

Alternative Level of Care: Canada's Hospital Beds, the Evidence and Options

Autre niveau de soins : lits d'hôpital au Canada, données et options



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Abstract

Patients designated as alternative level of care (ALC) are an ongoing concern for healthcare policy makers across Canada. These patients occupy valuable hospital beds and limit access to acute care services. The objective of this paper is to present policy alternatives to address underlying factors associated with ALC bed use. Three alternatives, and their respective limitations and structural challenges, are discussed. Potential solutions may require a mix of policy options proposed here.

Inadequate policy jeopardizes new acute care activity-based funding schemes in British Columbia and Ontario. Failure to address this issue could exacerbate pressures on the existing bottlenecks in the community care system in these and other provinces.

Résumé

Les patients qui attendent un autre niveau de soins (ANS) constituent une préoccupation constante pour les responsables des politiques de santé partout au Canada. Ces patients occupent de précieux lits d'hôpital et limitent l'accès aux soins de courte durée. L'objectif de

cet article est de proposer des options de politiques pour traiter les facteurs sous-jacents associés à l'utilisation des lits ANS. On y discute trois options en tenant compte de leurs limites et défis structurels. Les solutions à ce problème nécessitent peut-être une combinaison des options de politiques proposées ici.

Les politiques inadéquates mettent en jeu les schémas de financement de nouveaux soins de courte durée axés sur l'activité en Colombie-Britannique et en Ontario. Si cette question n'est pas traitée adéquatement, cela pourrait accentuer les pressions sur la congestion du système des soins communautaires de ces provinces et des autres.

SOME VULNERABLE CANADIANS ARE EXPERIENCING DIFFICULTY IN ACCESSING ACUTE care on a timely basis. Lengthy wait times for hospital admission from the emergency department are widely reported across the country (CBC News 2011; CTV News 2011), while surgical wait times outside those procedures prioritized by federal incentive programs have generally increased (CIHI 2012).

These long delays for accessing hospital beds are occurring in spite of significant increases in hospital spending. The five-year average rate of hospital expenditure growth has increased by 5.9% (CIHI 2010a). Meanwhile, the number of same-day surgical procedures increased 30%, from 1.3 million to 1.8 million, from 1995/96 to 2005/06 (CIHI 2007). Based on these trends, one would expect reduced pressures on hospital beds; but instead, planners are left questioning why some Canadians have significant problems accessing hospital-based services.

Hospital beds are the “choke points” in the system; with a fixed number of beds, they limit the number of admissions and regulate access to hospital-based services. According to the Canadian Institute for Health Information, there are approximately 57,000 hospital beds in Canada (excluding Quebec) (CIHI 2011a). Within Quebec, another 15,999 beds are designated as “physical health and geriatric” (an approximation for acute care beds) (Quebec Databank of Official Statistics 2011). Digging deeper, current estimates report that 13% of Canadian beds are occupied by patients who no longer require the intensity of care provided by acute care hospitals and are awaiting formal discharge (CIHI 2010b). That is, approximately 7,500 hospital beds, every day, are occupied by patients who could be safely discharged elsewhere.

Unfortunately, having patients waiting for discharge from hospital is so common in Canada that there is a term for it – “alternative level of care,” or ALC. Though these patients have been approved for discharge by their physician, they cannot access the appropriate post-acute care for their condition (CIHI 2009). ALC represents an inefficient use of hospital resources – these patients are occupying beds, staff time and equipment that could otherwise be used by patients waiting in the emergency department or those who have had their surgeries postponed. Yet, hospitals cannot be held solely responsible for this inefficient use of resources and funding; lack of capacity and flexibility in post-acute care is directly related to

the gridlock in hospitals. Thus, a quick resolution to accessing hospital beds lies beyond our grasp if there is nowhere for patients “stuck” in hospitals to safely go.

The high prevalence of ALC bed use puts recent healthcare reforms at risk. British Columbia and Ontario have recently made changes to the way they fund hospital-based care, moving away from global budgets towards partially funding hospitals for their patients (i.e., activity-based funding). These policies, as the evidence shows, have the potential to shorten lengths of stay and increase hospital activity (O’Reilly et al. 2012). Yet, without complementary policies for post-acute care, the intended effect of increased activity in hospitals may not occur. The purpose of this paper is to describe some of the key structural challenges to reducing the impact of ALC patients on Canadian hospitals and to propose policy alternatives that could free hospital beds.

Hospital Bed Use: The Case of Alternative Level of Care

What do we know about ALC patients? The data tell us that over 50% of ALC patients are eventually discharged to facility-based post-acute care (CIHI 2010b). The remainder of patients are discharged to assisted living or to their homes (with or without support). Over 35% of ALC patients are 85 years or older, and nearly a quarter of ALC patients have been diagnosed with dementia (CIHI 2011b).

In terms of resources, ALC patients consumed the equivalent of 2.4 million hospital days over the course of fiscal year 2008/09; the equivalent of approximately 7,500 beds are occupied by a patient designated as ALC on any given day (CIHI 2010b). On average, one ALC patient occupying a bed in the emergency department denies access to four patients per hour to that emergency department (Canadian Association of Emergency Physicians 2005).

We also know that waiting in hospital for post-acute care prolongs patients’ exposure to an environment that experiences thousands of avoidable adverse events each year (Baker et al. 2004). Moreover, delays in discharges, particularly for frail geriatric patients, can lead to rapid deterioration in health, eventually requiring additional acute care or necessitating premature admission to long-term care (Canadian Healthcare Association 2009).

The Build More Option

An obvious solution to improving access to hospital beds is to expand acute care capacity. The additional beds would allow a greater number of admissions from the emergency department or for surgery. Optimistically, increasing capacity would improve access to acute care and shorten elective surgery wait times.

The reality is that a “build more” approach is a temporary, and costly, fix. Without addressing the underlying problem of safely transitioning patients to post-acute care in a timely manner, this approach could lead to more beds being occupied by ALC patients, exacerbating the current problem.

Can the build more option be redefined?

Expanding post-acute care capacity is another “build more” solution. Under this option, provincial governments would further increase healthcare spending by expanding post-acute care capacity (in its current form, with a mix of public and private providers). The obvious benefit of this policy option is that current ALC patients could be discharged to post-acute care, vacating hospital beds and facilitating more hospital admissions.

Like building more hospital beds, this option also faces considerable challenges. First, to expand post-acute care capacity effectively, policy makers would be required simultaneously to identify the post-acute care type currently in the most need (i.e., the care needs of current ALC patients) without over- or under-investing for the needs of future ALC patients.

Further challenges to this option include the lack of strong clinical evidence supporting the appropriateness of post-acute care. Recent research in the United States demonstrates how funding policies, not necessarily the care needs of patients, alter the type of post-acute care a patient receives, and clear clinical guidelines for post-acute care settings are often lacking (Buntin et al. 2009).

The reality is that healthcare budgets are under considerable strain, and “build more” options would be less unpalatable if capital funds were easily available. However, in this environment of restraint, expanding acute or post-acute capacity is an expensive experiment with no guarantee of success.

The Integrated Care Option

The prevalence of ALC patients is another indicator of the need for more integrated care, as closer relationships between acute and post-acute care providers have been posited as a way to improve the efficiency and effectiveness of healthcare resource use (Ham et al. 2011; Vedel et al. 2011) and reduce failures of transitional care between settings. Integrated healthcare delivery may produce pressures to minimize the number of ALC patients, because integrated models can have either the administrative authority or the financial incentives (or both) to ensure that patients are treated at the lowest-cost provider appropriate for their condition (Robertson et al. 2004).

Integrating care across provider types was one of the motivations behind the regionalization of many provincial healthcare systems (Hurley 2004). To date, however, regionalization has fallen well short of this goal. Regional authorities have failed to promote clinical guidelines to coordinate care across settings, invest in integrated information technology systems, address unwarranted variations in the utilization of healthcare services, leverage non-physician healthcare professionals, or disseminate efficient and efficacious technologies, all of which are factors that impair the integration of healthcare providers (Leatt et al. 2000). Or, the regional authorities have been unable to resolve policy conflicts among providers beyond their control, such as physicians (Simpson 2011).

Barriers to the integrated care option

Cited examples of effective integrated care models are largely based in the United States, such as the Kaiser Permanente and Geisinger Health systems. These systems are privately operated, often with salaried physicians, and have tightly networked their funding and delivery arms. The results from these systems are likely not generalizable to the Canadian setting, where physicians are remunerated by a third party (i.e., the province), are rewarded for how “much” they do, and whose costs are externalized from the effects of inefficient hospital care. In addition, many post-acute care providers are privately owned and do not share hospitals’ community-based mission. As well, the penetration of cross-continuum electronic medical records remains poor (McGrail et al. 2010).

One model from the United States that may be worth closer examination is the Program of All-inclusive Care for the Elderly (PACE). Under this program, organizations develop an integrated program of care for those 55 and older who have complex needs and where care is provided in the community, rather than in a nursing home. PACE providers receive a capitated monthly payment for each patient they care for; thus, they have a financial incentive to keep patients out of hospital. Evaluations of the PACE model have reported significant reductions in hospital utilization and improved quality of care (Beauchamp et al. 2008; Meret-Hanke 2011).

A project similar to PACE was piloted in Quebec, raising the prospect of integrated models of care in Canada (Béland et al. 2006). The SIPA (Services intégrés pour les personnes âgées en perte d’autonomie) project used a randomized control trial to evaluate the performance of community-based multidisciplinary teams integrated across health and social services compared to usual care. Costs of community-based services were higher for the integrated care group compared to the usual care group, but facility-based costs were lower, and the integrated care group experienced a 50% reduction in ALC occupancy.

While the PACE and SIPA programs offer a potential model for integrated care, there are several limitations to their broader implementation. First, the scope of these programs extends beyond healthcare into social services, assisting patients in finding work and affordable housing, and in navigating government programs. Second, both the PACE and SIPA programs have policies in place to align incentives of providers with integrated models of care. They both offer their participating providers a capitated payment on a per-patient basis, intended to cover the extra cost associated with integrated care models (e.g., developing care plans, communicating with other providers on patient care, following up with referrals).

The Financial Incentives Option

Creating financial incentives for improving the quantity, quality or effectiveness of healthcare is not the norm in Canadian provinces, as it is frequently associated with private, for-profit care. However, there is an abundance of evidence from other countries – including ones with strong, publicly funded healthcare systems, such as Australia, the United Kingdom, and many European countries – that healthcare institutions respond to financial incentives (Street and Maynard 2007).

Hospitals across Canada have historically been funded by way of a global budget (Sutherland 2011). A global budget is a single payment intended to fund all care over a given period, irrespective of the volume or type of care provided. Similarly, post-acute care tends to be funded through a global budget (though recent changes in Alberta and Ontario's long-term care sector are the exception), independent of hospital expenditures. Global budgets create incentives for cost controls, and the policy leaves the hospital or post-acute care providers at risk for changes in volume or complexity of patients.

Recently introduced activity-based funding initiatives targeting hospitals in British Columbia and Ontario are creating incentives for hospitals to "push" patients from acute care (because new admissions generate additional revenue). These incentives are expected to put increased pressure on limited post-acute care capacities as a result of hospitals' (presumed) increase in activity.

Similar financial incentives could be developed for post-acute care providers to admit waiting hospitalized patients and give these providers the ability to create capacity for ALC patients.

Barriers to the financial incentives option

Creating financial incentives for post-acute care may be a viable strategy that complements policies encouraging hospitals to increase the volume of care, and this approach targets the post-acute care needs of patients. British Columbia is already experimenting with financial incentives for community-based programs (BC Health Services Purchasing Organization 2011). But these policies necessitate careful surveillance of timely and reliable data on quality to ensure that patients are not discharged from hospitals too early or being cared for in an inappropriate setting. Such surveillance would require linking clinical practice guidelines to current patterns of care – something that is sorely lacking in post-acute care across the country (Buntin et al. 2009).

Introducing new funding policies for post-acute care would also have to include mechanisms to ensure that post-acute care providers were not "cream skimming," that is, admitting only those patients who are less costly (than the payment amount) to care for, or refusing admission to complex and costly patients. These problems can be avoided by risk-adjusting payments based on the clinical complexity or care needs of the patient.

Discussion

High ALC use is a significant barrier to effective use of costly hospital care – a problem that hospitals have largely failed to address over the past decade. The most cost-effective approaches to improving access to hospital beds involve using the bed capacity we have now in a more efficient manner. However, reducing ALC will increase the number of hospitalizations for the same number of beds, challenging fiscal constraints by freeing new bed capacity.

Reducing ALC will cost the healthcare system real money, whether it is done by building more capacity, integrating providers or developing financial incentives. System-level savings

will be realized only by re-tasking hospital beds as long-term care beds or closing a share of hospital beds and reallocating the funds to other sectors.

Yet, the risk of doing nothing is also expensive. Current activity-based funding policies' singular focus on hospitals, without commensurate changes in post-acute care, jeopardizes the viability of these policies by exacerbating pressures on bottlenecks in the system. We have discussed three policy options – building more, integrated care and financial incentives – that offer potential solutions. These are not intended to be presented as either/or options; given the complexity of the problem, a solution may well involve a combination of all three.

These three options address how policy makers might alleviate current ALC. However, this paper does not address the complementary issue of reducing "future" ALC (such as by expanding primary care, improving the continuity of care and reducing avoidable hospital admissions), a topic that requires further linkages between community and secondary care providers.

Improving access to hospital care and reducing wait times are important goals for many Canadians, yet our current methods for funding care may be inhibiting our ability to realize those goals. Hospitals and post-acute care providers are known to respond to financial incentives. Let's use this knowledge to explore whether financial incentives could improve access to hospital-based care and expand post-acute care in a way that responds to patients' medical and social needs.

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