The Sector Linkage Model for Improved Patient Flow

Dr. Peter Nord
Based on Premise that
Better Quality Outcomes Result from Better Flow
Healing Trajectories Current & Future

Duration of Outpt. Care

Health Status Measures (FIM)

Duration of Inpt. care

Time to “Outpatient” Care Reduced

Future state

Current state
• Number of Acute Care beds in Ontario

• Number of Rehab beds in Ontario

• Number of CCC beds in Ontario

• Number of LTC beds in Ontario

• Number of Support Housing / Assisted Living beds

• Number of Home beds in Ontario

= 29,000

= 77,000

= 75,000

= 13 million
Sector Linkage Model: Integration

TCLHIN

SHSC/TEGH/SMH

TCLHIN

Community MD’s

TCCCAE

CELHIN

TSH

CELHIN

Community MD’s

CECCAE
Sector Linkage Model for Improved Patient Flow

- AatH initiatives have not demonstrated changes to ER/ALC metrics.
- The SLM was developed to provide a more focused, effective, sustainable solution that has potential for spread.
- Based on the healing trajectories of the persons we care for.
- Three themes: integration, steady-state/sustainability, culture change.
Sector Linkage Model for Improved Patient Flow

• SLM predicated on building capacity in community: highly elastic/cost-effective/rapid ramp-up/potential for high levels of customer satisfaction.
Sector Linkage Model: Culture Change

• ALC standard definition adopted provincially.
• Earlier intervention in acute care.
• CCAC to designate ALC for LTC destination.
• Actively “pull” from acute care to rehab.
• Aggressive needs-based rehab with focus on sustained independence in home.
• More case management and navigation in community (family physician, pharmacists).
To reduce the flow in:

- Avoid Readmissions ("Virtual Ward"/ Early Discharge Planning / CDM / Case Management)
- ER Diversion / GEM Nurses
- Support for Community MD’s
- Primary Care Extended Hours
- Urgent Care Centres
To increase the flow out:

• “Home First” / “Waiting At Home”
• Increase Community Rehab Capacity
• CCAC’s accountable for D/C Planning
• Supportive Housing / Assisted Living
• ALC Long Waiters Strategy
• ALC within 48 hours strategy
Our local health integration network…

Providence Healthcare
The bridge between acute care and home
Once at Providence Healthcare…

As many as 35 care providers

X 2 if you transfer to another unit
Gap between our own inpatient and outpatient services
Once home…
Providence Healthcare
The bridge between acute care and home
Philosophy and Supporting Structures

Providence Healthcare
The bridge between acute care and home
Philosophy and Supporting Structures
Rehab everywhere, always, one patient at a time

Providence Healthcare
The bridge between acute care and home
“The Essential 13”

mobility, wound care, safe swallowing, continence, cognition, mental health, suicide prevention, pain management, home safety, medication management, caregiver support, spiritual support, family physician engagement
Philosophy and Supporting Structures
Communication, Collaboration, Coordination

Providence Healthcare
The bridge between acute care and home
Philosophy and Supporting Structures

Our environment supports our philosophies, flow and processes
Right patient,
Right bed,
Right time in the patient’s journey
Hello, my name is ____________________________, and I work for Providence Healthcare. I have been working with your team here at ____________________________ to learn more about you, your health care needs and your goals. I believe that we can help you, with the support of your family and friends, to meet your goals.

At Providence, we believe that your recovery continues beyond your stay at our Hospital. Support from the community is very important to your continued health and well-being. As part of your recovery at Providence, you will be encouraged to go on outings to the community and to visit your home before your discharge. This will help you plan for your safe transition from hospital to home. At Providence, we know you don’t want to spend any more time in the hospital than you need to.

We offer rehabilitation in two phases:

**Phase 1:** We focus on improving your abilities while staying with us.

**Phase 2:** You continue therapy while living at home, learning to adapt to your new life.

I will come back to see you on ____________________________ to answer any questions you may have. With your consent, I would like to call ____________________________ to answer any questions that they may have. For more information, call me at ____________________________.

---

**Restoring independence—it’s a team effort**

Our goal is to restore your independence and help you return safely home. It will involve:

- Clear goals and clear communication
- Early discharge planning
- Attending therapy
- A safe, supportive environment
- Daily check-ins to assess feelings, physical recovery and readiness for home
- Dignity, compassion and respect
Maximum of 13 care providers
Inpatient staff + Outpatient staff = one care team
"I have a full team to support me once I am home"

Physiotherapists
Occupational Therapists
Therapeutic Recreationist
Registered Nurse
Social Worker
PT/OT Assistant
Physician
Community Health Navigators
And our most important downstream partners:

TC-CCAC, CE-CCAC, C-CCAC
Skin in the game

• As a pilot project, Providence established an agreement with CE-CCAC (this fiscal year) to provide funds from Providence global budget to top up services above CCAC budgeted service maximums in order to facilitate our discharged patients return to home.
Community Health Navigators
<table>
<thead>
<tr>
<th>From acute care to Providence</th>
<th>Indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of admissions</td>
</tr>
<tr>
<td></td>
<td>Average FIM™ score on admission</td>
</tr>
<tr>
<td>Inpatient at Providence</td>
<td>Number of internal transfers</td>
</tr>
<tr>
<td></td>
<td>Average length of stay in days</td>
</tr>
<tr>
<td></td>
<td>% of patients discharged home</td>
</tr>
<tr>
<td></td>
<td>Patient satisfaction</td>
</tr>
<tr>
<td></td>
<td>Incidents of harm</td>
</tr>
<tr>
<td></td>
<td>Average FIM™ score on discharge</td>
</tr>
<tr>
<td>From inpatient to home and outpatient clinic</td>
<td>% of patients discharged with a family doctor</td>
</tr>
<tr>
<td></td>
<td>% of patients contacted 48 hours post discharge home</td>
</tr>
<tr>
<td></td>
<td>Average FIM™ score at 4 months post discharge home</td>
</tr>
<tr>
<td></td>
<td>Number of patient visits to ER post discharge home</td>
</tr>
<tr>
<td></td>
<td>% of patients returning to an outpatient clinic</td>
</tr>
</tbody>
</table>
How did we pay for all this?

Closed 50 beds of 347 beds
Results:

- People served from 1905 to 2040
- Balanced budget
- ALC for LTC from 100 to 30
- Percent discharge to home 78%
- Ave. monthly cost for enhanced service package $1500
- Ave FIM at 4 mos. post dc: 13 pt. increase
Peter Nord M.D.
V.P., C.M.O. and Chief of Staff
Providence Healthcare
Assistant Prof. U. of T.
3276 St. Clair Ave. East
Toronto, Ontario
M1L 1W1
pnord@providence.on.ca