Improving Performance Management of Appropriate Care Delivery: Examining Definitional and Information Management Issues associated with Alternate Level of Care (ALC) and Evolving Care Levels and developing a Policy Framework for British Columbia

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1.0 Acknowledgements

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2.0 Key Messages

- The public, providers and policy makers care about a service continuum of "appropriate care in appropriate place" because of the access, quality and cost implications of inappropriately placed services.
- The British Columbia Ministry of Health (MoH) and Health Authorities (HA's), as a component of the Performance Management and Accountability Framework, use Alternate Level of Care (ALC) as one of the indicators to evaluate the goal of providing "appropriate care in the appropriate place". ALC is the designation that the Canadian Institute of Health Information (CIHI) uses to define patients who no longer require acute care but remain in an acute care bed. Measuring ALC has uncovered definitional, information management and policy concerns about the emerging care levels of sub-acute and convalescent care and where they fit along the care continuum.
- A Cross-Canada survey indicates that standard definitions and a national reporting system for all care levels across the care continuum, does not exist. Hospital care is the most defined with case mix groupings, reporting requirements and utilization tools to assess appropriateness of the setting.
- Research suggests that a substantial portion of care in acute care settings could potentially be provided less expensively in other settings. Canada and other jurisdictions concerned with access, costs and quality are developing programs to meet the needs of patients who no longer require the intensity of the hospital.
- Without a provincial policy framework, these programs are developing independently within BC HA's. As a result, different standards are being applied leading to inconsistent access, service charges and quality of services to patients. Further, data collection and submission is being captured in different

- systems or not at all, leading to data gaps, a lack of comparable reporting to assess system trends and evaluate program effectiveness.
- While several countries have developed policy frameworks for sub-acute and convalescent care, the systems are diverse with different definitions, standards, case mix, data collection and reporting systems. As well, these care levels are not adequately described by existing case mix classifications that are based on medical diagnosis. Australia seems to have the most comprehensive framework, including a national case mix system that is better able to describe the care needs of patients.
- A policy framework for sub-acute and convalescent care in BC, developed in collaboration with HA's and CIHI, offers the opportunity for improved quality care for patients, consistent application of current legislation, and improved data comparability for evaluation.
- While a national reporting system exists for acute care via CIHI, this project raises questions about the implications for this system given the shifting definition of acute care as other care levels emerge. Further, given the inadequacy of our understanding of health system capacity and output, consideration of a comprehensive national reporting system along the care continuum may be warranted.
- This project is an example of effective collaboration between the provincial government, a national organization and health authorities and suggests that provincial governments can participate in a meaningful way to accomplish research informed health services policy. The CHSRF changed its admission criteria for the EXTRA Program in 2007 to include senior policy makers from government ministries or departments whose responsibilities include significant linkages to providers of direct care and delivery of services. This may be helpful in moving towards improved integration between health services policy and service delivery.

3.0 Executive Summary

The purpose of this Intervention Project (IP) was to develop a sub-acute and convalescent care policy framework for British Columbia that guides health authorities to provide consistent service standards and comparable information for these services, with the strategic goal of "appropriate care in the appropriate place". This is important because of the access, quality and cost implications of inappropriately placed services.

Research suggests that a substantial portion of care in acute care could potentially be provided less expensively in other settings. A Pan-Canadian survey and international literature indicates that Canada and other jurisdictions concerned with access, costs and quality are developing programs to meet the sub-acute and convalescent care needs of patients who no longer require the intensity of traditional hospital care. Without a policy framework, these programs are developing independently within BC HA's. As a result, different standards are being applied, leading to inconsistent access, service charges and quality of services to patients. Further, data collection and submission is being captured in different systems or not at all, leading to data gaps, a lack of comparable reporting, and poor information to assess performance, determine system trends and evaluate the effectiveness of sub-acute and convalescent care.

These issues became apparent to BC HA's and the MoH through the monitoring of Alternate Level of Care (ALC), one of the indicators within the Performance Management and Accountability Framework. ALC is used by the Canadian Institute Health Information (CIHI) to define patients who no longer need acute care but remain in an acute bed, and by the province to evaluate the goal of providing "appropriate care in the appropriate place". This measure is one component of the performance agreement between the MoH and BC's five regional HA's and is also a national indicator monitored by CIHI.

With these issues in mind, the goals of the intervention project were: to determine how sub-acute and

convalescent care should be defined in BC; to identify how these care levels could be aligned with existing legislation to provide more consistent service standards to patients; and , to determine what reporting requirements were needed for system planning and performance management.

The methodology to identify and assess the various sources of evidence influencing the intervention design and implementation included: a literature review to determine international trends in performance management, care delivery models and change management; an across–Canada survey to determine the directions of other provinces on the defined issues and a BC survey to provide a current state analysis of programming within the five regional HA's. The evidence on performance and change management informed the project design while the service delivery trends and local evidence on programming informed the consensus workshops and resulting recommendations.

The intervention project was organized into three components. The first engaged CIHI to work with the MOH and BC HA's in a series of workshops to reach consensus on definitions, address information management issues and identify any concerns about alignment of care levels with current legislation. The second applied this advice to develop recommendations for the approval of the Deputy Minister and Executive. The third utilized the approved recommendations to develop and disseminate a policy on sub-acute and convalescent care for BC, as well as, develop the groundwork for its implementation and sustainability.

A policy framework (Appendix B) for sub-acute and convalescent care has been developed to begin to address the concerns raised and provide a base for performance measurement. The policy has been approved by the Deputy Minister of Health and disseminated to BC HA's for implementation. An implementation plan (Appendix C) has been developed and agreement has been reached to integrate implementation activities into existing processes/committees within various MoH divisions. This policy will

be evaluated through the ongoing performance measurement processes as baselines, benchmarks and targets are revised within the context of an evolving provincial accountability framework.

The policy framework will have implications for HA decision makers, providers and patients, as well as the MoH divisions moving forward with implementation. The short term benefit is clear policy guidance for HA's program development and implementation of sub-acute and convalescent care services. As the new reporting requirements are implemented and data gaps addressed, improved comparability of provincial performance information, and improved integrity of the national acute care Discharge Abstracting Database (DAD) is anticipated. Standardized program development tailored to the needs of patients should lead to improved efficiency in acute care bed use and equity of access, service charges and quality for patients requiring sub-acute and convalescent care.

4.0 Context

In 2001, the regional health structure in BC was reorganized into five regional health authorities and one provincial health services agency to improve accountability for performance and to respond to patient needs where they live. (Ministry of Health, 2006) Within this system, the Ministry of Health is responsible for British Columbia's health system, with a mandate to guide and enhance the province's health services to ensure British Columbians are supported in their efforts to maintain and improve their health. The ministry provides leadership, direction and support to service delivery partners, such as health authorities, physicians and other health professionals, who directly deliver the majority of health services in BC. The province's five regional health authorities are the main organizations responsible for delivering a full continuum of health services to meet the needs of the population within their respective regions. A sixth health authority, the Provincial Health Services Authority, is responsible for ensuring British Columbians

have access to a coordinated network of high quality specialized health services, such as cancer care, specialized cardiac services and transplant operations.

The Health Authority Division is the central link between the British Columbia MoH and the six Health Authorities (HA) for performance monitoring, strategic intervention and evaluation. Beginning in 2002/03, performance expectations are negotiated to advance system improvement and key metrics are established to ensure indicators and targets are aligned with the MOH long term goals of high quality patient care, improved health and wellness and sustainable affordability. These accountability processes between the BC government and HA's are meant to enable greater accountability for performance and have continued to evolve and improve as data quality improves, deliverables become more explicit and performance targets are enabled.

Alternate level of care (ALC) is a performance metric that has been collected by CIHI for the past decade and monitored in BC since 2003. It is the designation that CIHI uses to define patients who no longer require acute care but remain in an acute bed. The BC Ministry and HA's use ALC as one of the Performance Agreement indicators to evaluate the goal of providing "appropriate care in appropriate place." Also, ALC is considered a measure of inefficiency because a patient who no longer needs acute care is occupying an acute care bed. ALC, when combined with other indicators such as wait-times for admission to an inpatient bed, and wait times for surgery can provide an indication of balance/imbalance in the HA capacity across the care continuum. Consistency with regard to the definitional and reporting practices across the provinces and nationally is important for BC and CIHI to ensure comparability and for consistent trending over time. Both are important elements of providing quality information to monitor performance and support planning and decision-making.

As programs are developed to meet the needs of ALC patients, care levels are expanding beyond the

traditional acute and community care levels. Figure 1 illustrates some of the care levels that are emerging in British Columbia.

Figure 1: Traditional and Emerging Care Levels

Traditional

Acute Care	Home Care	Residential Care (personal, intermediate & extended)

Emerging

Acute Care	Sub-acute Care	Convalescent Care	Home care	Supportive Housing	Assisted Living	Residential Care…complex

Unlike new community care levels (eg: supportive housing, assisted living) which have developed within a provincial policy framework, the care levels within acute care or at the transition between acute and community have developed independently within BC HA's. As a result different programs have developed, with different applications of policy and legislation leading to questions about access, service charges and quality of services to patients.

Further, data collection/ submission for these emerging care levels have been captured in different systems or not at all, leading to data gaps and a lack of comparative reporting. For health authorities and the BC Ministry to evaluate their goals and plan for improvements there must be confidence in the consistency, accuracy and comparability of the information across jurisdictions. Also, standardized care level definitions across health authorities are required for consistent application of BC policy and legislation. Currently, this is not the case.

In response to increasing pressure on acute care, health authorities are constantly striving to improve utilization of acute care beds and minimize costly hospital stays. Most Health Authorities in British Columbia use a criteria-based tool that has been developed through an expert-consensus process, to assess appropriate use of acute care. The most commonly used tools include Appropriateness Evaluation Protocol (AEP), Intensity Severity Discharge-Appropriateness (ISD-A, often referred to as InterQual). These tools for appropriateness of setting are applicable only to acute care provided in hospitals. (Lavis & Anderson, 1996)

While the Inter-RAI assessment tools for home care and residential care are being implemented in BC and hold the promise of providing a minimum data set, there is currently no systematic approach to identifying patients in long term care who could receive home care (or vice versa) or patients in home care programs who could use self-care (or vice versa). (Lavis & Anderson, 1996) However, designations such as Alternate Level of Care (ALC) have been developed to help health care providers identify patients who could be effectively treated in alternate settings to acute care.

As ALC rates became part of the monitoring tool, questions were raised about the differing rates across BC HA's and CEO's became aware of the definitional and data comparability issues. Some work undertaken to address the issues without conclusion, led to frustration and impatience to find solutions. Thus, in the summer of 2005, in soliciting ideas for an intervention project, ALC and care levels was the project that gained highest priority with the Assistant Deputy Minister of Health. While ALC rates in BC have been declining for the past few years, BC rates remain 3% higher than national, where over 8% of acute beds are occupied by patients who no longer require acute services.

5.0 Problem Statement

As programs are developed to meet the needs of ALC patients, care levels are expanding beyond the traditional acute and community care levels as illustrated by Figures 1 and 2 above. Given the absence of a

provincial framework that provides clear definitions for emerging care levels and clarity about legislative and reporting requirements, the following concerns have arisen:

- inconsistent program development and legislation/policy application affecting access, service charges and quality of services to patients;

- inconsistent application and documentation of ALC, leading to concerns with performance monitoring; and,

- data submission gaps and inconsistent data submission practices which compromise the integrity of the CIHI data and affects the comparability of data within BC and between BC and other provinces.

These issues are compromising the ability of health authorities and the BC Ministry to generate a collective and accurate view of how services and beds are being utilized across BC. More importantly, there are questions about differences in access, service charges and quality of service to patients. With these issues in mind, the objectives of the intervention project were as follows:

- to determine how sub-acute and convalescent care should be defined in BC, given current legislation and emerging trends;

- to identify how these care levels should be aligned with existing legislation to provide more consistent service standards to BC patients; and,

- to determine what reporting requirements were needed for system planning and performance management.

6.0 Methodology & Evidence Review

6.1 Methodology

The methodology to identify and assess the various sources of evidence influencing this intervention project design and implementation strategy included:

- A review of documents and files from previous MOH and CIHI work on this issue;
- Meetings with people involved in the previous initiative to gain an understanding of the approach, challenges and outcomes;
- A literature review to understand the international trends in performance management, care delivery models, and change management;
- A Pan-Canadian survey to determine the directions of other provinces on the defined issues
- A provincial survey (questionnaires and interviews) with representatives from each HA to document a current state analysis of programming within the five regional HA's.

6.2 Evidence Review

The key literature evidence that informed the design and implementation of the intervention project covered the areas of performance management; appropriate care delivery, evolving care levels and change management and implementation effectiveness.

<u>Performance Management</u>

Performance Management, the general context for this project, including performance measurement

and reporting has been accelerating in Canada since the 1980's. According to Brown, Bhimani, & MacLeod (2005), healthcare performance reporting may have begun with the release of statistics on the utilization and efficiency of publicly insured hospital care, moving to small area variation research in Manitoba and Ontario in the 1980s and 1990s and culminating in "a series of clinical atlases, reports and papers that described substantial variations in utilization and efficiency across communities and hospitals in both provinces"(p. 2). A second major acceleration started in the mid 1990s with the release cardiac surgery mortality across New York State. Since then, performance reporting has been linked with three consistent trends across Europe, North America and Australia. These include: an increase in the range, number, and types of performance indicators; an increased use of a balanced format; and strong support by government.

Given that performance measurement is about "what is done and how well it is done" (JACHO, 2005) , this information has relevance if it has an impact on consumer choice, provider and system performance. A recent review by Adair, Simpson, Casebeer, Birdsell, Hayden & Lewis (2006) conclude that the research base on performance measurement is in its infancy and is lagging far behind practice in both healthcare and business. The systematic review by Brown et al (2005) quoted above concludes as follows:

- Public reporting does not directly and consistently drive consumer behaviour;
- The importance of public performance reporting may be to stimulate and recognize quality and performance against key goals;
- The clear articulation of system goals and strategies to achieve these goals are important accompaniments of performance reporting; and,
- The importance of information management lessons to stakeholder acceptance. These include: a common set of standards, a single system for performance reporting, transparent methods and a verified and balanced source of data.

While the science of performance measurement is in its infancy, the necessity of PM and its potential benefits are widely supported and some suggest that information about expectations and performance is the "life blood of accountability". (Brown et al 2005) In this context, improved accountability is a goal of most provincial governments and is one that is active in BC. A new accountability tool, the government letter of expectation (GLE), is meant to further evolve the alignment of HA's with government direction.

The importance of information management to effective performance management cannot be overstated. While performance management processes and tools are being implemented to push system change, the challenges of information management largely related to a lack of e-health is widely recognized. Jurisdictions around the world have recognized e-Health as an enabler for system change. For example, the United Kingdom 's National Health Service has committed 6.2 billion pounds (approximately $14 million) over the 10 year timeframe of its projects. (NHS Connecting for Health) Perhaps the best example of positive system reform made possible by the introduction of e-Health is that of the Veteran's Health Administration (VHA) hospitals in the United States. VHA hospitals, long derided by critics as "dangerous" and "inefficient", executed a quality improvement strategy centered on the adoption of information technology. They found that "advanced information technology serves not only to deeply reduce medical errors at VHS, but also improve diagnosis and coordinated evidence – based care. (Longman, 2005)

Appropriate Health Care Delivery

Providing care in the appropriate place is a topic of importance to health care providers, policymakers and the public because of the implications for access, cost and quality of health care. Because the hospital sector accounts for a substantial share of health resources, attempts to improve efficiency and reduce costs often begins in this sector. Criteria based tools are the accepted way of measuring inappropriate days of stay and admissions. The most commonly used tools include Appropriateness Evaluation Protocol (AEP),

Intensity Severity Discharge-Appropriateness, ISD-A, often referred to as InterQual. (McDonagh, Smith, & Goddard, 2000) These tools for appropriateness of setting are applicable only to acute care provided in hospitals and research suggests that a substantial proportion of the care provided in acute care settings could potentially be provided less expensively in other settings. (Conference of Federal/Provincial/Territorial Deputy Ministers of Health, 1994)

While the Inter-RAI assessment tools for home care and residential care hold the promise of providing a minimum data set, there is currently no systematic approach to identifying patients in long term care who could receive home care (or vice versa) or patients in home care programs who could use self-care (or vice versa) (Lavis et al, 1996) However, designations such as Alternate Level of Care (ALC) have been developed to help health care providers identify patients who could be effectively treated in alternate settings to acute care.

Alternative level of Care (ALC) is also the designation that the Canadian Institute Health Information (CIHI) uses to define patients who have completed the acute phase of illness but remain in an acute care bed. CIHI diagnostic codes are abstracted and reported nationally, however, the different definitions for care levels across provinces impact the application of ALC. While different applications may lead to data quality issues, ALC is viewed as a measure of inefficiency because a patient who is ready for discharge is occupying an acute care bed. When combined with other indicators such as wait-times for emergency department admission to an inpatient bed, and wait-times for surgery, ALC rates can provide an indication of balance/imbalance in the HA capacity across the care continuum. While ALC abstract codes are standardized across Canada and ALC is reported as a percent of inpatient days, ALC data collection and auditing procedures are not standardized and a lack of standardized definitions for care levels will influence the comparability of data. This lack of standardization makes it difficult to compare how ALC is distributed

between other care levels such as long term care or home care etc. Some of this information and age – related data may be available at a health authority level.

However, ALC data collected by CIHI indicates a significant percent of acute care beds across Canada are occupied by patients who no longer require acute care services. While BC data indicates that the utilization rate of ALC has steadily declined since 2000, (CIHI report, 2006) the percent of inpatient days spent awaiting an alternate level of care in BC in 2004/05 remains at 11.4%. This compares to a Canadian average rate of 8.62 %. (Ministry of Health Report, 2006) At a time of increased demand for more timely access to services and concern with costs, this represents an area for improvement because patients designated as ALC who remain in an acute care bed may not be receiving the goal oriented care that they require.

Evolving Care Levels

Canadian and other jurisdictions concerned with access, costs and quality are developing programs such as sub-acute care and transitional care to provide services to patients who no longer require the intensity of acute care provided in a traditional hospital setting. Sub-acute care emerged in the United States in around the mid 1980s in response to Medicare payment scheme requirements and is now a well developed level of care falling between acute and long-term care. (Griffin, 1995 ; Griffiiths, Edwards Forbes, Harris & Ritchie, 2005) The defining features are that a patient still requires hospital like services but also requires goal oriented care that is focused on improving function. Care is provided in long-term care hospitals, hospital based skilled nursing facilities (SNF) and free standing SNF.

In the United Kingdom, these services are labelled “intermediate care” and have been widely introduced as part of the National Health Services National Service Framework for Older People in 2001. The aim was to reduce hospital and long term care use. (Roe, Daly, Shenton & Lochhead, 2003) While

many aspects of intermediate care overlap with the concept of sub-acute care, it is broader than the concept typically applied in the US because there is a focus on at-home services. It is similar to post-acute care in the US and its implementation has sparked concerns that NHS patients pay more than before because they are charged for personal care. (Pollock, 2000).

In Australia, sub-acute care is provided in the hospital and the community, with a focus on improved functional status or quality of life. It encompasses palliative care, rehabilitative medicine, psychogeriatrics, and geriatric evaluation and management but not convalescent, respite or long term care. (Lee, Eagar, & Smith, 1998) Australia seems to have the most clearly defined and mutually exclusive definitions for sub-acute and convalescent care and have also developed a national case mix classification system that provides solutions to some of the data comparability issues.

In Canada, no umbrella definition or standards exist for sub-acute and convalescent care. While the components and structure of programs vary across and within jurisdictions, most commonly health regions and hospitals have designated sub-acute units within acute care facilities and label them transitional or sub-acute. In Ontario, some sub-acute is provided in acute facilities and a convalescent care program is being piloted in the long term care system to provide goal oriented, short term care for patients who do not require acute care but cannot return home until health status is further restored. Other Canadian provinces are focused on addressing information management issues as: Manitoba is undertaking a process to standardize data collection and auditing processes for ALC; Alberta is the only province who submits sub-acute data to CIHI. Other provinces count and submit this patient population under acute care; and, New Brunswick is mandating a standard utilization management tool for the assessment of acute care appropriateness.

Because the systems providing sub-acute care are diverse with different definitions, standards, case mix, data collection and reporting systems, it is difficult to evaluate the effectiveness of sub-acute care. However, a recent Cochrane Collaboration review of ten trials of "nursing led inpatient units" compared to traditional inpatient units showed no statistically significant effect on mortality, increased functional status, and reductions in early readmissions to hospital and discharges to institutional care. (Griffiths et al, 2005) While intuitively sub-acute care is a less costly alternative to acute care, Lee et al (1998) conclude that the costs of sub-acute care and non-acute care (convalescent, respite and nursing home) are not adequately described by existing case-mix classifications.

The provincial survey indicates that health authority programs for sub-acute care and convalescent care are at different stages of development with different definitions, labels and policy application. This posed a risk that HA representatives would be vested in current models and not able to reach consensus on a provincial approach.

Understanding and Implementing Organizational Change

The issues to be addressed by this intervention project had been under review for two years at the MOH without successful resolution. Upon reflection, it was determined that a collaborative approach with HA's and CIHI was required to reach consensus on definitions for care levels that would guide program development and provide the base for consistent policy application. Organizational change literature was reviewed to ascertain the best approach to developing inter-organizational consensus and system change.

Organizational change is far from straightforward and is consistently reported as a high priority concern for Chief Executive Officers in Canada. (Arnstrong, Brunelle, Angus & Leva, 2001) As well, organizational research points to the difficulties associated with implementing system change into well

established organizations such as those in health care. (Weick & Quinn, 1999) However as the need for change in health services is now widely recognized by the public, professionals and governments, systematic reviews of the literature to synthesize evidence on effective tools and approaches to change are being carried out. (Iles & Sutherland, 2001; Fixsen, Naoom, Blasé, Friedman & Wallace, 2005) These reviews, while providing little empirical evidence on effective strategies to use and under what conditions, did provide a summary of strategies and tools and some lessons for consideration:

- The systems of interest in managing change can all be characterized as open systems that exchange materials, energy and information with their environment.
- Several models suggest that successful change is a result of the content (goals , purpose) the process (how or implementation) and the context of change (the internal & external environment)
- Change needs to be defined as necessary by some of the people involved so they will devote time and energy to make it happen.
- Involvement at the local level is also required to ensure that the local context is considered in the design and balanced with the need for standardization.
- Influential approaches to implementation include: Organizational developmental, Organizational learning, Action Research and Project Management.
- The relationship between measures of readiness and later implementation success is unknown.
- Outcomes of implementation include changes in professional behaviour, changes in organizational structures/processes/cultures, and changes in relationships to stakeholders and partners.

- Passive approaches such as dissemination of information do not result in positive implementation outcomes. There is a dearth of knowledge on effective change strategies that is based on empirical research. Some literature around introducing evidence based guidelines, suggests that multi-level strategies and a high level of involvement by program developers is a feature of successful implementation.
- A leadership approach described in the literature for learning organizations includes that leaders model the openness, inquiry and reflection necessary to learn from others and work together for common solutions.

7.0 Intervention Approach & Implementation Strategy

7.1 Approach

There was a sense of urgency on the part of MoH and HA's to resolve the issues surrounding sub-acute and convalescent care because it was influencing the performance record of HA's. HA CEO's supported standard definitions to improve the comparability of performance agreement monitoring and middle managers, pressed to implement programs and reduce ALC rates to meet performance targets, welcomed the opportunity for definitional clarity and policy direction. A policy model that fit the context, Howlett & Ramesh's, 1995 Policy Cycle (p 11) based on the logic of applied problem solving and illustrated in Table 1 below, was chosen as the conceptual model.

Table 1. **Five Stages of the Policy Cycle and their Relationship to Applied Problem Solving**

Phases of Applied Problem Solving	Stages in Policy Cycle
○ Problem Recognition	○ Agenda Setting

○ Proposal of Solution ○ Choice of Solution ○ Putting Solution into Effect ○ Monitoring Results	○ Policy Formulation ○ Decision making ○ Policy Implementation ○ Policy Evaluation

In addition, evidence on successful change management and practical experience suggesting a multi-strategy approach inclusive of technical, political and symbolic management processes influenced the design. A project management strategy was used to integrate the various methods and activities that are outlined in a formal project charter. The project charter was useful in reaching a common understanding and commitment from the three organizations and to mitigate the risks associated with a multi-organization project. The existing provincial governance structures (Appendix A) were used to guide the project and support the provincial working group. This structure included HA executives across the system, with known interaction patterns and distribution of power. This provided an opportunity to get executive support for policy givens and deal with funding concerns prior to beginning the project. The executives were requested to provide their organizational representatives for the working group, given specific agreed to criteria. Given the technical nature of the deliberations, and that public concerns about equity of access and patient charges were known, representation from the public was not considered.

7.2 Implementation Strategy

The intervention project was organized into three components. The first engaged CIHI to work with the MoH and BC HA's to reach consensus on definitions, address information management issues and identify

any concerns about alignment of care levels with current legislation. This component was implemented through four days of workshops that occurred over a four month period and the objectives for each day are outlined below.

The second component applied the advice from the workshops to develop recommendations for the approval of the Deputy Minister and Executive. The third utilized the approved recommendations to develop and disseminate a policy on sub-acute and convalescent care for BC and, to develop the groundwork for its implementation and sustainability. These two components are discussed further under the results section.

Component One

During the workshops local, national and international evidence was reviewed, issues discussed and consensus reached on key policy questions. A third party facilitator was engaged to facilitate the process to ensure involvement of all parties and to maintain transparency and accountability. The following daily objectives were met.

Objectives for Day 1:

1. Established a common understanding of the drivers for change and the policy givens or non-negotiables ;
2. Established the roles and responsibilities of MOH, CIHI, and Health Authorities in regards to these issues;
3. Validated the evidence, including current state analysis for each Health Authority with regard to Sub Acute, Convalescent and ALC; and,
4. Established responsibilities for homework in preparation for Day 2 .

Objectives for Day 2:

1. Established a common understanding of the current state of sub acute and non acute programs,

terminology, tools, and criteria in each Health Authority;

2. Identified commonalities, differences, and areas of conflict between the approaches taken by each health authorities with regard to sub acute and non acute programs / client groups;

3. Built on the commonalities and developed a common mental model, definitions and criteria for programs and client groups across all Health Authorities; and,

4. Established a process to test definitions and criteria with front line staff.

Objectives for Day 3:

1. Reviewed the results of testing the draft definitions for Acute, Sub-acute, and Convalescent Care;

2. Tested criteria against information collected by CIHI from each HA (Reconcile the `Fit' for HA tools currently in place);

3. Revised and confirmed criteria for Acute Care, Sub-Acute, and Convalescent Care; and

4. Tested the policy implications of definitions.

Objectives for Day 4:

1. Established a common understanding of current data submission practices for ALC, Sub-Acute and Convalescent care and associated data submission issues;

2. Reviewed CIHI's recommended option for submitting data on Sub-Acute care to CIHI; and,

3. Established recommendations for data submission.

While no formal deliberative process was conducted to weight the evidence, both scientific and contextual evidence played a significant facilitation role in moving the intervention process forward. The evidence provided a common platform to begin the discussion. International evidence helped to move debates such as location of services and utilization tools, while local evidence provided transparency about existing practices and allowed the group to quickly assess commonalities and move beyond differences to reach consensus. This first component informed the development of components two and three of the intervention project which are discussed below in the Results section.

8.0 Results & Key Lessons

8.1 Results

The intervention project was successful in meeting the goal of a policy framework for sub-acute and convalescent care for BC (Appendix B). Advice received from the workshops (component one) informed the development of recommendations (component two) which included: consensus definitions and criteria to guide more standardized development of sub-acute and convalescent programs in BC HA's; changes in the reporting requirements to address data gaps and improve comparability of information; and, clarity regarding the application of existing legislation to sub-acute and convalescent care programs. For example, what patient charges and Medical Service Plan payments apply?

These recommendations were presented to the Provincial Acute Care and Home and Community Care Planning Councils during the summer of 2006 and received final approval from the Executive sponsors in the fall of 2006.

The third and final component of the intervention project included the formal development of a policy document and internal MoH consultations with divisions implicated in the implementation of the policy. The policy and implementation plan received Deputy Minister approval and was disseminated to HA CEO's from the Deputy minister's office in December 2006. (See Appendix B & C) This work was presented at the 6th Annual Public Sector Performance Management, January 16 & 17, 2007, with a focus on "Effecting Change through Performance Measurement".

8.2 Key Lessons

- What gets measured and benchmarked gets attention and action. This project is an example of effecting change through performance measurement.

- Because of previous work on these issues, it was important to maintain the continuity with the past and learn from these efforts. It became apparent that the previous attempt compartmentalized the problem to either policy or information management, and no attempt had been made to establish consensus definitions. The lesson that a systematic approach was required to examine the inter-related issues of care levels (definitional, policy & information management) was integrated into the project design.

- The intervention project is multi-organizational and was exposed to the known risks of communication, coordination and collaboration. These challenges were mitigated by the structured project management approach where the governance structure, roles, deliverables and timeframes were all signed-off by the executives. This approach also served to keep the project on track and became a valuable transition tool with a changeover in executives (ADM & DM) at the MoH.

- Health authority programs for sub-acute and convalescent care were at different stages of development with different definitions and policy application so there was a risk that HA representatives would be vested in current models and not able to reach consensus. This was mitigated by the establishment of policy givens and the extensive evidence that was brought to the table (International, Canadian and BC) The evidence provided a common platform to begin the discussion. While international evidence helped to move debates such as location of services and utilization tools, local evidence provided transparency about existing practices and allowed the group to quickly assess commonalities and move beyond differences to reach consensus. Also, HA CEO's were interested in standard definitions to improve the comparability of performance agreement monitoring and middle managers, pressed to implement programs and reduce ALC

rates to meet performance agreement targets, welcomed the opportunity for definitional clarity and policy direction. Further, a third party facilitator neutral to the issues was found to be helpful in maintaining the perception of a fair and open process.

9.0 Implications for decision makers

- Patient care: The short term benefit is clear policy guidance for consistent service standards for BC HA's as they develop and implement sub-acute and convalescent services. Standardized program development tailored to the needs of ALC patients should lead to improved efficiency in acute care bed use and equity of access, service charges, and quality for patients requiring sub-acute and convalescent care in BC.

- Provincial Information Management: As the new reporting requirements are implemented and data gaps addressed, improved comparability of provincial performance information is anticipated. However, it will be important for the MoH and HA's to refine metrics, monitor progress and evaluate the outcomes of sub-acute and convalescent care within the context of BC's evolving accountability framework (eg: Government Letter of Expectation). Further, while common definitions and new reporting requirements begin to address data gaps and data quality in BC, other provinces, many who are addressing these issues, may offer solutions of value to BC.

- National Information Management: While a national reporting system exists for acute care via CIHI, this project raises questions about the implications for this system given the shifting definition of acute care as other care levels emerge. Challenges will continue to exist with comparable information across Canada without a national reporting system across the care continuum.

- Integration of policy and service delivery: This project is an example of effective collaboration between the provincial government, a national organization and health authorities and suggests that provincial governments can participate in a meaningful way to accomplish research informed health services policy. The Canadian Health Services Research Foundation (CHSRF) changed its admission criteria for the Executive Training for Research Application (EXTRA) Program in 2007 to include senior policy makers from government ministries or departments whose responsibilities include significant linkages to providers of direct care and delivery of services. This may be helpful in moving towards improved integration of health services policy and service delivery .

10.0 Next Steps

- Health Authorities are engaged in reviewing their program development against the recent policy that has been disseminated. Four of five HA's are developing sub-acute and convalescent programs. The fifth, primarily rural HA, will be challenged with a lack of critical mass and may be able to learn from other HA's who are developing "flex beds" to meet special needs when the critical mass is lacking.

- The provincial Data Quality Committee led by MoH, Knowledge Management Division, with membership from HA's and CIHI, are implementing the mandatory reporting of Sub-acute care into the CIHI Discharge Abstracting Database for 07/08.

- The MoH Acute Care, Home and Community Care Branches and the Medical Services Division are aligning and integrating the policy framework into their existing policies and transition processes.

- The MoH Home and Community Care Branch are undertaking a review of palliative care because of questions raised about the fit with care levels.

- The MoH submitted two applications for the 2007 EXTRA cohort proposing multi-organizational project involving the MoH and health authorities to further the linkage between policy and provider sectors.

- The evaluation of this framework will be part of the ongoing performance monitoring in BC within the context of the evolving accountability framework.

- The MoH, Health Authority Division and HA's plan to continue the monitoring of ALC rates in BC, and have set long term targets. This monitoring will remain part of the health system performance framework between the MoH and HA's and will serve to monitor and evaluate the implementation of this policy. Also, as the mandatory reporting requirements are implemented, data will become available to better understand service needs and to trend service patterns. This information will be helpful in assessing trends over time and evaluating the sub-acute and convalescent care programs.

- Implementation plans (Appendix C) are underway and have been integrated into the existing processes and functions of internal divisions within the MoH. Overall accountability for the evolving accountability system rests with the Executive Director, Health Authority Division.

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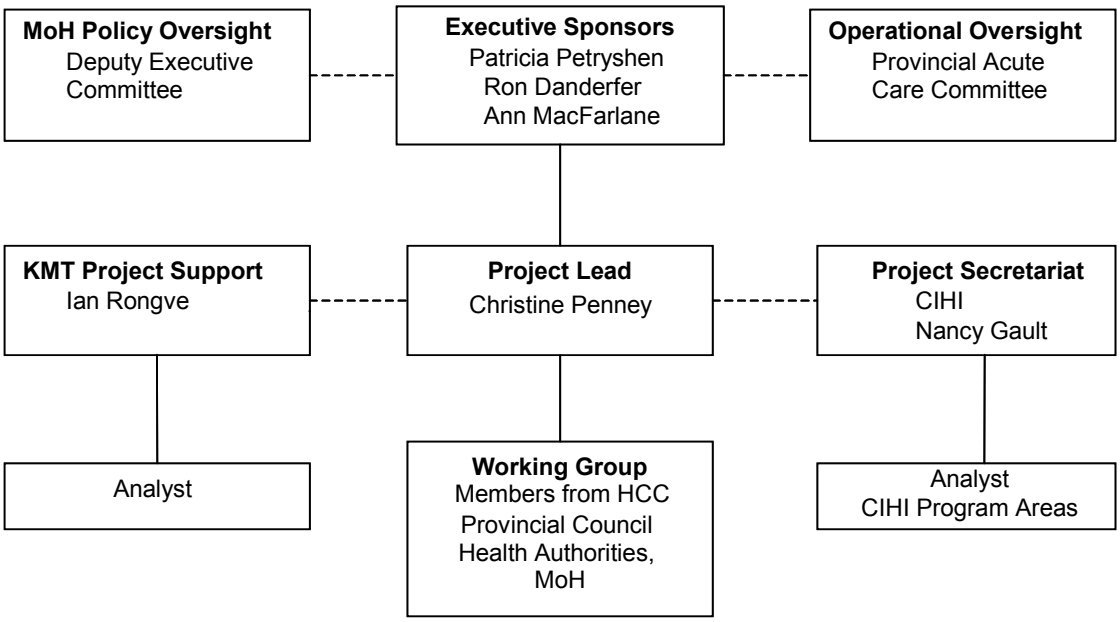
APPENDIX A

Project Governance Structure



Project Roles and Responsibilities

Role	Composition	Responsibilities
MOH Policy Oversight	Deputy Ministers Executive Committee	Final approval of recommendations and go forward decision
Operational Oversight	Provincial Acute Care Committee	Approves the overall objectives of the project Monitors progress of the project via status reports from the Project Lead
Executive sponsors	Patricia Petryshen Ron Danderfer Anne McFarlane	Signs off on project charter Authorizes any changes in project scope, timelines and deliverables Reviews Working Group recommendations and approves for implementation Assigns resources from within ministry to provide analytical or program support as required Makes decisions on issues that cannot be resolved by the ProjectLead, and assists in issue resolution and mitigation as required
Project Lead (MOH)	Christine Penney	Oversees development of project charter Provides status reports to Sponsors and Committee Keeps project on time and on budget Identifies, troubleshoots and escalates issues as required Oversees production of reports Is accountable for quality and timeliness of project deliverables Maintains stakeholder relationships Ensures efficient and timely communication among project stakeholders
Project Secretariat (CIHI)	Nancy Gault (Secretariat Lead) Analyst (TBD)	Develops project charter Tracks progress on project milestones and deliverables Arranges contracts Supports Project Lead with progress reports, documentation and information synthesis Produces supporting material and status reports for Sponsors and Working Group as required Takes minutes of meetings with Sponsors and Working Group Identifies, troubleshoots and escalates issues to Project Lead as required
Working Group	Christine Penney, MOH, (Chair) Nancy Gault (Secretariat) Representatives from each health authority	Identify issues from their organizations perspective Communicate back to organization Participate in discussion & work towards project goals Provide documentation

Role	Composition	Responsibilities
Program Areas CIHI & MOH KMT	Cathy Davis, Manager, Clinical Administrative Databases, CIHI Ian Rongve, Director, KMT & KMT Project Sponsor	Advises on analytical issues Oversees data analysis Develops communication materials regarding data submission

Communications, Consultation and Education

As this project will have an impact on all of the health authorities, it is important that the health authorities are engaged in the discussions from beginning of the project. The Working Group will consist of representatives from each of the health authorities who will be responsible for ensuring appropriate communication within their respective health authorities.

APPENDIX B:

Chief Executive Officers
Regional Health Authorities

Dear Chief Executive Officers:

RE: Policy Communique #2006-10 Policy Framework for Sub-Acute & Convalescent Care

Further to the provincial project to address policy issues on Alternative Level of Care, Sub-Acute & Convalescent Care, I am pleased to provide you with the attached policy framework for implementation. Other associated documents are also included for your information.

As you may be aware the project was led by the Ministry of Health and included the Canadian Institute Health Information (CIHI) and a working group with representatives from each Health Authority. The governance structure included regular reports and vetting of recommendations at the Provincial Acute Care Committee and the Provincial Home and Community Care Council.

We trust this framework will clarify many of the issues associated with these emerging care levels and will lead to more consistent standards for patients who require this care.

Please do not hesitate to contact Ministry staff if you have questions.
Thank you.

Sincerely,

Gordon Macatee
Deputy Minister

Attachment

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Policy Framework for Sub-Acute and Convalescent Care Programs

Background:
In British Columbia, all of the regional health authorities have developed or are planning the development of sub-acute and convalescent care programs located in acute facilities or in non-hospital facilities, such as residential care facilities. These programs are typically designed for patients who, following an acute inpatient stay, continue to require health and support services on a 24 hour basis, but may not require the full diagnostic and therapeutic capabilities of an acute care hospital. Different terms have been used to describe this care, such as sub-acute, transitional care, convalescent care, rehabilitative care, reactivation, or step-down care and different standards have been applied.

As a result of a provincial project involving BC health authorities, Canadian Institute for Health Information and the Ministry of Health to address definitional, reporting and policy issues, this document provides the Ministry of Health policy framework for sub-acute and convalescent care to enable consistent standards across the province.

Policy Objective:
The purpose of this policy is to allow health authorities the flexibility to provide care at the appropriate level in the appropriate setting leading to the best patient outcomes and service efficiencies. Also, to ensure, that regardless of the setting in which the care is delivered, all inpatient care is: provided in a manner that is consistent with the principles of the Canada Health Act and relevant provincial legislation such as the Hospital Act or Community Care and Assisted Living Act; and reported fully and consistently.

Policy Scope:
This policy applies to sub-acute and convalescent inpatient programs within hospitals and community care facilities and defined as follows:

Sub-Acute Care: (Curative & Functional Improvement)
This level of care, a sub-component of acute care, is provided to patients who have had an acute event, and

who still require frequent medical supervision and intense therapy to achieve functional improvement before

going home. (See assessment criteria).

Convalescent Care: (Functional Restoration & Reactivation)
Convalescent Care is provided to patients with a defined and stable treatment plan who no longer meet acute care criteria, but still require therapy and medical services to restore function to enable the transition from acute care to home. (See assessment criteria).

Sub-acute and Convalescent services are:

Typically part of or to prevent a medically required acute care hospitalization during treatment of

and/or convalescence from an acute episode of illness or injury, where the patient requires health and support services on a 24 hour basis, but may not require the full diagnostic and therapeutic capabilities of an acute care hospital;
Goal oriented care provided to patients who are stable, with an established diagnosis and care plan that includes planned discharge to home;
Care which cannot be safely provided in an outpatient setting or the patient's home because of the patient's need for professional services, nursing care, equipment or medication;
Does not include services such as respite care or care for patients assessed as requiring residential care who are waiting for a permanent placement; and

Does not include services provided in an outpatient setting or the patient's home.

Policy Directives:

Health authorities are required to fund the same basket of goods and services for acute, sub-acute and convalescent care, regardless of location of the program.
Health authorities are responsible for the costs of goods and services provided within these programs as specified in the payment responsibility table (below) and may not transfer these costs to patients or other parties. If patients have been assessed for and are waiting for a long term care bed for 30 days they may be charged according to the current policy.

Payment Responsibility Table

Goods or services	Sub-Acute Care	Convalescent Care
Skilled nursing	Health Authority	Health Authority
Assistance with ADL	Health Authority	Health Authority
Rehabilitation services	Health Authority	Health Authority
Room and board	Health Authority	Health Authority
Medical supplies	Health Authority	Health Authority
Wheelchairs, mobility aids	Health Authority	Health Authority
Medications—prescription	Health Authority	Health Authority
Medications—non-prescription	Health Authority	Health Authority
Lab / diagnostic tests	Health Authority	Health Authority
Ambulance transfers between facilities (BCAS user fee)	Health Authority (if stay < 24 hrs) or Patient (if stay ≥24 hrs)	Health Authority (if stay < 24 hrs) or Patient (if stay ≥24 hrs)

Physician Remuneration	Medical Services Plan	Medical Services Plan

Sub-acute care program beds, regardless of location, must be designated under the Hospital Act, with quality and patient safety measures in place as specified by the Act.
Convalescent care program beds, regardless of location, must be licensed under the Community Care and Assisted Living Act, with quality and patient safety measures in place as specified by the Act.

General practice physicians attending sub-acute and convalescent care to inpatients must bill Medical Services Plan in accordance with the fee schedules approved by the Medical Services Commission.

It is mandatory that health authorities report sub-acute care to the Discharge Abstracting Database (DAD) regardless of the location of the program.

It is mandatory that health authorities report convalescent care, regardless of location, in the Continuing Care Information Management System (CCIMS) transitioning to the Minimum Reporting Requirement (MRR

APPENDIX C
IMPLEMENTATION RESPONSIBILITIES:

Recommendation	Rationale	Responsibility
Care Levels Framework: * Implement working group definitions, criteria and policy clarification * Align Ministry of Health (MoH) policies to be consistent with definitions * Align Medical Services Plan (MSP) policies to be consistent with definitions	Address definitional issues and provide foundation for clear reporting and policy application	Health Authorities (HA's) Home & Community Care (HCC) and Provincial Branches of MoH MSP Branch of MoH
ALC Data Collection: * More rigorous monitoring and consider standardization of data collection and auditing procedures	Improve comparability of data	Data Quality Committee
Reporting and designation of Beds: * HA's are required to notify MoH and report in HAMIS the designation of beds for sub-acute and convalescent programs	To Improve accuracy and comparability of data	HA's
Sub-acute Care Data Submission: * That HA'S differentiate between acute and sub-acute in DAD to Canadian Institute for Health Information (CIHI)	Provides valuable system planning information as care levels evolve to meet patient needs	Data Quality Committee, Knowledge Management & Technology (KMT), MOH, that has HA representation, to lead the implementation

Recommendation	Rationale	Responsibility
* That CIHI make available the ability to code sub-acute as separate from acute		CIHI is working with Data Quality Committee to implement by 07/08.
Convalescent Care Data Submission: * HA's are required to report in CCIMS & transition to MRR	Correct data gaps for 432 beds	Minimum Reporting Task Group, KMT & HA's
Convalescent Care Legislation Driving Quality: * Transition from Hospital Act to CCALA as RC transitions	Convalescent care is defined as a community service and beds need to be licensed under the CCALA.	Home and Community Care Branch of MoH & HCC Planning Council

KEY:

KMT : Knowledge Management & Technology Division at MOH
DAD : Discharge Abstracting Database
MSP : Medical Service Plan
HAMIS : Health Administrative Management Information System
MRR : Minimum Reporting Requirements
CCALA : Community Care & Assisted Living Act
RC : Residential Care