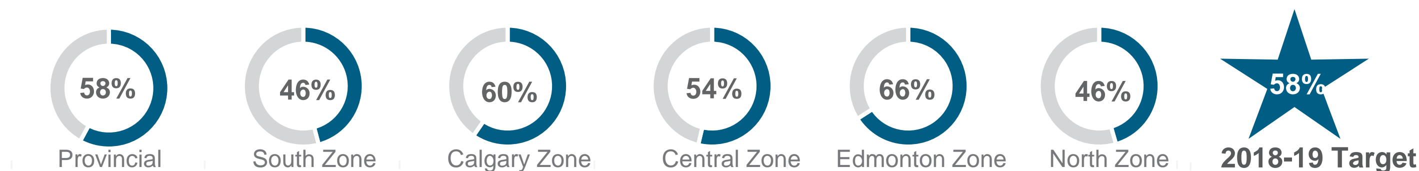
AHS Report on Performance FY 2018-19

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 2018-19



Percentage Placed in Continuing Care within 30 Days Trend

Zone Name	2013-14	2014-15	2015-16	2016-17	2017-18	2018-19	Trend	2018-19 Target
Provincial	**69.2%**	**59.9%**	**59.6%**	**56.1%**	**51.8%**	**57.9%**	☆	**58%**
South Zone	77.2%	59.5%	47.6%	45.9%	43.3%	45.9%	⇧	58%
Calgary Zone	72.0%	57.1%	58.4%	57.4%	58.7%	59.6%	☆	58%
Central Zone	40.7%	54.6%	61.5%	60.3%	54.6%	53.7%	⇨	58%
Edmonton Zone	78.4%	66.2%	64.5%	55.8%	48.7%	65.9%	☆	58%
North Zone	62.8%	58.8%	58.7%	57.5%	43.9%	45.5%	⇧	58%

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	2018-19
Provincial	**7,879**	**7,963**	**7,927**	**8,098**
South Zone	887	925	905	908
Calgary Zone	2,722	2,438	2,632	2,668
Central Zone	1,060	1,352	1,236	1,312
Edmonton Zone	2,506	2,575	2,388	2,525
North Zone	704	673	766	685

Source: AHS Seniors Health Continuing Care Living Options Report, as of April 25, 2019

Improve Patients' and Families' Experiences

Objective 1: Making the transition from hospital to community-based care options more seamless.

WHY THIS IS IMPORTANT

Increasing the number of home care services and community-based options reduces demand for hospital beds, improves the flow in hospitals and emergency departments, and enhances quality of life. AHS has two performance measures to assess how quickly patients are moved from hospitals into community-based care.

AHS PERFORMANCE MEASURE

People Placed in Continuing Care within 30 Days is defined as 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) within 30 days of the assessed and approved date the client is placed on the waitlist.

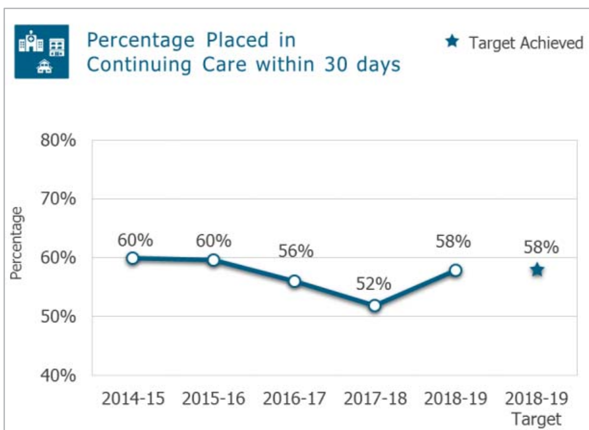
UNDERSTANDING THE MEASURE

Timely and appropriate access to Continuing Care Living Options is a major issue in Alberta. By improving access to a few key areas, AHS will be able to improve flow throughout the system, provide more appropriate care, decrease wait times, and deliver care in a more cost-effective manner. Timely placement can also reduce the stress and burden on clients and family members.

AHS wants to offer seniors and persons with disabilities more options for quality accommodations that suit their healthcare service needs and lifestyles.

This measure monitors the percentage of people who are quickly moved from hospitals and communities into community-based continuing care settings. 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).

HOW WE ARE DOING



Source: Meditech and Stratahealth Pathways

AHS performance improved as well as achieved the target in 2018-19 for this measures which means that, gradually, people are more efficiently being moved after they have been waitlisted for a continuing care living option, including those who are moving from a hospital setting to a more appropriate (and often more cost-effective) community-based setting.

WHAT WE ARE DOING

To keep pace with population growth and aging, AHS needs to target increasing community capacity by 800-1,000 designated spaces annually. In 2018-19, AHS opened 1,267 new continuing care beds.

Since 2010, AHS has opened 7,463 new beds to support individuals who need community-based care and supports (including palliative). Details on continuing care bed capacity across the province can be found in the Appendix.

In 2018-19, the average wait time for continuing care placement from acute/sub-acute care was 46 days compared to 51 days for the same period last year; a 10% improvement. The number of people waiting in acute/sub-acute care was 474 as of March 31, 2019 compared with 676 people waiting in the same period last year; a 30% improvement over last year.

In 2018-19, there were 8,098 people placed into continuing care from acute/sub-acute care and community compared to 7,927 people for the same period last year. Of these, 38% of clients were placed from the community compared to 34% from the same period last year.

It is important to note that not all of these patients are waiting in an acute care hospital bed. Many are staying in transition beds, sub-acute beds, restorative/rehabilitation care beds, and rural hospitals where system flow pressures and patient acuity are not as intense.

AHS PERFORMANCE MEASURE

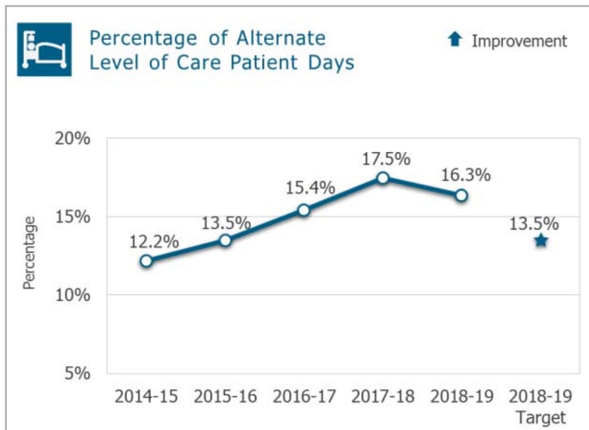
Percentage of Alternate Level of Care Patient Days is defined as the percentage of all hospital inpatient days when a patient no longer requires the intensity of care provided in a hospital setting and the patient's care could be provided in an alternate setting. This is referred to as alternate level of care (ALC).

UNDERSTANDING THE MEASURE

Hospital beds are being occupied by patients who no longer need acute care services while they wait to be discharged to a more appropriate setting. These hospital days are captured in hospitalization data as patients waiting for an alternate level of care.

If the percentage of ALC days is high, there may be a need to focus on ensuring timely accessibility to options for ALC patients. Therefore, the lower the percentage the better.

HOW WE ARE DOING



Source: Discharge Abstract Database (DAD) - AHS Provincial

This measure has shown improvement compared to last year but did not achieve target. Prior to 2018-19, the percentage of alternate level of care (ALC) days rose as AHS safely discharged more complex patients with unique housing needs who experienced higher numbers of days in hospital. By investing in new community capacity and targeted program supports aimed at serving complex clients, AHS has bent the curve and is trending in the right direction. It's important that we add 800-1,000 community beds per year to keep up with the aging population needs to sustain and further improve hospital system flow. AHS is committed to reducing the time patients wait in hospital for the appropriate level of care.

WHAT WE ARE DOING

Enhancing Care in the Community (ECC) is the roadmap for improving community-based care and services and reducing reliance on acute care services. The goal of ECC is to ensure that Albertans receive high quality care while we shift the focus of our current hospital-based care system to a community-based care focus. This way, we can provide patient-centred care within local communities, keeping Albertans out of hospital when not required. This, in turn, frees up beds for those who really need them.

- The **expansion of home care services and palliative care services** continued in 2018-19 which enables people to remain safely in their homes for longer by connecting them with care options in their local communities. In 2018-19, there were 127,214 unique/individual clients who received home care, an increase of 4.3% from 2017-18 (121,929 clients). The expansion of palliative home care services across the province grew by 14%. The average number of days home care clients spent in hospital within their last 30 days of life has dropped from 10.5 days to 8.5 days provincially and demonstrates the benefit of this expansion.

- **Emergency Medical Services Programs** (Community Paramedic Teams, and Assess, Treat and Refer (ATR) processes) are fully implemented and operational in all zones. These programs improve access to care in the community and at home. For example, **Community Response Teams** have demonstrated a high success rate in safely providing medical treatment in the community reducing the need for EMS transport, emergency department admission or hospitalization. Expanding these services will allow patients and families to remain in their own homes, avoid hospital admission, and provide referral and transportation services where appropriate.

- The **Virtual Hospital Project** in Edmonton Zone 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 Rockyview General Hospital in Calgary became operational in 2017-18. This year, the program facilitated over 100 admissions and saved over 1,350 days of acute and sub-acute care by providing care outside of hospital. An evaluation model was established and the program began its expansion to South Health Campus in Calgary. Patients receive daily care and monitoring within the comfort of their own home or at the hospital in an outpatient unit. The multidisciplinary care team can connect patients with services and supports as their needs change.

- **Enhanced Respite Day Programs** have increased the availability of services through the use of adult day programs in communities across the North Zone. These programs are aimed at decreasing social isolation, improving cognitive and physical wellbeing of community clients, and giving caregivers a break from care duties during program hours. Across Alberta, the number of respite home care clients served was 6,711 in 2018-19 (6,372 in 2017-18) and the number of adult day program clients served was 4,591 in 2018-19 (4,287 in 2017-18).

- The **Calgary Rural Palliative In-Home Initiative** increases equitable access to home care services for clients living in rural areas. This initiative has served 74 new clients this year. The percentage of deaths occurring in Calgary Zone rural hospitals has dropped from a range of 36% to 49% to under 15% in 2018-19. Meetings have been occurring with First Nations communities to determine modifications to processes that may be needed to serve Indigenous communities.

- **Intensive Home Care** programs will provide wrap-around services to clients who have recently been discharged from hospital to safely enable them to remain at home until a designated living option becomes available. The service will also be responsive to a client's changing needs in the community and provide resources to address changing health and personal care needs. This results in a decrease in less urgent Emergency Department visits for home care clients.

- The **Community Support Teams** initiative will focus on developing a multidisciplinary team that will provide urgent care and consultation, and assist with developing an intermediary care plan and follow-up care and diagnostics as required for complex clients. Services include providing home care and self-help services, enhancing primary care, addressing housing and transportation issues, and tackling social isolation. This results in a decrease in non-emergent Emergency Department visits for home care clients and continuing care 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 provide **Dementia Advice** through Health Link 811 affording Albertans equitable access to dementia supports across the province. The total number of referrals in 2018-19 (710) increased by more than 33% compared to the same period last year (532). AHS also provides dementia education for current staff, including mentorship.