ALC: Helping the "Alternate" become "Appropriate" through application of Geriatric Principles

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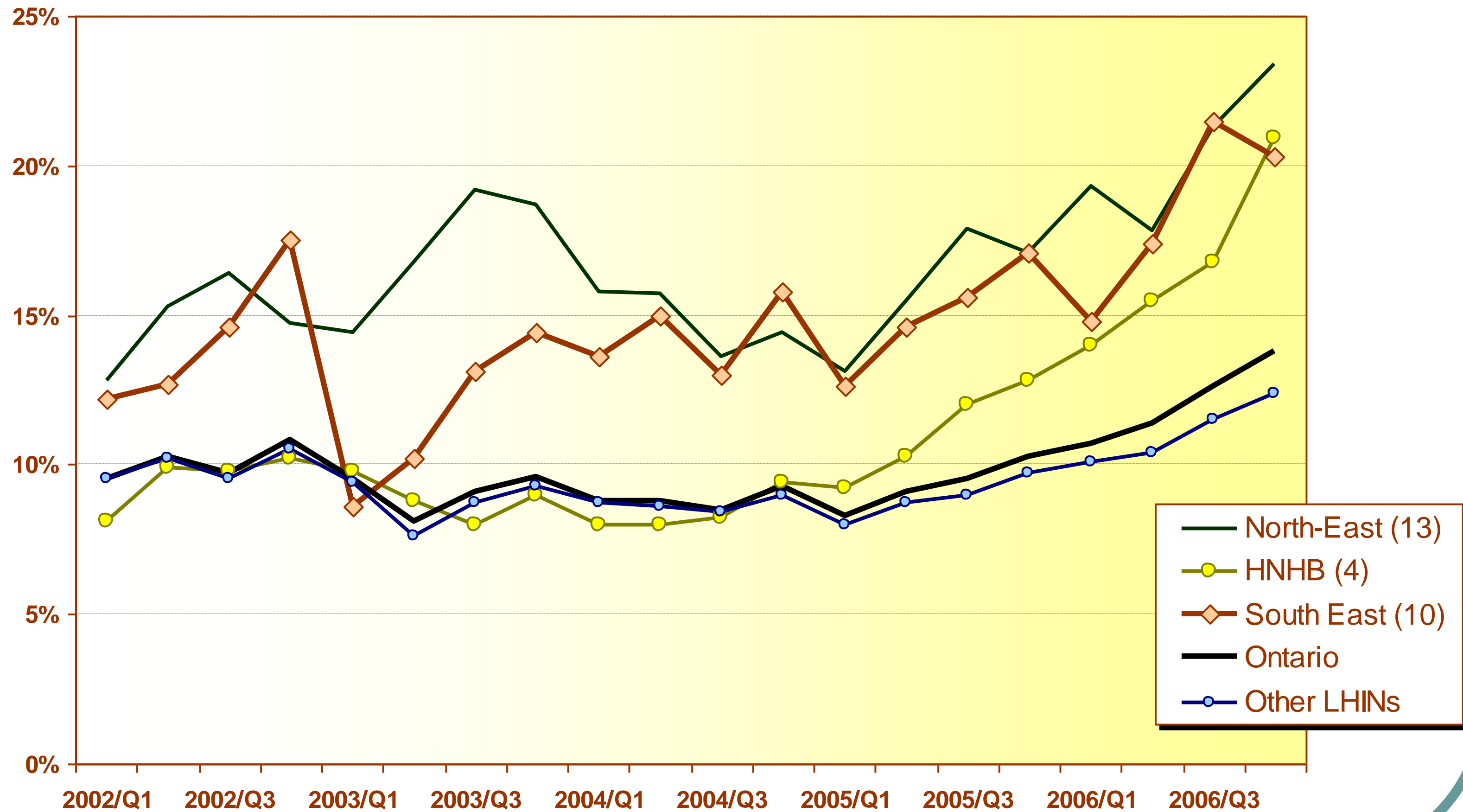
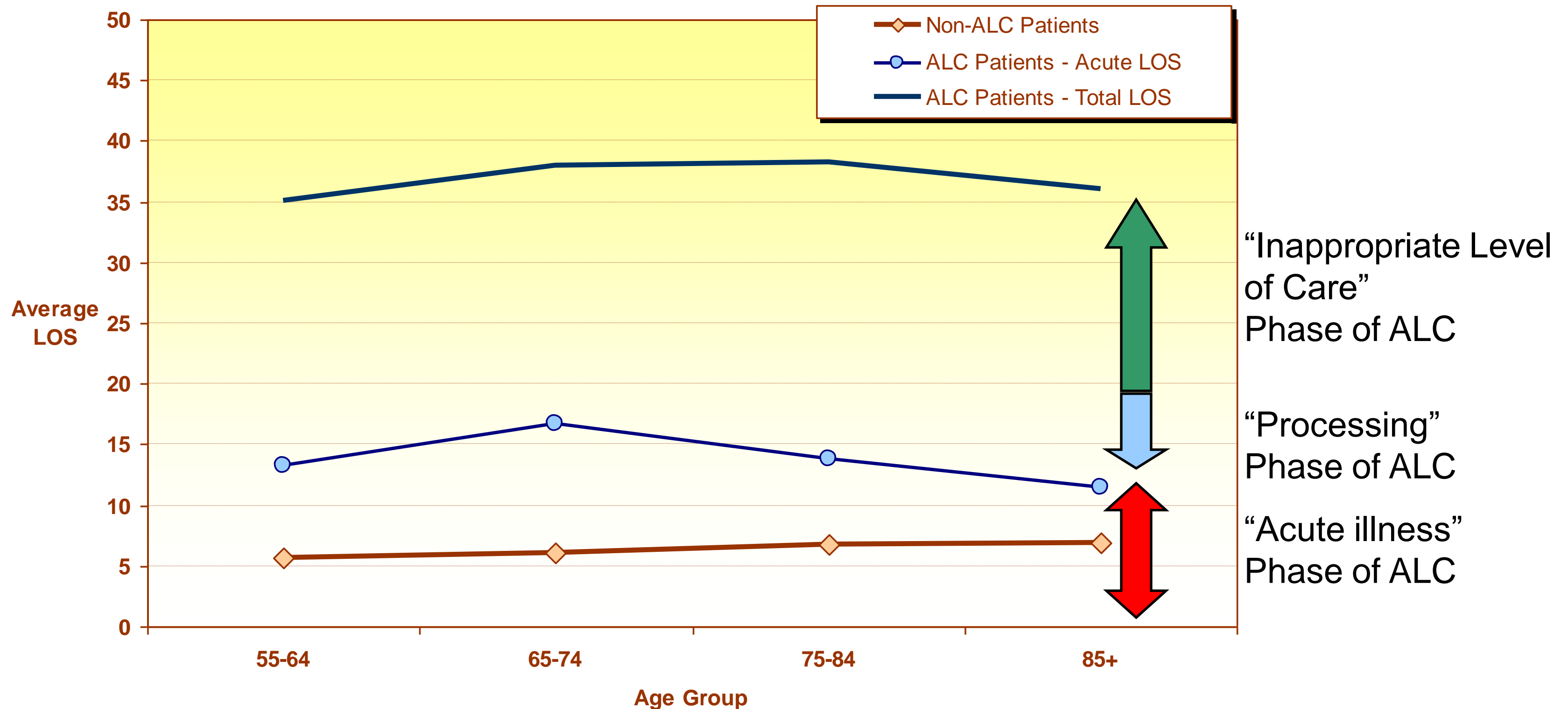
Queen's University
And the RGP's of Ontario

Percent ALC over time

LHINs Across Ontario, Fiscal Year 2002-2006



Average LOS for ALC and non-ALC Patients



Who are the ALC Patients?

- In 2006, 25% of ALC patients were transferred to LTC, 24% were transferred to their private residence (with no home care services or their transfer status was unknown), 13% home with Home Care services, 22% to Chronic Care facilities, and 11% to a Rehabilitation facility
- Those admitted to LTC were typically
  - Very old*
  - Female*
  - Cognitive Issues and Functional Decline*
  - Previous high users ER/Hospital (frequent fliers)*
  - Often multiple co-morbidities and drugs*
  - 75% admitted from ER
  - 60% NOT receiving CCAC previously!
  - Decline in function occurs after admission to hospital!

* Frail elder characteristics

Ms. P.: An illustrative example

Home

- Mrs P is an 89 women Previous Medical History of
  - Myocardial Infarction 10 years ago with tendency to Congestive Cardiac Failure
  - Osteoarthritis of hips and knees
  - Bilateral Cataracts
  - Diabetes Mellitus for 4 years
- Recent records note two attendance at A&E in last three months with falls

Ms. P.: An illustrative example

Hospital

- She is brought to the A&E by her daughter who reports her Mother is very short of breath, legs are swollen and new onset of confusion
- Recorded prescribed medications are
  - Furosemide, Digoxin, Ty #2's, Ibuprofen, Ativan and Metformin
- A decision to admit to hospital with a diagnosis of CCF, possible pneumonia and acute confusion is made within the A&E department.

Ms. P.: An illustrative example

Hospital

- No beds are available in hospital
- It is decided to adjust her CCF therapy, commence an antibiotic and request crisis admission to LTC as soon as bed available.
- However, late that night she falls off the gurney and is found lying in apparent severe pain. A hip fracture is diagnosed.
- She has to wait another 10 hours before a bed is available to admit her to an orthopedic unit for surgery the next day.

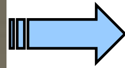
Ms. P.: An illustrative example

Hospital

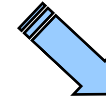
- On the first post-operative day worsening agitation and disorientation is noted. Physical restraints and prn haldol are ordered.
- Some improvement is reported however she remains disorientated but is now considered to be “pleasantly confused” requiring assistance with washing, dressing and two nurses to transfer from bed to chair. She has been incontinent of urine since her catheter was removed.
- The presence of Stage 2 pressure sore of the sacrum is noted in nursing charts.
- The surgical note progress note reports good wound healing and alignment of fracture. An immediate discharge planning order is recorded. She is designated as ALC awaiting discharge to LTC.

Ms. P.: An illustrative example

Home



Hospital



ALC

ALC: System Impacts

- **Domino effect** across the system
- **patients wait** in emergency rooms for inpatient beds,
- **ambulances wait** to offload patients in to crowded emergency departments
- **redirection of patients from emergency departments** to other hospitals, communities
- **cancellation of elective surgical procedures** due to lack of post-op acute beds

ALC: Quality of Care Impacts

- Premature ALC Decisions
- “Second class citizens”
- Increased dependency
- Risk of Iatrogenic disease
- Reduction in effective bed count
- Delays in “elective surgery”
- Inappropriate Tx sites (ER)
- Increasing #s ALC

ALC: Why the issue?

- Number of identified demographic factors contribute to trends towards rising ALC
  - Aging of population
  - Age-related increasing prevalence of dementia
  - changes in access to and role of the family physician
  - transformation of families (smaller and/or recombined family units) and geographic dispersion of families
  - changing expectations of seniors and caregivers (aging baby-boomers, better educated seniors, diverse populations)

ALC: Why the issue?

- Significant changes within the health care system including:
  - **Hospitals**
    - targeted financial growth
    - reduction of beds
    - Hospital Accountability Agreement
    - increased use of performance measurement and comparison between hospitals influencing patient care, service planning and funding decisions
  - **CCACs**
    - emphasis on post acute hospital care (reduced emphasis on “chronic home care and personal supports)
    - changes/refinement of eligibility criteria/legislative changes
    - amalgamation of CCACs
  - **LTC homes** legislative changes

ALC: Why the issue?

- Communication and coordination issues
  - lack of consistent hospital practices, discharge policies and utilization management protocols
  - awareness of, access to and utilization of specialist services and post-acute services
  - communication and coordination between providers (hospitals & community)
- Housing gaps
  - Lack of supportive housing
  - Mal-distribution of LTC beds
- Service gaps
  - Specialist Services, High-tech services eg ventilators, dialysis, Specific populations needs eg ABI patients, Behavioural issues
  - Community support services
- Inefficiencies
  - cumbersome assessment and referral processes with built in time delays
  - use of multiple re-assessments at multiple points
- Person power gaps
  - Primary care
  - Nursing/Allied Health/PSWs

ALC
Premature designation
Knowledge and Awareness Gaps
Medical instability
Infection control issues

Acute Care
Atypical Complex Presentations
Longer LOS
Limited access to rehabilitation
Secondary losses
High ALC rate
Adverse outcomes common

Long Term Care
Crisis admissions common
Medically complex care
High morbidity and mortality
High prevalence of dementia
Resource gaps (staff/skills)

CCAC
Funding Envelope
Person power
Complex case load
Orphan patients

CSS
Funding Envelope
Knowledge and Awareness Gaps

Frail Elderly
Very Old
Female
Living Alone
Co-Morbidities
Multiple Meds

Supportive Housing
Limited availability
Shared care models lacking

Emergency Room
Atypical Presentations
Communication Gaps
Early Repeat Visits
Longer LOS
Increased hospitalization and Crisis admission LTC

Family
Isolation
Caregiver stress
Navigation issue
Information Gaps

Primary Care
Knowledge and Awareness Gaps
Communication Gaps
Orphan Patients

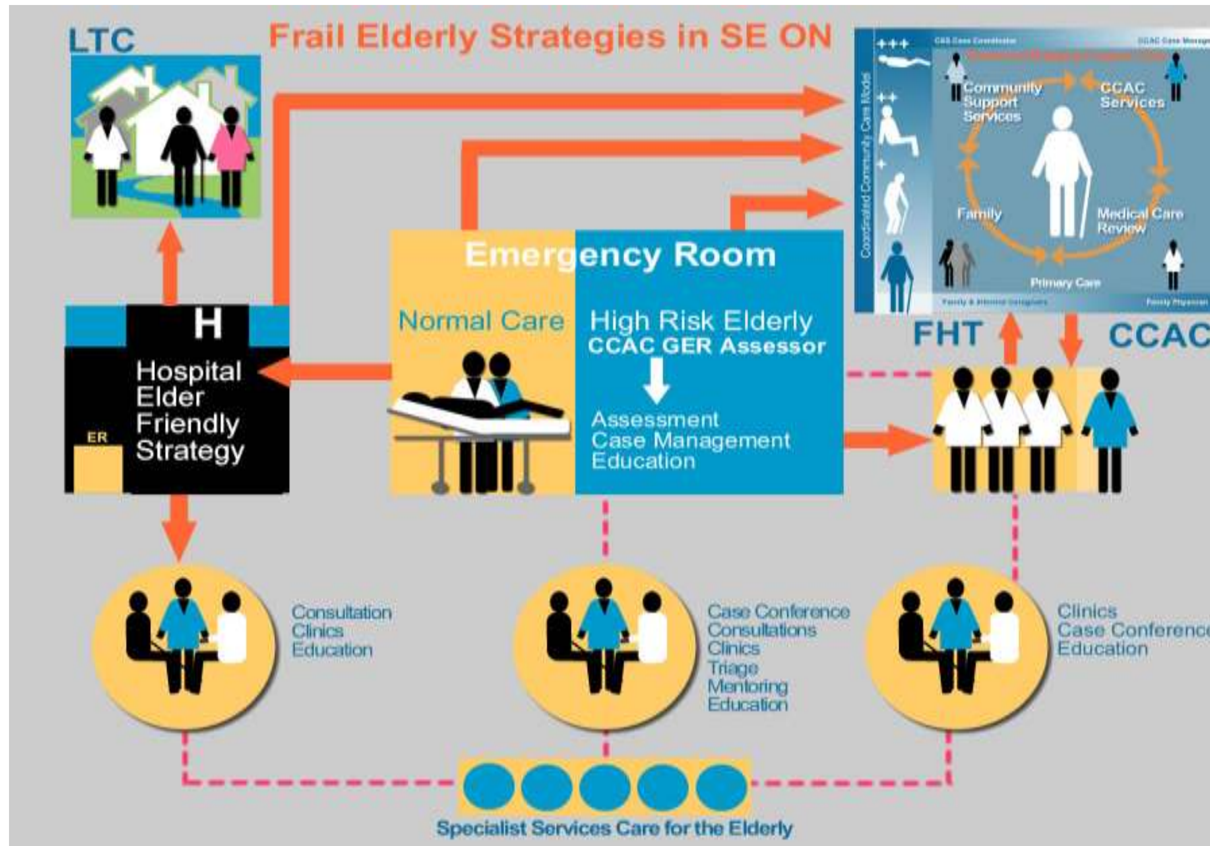
Specialized Services
Medical instability
Infection control issues
ALC Pressures
Limited resources
Commonly under-utilized

Potential Components of a Strategy

- Reduce size of “high-risk” group
- Target assessment/intervention to high-risk
- Multidimensional Inter-professional approach to assessment and care
- Rehabilitative environment and focus on Senior-Friendly Hospitals
- Increased awareness and care capacity in all sectors through education and training
- Maximize system navigation
- Integrated strategy for “care” between primary care, community, in complex continuing care and rehabilitation programs, and long term care homes
- Availability of supportive housing and flexible intense case-management resources

Need to align efforts

Responding to the need: EASIER+



EASIER + Building on an evidence-based strategy it aims to target high risk elderly and create improved care responses through linkages and liaisons between ER staff, primary care practitioners, CCAC, community support services, and specialist services

Changing the trajectory to ALC designation: The key to start early, target and treat

	Objective	Target Population	Initiatives	Responsibilities
1	Maintain independence prevent functional loss	HEALTHY ELDERLY ↓	**HEALTH PROMOTION**	Primary Care (1° Care)
2	Restore independence/ Reverse functional loss	FRAIL ELDERLY ↓	Review and Intervene **UNFRAIL:** Diseases Drugs Deconditioning Rehab	CCAC + Primary Care + Specialized Geriatric Services (SGS):OP
3	Identify and manage conditions contributing to frailty and functional loss	FRAIL & NOW SICK ELDERLY IN ED ↓ → SENT HOME →	Screening for high risk to return to ED	ED GEM, CCAC RISC 1° Care, and SGS
4	Identify and manage conditions contributing to frailty and functional loss (10%)	FRAIL & NOW SICK ELDERLY IN ED ↓ → BEING ADMITTED →	**ADMIT TO HOSPITAL** • Screen for high risk by 48 hrs • Prevent deconditioning/ Iatrogenesis →	• Geriatric consult unless clear D/C plan • Hospital Care Team
5	Return home or to lower level of care (10%)	ALC Patient ↓	**ASSESSMENT** Prior to ALC designation to ensure NO reversibility	
6	Reduce demand for placement by optimizing function for patients referred (17%)	ALC UNIT ↓	**ACTIVATION** and time (still some "recoveries" possible)	

LTC PLACEMENT

6 Safety Nets

The GiiC Initiative:

Geriatric, Interprofessional, and Interorganizational Collaboration

Project Background

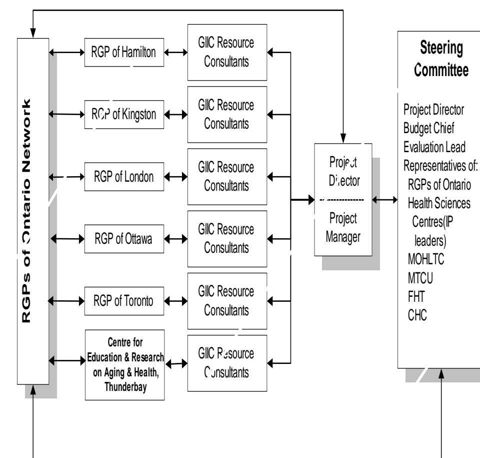
The Regional Geriatric Programs of Ontario and the Centre for Education & Research in Aging & Health at Lake Head University have been given funded by the Ministry of Health & Long Term Care for the purpose of developing primary care capacity to provide effective inter-professional and collaborative shared care for seniors across the Province of Ontario. This initiative will involve working together with Family Health Care Team and Community Health Centres.

KTP Resources

Key KTP Materials in Geriatrics :

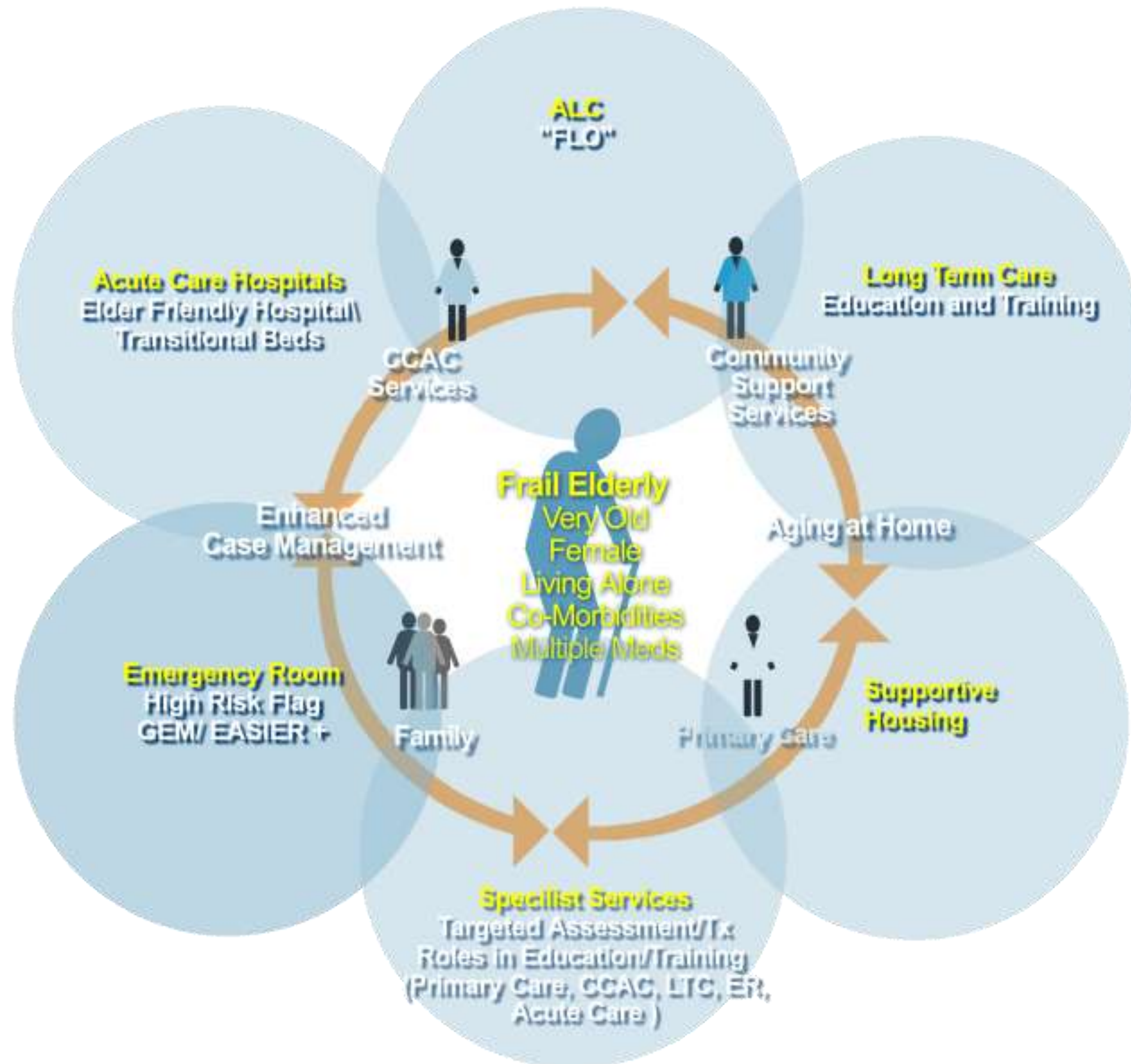
- Advanced Directives
- Caregiver support
- Dementia screening
- Driving assessment
- Falls risk
- Oral care
- Pain
- Periodic Health Exam
- Capacity assessment
- Delirium
- Depression
- End of life care
- Incontinence
- Osteoporosis
- Polypharmacy

Members of GiiC



Enhancing Primary Care Capacity for Care of the Eldelry

Building an Integrated Strategy



Summary

- The causes of the ALC issue are **multiple, inter-dependent and complex**
- There is **no single strategy** that will “fix” the system
- The **solution** requires a **multi-layered system-wide strategy** building upon principles of
  - Reduce size of “high-risk” group
  - Target assessment/intervention to high-risk
  - Multidimensional Inter-professional approach to assessment and care
  - Rehabilitative environment and focus
  - Increased awareness and care capacity in all sectors through education and training
  - Maximize system navigation
  - Integrated strategy for “care” between primary care, community, in complex continuing care and rehabilitation programs, and long term care homes
  - Availability of supportive housing and flexible intense case-management resources
- Most effects will be measurable over years (not in weeks or months)
- Planner, provider, environment and user (patient, family) behaviours need to change