



THAMES VALLEY
HOSPITAL PLANNING
PARTNERSHIP

Complex Continuing Care Bed Access and Utilization in Thames Valley Hospitals

**An investigation of CCC beds in the Thames Valley Hospitals
and options for Sub-Acute and Alternative Level of Care
patients.**

June 2008

Prepared by Natalie Berkiw, Project Facilitator

Integrated Strategic Alliances and Networks (ISAN)
Planning and Operational Improvement

London Health Sciences Centre and
St. Joseph's Health Care, London

St. Thomas-Elgin
General
Hospital

London Health
Sciences
Centre

St. Joseph's
Health Care
London

Four Counties
Health
Services

Strathroy
Middlesex
General
Hospital

Alexandra
Hospital

Tillsonburg
District
Memorial
Hospital

Woodstock
General
Hospital

The Authors

ISAN – Integrated Strategic Alliances & Networks
is jointly sponsored and supported by the London Health Sciences Centre
and St. Joseph’s Health Care, London.

Our mandate is to work with health care providers and organizations
in Southwestern Ontario, especially hospital-based services,
to develop innovative solutions to regional health care delivery issues.

For more information:

100 Collip Circle, Suite 230A
London, ON N6G 4X8
p. 519.685.8500 x72010
f. 519.439.7199

www.lhsc.on.ca/isan
isan@lhsc.on.ca

Complex Continuing Care Bed Access and Utilization in Thames Valley Hospitals

An investigation of CCC beds in the Thames Valley Hospitals and options for Sub-Acute and Alternative Level of Care patients.

Table of Contents

1.0 Executive Summary	5
2.0 Introduction / Background	7
3.0 Stakeholders	7
4.0 Methodology	7
5.0 Current State	8
Complex Continuing Care Beds in Thames Valley	8
<i>Table 5.1: Number of Complex Continuing Care Beds per Hospital and Bed Utilization Rates for 2006/07</i>	8
<i>Table 5.2: Number of Complex Continuing Care Beds per Hospital and Bed Utilization Rates at Current State (March 2008)</i>	8
Investigating the ALC Population	9
<i>Table 5.3: Number of Patients Waiting for LTC Home Placement by Hospital</i>	9
<i>Table 5.4: Non-CCC Patients Currently Occupying Complex Continuing Care Beds by Hospital at Current State (March 2008)</i>	10
Average Length of Stay in Complex Continuing Care Beds	10
<i>Table 5.5: Average Length of Stay in Complex Continuing Care Beds by Hospital</i>	10
Challenges and Opportunities Identified by Thames Valley Hospital	11
Comparing Bed Costs	12
<i>Table 5.6: Cost per Chronic RUG-III Weighted Patient Day in 2006/07</i>	12
<i>Table 5.7: Comparison of Costs for Complex Continuing Care Beds for 2006/07</i>	13
Complex Continuing Care Co-Payment	13
Long-Term Care Bed Funding	13
<i>Table 5.8: Long-Term Care Ministry Funding Per Day</i>	14
Long-Term Care Bed Co-Payment	14
Bed Cost Comparison	14
<i>Table 5.9: Co-payment Comparison Between Complex Continuing Care and Long Term Care</i>	14
<i>Table 5.10: Comparison of Ministry Funding Per Day Between Complex Continuing Care and Long-Term Care</i>	15

<i>Table 5.11: Bed Cost Comparison including Ministry Funding and Maximum Patient Co-Payment</i>	15
Investigating Long-Term Care Beds	15
<i>Table 5.12: Breakdown of Current Long-Term Care Beds by County for 2006/2007</i>	16
<i>Table 5.13: Comparison of Required Beds vs. Available Beds by County for 2006/07</i>	16
<i>Table 5.14: Forecast of LTC Beds Requirements for Thames Valley</i>	17
Benchmarking	17
Southwest LHIN	17
<i>Table 5.15: Comparing the Number of Complex Continuing Care Beds Across the SW LHIN Over Recent Years</i>	17
Erie St. Clair LHIN	18
6.0 Review of the Literature	19
7.0 Next Steps and Recommendations	20
8.0 Conclusion	21
9.0 References	22

1.0 Executive Summary

Complex Continuing Care (CCC) is a specialized program of care for medically complex patients whose condition requires them to be in hospital. However, many designated CCC beds in Thames Valley hospitals are currently occupied by sub-acute and alternative level of care (ALC) patients. The TVHPP Executive Committee has agreed that there is a need to investigate the possible implications of changing Complex Continuing Care beds into sub-acute or ALC beds and delivering service to these beds in another way. This report will track the current utilization of these beds to help identify strategies around improving patient flow.

As of March 2008, there were 346 Complex Continuing Care beds in the Thames Valley region with the average occupancy rate at 99.13%. In comparison, the average occupancy rate for 2006/07 was 78.41%, showing a dramatic decrease in capacity over recent time. It is important to take into consideration that 126 out of the 346 beds are designated for the Veteran's Care Program at St. Joseph's Health Care, London through Veteran's Affairs and are not available for consideration leaving only 220 available beds in Thames Valley.

Accurate data around the number of ALC patients waiting in each hospital has been challenging to collect. Due to some discrepancies in the collection of data across hospitals and the inconsistent definition of ALC, the South West Community Care Access Centre has experienced some challenges with verifying the number of ALC patients occupying beds within each hospital. However, we are aware that that within Complex Continuing Care, 135 beds out of the 220 available beds (61%) are currently occupied by patients waiting for an alternative level of care (March 2008).

Discharging patients when there is a lack of available long-term care beds to send these patients to is slow. This has a direct impact on a patient's length of stay within the hospital. The average length of stay (ALOS) varies within each hospital but collectively, the ALOS for the Thames Valley hospitals is 107 days (with a range of 27 days to 280 days).

Some challenges and opportunities have been identified through discussion with each hospital. St. Joseph's Health Care, London and Tillsonburg District Memorial Hospital have several patients that have been occupying beds for an excessive length of time as a result of patient or family refusal to make alternative arrangements or because prior approval was given by the hospital to stay in those beds long-term. As a result, several beds are not available to complex patients who require these resources. In terms of opportunities both Alexandra Hospital (Ingersoll) and Tillsonburg District Memorial have identified potential space for hosting additional beds if funding was made available to them. St. Joseph's Health Care, London has been working on a joint proposal with London Health Sciences Centre (LHSC) for the funding of an additional 40 beds to support the over 80 ALC patients at LHSC on a daily basis.

Complex Continuing Care bed costs vary within the Thames Valley region but the average cost per weighted day is \$480 (with a range of \$417 to \$623) for the 2006/07 fiscal year. This level of funding is based on the Resource Utilization Group-III (RUG-III) classification. The average direct cost reported by the hospitals for the same fiscal year is \$347 and the average total cost is \$504. Although it is not a direct comparison, the cost per day for a long-term care bed is currently funded at \$133.75 and is based on a Case Mix Index (CMI) classification. Despite the inability to directly compare the daily costs for these types of beds, there is still a significant reduction in cost to fund long-term care beds rather than CCC beds.

Co-payments remain the same from CCC to LTC beds at a standard rate (and maximum) of \$50.76 per day or \$1,543.95 per month.

It is expected that an additional 608 long-term care beds will be opened in the city of London. These beds are expected to be licensed and ready for patients by the end of 2009. However, due to human resource staffing shortages, several of these beds may be ready but not open. As of 2006/07, there were a total of 555 absent long-term care beds based on the needs of the population.

Exploring the rest of the SW LHIN, the number of Complex Continuing Care beds has continued to decrease over the past few years. The number of beds went from 549 in 2003/04 down to 430 by 2007/08. Most of these remaining beds are filled with ALC patients at the present time (May 2008).

Benchmarking against other areas, the Erie St. Clair LHIN opened several transitional care beds in various locations including a retirement home setting, in hospital, and within the long-term care setting. Funding was provided by the LHIN and the local CCAC to ensure that these beds were made available to free up capacity elsewhere.

A review of the literature was done from a number of published reports from the Ontario Hospital Association, the Canadian Institute for Health Information and the Health Services Restructuring Commission. Findings suggested that a comprehensive resolution of the ALC problem requires a system orientation and collaborative approach by long-term care homes, Community Care Access Centres, other community providers and hospitals. Issues stem from the inconsistency of the term "ALC" and inadequate data.

Recommendations to move forward involve taking steps outlined by the Health Services Restructuring Committee including estimating the number of beds required, developing options and determining the sensibility of the overall decision. Adopting the methodology outlined in this paper has been recommended to the Thames Valley Hospital Planning Partnership. Several options to increase capacity are being brought forward for discussion.

2.0 Introduction / Background

Complex Continuing Care¹ (CCC) is a specialized program of care for medically complex patients whose condition requires them to be in hospital. However, many designated CCC beds in TVHPP hospitals are currently being used by sub-acute and alternative level of care (ALC) patients. Since many of these patients are waiting for significant periods of time for long-term care home placements, this creates a bottleneck in the system, thereby impacting optimal patient flow. Patients requiring these specialized complex care beds are unable to access them because resources are being diverted to care for the sub-acute population. At the same time, the overall demand of CCC services has decreased across the system due to increases in the capacity of long-term care homes to serve the traditional hospital-based CCC population.

Looking at these issues specifically within the Thames Valley region, this paper will examine the patient profiles and challenges that exist in each hospital, data around bed numbers and occupancy rates and bed cost comparisons. A review of the literature will also be presented and based on overall findings and benchmarking against other hospitals within the South West Local Health Integration Network (LHIN), possible options to create capacity will be suggested.

The goal is to support the existing patients requiring these complex care services, and to find sustainable resources for sub-acute and ALC patients by looking at delivering service to this population in another way, thereby providing the most appropriate setting and care for the needs of these patients. The question to be addressed is how to deliver care to these patients in an innovative way and thereby release the resources that hospitals can then make available to other patients in need of care and services.

3.0 Stakeholders

The stakeholders include the TVHPP Executive Committee and its member hospitals, the South West Community Care Access Centre (CCAC), and the South West LHIN.

4.0 Methodology

1. Review the current access to CCC beds in the Thames Valley including current utilization and patient profiles.
2. Review the literature to access best practices and benchmarking by leading hospitals in Ontario.
3. Investigate successful strategies that have been used by other hospitals.
4. Identify strategies to address CCC bed needs from a TVHPP perspective.
5. Identify strategies to address the use of CCC beds by non-CCC patients.
6. Present findings and recommendations

¹ Definition of CCC: Complex Continuing Care is a specialized program of care providing programs for medically complex patients whose condition requires a hospital stay, regular onsite physician care and assessment, and active care management by specialized staff. (Source: *Optimizing the Role of Complex Continuing Care and Rehabilitation in the Transformation of the Health Care Delivery System, May 2006*)

5.0 Current State

The TVHPP Executive Committee has agreed that there is a need to investigate the possible implications of changing Complex Continuing Care beds into ALC or interim care beds and delivering service to these beds in another way. Profiling the current utilization of these beds was recognized as a necessary step towards determining how to improve patient flow.

Complex Continuing Care Beds in Thames Valley

As stated in statistics for the **2006/07 fiscal year**, there were a total of 359 designated CCC beds throughout the Thames Valley Hospitals. The following table provides a snapshot of the location of these beds and the utilization rate for the 2006/07 fiscal year.

Table 5.1: Number of Complex Continuing Care Beds per Hospital and Bed Utilization Rates for 2006/07².

Hospital	# of Beds	Utilization Rate
St. Joseph's Health Care, London	216	84.5%
St. Thomas-Elgin General Hospital	49	92.2%
Woodstock General Hospital	25	91.1%
Strathroy Middlesex General Hospital	25	93.7%
Tillsonburg District Memorial Hospital	24	98.9%
Alexandra Hospital (Ingersoll)	14	51.4%
Four Counties Hospital (Newbury)	6	37.1%
London Health Sciences Centre	0	0.0%
TOTAL	359	Average: 78.41%

Looking at the **current state** as of March 2008 in comparison to the above table, the data has changed slightly in the number of beds and significantly in terms of the occupancy rates. The following table shows current beds in service, and occupancy rates based on recent discussions with each hospital.

Table 5.2: Number of Complex Continuing Care Beds per Hospital and Bed Utilization Rates at Current State (March 2008)

Hospital	# of Beds	Utilization Rate
St. Joseph's Health Care, London	206	100% (Parkwood) 80% (Veteran's Care)
St. Thomas-Elgin General Hospital	49	100%
Woodstock General Hospital	25	96%
Strathroy Middlesex General Hospital	22	100%
Tillsonburg District Memorial Hospital	24	117%
Alexandra Hospital (Ingersoll)	14	100%
Four Counties Hospital (Newbury)	6	100%
London Health Sciences Centre	0	0.0%
TOTAL	346	Average: 99.13%

There are two changes in the number of beds from the earlier data. The reason behind the difference in the number of beds at St. Joseph's Health Care (216 vs. 206) is not clear. But

² Source: Planning Decision Support Tool, Finance and Information Management Branch, Ministry of Health and Long Term Care, <http://www.fimdata.com/pdst/default.asp>

according to Janice Cosgrove, Director of Complex Care and Deb Wiltshire, Director of the Veteran’s Care Program, 80 beds are currently in service through Parkwood Hospital and 126 beds are Priority Access Beds – these beds are only available to Veteran’s through the Veteran’s Care Program (March 2008).

The second change is reflected in the bed numbers at Strathroy Middlesex General Hospital. The hospital has made a decision to reduce their number of Complex Continuing Care beds by 10 to meet their financial targets for the current fiscal year. Three beds have been closed to date (March 2008).

Occupancy rates are currently close to full capacity at nearly every hospital. The average over the 2006/07 fiscal year was approximately 78% leaving some room for those patients who needed a Complex Continuing Care bed. However, the current state profile shows occupancy at over 99%, leaving little to no room for capacity at the present time.

Investigating the ALC Population

Developing a full understanding of the ALC issue in the Thames Valley hospitals requires obtaining accurate data around the number of patients waiting for long-term care home placements. However, the South West Community Care Access Centre has experienced some challenges within the hospitals in verifying the data due to inconsistencies in the data reconciliation which is primarily caused by inconsistent definitions of ALC throughout the hospitals. Since we cannot verify these numbers, the chart below is not yet complete.

Table 5.3: Number of Patients Waiting for LTC Home Placement by Hospital

Hospital	Total # of Pts Waiting for Long Term Care Home Placement
St. Joseph’s Health Care, London	
St. Thomas-Elgin General Hospital	
Woodstock General Hospital	
Strathroy Middlesex General Hospital	
Tillsonburg District Memorial Hospital	
Alexandra Hospital (Ingersoll)	
Four Counties Hospital (Newbury)	
London Health Sciences Centre	
TOTAL	

This table, once completed, will demonstrate the number of patients waiting for LTC across the hospitals, in all beds.

However, a closer look at the patients within the Complex Continuing Care beds shows that there is a lack of available beds due to the number of patients who are not in the right place to receive the care they require. The following table shows the non-Complex Continuing Care patients using the available beds.

Table 5.4: Non-CCC Patients Currently Occupying Complex Continuing Care Beds by Hospital at Current State (March 2008)

Hospital (Number of Beds)	# of Patients Waiting for LTC	# of ALC Patients ³	# of Rehab Patients
St. Joseph's Health Care, London (206)	20	20	0
St. Thomas-Elgin General Hospital (49)	25	37	unsure
Woodstock General Hospital (25)	16	23	6
Strathroy Middlesex General Hospital (22)	11	11	10
Tillsonburg District Memorial Hospital (24)	18	24 + 2 overflow patients	6 + 1 overflow patient
Alexandra Hospital (Ingersoll) (14)	10	12	0
Four Counties Hospital (Newbury) (6)	6	6	0
London Health Sciences Centre (0)	0	0	0
TOTAL	106	135	23

The numbers here are based on data provided directly by each hospital and this shows the number of patients who are waiting for LTC placement, ALC, and rehabilitation patients taking up a CCC bed.

Average Length of Stay in Complex Continuing Care

Due to a lack of LTC beds available to these patients, discharge of ALC patients is often slow. This is reflected in the length of stay data provided by each hospital. The table below profiles data on the average or typical length of stay for patients in these Complex Continuing Care beds.

Table 5.5: Average Length of Stay in Complex Continuing Care Beds by Hospital

Hospital	Current Average Length of Stay (Includes All Patients)
St. Joseph's Health Care, London	214 days
St. Thomas-Elgin General Hospital	280 days
Woodstock General Hospital	38 days
Strathroy Middlesex General Hospital	42 days
Tillsonburg District Memorial Hospital	98 days
Alexandra Hospital (Ingersoll)	52 days
Four Counties Hospital (Newbury)	27 days
London Health Sciences Centre	0 days
AVERAGE	107 days

³ Note that ALC is defined here as *all* patients waiting for placement elsewhere *including* patients waiting for long-term care (which is shown in the first column).

Challenges and Opportunities Expressed by Thames Valley Hospitals

After discussions with each hospital within the Thames Valley region, some challenges as well as opportunities were identified that are worth noting.

Challenges Identified

St. Joseph's Health Care, London

- 126 out of 206 CCC beds are designated as Priority Access Beds through Veteran's Affairs and are only available to Veteran's. However, although these beds are not accessible to non-veterans, they do free up capacity elsewhere within the system.⁴
- Within the 80 CCC beds at Parkwood Hospital, 15 patients are long-stay patients (they have been in these beds since before 1996). These patients have been given permission by the hospital to stay in these beds. Recently, two patients have died providing access to these beds.⁵ This leaves Parkwood with approximately 67 CCC beds that are available to serve their CCC patient population.

Tillsonburg District Memorial Hospital

- Within the 24 CCC beds at TDMH, three patients have been occupying these beds for a significant length of time leaving 21 beds available for the general CCC population of this hospital.⁶

St. Thomas Elgin General Hospital

- Of the 49 CCC beds at STEGH, no rehab patients were identified as occupying their Complex Continuing Care beds. However, there are CCC patients currently taking up rehab beds (they have 10 general rehabilitation beds) due to the lack of access of CCC beds.⁷ A significant number of CCC beds at STEGH are currently occupied by ALC and not CCC patients 39 out of 49 beds as of January 2008.

Woodstock General Hospital

- Number of ALC days is continuing to increase causing further strain on available resources. The hospital had 2042 ALC days in 2007 compared to 1611 ALC Days in 2006.⁸ This represents an increase of 26.8%.

Exploring the challenge presented by both St. Joseph's Health Care and Tillsonburg District Memorial Hospital further, some patients who should be cared for in another setting are either not transferred due to a lack of available long-term care beds, or difficulties having patients and family members make alternative arrangements. There has been some discussion and commitment at the LHIN's regular meeting of hospital and CCAC leaders to standardize the discharge processes to long-term care homes.⁹

⁴ Source: Deb Wiltshire, Director, Veteran's Care Program, St. Joseph's Health Care

⁵ Source: Janice Cosgrove, Director, Complex Care, Parkwood Hospital, St. Joseph's Health Care

⁶ Source: Kelly Verhoeve, Executive Leader Patient Services, Tillsonburg District Memorial Hospital

⁷ Source: Christine Sanderson, Director, St. Thomas Elgin General Hospital

⁸ Source: June Spruce, Hospital Risk Manager/Director of Rehab, Woodstock General Hospital

⁹ Source: Tom McHugh, CEO, Tillsonburg District Memorial Hospital, TVHPP Executive Committee

Opportunities Identified

St. Joseph’s Health Care, London

- St. Joseph’s Health Care and London Health Sciences Centre are working on a joint proposal for an addition 40 beds to help accommodate the 80+ ALC patients within LHSC on a daily basis.

Alexandra Hospital, Ingersoll

- The Complex Continuing Care beds were spread out throughout the hospital at one time. Now, they are all in one central area. With the movement of beds, this has caused their entire second floor to be empty and they could host more beds if there was funding available.¹⁰

Strathroy Middlesex General Hospital

- If ALC patients were no longer an issue, this hospital feels that only 14 Complex Continuing Care beds would be required to care for this patient population within their hospital.¹¹

Tillsonburg District Memorial Hospital

- As of January 2009, 20 additional beds will become available for use.¹²

Comparing Bed Costs

The next table looks at the cost per case spending at each hospital in Thames Valley for Complex Continuing Care. The **average cost in this region is \$480 per weighted patient day** based on the 2006/07 data.

Table 5.6: Cost per Chronic RUG-III Weighted Patient Day in 2006/2007¹³

Hospital	Chronic Expenses	Chronic RUG-III Weighted Days	Chronic Cost per Weighted Day
St. Joseph’s Health Care, London	\$30,164,954	59,459	\$507
St. Thomas-Elgin General Hospital	\$8,088,562	16,042	\$504
Woodstock General Hospital	\$4,050,402	8,546	\$474
Strathroy Middlesex General Hospital	\$3,481,263	9,009	\$386
Tillsonburg District Memorial Hospital	\$3,249,432	7,228	\$450
Alexandra Hospital (Ingersoll)	\$872,630	2,093	\$417
Four Counties Hospital (Newbury)	\$560,695	900	\$623
London Health Sciences Centre	\$0	0	\$0

¹⁰ Source: Lisa Gardner, Director of Patient Services, Alexandra Hospital, Ingersoll

¹¹ Source: Mary Robertson, Director of Patient Care, Strathroy Middlesex General Hospital

¹² Source: Tom McHugh, CEO, Tillsonburg District Memorial Hospital, TVHPP Executive Committee, March 20, 2008 meeting

¹³ Source: Ministry of Health and Long Term Care, Health System Information Management Division

These costs associated with each weighted day are based on the Resource Utilization Group III (RUG-III) classification.

Looking at the direct costs and total costs reported by each hospital, this following chart compares these costs between the Thames Valley hospitals and the RUG-III weighted patient day cost for the 2006/07 fiscal year.

Table 5.7: Comparison of Costs for Complex Continuing Care Beds for 2006/07¹⁴

Hospital	Chronic Direct Cost	Chronic Total Cost	Cost per RUG-III Weighted Day
St. Joseph's Health Care, London	\$354	\$453	\$507
St. Thomas-Elgin General Hospital	\$354	\$490	\$504
Woodstock General Hospital	\$372	\$488	\$474
Strathroy Middlesex General Hospital	\$291	\$401	\$386
Tillsonburg District Memorial Hospital	\$264	\$375	\$450
Alexandra Hospital (Ingersoll)	\$212	\$333	\$417
Four Counties Hospital (Newbury)	\$585	\$987	\$623
London Health Sciences Centre	\$0	\$0	\$0
AVERAGE	\$347	\$504	\$480

According to the Finance department at St. Joseph's Health Care, the direct cost for Complex Care for the 2007/08 fiscal year was \$8,890,621.47 with total days of 27,781 for a cost per day of \$320. This amount is slightly less than the 2006/07 reported data.

Complex Continuing Care Co-Payment

Complex Continuing Care co-payments are in addition to the Ministry of Health and Long Term Care (MOHLTC) funding for the CCC beds in each hospital. The cost of the co-payment provided by patients for a CCC bed can range from \$0.00 to a maximum of \$50.76 per day (or up to \$1,543.95 per month). Patients who demonstrate financial difficulty can apply for a decrease of co-payment from the standard amount of \$50.76 per day.

Long-Term Care Bed Funding

Long-term care home beds are funded by the MOHLTC through envelope-based funding and are based on the Case Mix Index (CMI) classification¹⁵. The homes are 100% funded in three envelopes: Nursing and personal care, programming and support services, and raw food. The

¹⁴ All cost comparison data taken from Ministry of Health and Long Term Care, Health System Information Management Division, 2006/07 Year End Hospital Data Blitz Reports.

¹⁵ Case Mix Index (CMI): The case mix index is a numerical value and represents the aggregate nursing and personal care needs of the residents in each home in relation to the provincial average. A value of 100 represents the provincial average. Funding entitlement is based on the numerical value assigned for each home.

amount of funding per resident, per day, may fluctuate based on occupancy rates, but if occupancy is at least 97% full, the following funding applies for each resident on a daily basis.

Table 5.8: Long-Term Care Ministry Funding Per Day

Envelope-Based Ministry Funding	Amount Per Day
Nursing and Personal Care	\$73.69
Program and Support Services	\$7.12
Raw Food	\$7.00
Other Accommodation	\$45.94
Total	\$133.75

The additional costs associated with long-term care beds is accommodation. The cost shown in the table above is \$45.94 per resident per day. The Ministry guarantees this amount per day of basic accommodation revenue. This cost may be offset by co-payments provided by the resident and this is where LTC homes can make their profit, if they are a for-profit organization.¹⁶ The resident may provide this amount or it may be a combination of patient co-payment and Ministry subsidy for the difference.¹⁷ It is important to note that the patient co-payment may be higher than the guaranteed accommodation revenue. **The total amount of funding to run a LTC bed anywhere in Ontario is \$133.75** (although this amount may fluctuate based on occupancy).¹⁸

Long-Term Care Bed Co-Payment

Co-payments for long-term care beds may vary based on a resident's financial situation. Long-term residents continue to pay a standard maximum co-payment of \$50.76 per day (or \$1,543.95 per month). Short-term residents (90 days or less) or long-term residents who require a rate reduction due to financial hardship would pay a lesser co-payment of \$33.02 a day (or \$1,004.36 per month). The amount of this co-payment would be assessed based on average monthly income and number of dependants. Severe financial difficulties would permit further rate reductions however this would only be granted under exceptional circumstances.

Bed Cost Comparison

Table 5.9: Co-payment Comparison Between Complex Continuing Care and Long-Term Care Beds

Type of Bed	Range of Co-payment by Day	Range of Co-payment by Month
Complex Continuing Care	\$0.00 to \$50.76	\$0.00 to \$1,543.95
Long-Term Care	\$33.02 to \$50.76	\$1,004.36 to \$1,543.95

The standard (and maximum) amount of co-payment is the same across both services to enable patient flow-through by removing the barrier of an increase in cost when moving from a CCC bed to a LTC bed.

¹⁶ There are three types of LTC homes – for-profit nursing homes, charitable homes for the aged and municipal homes for the aged. The charitable and municipal homes are not-for-profit.

¹⁷ Source: Call for Applications to Operate Interim Long Term Care Beds, MOHLTC, August, 2005

¹⁸ Source: Aasif Khakoo, Director of Financial Policy and Planning, Ontario Long Term Care Association

It is important to understand that although it is not a direct comparison between Chronic Care Weighted Days and Long-Term Care funding, there is still a significant reduction in cost to funding long-term care beds rather than CCC beds.

Table 5.10: Comparison of Ministry Funding Per Day Between Complex Continuing Care and Long-Term Care

Type of Bed	Funding Amount per Day
Complex Continuing Care	\$480 (based on Thames Valley average - ranging from \$386 to \$623)
Long Term Care	\$133.75 (base amount required to run a LTC bed including <i>other accommodation</i> cost)

Table 5.11: Bed Cost Comparison including Ministry Funding and Maximum Patient Co-Payment

Base Cost Per Bed	Cost per Day (with Maximum Co-payment)	Cost Per Month ¹⁹ (with Maximum Co-payment)
CCC - \$480 per Day (based on Thames Valley average)	\$530.76	\$16,143.97
LTC - \$87.81 per day ²⁰ (not including <i>other accommodation</i> envelope)	\$138.57	\$4,214.84
Potential Difference in Cost	\$392.19	\$11,929.13

From *this* comparison, it can be assumed that the daily cost for every Complex Continuing Care bed would be equivalent to the daily cost of **3.8** Long-Term Care beds if the maximum co-payment was provided by the patient (*using the Thames Valley average of \$480 per weighted patient day*).

Investigating Long-Term Care Beds

According to the SW LHIN, by the end of the calendar year of 2009, an expected 608 Long-Term Care beds will be added to the system locally within the city limits of London, Ontario. There were 640 beds in the initial Request for Proposal, but this amount was decreased. Of these 608 upcoming LTC beds, 68 beds will be built on the Oneida Nation on the Thames reserve for the aboriginal population. Although these beds would not be made available to non-aboriginals, they would free up capacity elsewhere in the system.²¹

There are some expected challenges with the new long-term care beds as human resources continue to be a key concern. Despite the availability of the 608 beds in the near future, there remains the possibility that some beds will be licensed and ready to go but not open due to understaffing.

¹⁹ Monthly amount is based on MOHLTC formula: Daily Rate x 30.4167 = Monthly Rate

²⁰ This amount is shown without the other accommodation envelope because the assumption is that the maximum co-payment is being provided. If this co-payment is provided by the resident, the Ministry does not need to pay this additional cost.

²¹ Source: Mary Raithby, South West Local Health Integration Network

The current number of long-term care beds in the Middlesex, Oxford and Elgin counties according to the Ministry of Health and Long Term Care is 3629. This is based on the 2006/07 data. A breakdown of the beds by county is shown in the table below.

Table 5.12: Breakdown of Available Long-Term Care Beds by County for 2006/2007²²

County	Available Number of LTC Beds
Middlesex	2300
Oxford	788
Elgin	541
TOTAL LTC BEDS	3629

Recommended by the Health Services Restructuring Commission's final report, *Looking Back, Looking Forward: A Legacy Report (2000)*, the target number of beds for 2003 was 99.1 beds per 1,000 of the population that is age 75 and over. Based on this ratio, there is a shortage of beds for the population that exists when looking at the current data for 2006/07. The chart below will demonstrate the number of required beds (based on these recommendations) compared to the number of actual available beds.

Table 5.13: Comparison of Required Beds vs. Available Beds by County for 2006/07

County	Population (Age 75 and over)	Recommendation by HSRC	Required Beds	Available Beds
Middlesex	28,617	99.1 beds per 1000	2836	2300
Oxford	8,128		805	788
Elgin	5,479		543	541
TOTAL	42,224		4184	3629

According to this data, there were a total of **555 absent long-term care beds** that should have been available based on the population during the fiscal year. The greatest lack of beds existed in the Middlesex County with a difference of 536 required beds.

Looking at the current fiscal year of 2008/09, the expected population of people who are 75 years and older for the Middlesex, Oxford and Elgin counties is 43,923. Using the existing recommendations, there should be 4,353 available long-term care beds for this fiscal year meaning there is a current shortage of 724 beds. Once the 608 beds come online, the Thames Valley will still be short 116 beds. This number will continue to rise as the population aged 75 and over increases over the coming years. Outlined in the table below is the forecast for the number of required beds in Thames Valley for each fiscal year until 2015.

Table 5.14: Forecast of LTC Beds Requirements for Thames Valley

Year	Population (Age 75 and over)	Recommendation by HSRC	Required Beds
2008/09	43923	99.1 beds per	4353
2009/10	44385		4399
2010/11	44891		4449

²² Source: Planning Decision Support Tool, Finance and Information Management Branch, Ministry of Health and Long Term Care, <http://www.fimdata.com/pdst/default.asp>

2011/12	45416	1000	4501
2012/13	45855		4544
2013/14	46447		4603
2014/15	47178		4675

Another challenge recognized within the Thames Valley Region is that we cannot fully anticipate the impact and pressures of upcoming closures to geriatric psychiatry beds in the area. It is understood that 60 mental health beds within London will be divested to Windsor and an additional 15 mental health beds will be divested to St. Thomas. When the upcoming 608 LTC beds come online, we will still be far behind and the additional challenges this will create is not yet determined.

Benchmarking

As options are explored to improve bed access and capacity, benchmarking against what is happening elsewhere in the Southwest LHIN and in other Local Health Integration Networks provides a broader perspective that will aid in the discussion of the next steps.

Southwest LHIN

Within the SW LHIN as a whole, the number of Complex Continuing Care beds is decreasing and the patients within those beds are not primarily CCC patients. The table below shows the trend of beds over the past few years.

Table 5.15: Comparing the Number of Complex Continuing Care Beds Across the SW LHIN Over Recent Years

Hospital(s)	Number of Beds 2003/04	Number of Beds 2006/07	Number of Beds 2007/08
Thames Valley Hospitals	388	359	346
Grey Bruce Health Services	38	6	0
Listowel Memorial Hospital	25	25	25
Wingham and District Hospital	18	12	12
South Bruce Grey Health Centre	4	0	0
Hanover & District Hospital	27	1	0
Alexandra Marine and General Hospital	14	14	14
HPHA – Stratford General Hospital	18	25 ²³	18
HPHA – Seaforth Community Hospital	11	10	10
HPHA – St. Mary's Memorial Hospital	6	5	5
TOTAL CCC BEDS IN SW LHIN	549	457	430

²³ According to the Planning Decision Support Tool, there was an increase in the number of beds, however the increase reflects the chronic palliative care beds during that year that were counted in with the other CCC beds.

Investigating the hospitals within the SW LHIN, Grey Bruce Health Services went through bed restructuring in 2004/05 when they decided to close their Complex Continuing Care beds. They originally had 38 beds in 2003/04, but based on an assessment of the patients utilizing these beds, they found that all fit within the LTC assessment. Gradually they moved these patients to LTC and closed the beds.²⁴

Listowel Memorial Hospital continues to have 25 CCC beds within their hospital and reports that there are no ALC patients within their hospital and all current patients are Complex Continuing Care patients. However, both Wingham and District Hospital and Alexandra Marine and General Hospital report the opposite. These hospitals have indicated that their beds are nearly full of ALC patients with the exception of one bed each.

Erie St. Clair LHIN

The Erie St. Clair LHIN was brought forward in discussion at the TVHPP Executive Committee meeting as interim care beds were opened to create capacity. Investigating this further, the LHIN, hospitals and the local CCAC made the decision to utilize some one-time urgent priority funding available through the LHIN to open “transitional” care beds within a retirement home setting to provide some immediate relief of their ALC issue. Capacity was available at Central Park Lodges in Windsor, and several beds were opened that currently house 30 patients who are ALC²⁵.

In addition to these beds within the retirement home setting, the Erie St. Clair LHIN and the Community Care Access Centre provided funding to Bluewater Health to open 6 Complex Continuing Care beds in hospital at their Petrolia Site. Approximately \$200,000 was offered with the expectation that the beds would stay open for at least 6-7 months. It is now expected that these beds will remain open for a longer period of time as funds are not being used as quickly as initially expected. Additional funds (approximately \$100,000) was given to Bluewater Health (to act as a “paymaster”) to open 6 short-term beds within the long-term care setting. The expectation was that the resident’s co-payment would be covered during their stay. All of these beds were opened recently in March 2008.²⁶

²⁴ Source: Susan McCutcheon, VP Clinical Services, Grey Bruce Health Services

²⁵ Source: Frank Chalmers, Integration Consultant, Erie St. Clair Local Health Integration Network

²⁶ Source: Ralph Ganter, Senior Director of Planning and Integration, Erie St. Clair Local Health Integration Network

6.0 Review of the Literature

Published literature from a variety of sources was reviewed with respect to Complex Continuing Care beds and utilization, ALC patient populations, and existing initiatives that are intended to systematically improve bed access and capacity. Benchmarking was also done by learning what other hospitals in Ontario have done when addressing this issue of bed access.

The Ontario Hospital Association has published several significant publications. The first publication is ***Optimizing the Role of Complex Continuing Care and Rehabilitation in the Transformation of the Health Care Delivery System (2006)***. This report sets out a number of recommendations to help alleviate pressures on the health care system. These include:

- Work with the post-acute sector to develop a systemic approach to managing/planning Complex Continuing Care at the local, regional and provincial level.
- Further articulate the differences in care among programs (i.e. CCC, LTC, interim ALC beds, convalescent care, etc.).
- Develop a systemic approach to discharge planning.
- Establish new programs to better meet the needs of specific population groups.
- Strengthen policy leadership to support post-acute care services, and position CCC as a critical resource along the care continuum.

The second publication from the Ontario Hospital Association is ***Alternative Levels of Care: Challenges and Opportunities (2006)***. This position paper suggests that applying best practices will improve efficiency, reduce avoidable hospital days and enhance continuity of care. A comprehensive resolution of the ALC problem requires a system orientation and collaborative approach by LTC homes, CCACs and other community providers as well as hospitals.

This report identified several challenges contributing to the problem. One issue is that the term ALC is not used consistently across all hospitals. Inadequate ALC data is also an issue. Long-term care placement regulations are a challenge because some hospitals require that patients choose three LTC homes to apply to, at least one of which must have known vacancies or short-waiting lists. However, some hospitals report that many applicants choose to apply to only one LTC home.

According to the publication ***Complex Continuing Care: Resident Demographics and System Characteristics (2004)*** by CIHI, the Complex Continuing Care population is becoming more resource intensive over time. Their high level analysis between July 1, 1996 and March 31, 2003 provides background information regarding the Ontario Chronic Care Patient System (OCCPS) and observes trends in the demographics of patients utilizing these beds. In 2002, this report showed on average, the discharge status for CCC patients included 34.2% deaths in hospital, 21.3% discharged to nursing homes or chronic care hospitals, and 19% sent home with home care. The overall average age for admission to CCC beds was 76 and at least 75% of patients were aged 70 or older. The report also showed that in the time period recorded, the numbers of admissions increased by 18%.

Another report published by CIHI was the ***Facility-Based Continuing Care in Canada, 2004-2005 (2006)***. This report looked at the sources of admission of all residents admitted to hospital-based continuing care in 2004/05. The report stated that most residents admitted to CCC beds came from an acute care bed. It showed that 87% of patients were transferred from the hospital setting (i.e. acute care beds), 10% were admitted from home, and 3% entered Complex Continuing Care from either residential care facilities or other.

The average age of patients in CCC beds was 76, and the population was 56% female. Of interest, 70% stayed 92 days or less. Those longer staying patients were primarily discharged to other hospitals or residential facilities, or died in hospital. However, shorter staying patients were more likely to die in hospital or go home.

In July 1998, the Health Services Restructuring Commission (HSRC) announced an increase in spending of \$38 million in the restructuring of home care, long term care, sub-acute care and rehabilitation services in London. In their ***London Health Services Restructuring Report*** (1997), the Commission recommended consolidating all Complex Continuing Care services at both St. Joseph's Health Care, Parkwood site and Grace Villa to Parkwood Hospital to allow for the development and provision of a broader range of specialized services within the definition of Complex Continuing Care. The change in delivery of these services was to enhance and increase provisions for sub-acute care for those requiring skilled therapy, specialized equipment or nursing care on a short-term basis to regain function and return home. To date, all beds have been successfully consolidated at Parkwood Hospital.

7.0 Next Steps and Recommendations

The report ***Looking Back, Looking Forward: A Legacy Report (2000)*** by the Health Services Restructuring Commission suggested that a number of steps be taken to look at capacity requirements and siting options. These steps outlined in this report included:

- 1) Estimate total bed requirements by assessing utilization indicators, benchmarks and referral patterns for Complex Continuing Care.
- 2) Develop options for the configuration of hospital services taking into account facility capacity.
- 3) Assess the configuration options against the criteria of quality, accessibility and affordability.²⁷
- 4) Determine the "sensitivity" of the overall decision.

It is recommended that the TVHPP Executive Committee consider adopting the methodology outlined by the HSRC above.

Based on discussions with each hospital, several themes emerged.

- Several hospitals felt that changing beds over to transitional beds would help in terms of resources. ALC patients are the main influence in bed capacity and availability throughout all hospitals.
- There is physical space in some of the hospitals to accommodate more patients should funding become available (i.e. Alexandra Hospital, Ingersoll).
- The need for the current number of Complex Continuing Care beds would be far less if ALC patients were no longer a key concern.

The following potential discussion points are being brought forward to the TVHPP Executive Committee for consideration around the options to potentially increase capacity:

²⁷ Based on the Health Services Restructuring Commission, quality consists of two components (critical mass and clinical coherence), accessibility has four elements (population need, proximity, patient transfers, access to tertiary & specialized programs, and affordability also has four elements (clinical efficiencies, support services consolidation, administrative efficiencies and overhead savings, and restructuring savings).

- 1) Status quo – number of beds remain the same. However, no change would mean no improvement in capacity.
- 2) Consolidate CCC beds within hospitals and place them where physical space is available (i.e. Alexandra, Tillsonburg).
- 3) Close the unnecessary beds within each hospital and use the remaining beds for CCC, Slow-stream Rehab, or Acute Care.
- 4) Close the unnecessary beds within each hospital and open interim LTC or transitional beds either within the hospital setting or in another location.
- 5) Close all CCC Beds.

8.0 Conclusion

This paper is meant as a starting point to facilitate discussion between the members of the TVHPP Executive Committee around Complex Continuing Care bed access and building capacity. The goal will be to develop strategies to improve capacity in the Thames Valley hospitals. A facilitated discussion will take place to develop these strategies and next steps.

9.0 References

- Optimizing the Role of Complex Continuing Care and Rehabilitation in the Transformation of the Health Care Delivery System, May 2006, Ontario Hospital Association, www.oha.com
- Alternative Levels of Care: Challenges and Opportunities, May 2006, Ontario Hospital Association, www.oha.com
- Complex Continuing Care: Resident Demographics and System Characteristics, CIHI, www.cihi.ca
- Facility-Based Continuing Care in Canada, 2004-2005, CIHI, www.cihi.ca
- Alternative Levels of Care Strategy, Ministry of Health and Long Term Care
- London Health Services Restructuring Report, February 1997, Health Services Restructuring Committee
- London Health Services Restructuring Report, June 1997, Health Services Restructuring Committee
- Hospital Report 2007 – Complex Continuing Care, CIHI and Hospital Report Restructuring Collaborative, www.hospitalreport.ca
- Looking Back, Looking Forward: A Legacy Report, Health Services Restructuring Commission, 2000. <http://www.health.gov.on.ca/hsrc/home.htm>
- Call for Applications to Operate Interim Long Term Care (LTC) Beds, August 2005, Ministry of Health and Long Term Care

Organizations

- Ontario Long Term Care Association
- South West Community Care Access Centre
- South West Local Health Integration Network
- Erie St. Clair Local Health Integration Network
- Ministry of Health and Long Term Care
- Thames Valley Hospitals