Leadership. Services. Support.

HEALTH ASSOCIATION NOVA SCOTIA

Long Term Care Placement Process Review in DHA 9:
Hospital to Nursing Home Placements

A report completed by Health Association Nova Scotia
Continuing Care Council in collaboration with the Nova Scotia Department of Health and Wellness, and Capital District Health Authority

2 Dartmouth Road
Bedford, Nova Scotia
B4A 2K7

www.healthassociation.ns.ca

Acknowledgements

The author would like to thank the members of the Long Term Care Placement Review Committee who shared their expertise and knowledge of the system and provided their thoughtful comments on how to improve the placement process in the interests of better serving individuals awaiting placement into long term care. Gratitude is also expressed to Paula Barrett for sharing her family's journey into long term care with the Committee. Special thanks are extended to Sonya Stevens of Health Association Nova Scotia who analyzed the time interval data provided from various sources, prepared the process maps, and assisted with sub group interviews.

Carolyn Marshall
BA (Hon), MPA
Senior Policy Analyst
Health Association Nova Scotia

Long Term Care Placement Process Review in DHA 9: Hospital to Nursing Home Placements

Table of Contents

Long Term Care Placement Process Review in DHA 9: Hospital to Nursing Home Placements

Executive Summary

The impact of long term care placement delays on individuals, families, and the health care system can be significant. Health Association Nova Scotia Continuing Care Council, in collaboration with the Department of Health and Wellness and the Capital District Health Authority, undertook a review of the placement process from hospital to long term care, with the intent of identifying ways to improve and expedite placement. While it is acknowledged that people wait in the community for placement as well, this report focuses specifically on ways to expedite placement of individuals awaiting transfer from hospital (Alternative Level of Care) to long term care (LTC). The purpose of the review was to map the various processes involved in the long term care placement process, identify barriers, and recommend solutions to expedite placement.

For manageability, the scope of the project was confined to District 9 - Capital District Health Authority (CDHA), in recognition of the degree of complexity of the district, the number of nursing homes and hospitals involved in the placement process, and the fact that process mapping work had already begun in this district. It is anticipated that this work will have general applicability to other districts as well. Scope was also limited to the placement process from hospital to long term care, although it is recognized that this issue is multifaceted and affects/is affected by other components of the continuum of care.

A Committee comprised of representatives involved in the placement process from CDHA, the Department of Health and Wellness (DHW) and the long term care sector was formed. A family member of an individual in long term care was also asked to participate to ensure their views and experiences were also included. A mix of methods was used to inform the work of the committee: members involved in placement mapped out the process at a high level, and identified barriers encountered in their practice which contribute to delays. Data was collected from a variety of sources – DHW's SEAscape data on long term care, the QEII, and two long term care homes – which was used to identify time measurements for each step in the process and guide the work of the Committee. The key strategy was to address areas with the greatest potential for influence in terms of time reduction. In addition, interviews were conducted with long term care homes with the fastest placement times to identify best practices and suggestions for improvement.

The key findings of the work were as follows:

- Estimates of the length of the entire process ranged from 3.7 months (QEII) to 6.7 months (DHW).

- The longest time elapsed is when client is in hospital (up to 189 days).

- The majority of the time spent in hospital is from when the care-level and financial decisions have been made to when a vacancy occurs. Little can be done to influence this time frame itself; however, some arrangements to reduce the time from when a vacancy occurs to placement can be made during this time.

- The process of Referral to Assessment (23 days) to Care Level Decision (11-41 days) takes up to 64 days. The process of financial eligibility review (33.4 days), which takes place simultaneous to the functional assessment and care level decision, does not delay the process further. The time from Referral to Assessment and Referral to Eligibility Review Unit is virtually identical (at 23 and 22 days respectively) and the time from Assessment to Care Level Decision (11-41 days) matches or exceeds the time from Assessment to Financial Decision (11.4 days). However, it is important to note the efficiencies achieved in one area (care level) must be matched in the other (financial) so as not to delay the overall process.

  Opportunities to reduce time in both these areas were identified, both for "typical cases" (improved sharing of information and case flow management, more preparation of/support for families, expedited access to financial information via Canada Revenue Agency) and for more difficult cases (clients with dementia-related challenging behaviours, mental health issues, and wound care issues) which, while fewer in number, take longer to place (improved information management).

- The time from when a vacancy occurs to when the client is placed in a LTC bed takes about 21-25 days.

- The majority of this time (8-12 days) is spent by Placement Office trying to find a client to confirm their acceptance of the bed offer, while the remainder is taken up by the facility making a decision about whether they can meet the needs of/accept the client (7 days) and the arranging for the client to transfer from hospital (4 days). Ideas to reduce this time were also identified with emphasis placed on shifting activities to prepare a client for transfer before a vacancy actually occurs (earlier access to wait lists, earlier site visits by family, provision of equipment and medication with the client upon departure from hospital).

A series of recommendations with supporting rationale were offered to improve the process and expedite the transfer of individuals awaiting placement from hospital to long term care. While the time elapsing in some steps cannot be influenced, emphasis is placed on taking preparatory steps earlier in the process *before* a bed becomes available. Recommendations include: development of performance standards and accountability, leadership to monitor change, enhanced home care and community-based alternatives to long term care, provision of more support and information to families, support to identify a substitute decision-maker where necessary, enhanced case coordination, enhanced care team functioning, providing Care Coordinator access to the wait list to support earlier preparation of families, improved and

streamlined data collection to support quicker decision-making, development of a strategy to build sector capacity to better manage dementia-related challenging behaviours, improving understanding and communication among the partners in the placement process, measures to expedite both care level and financial decisions, improved access to equipment and medications upon departure from hospital, expediting admission into long term care, making better use of human and other resources, development of a standard contract by long term care facilities, and consideration of limits on inter-facility transfers. A list of the recommendations follows for ease of reference.

It is anticipated that these changes will improve the experience of families awaiting placement by reducing the time spent at certain stages. However, the current and planned supply of long term care beds is insufficient to meet current or projected demand so exploration of alternatives such as expanded home care and development of other community-based alternatives will be necessary. Given the projected demographics and disease trends contributing to the demand for long term care, early examination of these options, although beyond the scope of this report, is imperative.

Greater public understanding of the long term care placement process and access to home care and alternatives would not only help individuals and families prepare for their personal future, but also contribute to an informed public dialogue about our collective policy choices for the care of an aging population.

LIST OF RECOMMENDATIONS

1. Implement Performance Standards and an Accountability Framework

Implement performance standards which identify time targets/key performance indicators for each critical step in the placement process. Based on our review of the process, these time targets are suggested in the chart below as reasonable and achievable for most cases, acknowledging that not all cases will fit this standard. The current time elapsed, the proposed target times, and the estimated time savings for each step in the process are presented in Table 1. Based on these estimates, it may be possible to reduce the time elapsed over the entire process from referral to placement by up to 57 days.

Development of mechanisms to collect data on, and monitor achievement of, these targets is required in order to determine if the recommendations suggested here are effective in expediting placement and to identify further opportunities for improvement. Systems already exist to capture some of this information but some standardization (of terms, reporting intervals, definitions, etc.) is necessary.

In the long term, making better use of technology would enhance information quality and exchange and expedite decision-making in the placement process. Implementation of an automated information system to collect and transfer the information required by various parties within the placement process would not only expedite case processing, but can be used for auditing and accountability purposes.

Develop an Accountability Framework which identifies monitoring and reporting mechanisms, who is responsible for achieving what outcomes, how performance will be measured, how deviances from the norm will be addressed (what range of interventions might be necessary to support achievement, changing the targets if appropriate), who is responsible for monitoring and ensuring overall accountability for compliance, and how this will be done, is necessary. Accountability for achieving the outcomes identified in the Accountability Framework is shared as all players within the placement system must be jointly engaged in this effort and work together to achieve overall system improvement.

HOSPITAL TIMELINES			
Process Step	**Current** (calendar days)	**Target** (calendar days)	**Est. Savings** (calendar days)
STEP 1a: Referral Date to Assessment	23 days	10 days	**~12 days**
STEP 1b: Referral Date to Eligibility Review Unit	22 days	10 days	
STEP 2a: Assessment to Care-level Decision	11-41 days	10 days	**1-30 days**
STEP 2b: Eligibility Review Unit to Financial Decision	11.4 days	10 days	
STEP 3: Care-level Decision and Financial Decision to Offer Accepted	46-133 days	N/A (Minimal impact)	**0 days**
STEP 4a: Vacancy Occurs to Vacancy Declared	1 business day	1 business day	**0 days**
STEP 4b: Vacancy Declared to Offer Confirmed	8-12 days	5-8 days	**3-7 days**
STEP 4c: Offer Accepted to Client Info Sent to Facility	1 business day	3 days[1]	**~8 days**
STEP 5a: Client Info Sent to Facility to Facility Confirms Acceptance	7 days		
STEP 5b: Facility Confirms Acceptance to Client Notification	Same day		
STEP 5c: Client Notification to Client Acceptance	Same day		
STEP 6.0: Client Acceptance to Placement	4 days		

[1] Assuming all information and resources are readily available.

2. Identify Leadership to Support Implementation of Recommendations

Identify a central focal point of leadership for implementation of these recommendations and ensuring accountability for achievement of performance standards over time. In addition, the engagement of leadership within the Continuing Care sector, CDHA, and Department of Health and Wellness is required to support implementation of these recommendations. Both leadership and an accountability framework will be necessary to provide a mechanism for joint accountability.

While in Hospital

3. Enhance Home Care and Explore Other Community-based Options as Alternatives to Long Term Care

Enhance Home Care and community-based options to provide alternatives to long term care. Enhance opportunities for clients to return home from hospital through greater access to such programs as :

- An expanded Home Care program (with greater access to a range of supports such as OT, PT, social work, etc., more hours of service, and other measures which meet client need);
- Virtual bed program (providing evaluation proves it meets client needs)
- Convalescent care (to enable people to recover at home where safe to do so)
- Hospice/Palliative Care – at home or in community.

4. Support and Inform Patients/Families

Develop a standard package of information to provide to patients and families at the earliest possible opportunity to enable them to make informed decisions and act early to provide required information. Included in this package should be, among other items, information about the Personal Directives Act, nursing home information, and a sample financial contract (if not standard contract) used by long term care facilities.

5. Support Families to Identify a Substitute Decision-maker

Support families to identify a substitute decision-maker, where required, earlier in the process so as to avoid delays.

6. Enhance Case Coordination/Designate Team Lead

Enhance case coordination to facilitate the placement process by identifying a *primary lead person* on the care team for each patient while the person is in hospital. Responsibility includes coordinating information sharing among members of the care team, remaining current about patient health status, and ensuring families are informed and supported to provide necessary information, including financial information required for ERU, and the choice of substitute decision-maker where required, in an expeditious manner.

7. Enhance Care Team Functioning

Undertake measures to clarify team member roles and adopt relationship/team building strategies (esp. with staff not regularly on-site) to improve the internal communication process among the care team at the hospital (for ALC/TCU patients).

8. Support Family Preparation/Care Coordinator Access to Waitlist

Enable hospital-based Care Coordinators to access the waitlist for each LTC facility to facilitate patient/family preparation. This would enable Care Coordinators to share with patients the sites in which a bed is most likely to become available and can encourage families to visit these 3 or 4

facilities, *before* a bed becomes available. This would help reduce anxiety about placement and support individuals/families to mentally and emotionally prepare for admission into a nursing home. Once the bed becomes available, client may be better prepared to accept the offer immediately.

9. Create Single Patient Record to Streamline Data Collection Process

Create a *single patient record* which follows the client from hospital to long term care. Develop standardized data collection processes to capture and share information relevant to support key decision points of all parties in the placement process, so as to avoid duplication, reduce delays, and ensure information is complete, up to date, and accurate to ensure appropriate placement of clients. Better information/management is especially needed about wound care and challenging behaviours as these clients experience significant delays in placement. Incorporation of the Clinical Geriatric Assessment tool[*] into the data collection process may also be of benefit. Make better use of technology to both collect and share this information to allow for easy access to and quick transfer of information, as well as support auditing/quality review.

10. Develop Strategy to Better Manage Dementia-related Challenging Behaviours

Develop a strategy to enhance the capacity of LTC to meet the needs of clients with dementia-related challenging behaviours. This is critical in light of the fact that dementia rates are rising and 1/3 of those with dementia are anticipated to exhibit more moderate to severe forms of behaviours. Enhancing the capacity of LTC to meet the needs of this population will reduce delays in the placement process, free up beds in acute care, and better meet client needs (with and without dementia).

11. Improve Understanding and Communication among Partners in the Placement Process

Enhance communication and education opportunities among Care Coordinators, Classification Officers, and LTC providers to improve understanding of nursing home care level limits and the information required by LTC facilities for client acceptance/admission. Continue to encourage staff involved in the placement process to tour LTC facilities to understand LTC provider capacity/care level limits. This would enhance relationships and build understanding among parties involved in placement process as well to enable issues/challenges to be resolved more expeditiously.

[*] The Clinical Geriatric Assessment (CGA) is an evidence-based tool/process that captures information about the health status of a resident in long term care at four weeks post-admission. Information is captured by physicians and other members of the health care team in the long term care facility on the medical, functional, and psychosocial status of the resident. It is a point-in-time assessment which is intended to serve as a benchmark of health status to which the resident can be treated as his/her health condition changes. The CGA was made available for use in long term care facilities in Nova Scotia as of January 1, 2011.

12. Transfer Care Level Decision-making to Care Coordinators

Transfer responsibility for care level decision-making to Care Coordinators to expedite care level decision-making and create resource efficiencies.

Financial Review

13. Expedite Financial Eligibility Review

Allow the Eligibility Review Unit (ERU) to access the long term care wait list to help with prioritization/work flow to ensure the cases/clients with greater likelihood of immediate placement are reviewed first. *It is noted that DHW has just worked out an arrangement with Canada Revenue Agency to enable ERU staff to directly access client income tax returns with the client's consent. This will significantly reduce the burden on families to produce the files and the potential delays associated with waiting for financial information. The Committee supports this approach.*

14. Expedite Financial Re-assessment

It is recommended that the Department of Health and Wellness examine ways to manage the financial re-assessment process to avoid the potential for delay in case processing. Ensure new clients seeking placement do not encounter delays in their financial assessment process as a result of the annual re-assessment process.

Admission to Long Term Care

15. Develop a Standard Contract for use between Client and LTC Providers

Develop a standard contract for use between client/families and Long Term Care operators to ensure families are understand the roles, responsibilities, and legal obligations of both parties to the contract. Make the contract available (through the care team and on nursing home websites) for clients/families to review while in hospital in advance of a bed vacancy.

16. Expedite Access to Equipment

Any necessary equipment needs for each client should be anticipated and requested by the care team while the client is in hospital. Policy should be reviewed and amended to support this approach.

17. Expedite Access to Medications

The hospital care team should ensure the patient leaves hospital with a sufficient supply of medications if necessary from the hospital pharmacy for 3-4 days to enable the LTC facility to

accept the client.

18. Expedite Long Term Care Facility Admission Process

Allow LTC facilities access to the top 3-5 people on the LTC wait list to enable them to begin their assessment process earlier. Implement accountability mechanisms for review/audit of admission decisions to ensure an ethical selection of clients, as part of the overall accountability framework.

19. Shift Allocation of Resources

Re-align resources to allocate more to long term care to enable LTC to provide more complex care.

20. Make Better Use of Human Resources

Explore ways to support nurses in long term care to maintain their competency levels to enable them to work within their full scope of practice (e.g. exchanges with or placements in acute care settings or other measures). This could potentially reduce transfers to hospital and increase the ability of LTC facilities to manage care for clients out of hospital, as well as accept clients with more complex medical needs.

21. Implement Evening/Weekend/Alternate Hours of Admission into Long Term Care

Once consistent five day a week admissions are achieved consideration needs to be given to the implementation of evening/weekend/alternate hours of admission to an LTC facility. In order to support this, patients should leave hospital with sufficient drugs and necessary equipment, and other barriers (such as inadequate information) must first be addressed. Resource reallocation and/or additional funding will be required to allow LTC facilities to implement this significant change to the admission process.

22. Consider Limits on Inter-facility Transfers

Some thought should be given to more clearly defining limits on the number of transfers a client can make (transfers should only occur for legitimate reasons). Reasons should balance family and client needs – such as reasonable geographic proximity as per the family's situation, the need for clients to have access to family support, stability of a client once placed, whether a client is happy in the facility, etc.) – with the time it takes to process a transfer and potentially delay other placements.

Long Term Care Placement Process Review

1. Introduction and Background

The impact of long term care placement delays on individuals, families, and the health care system can be significant. Delays create unnecessary stress to clients and their families who need the care provided by a long term care facility. When clients must wait, for lack of alternatives, in hospital for placement in long term care, access to these beds by other patients needing acute care is precluded which contributes to log jams in emergency departments and other areas of the health care system, resulting in inefficient and inappropriate use of scarce resources, with the potential for deleterious client/patient outcomes. This problem is particularly acute in the Capital Health District. [1]

Health Association Nova Scotia Continuing Care Council, along with other health care system partners, have long been concerned about the time it takes to place people into long term care facilities. While this concern extends to placement from the community as well, this report focuses specifically on ways to expedite placement of individuals awaiting transfer from hospital (Alternative Level of Care) to long term care (LTC).

Council expressed its concern to the Department of Health and Wellness and, with their support, struck a Committee to review this process in December, 2010.

Purpose and Objectives
The purpose of the Long Term Care Placement Process Review Committee was to map the various processes involved in placement from hospital to long term care to identify barriers and potential solutions (which could be a range of changes in policy, practice, operational approaches, and the like). The intent was to streamline the process of placement into long term care from hospital, where such placement was appropriate.

The specific objectives were as follows:

1. Map the various processes and sub processes involved in long term care placement from hospital, identifying the decision points or areas where delays can occur.

2. Identify factors/barriers that contribute to delays at the various points.

[1] For example, processing of patients in emergency at the QEII, Nova Scotia's largest hospital, is compromised by a lack of bed availability to admit patients to hospital as beds are being taken up by many awaiting placement in long term care. Yet a number of long term care beds are vacant in the sector at any given time, the largest number in the Capital District. See: Dr. J Ross. The Patient Journey through Emergency Care in Nova Scotia: A prescription for New Medicine (2010).p. 45.

3. Examine barriers and potential solutions to barriers in order to expedite placement as appropriate to the needs of the client. This included examination of solutions posed, developed and/or tested in various DHAs/areas of the province to determine their effectiveness and potential applicability elsewhere.

4. Identify a range of solutions as appropriate to expedite placement appropriate to client need.

5. Develop recommendations, along with suggestions for ways to support implementation of the recommendations as appropriate.

Scope

For manageability, the scope of the project was confined to District 9 - Capital District Health Authority (CDHA), in recognition of the degree of complexity of the district, the number of nursing homes and hospitals involved in the placement process, and the fact that process mapping work had already begun in this district.

It is anticipated that this work will have general applicability to other districts as well. However, it is acknowledged that while the single entry access process should be similar in each DHA, the barriers and solutions may not be the same.

Scope was also limited to the placement process from hospital to long term care, although it is recognized that this issue is multifaceted and affects/is affected by other components of the continuum of care.

Committee Composition

A Committee comprised of representatives involved in the placement process from CDHA, the Department of Health and Wellness (DHW) and the long term care sector was formed. A family member of an individual in long term care was also asked to participate to ensure their views and experiences were also included (see Appendix 1 for a list of Committee members). Health Association Nova Scotia (HANS) staff provided leadership, facilitation, policy analysis, research, data collection and analysis, report writing, and administrative support. The Committee was chaired by HANS CEO.

2. Methodology

Mixed methods were used to capture data to inform the identification of barriers, challenges and solutions. Both qualitative and quantitative data were used to inform the identification of challenges and recommendations for improving the placement process.

Define Scope and Assess Data Needs
The first meeting of the Committee was facilitated by an external consultant which focused on: refining scope; identifying challenges, barriers and potential solutions from the perspectives and experiences of Committee members in their various workplaces; and identifying data needs to inform the process and point out the areas of greatest delay.

Initial efforts focused on clarifying and defining the scope of the Committee's mandate. Much time was spent discussing potential entry points into the process, the complexity and overlapping nature of the process, and the implications for placement. The following was determined to be out of scope: placement from the community, from the Emergency Department, of persons in hospital but unable to be classified for placement in long term care, Adult Protection cases, and transfers from one nursing home to another post initial placement in long term care. While these areas are important and deserving of examination, it was deemed necessary to focus on one segment of the process at this stage for manageability.

Committee members also reviewed the various maps produced by other groups in the province (Cape Breton/District 8, Physician Leaders/South Shore District Health Authority, and CDHA/District 9) who had engaged in mapping exercises to improve the placement process. It was determined that these maps were too complex and broader in scope than the mandate of the current committee. The group simplified the process into fewer "high level" steps for clarity and identified system barriers from their personal experience. Barriers perceived to contribute to time delays and potential solutions were documented by the consultant in the initial meeting and built upon in subsequent steps. Reports from the external groups were also reviewed prior to development of recommendations.

Data documenting the *actual* time spent moving through the various steps in the placement process was identified as needed to support informed decision-making. Key data elements were identified which committee members subsequently provided to HANS staff for integration and analysis. Data was provided from a number of sources - DHW's SEAScape data on long term care, the QEII hospital, and two long term care facilities – which was used to identify time measures for key steps in the process. From this data, a map depicting the time intervals for each stage in the process was created. (See Process Maps 1 and 2 in the next section of this report for an overview of the process and time intervals).

Review/Validate Data and Identify Additional Data Needs
The data and maps were reviewed and validated for accuracy, and assumptions and terms clarified (including the definition of the start and end points of intervals) for common understanding by the group.

Identification of Barriers and Solutions
Sub-group meetings: Two sub-committees were formed, facilitated by HANS staff, to discuss: (1) the hospital-based portion of the process (with hospital and DHW staff) and (2) the long term care-based portion of the process (with nursing home administrators). The groups met to "walk though" the maps and time interval data, further clarify the various processes and challenges/barriers involved in that particular stage of placement, as well as elicit suggestions for improvement. Using the process map and timelines as a framework, the groups worked to determine how to reduce the amount of time involved in their part of the placement process. The key strategy was to focus efforts on the areas with the greatest potential for impact in terms of time reduction. Each sub-committee formulated solutions that were then shared with the entire committee.

Best Practice Interviews: In addition, telephone interviews were conducted by HANS staff with intake staff/administrators in four of five nursing homes[2] across the province which had the lowest number of days to place a client. The "top five" were identified by DHW based on 2009 data provided to DHW by all long term care providers. The Department contacted the homes in advance to seek permission to share their data and be contacted for an interview. Interviews focused on the practices these nursing homes employed to place clients, methods they used to expedite the process, the challenges they encountered in placement and how these were addressed, and ideas or suggestions for improvement. Any unique features of the homes (size, geographic location, etc.) which may have influenced placement time were documented as well. These findings were also used to shape the recommendations.

Development of Recommendations
The barriers and proposed solutions developed by each sub-committee were shared with the full committee where members had the opportunity to clarify, challenge, and pose alternate solutions. From this process, a set of recommendations was developed. A final report housing these recommendations was prepared and supported by the Committee. Final endorsement and implementation of the recommendations rests with the stakeholder organizations.

[2] Only four were available within the data collection period.

3. Findings

This section begins with an overview of the placement process. A map depicting this process visually is provided, and a summary of the time lines involved in each step is shown in a second map. An overview of the key findings/observations from this mapping exercise is provided.

A more detailed description then follows of the placement process identifying what activities take place in each step, the time it takes for each stage, the barriers and challenges encountered, and other factors which influence or contribute to delays.

Lastly, the results of a best practice review of long term care facilities with the shortest placement time are presented.

3.1 Overview of Placement Process

When a person enters hospital, they may do so via emergency or planned admittance. Care needs while in hospital are met by a variety of staff – physicians, specialists, surgeons, nurses, social workers, and others. Once a person is considered "medically stable" by a physician, the person returns home. Sometimes the person cannot go home, either because their care needs are now too great for the person him/herself to manage or for family to manage, or the person has no family or alternate caregivers, or other reasons.

Efforts are first made by social workers and other members of the care team to see if the person is able to go home with supports from home care program or other family/caregivers.

If the person is not able to go home, the person may wish to be considered for placement in a long term care facility (nursing home). A referral is made for an assessment for long term care eligibility.
It is at this point the hospital typically designates the individual as requiring an Alternate Level of Care (ALC) – as distinct from acute care – and the person may be transferred to a Transitional Care Unit (TCU) or remain in a regular hospital bed. (While there are 17 TCU beds in the QEII, over 80 acute care beds are occupied at any given time by patients designated as ALC. Moving patients to LTC quicker not only places the person in a home-like setting which may better suit their needs, but presents an opportunity for better use of scarce acute care resources.)

The following summarizes the key steps involved in the placement process.

Hospital to Long Term Care Placement Process Steps

STEP 1: Referral Date to when information is sent to Assessment and Eligibility Review Unit

STEP 2: Information is sent to Assessment and Eligibility Review Unit to Care-level and Financial decisions.

STEP 3: Care-level Decision and Financial Decision to Offer Accepted

STEP 4: Vacancy Occurs to Client Information Sent to Facility
- **a:** Vacancy Occurs to Vacancy Declared
- **b:** Vacancy Declared to Offer Confirmed by Client
- **c:** Offer Confirmed to Client Information Sent to Facility

STEP 5: Client Information Sent to Facility to Client Acceptance
- **a:** Client Information Sent to Facility to Facility Confirms Acceptance
- **b:** Facility Confirms Acceptance to Client Notification
- **c:** Client Notification to Client Acceptance

STEP 6: Client Acceptance to Placement

Overview of Process Map 1: Hospital Referral to Placement in DHA 9

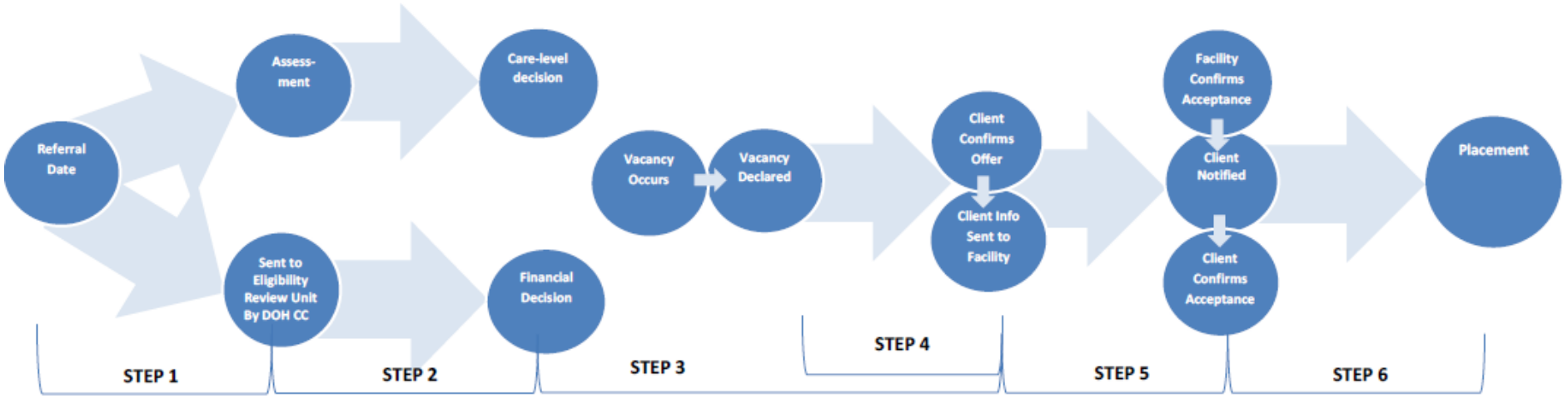
The starting point is defined as the point at which the client is referred to long-term care (Referral Date). After referral, client information is then sent for clinical assessment and financial eligibility review concurrently which leads to decisions regarding the care-level (Care-Level Decision) and the daily pay rate (Financial Decision) for the client.

After the care-level and financial decisions have been made, the client must wait for a nursing home bed vacancy. Once a vacancy occurs within a nursing home it is declared to the Placement Office, whose staff then work to identify a client to place in the vacant bed. Once the client confirms acceptance, the Placement Office then sends the client information to the nursing home facility so that they can review the client information, gather more information if necessary, and make a decision as to whether they can meet the needs of the client. Once the facility accepts the client, the client is notified and they must confirm their acceptance and make arrangements to transfer to the facility. The final step in the process is having the client successfully placed in the nursing home bed.

This is visually depicted in the following map.

Figure 1. LTC Process Map:
Hospital Referral to Placement in DHA 9

(Hospitals include: Eastern Shore Memorial, Hants Community Hospital, Musquodoboit Valley Hospital, Dartmouth General Hospital, Nova Scotia Hospital, QEII, Twin Oakes Memorial)



Overview of Process Map 2 with Time Estimates: Hospital Referral to Placement in DHA 9

The following map describes the time associated with each step in the process.

In order to establish time lines, data was gathered from several sources: (1) the SEAscape database from the Department of Health and Wellness, (2) internal data from the Social Work Department at the QEII Health Sciences Centre, and (3) internal data from two DHA 9 nursing homes (i.e., Oakwood Terrace and Oceanview). This data is presented in the context of the process map in Figure 2.

Unfortunately, one data source for all of the steps in the process was not available. As well, there is substantial discrepancy between some of the time estimates from DHW and QEII. This may be explained by the fact that the DHW data consists of all of the data from DHA 9 hospitals (i.e., Eastern Shore Memorial, Hants Community Hospital, Musquodoboit Valley Hospital, Dartmouth General Hospital, Nova Scotia Hospital, QEII, Twin Oakes Memorial), whereas the QEII data is exclusively from that facility. There are unique challenges at other institutions (e.g., Nova Scotia Hospital) that often make LTC placement a challenge. It is important to note that, although there is variability in the numbers reported by DHW and the QEII, the proportion of the timeline that each step accounts for is approximately the same (see Figure 2).

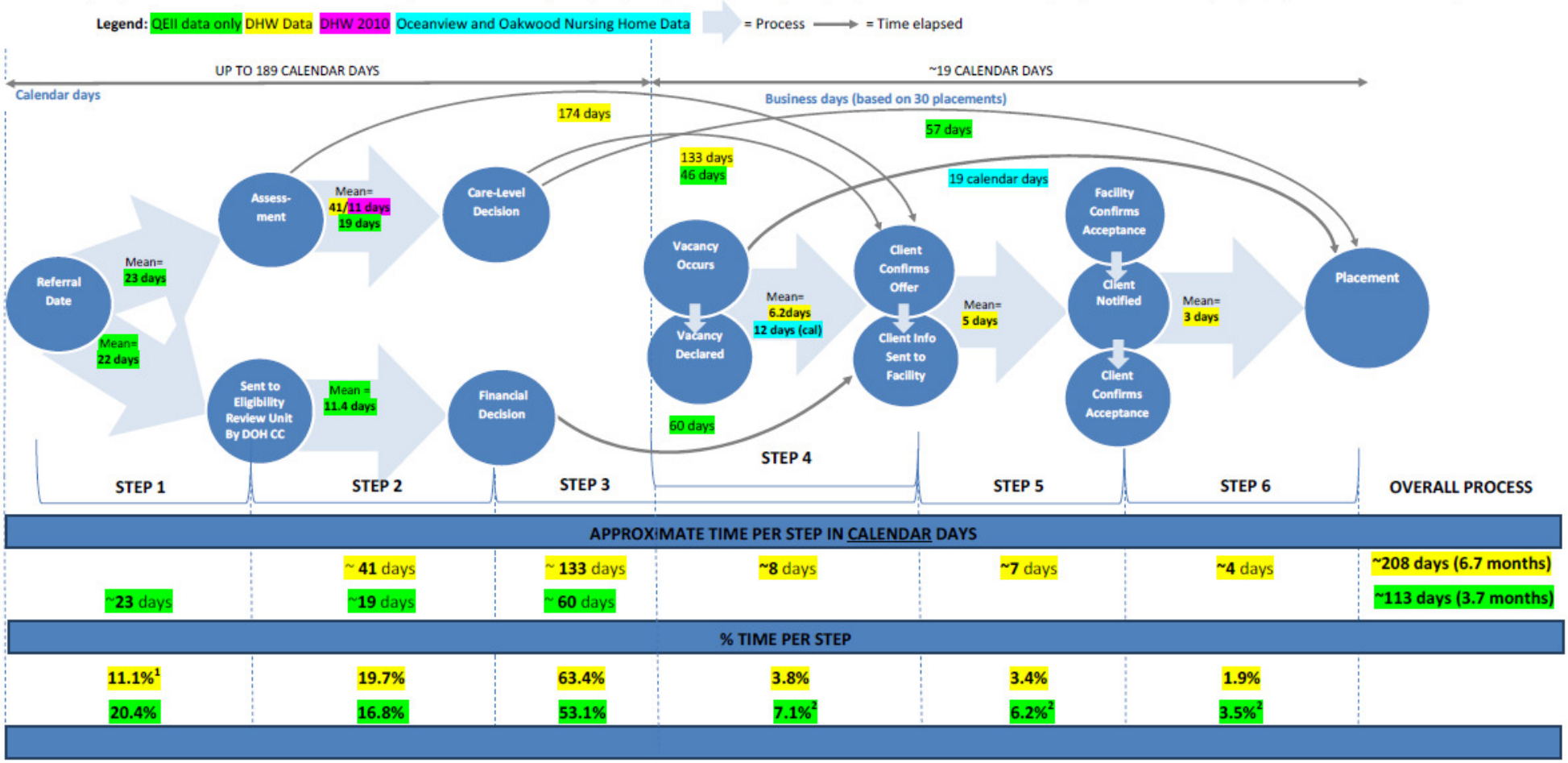
The estimates of the entire hospital to long term care placement process range from 3.7 months (QEII) to 6.7 months (DHW). The longest time elapsed is when client is in hospital (up to 189 days). The majority of this time is from when the care-level and financial decisions have been made to when the vacancy was declared (i.e., waiting period).

Both DHW and internal nursing home data suggest that the time from when a vacancy is declared to when the client is placed in a nursing home bed takes about 19 days. The majority of this time (8-12 days) is spent trying to find a client to confirm their acceptance of the bed offer.

Figure 2. LTC Process Map with Time Estimates:

Hospital Referral to Placement in DHA 9

(Hospitals include: Eastern Shore Memorial, Hants Community Hospital, Musquodoboit Valley Hospital, Dartmouth General Hospital, Nova Scotia Hospital, QEII, Twin Oakes Memorial)



[1] This value was calculated based on the available QEII data.
[2] This value was calculated based on the DHW data (which aligns with the data provided by Oceanview and Oakwood Nursin Homes).

3.2 Overview of Key Findings

Following are the key findings of the mapping and time interval analysis:

- Estimates of the length of the entire process ranged from 3.7 months (QEII) to 6.7 months (DHW).
- The longest time elapsed is at the "front end" of the process – when client is in hospital (up to 189 days).
- The majority of the time spent in hospital is from when the care-level and financial decisions have been made to when a vacancy occurs. Little can be done to influence this time frame itself; however, some arrangements to reduce the time from when a vacancy occurs to placement can be made during this time.
- The process of Referral to Assessment (23 days) to Care Level Decision (11-41 days) takes up to 64 days. The process of financial eligibility review (33.4 days), which takes place simultaneous to the functional assessment and care level decision, does not delay the process further. The time from Referral to Assessment and Referral to ERU is virtually identical (at 23 and 22 days respectively) and the time from Assessment to Care Level Decision (11-41 days) matches or exceeds the time from Assessment to Financial Decision (11.4 days). However, it is important to note the efficiencies achieved in one area (care level) must be matched in the other (financial) so as not to delay the overall process. Opportunities to reduce time in both these areas were identified, both for "typical cases" (improved sharing of information and case flow management, more preparation of/support for families, expedited access to financial information via Canada Revenue Agency) and for more difficult cases (clients with dementia-related challenging behaviours, mental health issues, and wound care issues) which, while fewer in number, take longer to place (improved information management).
- The time from when a vacancy occurs to when the client is placed in a LTC bed takes about 21-25 days.
- The majority of this time (8-12 days) is spent by Placement Office trying to find a client to confirm their acceptance of the bed offer, while the remainder is taken up by the facility making a decision about whether they can meet the needs of/accept the client (7 days) and the arranging for the client to transfer from hospital (4 days). Ideas to reduce this time were also identified with emphasis placed on shifting activities to prepare a client for transfer *before* a vacancy actually occurs (earlier access to wait lists, earlier site visits by family, provision of equipment and medication with the client upon departure from hospital).

3.3 The Placement Process from Hospital/ALC to Long Term Care and Barriers Contributing to Delay

The following is offered as a simplified overview of the process to assist the reader in understanding the placement process. This section also identifies barriers contributing to delays in the various stages as identified by participants in the placement process.

Referral to Assessment

Prior to referral, efforts are made to assist the person to return home, with home care supports if required. If the person is unable to return home, a referral is made typically by a hospital social worker to a Care Coordinator who conducts a functional assessment of the client's care level needs to determine their eligibility for long term care. Social workers collect a variety of documentation to support the assessment (nursing summary, medical status report, intake form, information about special needs and client/family preferences for long term care facility placement, notes indicating they have explained the DHW placement policy, and any additional information that may be of help to the Care Coordinator.)

Care Coordinators conduct a functional assessment in consultation with the individual, family, caregivers, and health professionals providing care to the person. They ensure there is no active medical treatment, review the client's hospital chart, and meet with client/family and care team. An RAI-HC assessment form is completed documenting care level needs, which is subsequently used by a Classifications Officer to make a care level decision.

The time from ***referral to assessment*** takes**:** ***23 days*****.**

Barriers Contributing to Delay:

Home Care Program Parametres: The current parameters of the Home Care Program limit the hours and types of service individuals may receive under the program; if needs are greater than what is available under the program, the person will not be able to return home with home support. *Note: CDHA is currently pilot testing a Virtual Bed Program to see if individuals can go home under different parametres than the home care program offers. Data is not available for evaluation as this program is in its infancy.* It is worthy to note that 38% of people on the home care wait list have no family or caregiver at home,[3] a significant impediment for people wanting to return home from hospital. Convalescent care is very limited.

Palliative Care: Some patients are palliative and may not survive the wait to LTC placement, yet palliative care in the community is limited as well.

Role clarity/team coordination: Multiple professionals are involved in caring for a patient in hospital and information must be gathered from many players within the system to make a decision. The way in which this information collection and referral process is handled presents potential opportunities for delay, lack of clarity of roles, and duplication of effort among the care team. Sometimes premature referrals are made before a client is medically stable in order to expedite the process but paradoxically this can result in deferrals or delays if the person is not medically stable by the time Classifications Officers are ready to examine the file to make a care level decision. Further, there are differing interpretations of "medically stable" among the care team.

[3] Department of Health and Wellness (Dec 7, 2010). Removing Barriers in Accessing Long Term Care (Draft). p.3.

Data Collection: Further, there a variety of data collection forms (Medical Status Report, Discharge transfer tool, case files, letters to parties, etc.) and processes (relying on faxing rather than e-transfer) which can be cumbersome and result in delays. The data collection process is not streamlined nor designed to meet the needs of all parties involved in placement (particularly long term care).

Cognitive Impairment: Some clients do not have the cognitive capacity to make decisions for themselves and require a substitute decision-maker to be selected to act on their behalf, consistent with legislation. This process also can contribute to delays.

Assessment to Care Level Decision

Once the functional assessment is complete, the case is referred to a Classifications Officer to assess their care level needs for placement in a LTC facility (classified as residential only, level 1 or level 2 nursing care which denotes the type, degree, and intensity of care the person will need from the nursing home). The person is then placed on the wait list as of the date the care level decision has been made (providing the financial review is complete – see below). Clients are offered placement in order of their wait list date.

> The time from ***Assessment to Care Level Decision*** takes: ***11-41 days*** (depending upon the data source).

Barriers Contributing to Delay: The workload of Classifications Officers may contribute to delay in that there are *only two* staff to serve the entire province. Further, Classification Officers often have to seek additional information from Care Coordinators or other members of the care team to make a care level decision; there is some duplication of effort in in the assessment and care level decision-making process.

Based on data provided by the QEII, care level decisions are often delayed or deferred due to two primary reasons/case types: wounds (lack of clarity regarding the extent of wound care required) and challenging behaviours (lack of information about the severity of behavioural and psychological symptoms of dementia and strategies used/required to manage these behaviours; lack of clarity as to what types of cases can be managed in different long term care facilities and what information is required for long term care to make admission decisions).

Referral to Eligibility Review

While the care level decision is being made, simultaneously the case is also referred to Department of Health and Wellness Eligibility Review Unit (ERU) officers to make a determination of financial eligibility and the cost to the person per day to reside in a nursing home. This review is dependent upon the individual's income level. In order to perform this review, ERU must receive financial information either from the individual (a copy of his/her income tax Notice of Assessment and Re-assessment from Canada Revenue Agency) or more recently, a consent form signed by the individual permitting ERU to obtain the records directly from Canada Revenue Agency (CRA). Social workers assist in this process by explaining to

individuals/families what financial information is needed and for what purpose and supporting/encouraging families to obtain the financial information which is then provided to the Care Coordinator for review by ERU.

The time from ***Referral to ERU*** takes***: 22 days***

Barriers Contributing to Delay: Sometimes families find it difficult to retrieve this information on a timely basis on behalf of individuals in hospital. This should be alleviated by the recent introduction of the process to directly access the records from CRA with client consent. In some cases, individuals have not filed tax returns for some time, which delays the process.

Eligibility Review to Financial Decision
Once the ERU unit has the information, the office assesses the financial information and determines the per diem rate to be paid by the client for their care in the LTC facility.

The time from ***Eligibility Review to Financial Decision*** takes: ***11.4 days***

Barriers Contributing to Delay: ERU conducts financial reassessments of individuals in long term care to assess their per diem rate for the upcoming year. This is done at the same time each year for all LTC clients which places a heavier burden on the office for that time period and delays processing of new applicants. Further, ERU processes the information of new applicants in the order in which it is received and has no information as to which clients might be able to be placed sooner, based on their preferred choice of LTC residence or other factors. ERU also processes both community and hospital-based clients. The office has no ability to prioritize processing of files so as to avoid delays in placement.

Care Level Decision/ERU Decision to Offer Accepted (by client)
There is a significant amount of wait time after decisions have been made when a patient is simply waiting, along with others on the wait list, for a bed to become vacant in a nursing home. A vacancy usually occurs when a client in the long term care facility dies or transfers to another facility. While there is little opportunity to influence this wait time, certain preparatory steps could be taken to ensure the client is ready to transfer when a bed becomes available.

The time from ***Care Level decision/ERU Decision*** to ***Offer Accepted*** takes***: 46-133 days***

How long a person may remain on the wait list is influenced also by the size of the wait list, the available beds in the province, the availability of alternatives to long term care (e.g. breadth and scope of home care program, availability of other community supports), and the policy regarding priority setting.

The wait list is organized into three priority groups:
- Priority 1 - Adult Protection clients

- Priority 2 – clients returning 'home' and requiring a different level of care, clients whose family member is in long term care, and clients requiring peritoneal dialysis), and
- Priority 3 – all others.[4]

Complicating the placement process itself is that the demand for LTC beds continues to exceed supply, despite increases in bed capacity in the province. For example, in the three year period between April of 2007 and April 2010, the wait list grew by 35.5% from 1284 clients to 1740 clients. Bed capacity in that same time period grew by only 13%.[5]

There are a number of factors influencing the size of the wait list:

- Demographics – Our population is aging. Nova Scotia has the oldest population in the country with 15.4% aged 65 or older[6]. Further, while the total population of Nova Scotia is expected to decline by approximately four and a half percent (4.69%) between 2007 and 2033, the seniors' population will increase of 86.3%.[7]
- health status – Nova Scotia has higher rates of disability at 20.1% for adult persons with disabilities 15 years+ than the national norm of 14.6%[8]. 65% of seniors over the age of 75 report a condition that reduces the amount and types of activities they can participate in. 16% of adults 75 and older have a very severe disability, compared to one in ten (9%) in the 15-44 age group.[9]
- Dementia and mental health – The prevalence of Alzheimer's disease and related dementias in Canada is increasing. In 2008, in Canada, there were 480,600 people with dementia (1.5% of Canada's population). By 2038, the number of people with dementia is expected to increase to 1,125,200 (2.8% of Canada's population).[10] One third of people with dementia will experience moderate to severe behavioural and psychiatric symptoms BPSD).[11] Further, prevalence rates of mental disorders in elderly residents of Long Term Care facilities are estimated at 80% or higher.[12]

These are all conditions which may result in higher numbers of individuals/families seeking long term care. Other social determinants of health play a role as well (e.g. income will influence the extent to which individuals can seek private pay options outside publicly funded home care or

[4] Department of Health and Wellness (2010). Removing Barriers in Accessing Long Term Care, p. 4.
[5] Ibid., p.5.
[6] Nova Scotia Department of Seniors: Statistical Profile 2009, p. 2.
[7] Ibid., p. 2.
[8] Disabled Persons Commission (2004). Persons with Disabilities In Nova Scotia: A Statistical Report.
[9] Nova Scotia Department of Seniors: Statistical Profile 2009, p. 7.
[10] Alzheimer Society of Canada (2010). Rising Tide: The Impact of Dementia on Canadian Society – Executive Summary. p.7
[11] Brodaty et al cited in New South Wales Department of Health (2006). Summary Report: The management and accommodation of older people with severely and persistently challenging behaviours. Pg 1. www.health.nsw.gov.au
[12] Zahradnik, N. (2007). Minding Our Elders: Mental Health in Long-Term Care. Network, Canadian Mental Health Association. Accessed on June 9, 2008 at: http://www.ontario.cmha.ca/network_story.asp?cID=7439

long term care). Caregiver availability and capacity, public understanding of the system and options available, client choice, and so forth also influence the magnitude of the wait list. Variances in waitlists for LTC among DHAs suggest other factors may play a role as well.[13]

Vacancy Occurs to Vacancy Declared

In the current system, when a vacancy appears in a long term care facility, the nursing home declares the bed to the Department of Health Wellness Placement Officers.

The time from ***Vacancy Occurs*** to ***Vacancy Declared*** takes***: 1 day***

Barriers Contributing to Delay: If a home does not declare a bed within the usual 24 hours, this delays processing and leaves beds vacant. This is usually done within 24 hours but may take longer if it occurs on a weekend and staff who usually declare the bed are not available, if room changes must be made to accommodate client compatibility issues within the home, or if room painting/repairs are required.

Vacancy Declared to Offer Confirmed

Once a bed is declared, Placement Office begins to contact the individual next on the placement list to offer him/her a bed in that facility. This person may be waiting at home or in hospital. Clients are offered placement in order of their wait list date (consistent with the prioritization process described earlier).

Exceptions: Current practice permits hospitals to use "variances" to give preference to hospital-based clients. This typically occurs when hospitals are at extreme overcapacity. Community variances are also permitted due to a crisis situation related to the care/safety of the client in community. However, in terms of volume, hospital cases have been placed greater than two times more frequently than clients in the community due to the combination of variances, the "first available bed provision of the placement policy, and the practice of filling beds in new facilities with larger volumes of hospital based clients. [14]

Current practice permits the client 24 hours to make a decision to accept the bed. If the person is waiting in hospital, they are required by policy to accept the first available bed within 100 kilometres driving distance of their "preferred community of residence". This may not be in their preferred facility, although if they accept the bed, they can choose to remain on the wait list until a bed becomes available in a facility of their choice. Data indicates that, of the 1363 clients placed from hospital into LTC (excluding placements from community to LTC), 36.3 % chose to remain on the wait list for transfer to their preferred facility.[15] A subset of data provided by the Department for District 9 indicates that of the 289 clients placed from District 9

[13] For example, Cape Breton District Health Authority comprises 31% of the provincial wait list yet only 15% of their population is over age 75. Ibid., Appendix D, pp.5, 29.

[14] Approximately 3% of clients from hospital were placed urgently as hospital variances in 2009 -2010, while 12% of all placements were due to community variances. DHW (2010). pp 10, 12.

[15] (DHW, 2010, p.5)

hospitals in 2008/9, 21 clients decided to remain on the waitlist to move to a preferred facility. Of the 21 clients, 5 clients accepted an offer and transferred to their preferred facility, and 2 decided not to accept the offer. Although about 50% of clients in hospital are not placed initially to their preferred facility, many do not end up transferring. [16]

The time from ***Vacancy Declared*** to ***Offer Confirmed*** takes***: 8-12 days***

Barriers Contributing to Delay: Individuals/families often require time to visit the facility or are otherwise mentally/emotionally not prepared to make an immediate decision about placement. They do not have information as to which home(s) are most likely to have a vacancy so have not visited the properties. Sometimes families do not understand contractual obligations they will have to the nursing home or what services the nursing home will provide. Nursing homes accommodate tours within the 24 hour period. All of this contributes to delays in family decision-making.

Often Placement Officers have to make several offers before a bed is accepted by the client, which delays the process. A significant portion of time (8-12 days) is spent making offers that are not accepted. While the client in hospital has the choice to accept or reject an offer, rejection means they must leave the hospital. Offers go to community-based clients as part of this process as well. Client choices may be influenced by many factors – the newness of the facility, availability of private rooms/bathrooms, geographic proximity and ease of access to family, their sense of community and others. The policy values a client-centred approach.

Client Accepts Offer to Placement/Admission

The time from ***Offer Accepted*** by the client to ***Placement*** takes: ***12 days***

This is broken down into three steps as follows:

Offer Accepted to Client Info Sent to Facility
Once a client accepts the offer of a bed, the information about the client and his/her needs is forwarded to the facility for review and acceptance (typically within one day).

Client Info Sent to Facility to Facility Confirms Acceptance and Client Accepts Placement
It typically takes 7 days before a facility can make a decision to accept a client. LTC providers have the right to refuse admission to a client if the nursing home can demonstrate they do not have the resources to meet the client's care needs.

Client Acceptance to Placement
It typically takes 4 days for a client to move into the facility.

[16] SEAScape, Department of Health and Wellness, December 31, 2010.

Barriers Contributing to Delay: Often the information needed to assess a client is inadequate and the facility must collect that information from the family or other care providers (hospital, Care Coordinators, etc.). Information is often insufficient regarding the presence, severity, and management of challenging behaviours; dietary, medical and equipment needs; and financial information. This often results in a duplication of process and the family must provide information it has already provided to others.

Sometimes, the facility is unable to accommodate clients due to their particular needs and resources availability in the long term care site. Refusals create placement delays as well. The most frequent reasons cited for refusal in this project are: challenging behaviours (absence of capacity – special care units to accommodate clients with dementia-related challenging behaviours separate from non-dementia clients, or secure units to address risk of elopement by wandering clients) ; and wound care. Clients have increasingly complex health care needs including wound dressing. While nursing homes can accommodate some clients with wound care and other heavier demands, there is a limit on the number they can accommodate at once, based on staffing resources.

Other issues which delay transfer relate to lack of timely access to medication and the need for equipment such as wheelchairs, without which the client cannot be admitted.

Placement during weekend and evening hours is problematic for LTC sites as the staffing complement is lower during these times and client admission takes significant amounts of time from staff. Medication and equipment challenges become more acute during these times as well. However, this delays placement.

In total, the time from ***Vacancy Occurs to Placement*** takes: ***21- 25 days.***

3.4 Best Practice Interviews

One representative from each of five nursing homes with the fastest placement times in DHA 9 was contacted and four were able to be interviewed within the study period. The purpose of the interviews was to ascertain best practice which might have applicability to other sites and identify suggestions for improvement in the placement process.

The most significant observation was that nursing homes which are co-located with hospitals have the fastest placement time. This makes the physical transfer process simpler and staff in both sites – hospital and long term care – tend to share information with each other much more readily. LTC staff visit the prospective client prior to transfer and the facility is familiar to family; indeed, the client has often participated in outreach recreational/leisure activities within the LTC site well before a bed becomes available. The site is both known to the client and his/her family, and the client is known to the LTC facility, making decision-making a quick process by the LTC facility. Information sharing among care providers involved in the placement process,

and family knowledge of the LTC facility are not barriers which delay placement. (Dietary is often shared between the facilities, wheelchairs and medications are not issues as they are known and planned for, and the extent of challenging behaviours or wound care requirements are known). However, when transfers occur from hospitals which are not co-located with the LTC site, these advantages are not applicable and the usual barriers cited are encountered. Best practices thus relate largely to enhanced information exchange among all those involved in placement, including clients/families, which expedites decision-making processes.

The other feature of these sites is that they are smaller enabling LTC staff to be much more familiar with clients and fewer placements in total are made. They are often located in smaller communities which are generally familiar with the long term care facility.

Other measures adopted by facilities include pre-planning for vacancies – internal moves of residents are planned and prepared for, as are room improvements reducing room preparation time. Having back up staff who can declare the vacancy expedites the process. All sites typically declared a bed vacancy within 24 hours.

Suggestions for improvement included better management of the wait list though better scrutiny of the first choice preference of clients to reduce later inter-facility transfers if possible, as these are disruptive to clients and time consuming for staff. Better disclosure by Placement Office of client needs (the quality and currency of information) and better understanding on the part of Placement Office of the facility limitations (room size to accommodate larger wheelchairs or equipment, availability of private rooms, ability to accept clients with challenging behaviours) is recommended to enable long term care to make admission decisions/reduce refusals. Information is not always up to date if clients have been waiting a lengthy period for admission into long term care. Challenging behaviours were identified as a significant barrier to client acceptance in some sites due to lack of facility capacity to care for these clients.

4. Discussion and Recommendations

In the spirit of mutual accountability and the interest of ensuring efficient access to long term care, the following recommendations are offered by the Committee. A supporting rationale for each recommendation is made to provide a context for the recommendation, which builds upon the previous section of this report.

The recommendations are predicated on the notion that, to the extent possible, steps to support/prepare clients for transfer to long term care should be taken earlier in the process, *before* a bed becomes available, to reduce actual placement time.

RECOMMENDED ACTIONS

1. Implement Performance Standards and an Accountability Framework

Rationale: Opportunities to streamline the process and reduce the time it takes to transfer individuals waiting in hospital to long term care are identified in this report. In order to expedite processing time system-wide, it is necessary to identify clear, reasonable, and achievable time performance standards. These must communicated to all those involved in the placement process, with the expectation that these targets will be met. It is acknowledged that some cases are atypical and may require less or more time. Monitoring these deviances from the expected time standard will assist planners in identifying impediments and further opportunities for improvement. Time performance standards/targets are necessary to communicate expectations to all players in the placement process. A mechanism to monitor achievement of these standards or targets is necessary, as without monitoring there is no assurance of change or consequence for not achieving them. Further, measurement of key performance indicators against baseline data and compared over time is necessary in order to know if progress has been achieved and at what pace.

An accountability framework which identifies the specific time targets, who is responsible for achieving what outcomes, how performance will be measured, how deviances from the norm will be addressed (what range of interventions might be necessary to support achievement, changing the targets if appropriate), and who is responsible for monitoring and ensuring overall accountability for compliance is necessary.

Recommendation: Implement performance standards which identify time targets/key performance indicators for each critical step in the placement process. Based on our review of the process, these time targets are suggested in the chart below as reasonable and achievable for *most* cases, acknowledging that not all cases will fit this standard. The current time elapsed, the proposed target times, and the estimated time savings for each step in the process are presented in Table 1. *Based on these estimates, it may be possible to reduce the time elapsed over the entire process from referral to placement by up to 57 days.*

Development of mechanisms to collect data on, and monitor achievement of, these targets is

required in order to determine if the recommendations suggested here are effective in expediting placement and to identify further opportunities for improvement. Systems already exist to capture some of this information but some standardization (of terms, reporting intervals, definitions, etc.) is necessary.

In the long term, making better use of technology would enhance information quality and exchange and expedite decision-making in the placement process. Implementation of an automated information system to collect and transfer the information required by various parties within the placement process would not only expedite case processing, but can be used for auditing and accountability purposes.

Develop an Accountability Framework which identifies monitoring and reporting mechanisms, who is responsible for achieving what outcomes, how performance will be measured, how deviances from the norm will be addressed (what range of interventions might be necessary to support achievement, changing the targets if appropriate), who is responsible for monitoring and ensuring overall accountability for compliance, and how this will be done, is necessary. Accountability for achieving the outcomes identified in the Accountability Framework is shared as all players within the placement system must be jointly engaged in this effort and work together to achieve overall system improvement.

HOSPITAL TIMELINES			
Process Step	**Current** (calendar days)	**Target** (calendar days)	**Est. Savings** (calendar days)
STEP 1a: Referral Date to Assessment	23 days	10 days	**~12 days**
STEP 1b: Referral Date to Eligibility Review Unit	22 days	10 days	
STEP 2a: Assessment to Care-level Decision	11-41 days	10 days	**1-30 days**
STEP 2b: Eligibility Review Unit to Financial Decision	11.4 days	10 days	
STEP 3: Care-level Decision and Financial Decision to Offer Accepted	46-133 days	N/A (Minimal impact)	**0 days**
STEP 4a: Vacancy Occurs to Vacancy Declared	1 business day	1 business day	**0 days**
STEP 4b: Vacancy Declared to Offer Confirmed	8-12 days	5-8 days	**3-7 days**
STEP 4c: Offer Accepted to Client Info Sent to Facility	1 business day		
STEP 5a: Client Info Sent to Facility to Facility Confirms Acceptance	7 days	3 days[1]	**~8 days**
STEP 5b: Facility Confirms Acceptance to Client Notification	Same day		
STEP 5c: Client Notification to Client Acceptance	Same day		
STEP 6.0: Client Acceptance to Placement	4 days		

[1] Assuming all information and resources are readily available.

2. Identify Leadership to Support Implementation of Recommendations

Rationale: Accountability for achieving these targets and improving system performance is shared, as all players within the placement system must be jointly engaged in this effort and work together to achieve overall system improvement. As this will require the engagement of the leadership and staff within the Capital District Health Authority, the Department of Health and Wellness, and the Long Term Care sector within District 9, there will need to be a central focal point for monitoring, reporting, and ensuring mutual accountability of all parties. Health Association Nova Scotia Continuing Care Council can also play a role in supporting the implementation of these recommendations. Both leadership and an accountability framework will be necessary to provide a mechanism for joint accountability.

Recommendation: Identify a central focal point of leadership for implementation of these recommendations and ensuring accountability for achievement of performance standards over time. In addition, the engagement of leadership within the Continuing Care sector, CDHA, and Department of Health and Wellness is required to support implementation of these

recommendations. Both leadership and an accountability framework will be necessary to provide a mechanism for joint accountability.

While in Hospital

3. Enhance Home Care and Explore Other Community-based Options as Alternatives to Long Term Care

Rationale: Demand for long term care beds outstrips supply and is forecast to do so for some time. It is critical to explore options to LTC to reduce pressures on acute care, support more effective and cost-efficient allocation of resources, and meet client needs in the setting best suited to them. Some clients could go home with an expanded array of supports beyond what current programs offer. In addition, some clients are palliative and may not survive until placement, yet would prefer to die at home, in hospice, or another setting of their choice.

Recommendation: Enhance Home Care and community-based options to provide alternatives to long term care. Enhance opportunities for clients to return home from hospital through greater access to such programs as :

- An expanded Home Care program (with greater access to a range of supports such as OT, PT, social work, etc., more hours of service, and other measures which meet client need);
- Virtual bed program (providing evaluation proves it meets client needs)
- Convalescent care (to enable people to recover at home where safe to do so)
- Hospice/Palliative Care – at home or in community.

4. Support and Inform Patients/Families

Rationale: In order for an individual to be placed on the waiting list for long term care, the individual must be assessed for their care level needs, a financial eligibility review completed to determine the accommodation rate they will be required to pay, and a substitute decision-maker identified in cases where an individual lacks the capacity to make his/her own decisions. Sometimes individuals or families have not provided the information required for eligibility assessment (e.g. have not filed income tax), are not clear about their contractual obligations to or services offered by nursing homes, require help understanding the requirements of the Personal Directives Act (or other relevant legislation), or other issues which can result in placement processing delays. While information currently is provided to families, preparation of a standard package may help expedite this process. Families must also play their part to provide information and actively support efforts to expedite processing.

Recommendation: Develop a standard package of information to provide to patients and families at the earliest possible opportunity to enable them to make informed decisions and act early to provide required information. Included in this package should be, among other items, information about the Personal Directives Act, nursing home information, and a sample financial contract (if

not standard contract) used by long term care facilities.

5. **Support Families to Identify a Substitute Decision-maker**

   Rationale: In order for an individual to be placed on the waiting list for long term care, a substitute decision-maker must be identified in cases where an individual is not cognitively competent to make his/her own decisions. Sometimes individuals or families need help understanding the requirements of the Personal Directives Act and its application to their situation, or need other relevant information (such as the role of the Public Trustee, Power of Attorney, etc.), which can result in placement processing delays.

   Recommendation: Support families to identify a substitute decision-maker, where required, earlier in the process so as to avoid delays.

6. **Enhance Case Coordination/Designate Team Lead**

   Rationale: Because a number of staff are involved in the collection and processing of information to support placement decision-making (assessment, classification, care level required, financial review), opportunity exists to streamline this process by designating one member of the care team as the primary lead responsible for ensuring all tasks are done to support more expeditious processing. This does not imply that this person does it him or herself, but rather *manages* the process to ensure information is complete and provided to the appropriate staff at the earliest opportunity.

   Recommendation: Enhance case coordination to facilitate the placement process by identifying a *primary lead person* on the care team for each patient while the person is in hospital. Responsibility includes coordinating information sharing among members of the care team, remaining current about patient health status, and ensuring families are informed and supported to provide necessary information, including financial information required for ERU, and the choice of substitute decision-maker where required, in an expeditious manner.

7. **Enhance Care Team Functioning**

   Rationale: Sometimes care team members (e.g. Hospital-based Long term care coordinators, social workers, placement coordinators) are not clear about their respective roles in the process, or are not aware of whether steps have completed, leaving room for either lapses or duplication to occur, or more staff being involved in the processing of cases than necessary, thus compromising efficiency. Further, some staff are not as familiar with other staff who are not based on-site which can impede information sharing and team functioning, which can also contribute to delays.

   Recommendation: Undertake measures to clarify team member roles and adopt relationship/team building strategies (esp. with staff not regularly on-site) to improve the internal communication process among the care team at the hospital (for ALC/TCU patients).

8. Support Family Preparation/Care Coordinator Access to Waitlist

Rationale: While patients/families may wait in hospital for some time for a bed to become available in a long term care facility, once a bed is available they are sometimes not prepared to make an immediate decision about accepting that bed. By current practice, patients/families have 24 hours to consider this offer, but if in hospital, are obliged to accept the first available bed. While they can choose to remain on the wait list after transfer to the facility with the first available bed, it is often difficult for families to decide immediately. They have often not visited the facility prior to the offer of a space, as they did not know which nursing home might have a bed. Given the multiplicity of nursing homes available in the HRM/District 9 area, this issue is particularly salient. Narrowing the range of likely options might encourage families to visit.

Recommendation: Enable hospital-based Care Coordinators to access the waitlist for each LTC facility to facilitate patient/family preparation. This would enable Care Coordinators to share with patients the sites in which a bed is most likely to become available and can encourage families to visit these 3 or 4 facilities, *before* a bed becomes available. This would help reduce anxiety about placement and support individuals/families to mentally and emotionally prepare for admission into a nursing home. Once the bed becomes available, client may be better prepared to accept the offer immediately.

9. Create Single Patient Record to Streamline Data Collection Process

Rationale: Current data collection processes are uncoordinated, do not capture or share information needed by all parties in the placement, and data is not necessarily complete or current at the time of transfer to long term care. This results in the need for long term care providers to collect data already collected by others (e.g. asking the family for financial/income tax records) or supplement information gathered (,contacting the care team, Care Coordinator, Placement Officer, or visiting the client) which adds further time to the placement process. Financial data provided to ERU is not shared with the long term care facility and client care needs are not always fully identified – both are required for the LTC provider to make decisions about client admittance.

In particular, long term care operators need:

- a full description of client needs (OT, PT, medications, dietary, equipment, etc.);
- information as to the nature and extent of any wound care required (as this impacts staff resources);
- information to identify roommate compatibility issues; and
- information about the presence, severity, and current management of challenging behaviours. Measures used to manage challenging behaviours in hospital settings are different from those available to LTC facilities so accurate information is required to make an informed assessment for placement so as not to compromise client care or jeopardize safety.

Additional information about wound care and challenging behaviours is also required to support care level decision-making and expedite processing of these clients.

Recommendation: Create a *single patient record* which follows the client from hospital to long term care. Develop standardized data collection processes to capture and share information relevant to support key decision points of all parties in the placement process, so as to avoid duplication, reduce delays, and ensure information is complete, up to date, and accurate to ensure appropriate placement of clients. Better information/management is especially needed about wound care and challenging behaviours as these clients experience significant delays in placement. Incorporation of the Clinical Geriatric Assessment tool[17] into the data collection process may also be of benefit. Make better use of technology to both collect and share this information to allow for easy access to and quick transfer of information, as well as support auditing/quality review.

10. Develop a Strategy to Better Manage Dementia-related Challenging Behaviours

Rationale: Clients with challenging behaviours while fewer in number, were among those with the longest wait times in hospital. Challenging behaviours was also a primary reason for refusal on the part of LTC to accept a client due to lack of capacity, due to physical layout (absence of special care units to care for the person separate from the non-dementia population, absence of private rooms, absence of secure units to prevent risk of elopement) or absence of staff resources in the home to accept the client.

Recommendation: Develop a strategy to enhance the capacity of LTC to meet the needs of clients with dementia-related challenging behaviours. This is critical in light of the fact that dementia rates are rising and 1/3 of those with dementia are anticipated to exhibit more moderate to severe forms of behaviours. Enhancing the capacity of LTC to meet the needs of this population will reduce delays in the placement process, free up beds in acute care, and better meet client needs (with and without dementia).

11. Improve Understanding and Communication among Partners in the Placement Process

Rationale: Better understanding on the part of the care team of the types of clients/care level needs that can be accepted in LTC and the information required to support LTC provider decision-making will clarify information needs and make the process more transparent to all parties participating in the placement process, as well as expedite decision-making throughout the process. Long term care can also benefit from better understanding the limits and challenges of an acute care environment.

[17] The Clinical Geriatric Assessment (CGA) is an evidence-based tool/process that captures information about the health status of a resident in long term care at four weeks post-admission. Information is captured by physicians and other members of the health care team in the long term care facility on the medical, functional, and psychosocial status of the resident. It is a point-in-time assessment which is intended to serve as a benchmark of health status to which the resident can be treated as his/her health condition changes. The CGA was made available for use in long term care facilities in Nova Scotia as of January 1, 2011.

Recommendation: Enhance communication and education opportunities among Care Coordinators, Classification Officers, and LTC providers to improve understanding of nursing home care level limits and the information required by LTC facilities for client acceptance/admission. Continue to encourage staff involved in the placement process to tour LTC facilities to understand LTC provider capacity/care level limits. This would enhance relationships and build understanding among parties involved in placement process as well to enable issues/challenges to be resolved more expeditiously.

12. Transfer Care Level Decision-making to Care Coordinators

Rationale: Currently, Department of Health and Wellness Classification/Placement Officers make the care level decision but this process often results in duplication of effort and delays in the process. DHA Care Coordinators have already had extensive involvement with the case file and consultation with the care team members in hospital as part of the assessment process. As a result, the Care Coordinator often has the greatest knowledge of the person's care needs and is in the best position to be able to make a care level decision. Requiring a further hand off of this information to another staff person for classification unnecessarily complicates and delays the process. It is acknowledged that shifting responsibility will impact the job descriptions of both District and Department staff and that staff training may be required in the classification system to enable Care Coordinators to assume this role.

Recommendation: Transfer responsibility for care level decision-making to Care Coordinators to expedite care level decision-making and create resource efficiencies.

Financial Review

13. Expedite Financial Eligibility Review

Rationale: Since these are simultaneous processes, efforts to expedite care level decision-making will be of no avail if the financial review process is also not improved.

A significant barrier to financial review has been the absence or delay in the provision of financial records/income tax returns to ERU. Often families experience difficulty in finding/providing these records to ERU on behalf of the family member in hospital. Sometimes, income tax returns have not been filed at all.

Further, if ERU had access to the files of clients who were likely to be placed in the near future, they could process those cases first, to ensure the financial review component is not delayed.

Recommendation: *It is noted that DHW has just worked out an arrangement with Canada Revenue Agency to enable ERU staff to directly access client income tax returns with the client's consent. This will significantly reduce the burden on families to produce the files and the potential delays associated with waiting for financial information. The Committee supports this approach.*

Allow the Eligibility Review Unit (ERU) to access the long term care wait list to help with prioritization/work flow to ensure the cases/clients with greater likelihood of immediate

placement are reviewed first.

14. Expedite Financial Re-assessment

Rationale: ERU completes a financial re-assessment for each client in or entering a nursing home on an annual basis. This done at the same time each year for all clients which can slow down the process once a year. The re-assessment process has the potential to delay placement (as clients and facilities await notification of the per diem the client will have to pay).

Recommendation: That the Department of Health and Wellness examine ways to manage the financial re-assessment process to avoid the potential for delay in case processing. Ensure new clients seeking placement do not encounter delays in their financial assessment process as a result of the annual re-assessment process.

Admission to Long Term Care

15. Develop a Standard Contract for Use between Client and LTC Providers

Rationale: Currently families do not understand their legal obligations to the nursing home, nor are they fully aware of the services offered by the nursing home. Delays can arise once the time comes to sign a contract to admit their relative to a long term care facility due to this lack of understanding and clarity about roles and responsibilities of the two parties. While different LTC providers may offer a different range of services and payment for these may differ, the basic core services are similar. While LTC are autonomous community-based agencies reporting to individual boards or municipalities, it should be possible to develop a standard agreement that outlines services provided and financial and legal obligations of the client/family. Such a contract could be made available to the client/family while the client is waiting in hospital, well before a bed becomes available, for review and clarification with the care team (social workers, care coordinators). While the contract would be reviewed again with the client/family by LTC providers prior to admission/signing, there should be less likelihood of misunderstanding or delay. A standard contract would also facilitate any inter-facility transfers occurring later.

Recommendation: Develop a standard contract for use between client/families and Long Term Care operators to ensure families are understand the roles, responsibilities, and legal obligations of both parties to the contract. Make the contract available (through the care team and on nursing home websites) for clients/families to review while in hospital in advance of a bed vacancy.

16. Expedite Access to Equipment

Rationale: Admission delays result if the equipment necessary to support the client (e.g., oxygen, wheel chair) is not available. For example, wheel chairs must be ordered up to 3 months in advance from the Red Cross. Usual practice dictates that, while these equipment needs are known to the hospital care team, they are not planned for or known to the LTC facility prior to receipt of the client file from Placement Office. There is a policy impediment to ordering the equipment in advance of client transfer.

Recommendation: Any necessary equipment needs for each client should be anticipated and requested by the care team while the client is in hospital. Policy should be reviewed and amended to support this approach.

17. Expedite Access to Medications

Rationale: Medication needs also delay admission. A resident transferring from hospital requires timely access to their medications. Some medications required by clients are not readily available in the LTC pharmacy and must be pre-ordered, necessitating that clients come with a sufficient supply for the first few days. Access to medications in long term care is particularly problematic on weekends.

Recommendation: The hospital care team should ensure the patient leaves hospital with a sufficient supply of medications if necessary from the hospital pharmacy for 3-4 days to enable the LTC facility to accept the client.

18. Expedite Long Term Care Facility Admission Process

Rationale: Once a bed becomes available, acceptance can be delayed pending a visit by the family for a tour, or by review of the file by the LTC site and subsequent collection of additional financial and client care information to enable the facility to make a decision to accept the client or not. LTC facilities could be contacting families on the top of the LTC list to encourage them to visit and collect their information earlier in the process, prior to a bed becoming vacant. It would be important to ensure facilities did not use this as an opportunity to "cherry pick" preferred clients, choosing those with fewer/less intensive care needs. Measures to ensure the protection of privacy of applicants who do not end up placed in facilities that may obtain information about them will also be critical.

Recommendation: Allow LTC facilities access to the top 3-5 people on the LTC wait list to enable them to begin their assessment process earlier. Implement accountability mechanisms for review/audit of admission decisions to ensure an ethical selection of clients, as part of the overall accountability framework.

19. Shift Allocation of Resources

Rationale: Funding impediments limit the scope of care long term care operators can provide. For example, with additional funding, long term care facilities could provide more complex wound care – and care in general. Care in LTC settings is less expensive than in acute care.

Recommendation: Re-align resources to allocate more to long term care to enable LTC to provide more complex care.

20. Make Better Use of Human Resources

Rationale: Nurses are in short supply, budgets are stretched, and it is imperative that the health care system makes best use of its scarce human resources. Currently, nurses in long term care are often limited in what services/interventions they can perform in long term care, inconsistent with their training and scope of practice. Nurses are required by their professional regulatory body, the College of Registered Nurses, to maintain their competencies in various skill areas to ensure good professional practice and patient safety/quality of care. In long term care settings, certain competencies can be difficult to maintain due to the frequency with which nurses are required to perform these particular tasks. This means some clients must transfer to hospital for certain procedures, which is disruptive to clients and increases the demand on acute care.

Recommendation: Explore ways to support nurses in long term care to maintain their competency levels to enable them to work within their full scope of practice (e.g. exchanges with or placements in acute care settings or other measures). This could potentially reduce transfers to hospital and increase the ability of LTC facilities to manage care for clients out of hospital, as well as accept clients with more complex medical needs.

21. Implement Evening/Weekend/Alternate Hours of Admission into Long Term Care

Rationale: Current practice dictates that most admissions to long term care take place during week day hours, leaving some beds unnecessarily vacant over the weekend. This represents an underutilization of scarce bed resources, delays the placement of other persons waiting for long term care and negatively impacts the efficiency and effectiveness of acute healthcare delivery.

Recommendation: Once consistent five day a week admissions are achieved consideration needs to be given to the implementation of evening/weekend/alternate hours of admission to an LTC facility. In order to support this, patients should leave hospital with sufficient drugs and necessary equipment, and other barriers (such as inadequate information) must first be addressed. Resource reallocation and/or additional funding will be required to allow LTC facilities to implement this significant change to the admission process.

22. Consider Limits on Inter-facility Transfers

Rationale: While inter-facility transfers do not comprise a significant volume of clients on the wait list, they do take up time on the part of the Placement Officer and long term care facility, and delay the placement of other clients waiting in hospital or community. However, knowing they have a choice to transfer later if they are unhappy in the facility where they are first placed is important for hospital patients who have little choice as to where they initially go from hospital.

Recommendation: Some thought should be given to more clearly defining limits on the number of transfers a client can make (transfers should only occur for legitimate reasons). Reasons should balance family and client needs – such as reasonable geographic proximity as per the family's situation, the need for clients to have access to family support, stability of a client once placed, whether a client is happy in the facility, etc.) – with the time it takes to process a transfer and potentially delay other placements.

5. Conclusion

It is anticipated that these changes will improve the experience of families awaiting placement by reducing the time spent at certain stages. However, the current and planned supply of long term care beds is insufficient to meet current or projected demand so exploration of alternatives such as expanded home care, expanded access to hospice or community-based palliative care, and development of other community-based alternatives will be necessary. Given the projected demographics and disease trends contributing to the demand for long term care, early examination of these options, although beyond the scope of this report, is imperative.

The scope of this report also did not permit a broad-based examination of other opportunities for achieving greater efficiency in either acute care or long term care settings. It merely looked at the interface of placement from hospital to long term care. However, there may be opportunities within both of these sectors to improve outcomes for patients/clients. Scope was also not sufficient to examine other points of interface (e.g. emergency and long term care, Adult Protection and long term care, and so forth). These areas should also be addressed.

Greater public understanding of the long term care placement process and access to home care and other supports would also be of benefit so individuals and families could give some thought to their options, make plans earlier, and be better prepared to deal with a crisis should it arise. This would also help contribute to an informed public dialogue and greater public involvement in the selection of policy choices to address the care needs of an aging population.

References

Alzheimer Society of Canada (2010). Rising Tide: The Impact of Dementia on Canadian Society – Executive Summary.

Brodaty et al cited in New South Wales Department of Health (2006). Summary Report: The management and accommodation of older people with severely and persistently challenging behaviours. URL: www.health.nsw.gov.au

Nova Scotia Department of Health and Wellness (Dec 7, 2010). Removing Barriers in Accessing Long Term Care (Draft).

Nova Scotia Department of Health and Wellness, December 31, 2010. SEAScape.

Nova Scotia Department of Seniors (2009). Statistical Profile 2009.

Nova Scotia Disabled Persons Commission (2004). Persons with Disabilities in Nova Scotia: A Statistical Report.

Ross, J. (2010). The Patient Journey through Emergency Care in Nova Scotia: A Prescription for New Medicine.

Zahradnik, N (2007). Minding Our Elders: Mental Health in Long-Term Care. Network, Canadian Mental Health Association. Accessed on June 9, 2008 at: http://www.ontario.cmha.ca/network_story.asp?cID=7439

Appendix 1: List of Committee Members

Paula Barrett
Family Representative

Lygia Figueiredo
Health Services Manager
Continuing Care Office, CDHA

Margie Lamb
Health Services Manager
Continuing Care, CDHA

Marilyn MacDonald
Program Manager
HI Med/Surg, Rehabilitation and Supportive Care, CDHA

Lori Sanderson
Health Service Manager
DGH site, CDHA

Annette Fougere
A/Service Delivery Coordinator
Continuing Care, DHW

Janet Ivory
Senior Program Evaluator
Continuing Care, DHW

Anthony Taylor
Administrator, Oakwood Terrace

Rob Chatwin
Social Worker, Ocean View Manor

Health Association Nova Scotia:
Mary Lee, President and CEO (Committee Chair)
Carolyn Marshall, Senior Policy Analyst
Sonya Stevens, Organizational Measurement and Research Specialist