AHS Report on Performance FY 2017-18

PEOPLE PLACED IN CONTINUING CARE WITHIN 30 DAYS

This measure monitors the percentage of people who are quickly moved from hospitals and communities into community-based continuing care. The higher the percentage the better, as it demonstrates capacity is available for long-term care or designated supportive living (levels 3, 4, and 4-dementia).

Percentage Placed in Continuing Care within 30 Days, FY 2017-18

Percentage Placed in Continuing Care within 30 Days Trend

Zone Name	2013-14	2014-15	2015-16	2016-17	2017-18	Trend	2017-18 Target
Provincial	**69.2%**	**59.9%**	**59.6%**	**56.1%**	**51.8%**	⇩	**56%**
South Zone	77.2%	59.5%	47.6%	45.9%	43.3%	⇩	56%
Calgary Zone	72.0%	57.1%	58.4%	57.4%	58.7%	☆	56%
Central Zone	40.7%	54.6%	61.5%	60.3%	54.6%	⇩	56%
Edmonton Zone	78.4%	66.2%	64.5%	55.8%	48.7%	⇩	56%
North Zone	62.8%	58.8%	58.7%	57.5%	43.9%	⇩	56%

Trend Legend: ☆Target Achieved ⇧Improvement ⇨Stable: ≤3% relative change compared to the same period last year ⇩Area requires additional focus

Total Clients Placed

Zone	2015-16	2016-17	2017-18
Provincial	7,879	7,963	7,927
South Zone	887	925	905
Calgary Zone	2,722	2,438	2,632
Central Zone	1,060	1,352	1,236
Edmonton Zone	2,506	2,575	2,388
North Zone	704	673	766

Source: AHS Seniors Health Continuing Care Living Options Report, as of April 24, 2018

Improve Patients' and Families' Experiences

Making the transition from hospital to community-based care options more seamless.

By improving timely and appropriate access to home care and continuing care living options in Alberta, AHS can improve flow throughout the system, provide more client-centred care, decrease wait time and deliver care in a more cost-effective manner. Timely placement can also reduce the stress on clients and family members.

Enhancing Care in the Community (ECC) is an initiative that focuses on the health and wellness of Albertans and improves access to health services and community-based care. By enhancing care in communities, we can ease pressures on hospitals and build the right services to support our growing and aging population.

AHS, with the support of Alberta Health and a broad stakeholder group, approved and set in motion the ECC strategy and action plan in 2017-18. Projects initiated in the fall of 2017 to support this work, include:

- The expansion of home care programs and services will continue in 2018-19 to enable people to remain safely in their homes for longer.
- The expansion of palliative home care service expansion across the province, including the addition of new teams and programs. In Alberta on average, over 65 people die each day; these programs help support people and their loved-ones to receive supportive palliative and end-of-life care services in all settings.
- An increase in the availability of respite services and adult day program supports through new adult day programs added in Grande Prairie and enhanced respite day programs in communities across the North Zone. AHS implemented a caregiver support and respite program in the Edmonton Zone aimed at providing flexible and meaningful supports.
- Across Alberta, the number of respite home care clients served was 6,018 in 2017-18 (5,861 in 2016-17) and the number of adult day program clients served was 3,843 in 2017-18 (3,716 in 2016-17).
- Implementation of emergency medical service programs to improve access to care in the community and at home (i.e., Community Paramedic Teams, and Assess, Treat and Refer processes).
- The development of Intensive Home Care programs designed to support clients in their homes while awaiting an alternate level of care.
- The Edmonton Zone Virtual Hospital project is incorporating a new operational model for the delivery of specialized transitional care by moving patients and families from hospitals to community in an integrated, collaborative and systematic way.
- The Complex Care Hub at the Rockyview General Hospital in Calgary became operational in February 2018. Its focus is a Hospital at Home-like program with inpatient admission, case management, and collaboration with patients' health home. The model aims to promote collaboration with acute care, the Community Paramedic Program, home care and primary care.
- A palliative home care program was established in the Calgary Zone which focuses on rural areas. This program supports families and caregivers by ensuring resources are available to support end of life care in client's homes.
- Community Support Teams were created to provide urgent care and consultation to complex clients and their care teams living in the community and requiring more intensive services.

As part of ECC, AHS is amending its policies to encourage more rapid discharge into home care for clients who might otherwise be placed on a waitlist for long-term care or designated supportive living. Several zones have begun implementing the policy suite.

In partnership and consultation with First Nations and Métis representatives and the Government of Alberta (Ministries of Health, Indigenous Relations, Seniors and Housing), AHS developed and launched the Continuing Care in Indigenous Communities Guidebook. AHS is committed to supporting Métis and First Nations communities in the development of continuing care services that meet their unique needs.

In 2017-18, there were 121,021 clients with unique needs who received home care, an increase of 1.9 per cent from 2016-17 (118,774 clients).

AHS strives to improve quality of care for continuing care residents and those living with dementia. To support the Alberta Dementia Strategy and Action Plan, AHS continues to implement the following actions.

- Seniors & Continuing Care Provincial Advisory Council was launched in January 2018 to strengthen community engagement and improve the delivery of services to seniors and those in continuing care across Alberta.

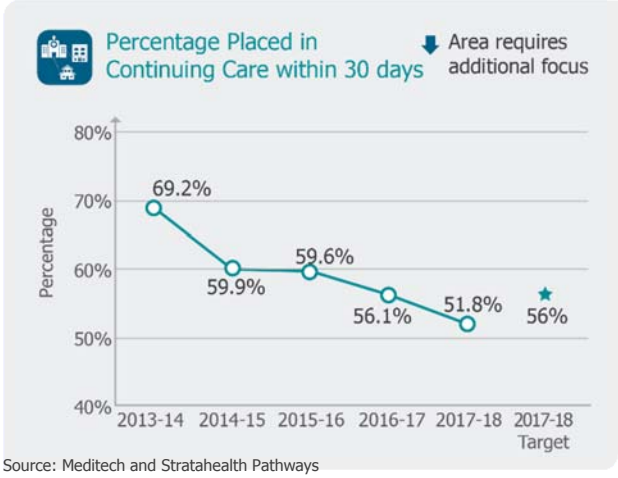
- The Appropriate Use of Antipsychotics initiative, which reduces inappropriate antipsychotic medication use for continuing care residents, was rolled out to all supportive living sites across Alberta.

- AHS is increasing availability and awareness of GPS locator technology for home care clients living with dementia.

- The provincial Housing and Health Services Steering Committee was established to address gaps and opportunities in the quality of residential continuing care services.

Measuring our Progress

People Placed in Continuing Care within 30 Days is the percentage of clients admitted to a Continuing Care Living Option (i.e., designated supportive living levels 3, 4, and 4-dementia or long-term care) from hospital and community within 30 days of the assessed and approved date the client is placed on the waitlist. It monitors the percentage of people moved from hospitals and communities into community-based continuing care settings. The higher the percentage, the better.



Source: Meditech and Stratahealth Pathways

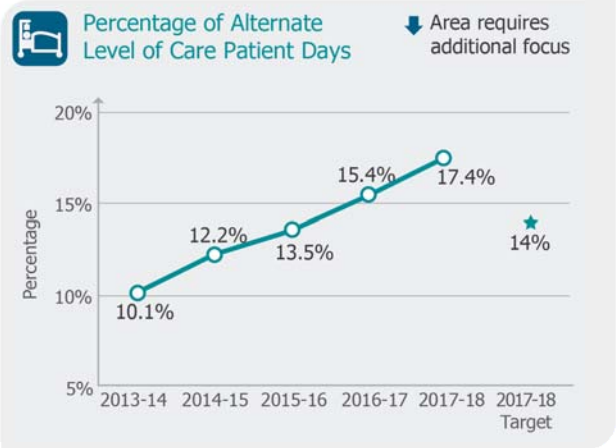
This measure continues to trend downward due to slower than required growth in home care, and continuing care and community living options.

To keep pace with population growth and aging, AHS needs to target increasing community capacity by approximately 1,000 designated spaces annually. In 2017-18, AHS opened 572 net new continuing care beds – more than the entire 2016-17 year (376 new beds).

Since 2010, AHS has opened 6,196 new beds to support individuals who need community-based care and supports (including palliative). Additional continuing care beds were opened in Medicine Hat in October 2017 (100+ beds) and Calgary in April 2017 (200+ beds). *Details on continuing care bed capacity across the province can be found in the Appendix.*

It's expected that new continuing care beds will be filled initially with clients who have been waiting for longer periods of time. As a result, the measure may show a deterioration before improving over the longer term.

Percentage of Alternate Level of Care Patient Days is the percentage of all hospital inpatient days when a patient no longer requires the intensity of care provided in a hospital setting and the patient's care could be provided in an alternate setting. This is referred to as alternate level of care (ALC). If the percentage is high, there may be a need to focus on ensuring timely accessible options for support or care for ALC patients. Therefore, the lower the percentage, the better.



Source: Discharge Abstract Data (DAD) – AHS Provincial

This measure shows a long-term trend towards deterioration year-over-year. The reasons for deterioration are multi-faceted and generally related to challenges in finding appropriate placement or services following hospital discharge. In some areas, this is due to slower than required growth in mental health, home care, continuing care or community care capacity.

By opening new capacity, we have seen an increase in discharges that inflate this rate. Increases in ALC percentage may also be due to a relative increase in patients needing supportive services when discharged to home.