient demand remains constant (i.e. the average number of patients discharged from hospital each day continues), the expected 0.5 day reduction in the average LOS – along with the planned investment in new hospital beds in the seven participating hospitals – will help free-up capacity by 7.55%, which will help AHS move towards occupancy targets.

Path to Home design:

To facilitate a seamless patient transition from acute care to the community (primary care, continuing care, home care), the information provided by the acute care team must be standardized, and the discharge/transition must be planned in advance. In order to reduce the variation of information provided and proactively plan for transition, a number of changes to services internal to acute care are required. The plan for discharge/transition must be determined upon patient admission and updated regularly. To achieve the desired plan for the patient, the defined hospital services will work to deliver their services in a predictable manner based on target performance indicators. Patient care plans will be used as follows:

- Continuity of Care: Patient plan of care will be used to proactively work with the community supports team to plan for transition in advance. Involving the patient and family in their care plan within the hospital and the transition plan out of acute care will improve the patient’s experience and empower them in their care pathway through the system.

- Care Traffic Control Centre: The rollup of all patient care plans within an acute care facility/zone will allow hospital managers to quickly understand which units and support services are approaching capacity/flow issues and mitigate this through backup support systems.

- Continuous Quality Improvement: When patient care plans are consistently defined and managed, as well as support services key performance indicators, AHS will have the data required to manage quality and target areas where improvement is required

Path to Home principles have been defined after extensive stakeholder engagement across the organization. The model is detailed and specific to facilitate a systematic approach for managing discharges across all providers and services within acute care and transition to community. Information system architecture has been designed to support the Provincial Discharge Model. Reporting is in place to begin monthly baseline consolidated reporting (initially at the seven sites) of:

- Number of admissions and discharges by day of week (measure used to test the distribution across seven days/week)
- Number of discharges by time of day (measure used to test the percentage of discharges before 11 a.m.)
Initial implementations at the seven sites in Calgary and Edmonton will include:

- Anticipated date of discharge recorded and utilized to trigger discharge pre-planning activities at least 24hrs in advance.

- CIHI standard Estimated Length of Stay recorded within 48 hours of admission. This will be used by the care team to benchmark length of stay in comparison to the anticipated date of discharge.

- AHS standard Readiness for Discharge assessment completed daily in the Medworxx information system
Appendix 3
Ongoing improvement initiatives to provide high-quality community care as an alternative to facility-based care

☐ Strengthen primary care

There is ongoing collaboration to strengthen primary health care and provide access for all Albertans to a primary health provider.

- Encourage individuals playing an active role in their own health.
- Prevent people from becoming ill or injured.
- Manage chronic conditions.
- Treat acute and episodic illness.

☐ Shift to home-based care and home care redesign

AHS is shifting many of its programs to focus on enabling patients to remain or be discharged home. This is consistent with industry trends and enables patients to continue to live independently with appropriate supports and should reduce utilization of more expensive services. There are many innovative approaches in this area to further this shift towards home-based care (Home Care Redesign, Destination Home, CHAPs) that are dependent on a foundational community care capacity.

- Home care focus: Ongoing investment is required to ensure that access to home care services are responsive and that there is adequate capacity to continue to support this shift. Budget limitations in home care will cause upstream issues in emergency and acute care. AHS will continue to reallocate funding to support this shift with appropriate evidence that home care is relieving pressure in the rest of the system.

- Palliative care support in the home: AHS is in the process of enabling EMS to provide services for pain management and other interventions to enable patients to remain in their home when possible rather than transporting them to an Emergency Department.

- 24/7 registered nurse on call: A service provided to home and supportive living clients who require professional case management and/or assessment and intervention to support chronic disease management and appropriate use of acute care services.

- Adult day programs: Programs (basic or comprehensive) to allow adults who may have physical and/or memory challenges or are living with a chronic illness to remain living in the community as long as possible by optimizing their level of physical, spiritual, social, and emotional function and by providing support respite and education to their informal caregivers (Includes C3, SROP, Bridges, CHOICE).

- Virtual Care Management Program: The Virtual Care Management program will create an integrated virtual care solution (using four established home health technologies) that transforms the delivery of care outside the acute care setting and demonstrates value (clinical, economic) by assisting at-risk seniors to remain independent longer and healthier while better managing chronic disease and minor dementia, falls and social isolation.
☐ Manage acute care admissions and flow effectively

Enable admission decision-making.

Admission decisions are influenced by many factors and are largely based on professional judgment as to the best care option that is available. As the health system shifts the available options, it is important to understand and monitor how the different alternatives are being used.

- Emergency Department to Home: In 2010, AHS implemented Emergency to Home (E2H) at four sites to better support seniors visiting the Emergency Department (ED). E2H connects seniors visiting the ED with services in the community through the efforts of the Emergency Department care co-ordinator. The evaluation was complete in spring, 2012 and did not have conclusive results. A closer look at this project is required to determine how to improve the focus on reconnecting patients to appropriate community alternatives to avoid unnecessary admission or ED/acute care visits in the future.

- Admission characteristics evaluation: A more in-depth understanding of admitting practices is required to determine if variation is occurring based on capacity in the system, availability of alternate services, facility or provider. A key question is whether patients identified during their stay as ALC would have been better cared for in another setting from time of admission. If that is the case, then strategies need to be developed and implemented to provide these alternate pathways and decision-making criteria.

Improve Emergency Department flow.

There are a number of in-flight activities that are continuing. These activities are in the following areas:

1. Consistent and common measurements
2. System navigation
3. Primary care access
4. Emergency patient flow initiative
5. Acute care flow impact on Emergency Departments
6. ED avoidance initiatives (chronic disease, home care, etc.)
7. Care pathway initiatives that support best practice within the ED

Balance capacity by clinical service.

Capacity challenges are not equally distributed across clinical services, and targets and actions must be tailored to be effective. Medicine and Mental Health are two key pressure points in the system and new (or reassigned) capacity should be focused on these clinical services. Occupancy targets should be set and measured at a clinical service level as facility-wide targets can be misleading. Ongoing monitoring of occupancy and length of stay data by clinical service will allow for focused interventions and rebalancing of capacity to meet evolving needs.
Edmonton Zone recently underwent a “Bed Allocation Methodology” project as part of the initial HQCA Response. This project resulted in a better understanding of the needs by service and a reallocation of a number of beds between services (focusing on Medicine and Mental Health). Capacity plans were set based on services achieving 90 per cent estimated length of stay. Bed Allocation Study & Project in Calgary Zone should be completed after South Health Campus is operational as there is too much change for this to be meaningful right now. To be completed by March 2014.

Reduce length of stay.

AHS has a number of initiatives underway to reduce length of stay.

- Care Transformation has made significant improvements in the length of stay for Medicine patients at University of Alberta Hospital. AHS is now working to spread the success of that initiative through integration with the Provincial Discharge Model across services and into other areas of the province.

- Provincial Discharge Model is providing a more systematic model to coordinate all teams within acute and transition care to complete the activities required prior to discharge in a timely manner to enable the patient to return home, with appropriate community supports if required. Other health systems that have implemented this model have realized an average reduction of 0.5 days in length of stay. (See below for further description)

- Strategic Clinical Networks can be leveraged to look at optimal clinical care pathways.

Implement Provincial Discharge Model.

The Provincial Discharge Model will reduce length of stay, improve patient flow within the acute care facilities, and improve ability to manage capacity at a site/zone level, thereby freeing up capacity. A key component of the model is redesigning more systematic processes within acute care to facilitate the transition to community services.

Recognizing planning for discharge starts at patient admissions, the directive to establish and implement standardized processes for discharge across Alberta is also highly connected to developing sustainable capacity management capability for acute care. To ensure these changes are made in a way that is sustainable in the long term, and efforts are focused where the most impact will be attained, AHS is approaching them as a structured program of work.

AHS has developed a standard model for proactive Discharge Planning and Capacity Management within acute care sites. This model was developed with extensive clinical and operational engagement including inpatient services, physicians, as well as patient and community stakeholders. Through the program, a detailed 30-month implementation plan has been defined to enable AHS to achieve this vision at the seven adult urban acute sites (Foothills, Peter Lougheed, Rockyview, University of Alberta, Royal Alexandra, Grey Nuns and Misericordia) as priority. The implementation strategy is based on the current state of the Zones and, to some extent, their current information technology environments. The Calgary Zone will be implementing one site at a time, and the Edmonton Zone (including Covenant Health) will implement clinical program by program.
Support transitions and long-term care decisions.

Improve transition decisions:

AHS will define strategies to better support the transition that many patients face for continuing care. Often this decision is triggered from an acute care episode and there is pressure to place these patients quickly to free up acute care capacity. AHS has a number of actions to improve the quality of these decisions by enabling patients and their families to make these life-changing choices at home or in a transition facility and after a well-supported convalescence period. Destination Home (for those patients that can return home) and transitional units (inside or outside acute facilities) will enable a better decision and may defer or reduce the demand for expensive facility-based care.

- Destination Home; Targets community-based clients who are at risk for institutionalization. The program will provide those who are safely able to do so with a chance to maximize their potential in the familiar surroundings of their home. Under Destination Home, transferring an individual from acute care to supportive living or long-term care will not be considered until all other community options have been exhausted. Moving to a residential care/facility-based setting is a life-changing decision that is optimally made from home. Destination Home is largely about changing the health system culture and processes to emphasize the quality benefits to patients of living at home. Investment $25-million Alberta Health grant for 2012-2015.

- Reviewing transition processes: A recent study that was completed in Covenant Health indicates more patients could be returning home with the appropriate supports. AHS will validate the report and determine which strategies, building on Destination Home and other programs, are required to provide the right level of care.

- Keep transition beds open (RGH, FMC): These transition beds will continue to be required until there is capacity in the community to facilitate placement for patients that are unable to go home, even with supports.

- Rehabilitation programs: AHS will provide intensive rehabilitation programs for specific populations that are candidates for returning to a higher level of independence. These programs can be delivered in an acute care, community or home-based environment and are intended to delay or reduce the need for higher levels of care. Adult Day Programs can be the vehicle for delivering this care in the community.

Balance the service mix of continuing care facilities.

Continuing care is a key component in facilitating overall system flow, providing services in a community setting that avoid requirements for acute care admission and allowing timely discharges from acute care. This is important both for the sustainability of the system, and for the quality of care for seniors and people with disabilities. As with acute care, it is not just a matter of adding more beds, but following a strategy to create the right types of care/services to give patients a range of options from home care to day support to facility based programs to best meet their needs. This strategy should also include sub-acute options and palliative care. An initial strategy has been developed and implementation has begun in the Edmonton Zone through the use of community care teams to enhance care capability in supportive living environments. Provincewide implementation needs to be pursued and accelerated to provide care at the right time and in the right place.
Address gaps in mental health continuing care.

Similar to continuing care, the Addictions and Mental Health program requires a housing continuum and an appropriate care model established for each level of care. Community housing and care for clients with addictions, mental health and developmental delays is significantly under-resourced. AHS, Alberta Health and Persons with Developmental Disabilities need to collaborate to fill in these gaps, and need to make it a high priority to purpose-build therapeutic environments to provide the right care in the right place for these vulnerable clients who are currently inappropriately housed in acute care beds.