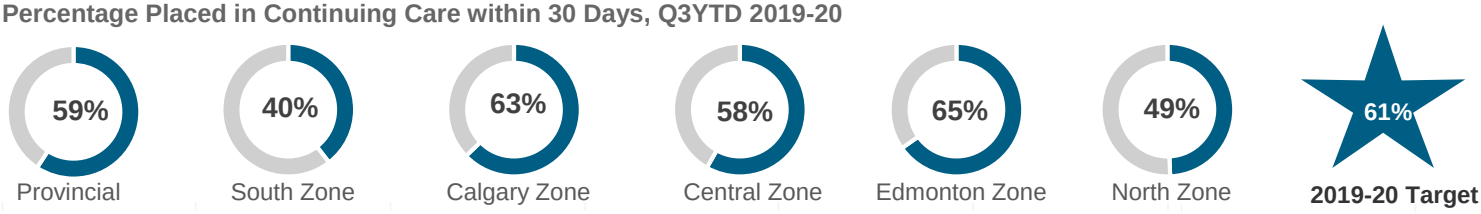
PEOPLE PLACED IN CONTINUING CARE WITHIN 30 DAYS

DEFINITION: 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.

WHY THIS IS IMPORTANT: 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.

Percentage Placed in Continuing Care within 30 Days, Q3YTD 2019-20



Percentage Placed in Continuing Care within 30 Days Trend

Zone Name	2014-15	2015-16	2016-17	2017-18	2018-19	Q3YTD 2018-19	Q3YTD 2019-20	Trend	2019-20 Target
Provincial	**59.9%**	**59.6%**	**56.1%**	**51.8%**	**57.9%**	**57.5%**	**59.2%**	⇨	**61%**
South Zone	59.5%	47.6%	45.9%	43.3%	45.9%	46.9%	39.5%	⇩	61%
Calgary Zone	57.1%	58.4%	57.4%	58.7%	59.6%	57.8%	62.8%	☆	61%
Central Zone	54.6%	61.5%	60.3%	54.6%	53.7%	54.5%	58.2%	⇧	61%
Edmonton Zone	66.2%	64.5%	55.8%	48.7%	65.9%	65.8%	65.2%	☆	61%
North Zone	58.8%	58.7%	57.5%	43.9%	45.5%	45.2%	49.3%	⇧	61%

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	Q3YTD 2018-19	Q3YTD 2019-20
Provincial	**7,879**	**7,963**	**7,927**	**8,098**	**5,992**	**6,235**
South Zone	887	925	905	908	652	645
Calgary Zone	2,722	2,438	2,632	2,668	2,013	2,050
Central Zone	1,060	1,352	1,236	1,312	930	1,063
Edmonton Zone	2,506	2,575	2,388	2,525	1,873	1,946
North Zone	704	673	766	685	524	531

Source: AHS Seniors Health Continuing Care Living Options Report, as of January 30, 2020

Improve Patients' and Families' Experiences

Objective 1: Making the transition from hospital to community-based care options more seamless (Enhancing Care in the Community).

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

Percentage 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.

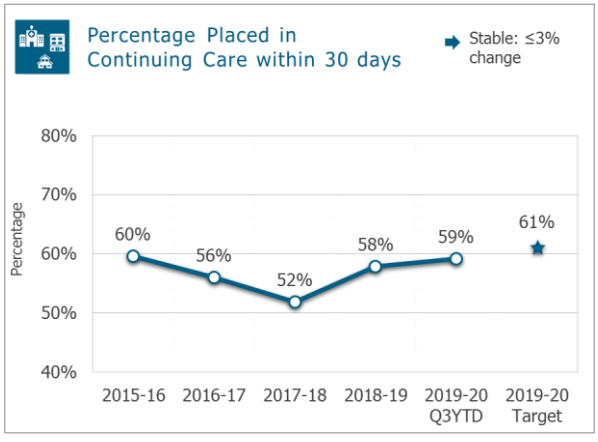
UNDERSTANDING THE MEASURE

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

This measure monitors the percentage of people who are moved from hospitals and communities into community-based continuing care settings within the target of 30 days. 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

This measure remained stable compared to the same period last year and did not achieve target in Q3. The goal is to move people more efficiently after they have been waitlisted for a continuing care living option including people 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. As of Q3YTD (year-to-date), AHS has opened 604 net new continuing care beds to support individuals who need community-based care and supports (including palliative). The 604 new beds are comprised of 62 long term care, 535 supportive living (including 179 dementia), and 7 palliative.

AHS opened two new continuing care facilities in Q3:

- South Valley Residential Living (North Zone)
- Chartwell Emerald Hills (Edmonton Zone)

The average wait time for continuing care placement from acute/sub-acute care in Q3YTD (37 days) improved by 23% compared to the same period last year (48 days). The number of people waiting in acute/sub-acute care in Q3YTD (467) improved by 13% compared to the same period last year (538).

The number of people placed into continuing care from acute/sub-acute care and community in Q3YTD (6,235) increased by 4% compared to the same period last year (5,992). Of those placed, 41% of clients were placed from the community compared to 38% in 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.

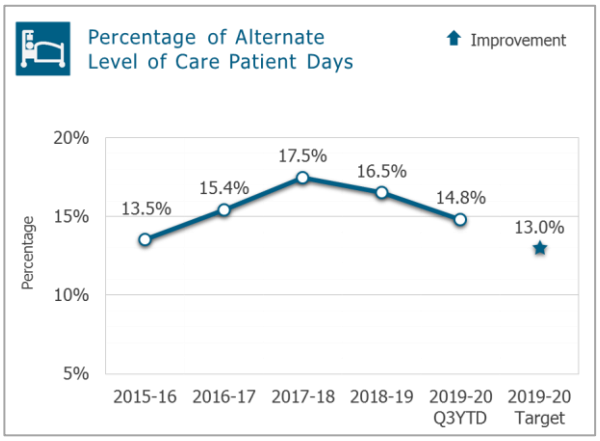
AHS PERFORMANCE MEASURE

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

The percentage of ALC patient days (14.8%) improved by 11% compared to the same period last year (16.6%) but did not achieve target in Q3. 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 continue to add community beds to keep up with aging population needs 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 need them.

ECC also involves developing partnerships and coalitions with not-for-profit and volunteer agencies, towns and municipalities, schools, other government departments, business and industry, and other partners with the goal of keeping Albertans healthy and well.

- Emergency Medical Services (EMS) has fully implemented two programs that improve access to care in the community and at home:
  - Community Response Teams (CRT) aim to support patients in continuing care with patient centered treatment, while avoiding emergency department visits and hospital admissions. In Q3, AHS established referral pathways with community shelters and agencies to support clients with mental health and addiction concerns at risk of an EMS response and emergency department admission. The number of CRT events in Q3YTD (15,958) increased by 40% compared to the same period last year (11,424).
  - The palliative and end-of-life care (PEOLC) Assess, Treat and Refer (ATR) program in Edmonton Zone enables EMS and Continuing Care to coordinate care in the community. The program continues to support the existing Crisis Response unit as well as providing additional support to ATR clients accessing the Mental Health Crisis Line.
- The expansion of home care and community palliative care services continued in Q3 with a focus on case review processes that include all members of the care team to ensure that, even though patients are geographically dispersed, they still receive high quality, consistent care. The number of unique home care clients in Q3YTD (117,315) increased by 5% compared to the same period last year (111,949).
- Enhanced Respite Day Programs in the North Zone increase the availability of services through the use of adult day programs. Programs are aimed at decreasing social isolation, improving the cognitive and physical wellbeing of community clients, and giving caregivers a break from care duties during program hours. In Q3, AHS began planning for a provincial rollout.
- The Calgary Rural Palliative In-Home Initiative supports patients who live in rural areas of the Calgary Zone with palliative conditions nearing the end-of-life to stay at home when desired. In collaboration with patients and their families, teams identify and authorize the amount and level of additional home care that is needed. The program is now fully operational and focused on quality improvement and client enrollment.
- The Virtual Hospital Project in Edmonton Zone is utilizing a new model for the delivery of specialized transitional care by moving patients from hospitals to the community in an integrated, collaborative, and systematic way. Preliminary data shows a 51% reduction in emergency department visits and a 42% reduction in acute care admissions for virtual hospital clients.
- Community Support Teams aim to provide early intervention by supporting the multidisciplinary teams that provide urgent care and consultation for complex clients, as well as assist with developing intermediary and follow-up care plans to ensure care can effectively be provided in the clients' current location. Work continued in Q3 to place complex clients from acute care into more appropriate care settings.
- Intensive Home Care programs 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. Programs are responsive to clients' changing needs in the community which decreases the need for ED visits for home care clients. As of Q3, 98% of IHC clients did not require another transfer within the first 60 days.

AHS continues to provide Dementia Advice through Health Link 811. Dementia Advice responds to the immediate needs of persons with dementia living in community settings and their care partners who require health related advice, education, information, and emotional support during the course of dementia. In Q3YTD, 507 referrals were made to the Dementia Advice line from Health Link.