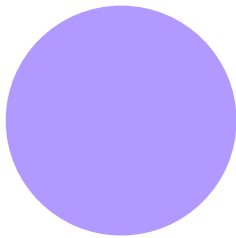




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## Briargate beds 'half empty'

As Kingston General Hospital continues to struggle with a full bed count, with 67 patients waiting placement in long-term or complex care facilities, 21 beds are empty at Briargate Retirement Living Centre.

Briargate was given the green light last year by the province to provide 38 interim long-term care beds, an effort to ease the situation at the city's only acute care hospital where almost two floors of people — many of them elderly — wait for a bed at a nursing home or complex care facility.

"We've been ready, willing and able since Nov. 20," to take the heat off KGH, says Mary Nestor, director of communications for Central Care Corporation, which manages Briargate. "We're half empty or half full, depending on how you look at it."

With only 50 per cent of the interim beds being used, "it's disappointing," Nestor admits. "The whole idea was to open up beds to serve the community." Briargate's 38 interim beds have yet to be filled. As of this week, about 17 people are in interim beds. There are, however, applications being processed.

"The picture could change in a week or two," Nestor adds. News of the available beds at Briargate was news to the CEO of Kingston General Hospital.

As for why the beds are cold, "good question," said Joe de Mora. "I'm happy to hear that there are some beds available," he said, "and hopefully we'll be able to get some of our ALC [alternate level of care] people to them."

Alternate level of care is a designation that applies to a patient who no longer needs acute care.

Last week, KGH warned ALC patients they could face a \$1,300/ day fee if they refuse to take a nursing home bed that isn't their first choice.

Not all ALC patients are waiting for a nursing home bed. Some are waiting for a spot at St. Mary's of the Lake Hospital for rehab, complex chronic care or palliative care. Some want to go back to their homes but need help from a visiting nurse or caregiver.

The Continuing Care Access Centre handles the placement of patients into long-term care beds and arranges nurse/caregiver in-home services. Placing patients is not a straightforward process, explains Joel Coté, CCAC manager of communications.

"You can't have male and female in the same room, some want private beds, some want semi-private," he explains. Plus, legislation dictates that patients do not have to go if they don't want.

Nestor can only speculate on the holdup, saying that some patients are reluctant to make that extra move to a temporary bed. Hospitals are not geared to provide long-term care, she says, adding that once people realize this and move to an interim bed, "there's an improvement on their quality of life."

de Mora says KGH staff continue to work with CCAC staff to make the transition for ALC patients. He estimates that of the 67 people in ALC beds, "about 50 per cent of them require long-term care."

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Lynn Rees Lambert  
Kingston This Week  
January 23, 2007



## Edmonton aims to screen all for diabetes

A new diabetes screening program in Edmonton goes further than any other in North America, effectively making diabetes a reportable disease.

Under the program, whenever someone in the city visits a doctor, hospital or walk-in clinic, their blood-sugar information is recorded in a central database. Edmonton's Capital Health Region plans to use the information to identify and treat anyone with diabetes or at risk for the disease. Left untreated or unmanaged, diabetes can have devastating results, such as blindness, loss of limbs, kidney failure and even death.

By 2010, the cost of treating diabetes in Canada is expected to rise to \$15.6 billion. The program's directors hope that the costs will be reduced dramatically through early screening and proper management. Blood test results showing high glucose levels would flag the risk for diabetes. Pharmacists, doctors and nurses would

encourage anyone who appeared to be at risk due to excess weight or inactivity to get the voluntary blood test.

Participants would also be offered the opportunity to enter a diabetes management program that includes diet and exercise advice.

Registered patients would be contacted every three months by their family doctor to ensure they are in good health. Those without family doctors would receive the same treatment from public health services.

"We're moving from this acute-care system of get sick, then we do something, then we wait until you get sick again, to a system where we are being really proactive and following up with patients," said Dr. Richard Lewanczuk, director of chronic disease management for the region.

*CBC.ca*



## QHC Belleville Approved for MRI

The approval of a Magnetic Resonance Imaging (MRI) machine at Quinte Health Care Belleville General will give Belleville-area residents increased access to better health care, Health and Long-Term Care Minister George Smitherman announced on December 22, 2006.

"A new MRI machine will make a significant difference for local residents who need faster diagnosis for a variety of needs," said Smitherman. "By making newer technology available at Quinte Health Care Belleville General, our government is helping patients access important health care services closer to home."

With the addition of a new MRI machine, the ministry estimates that Quinte Health Care Belleville General will be able to provide 4,160 MRI scans annually to its patients.

"A new MRI will go a long way to address patient needs in Belleville and the surrounding area," said Prince Edward-Hastings MPP Ernie Parsons. "We are providing local residents with faster access to better health services to keep them healthier, longer."

"This is welcome news for our community," said Agriculture Minister Leona Dombrowsky and MPP for Hastings-Frontenac-Lennox-Addington. "I know this new state-of-the-art equipment will help patients in this community get the quality health care they need in a more timely way."

The initiative is part of the government's plan for innovation in public health care, building a system that delivers on three priorities – keeping Ontarians healthy, reducing wait times and providing better access to doctors and nurses.

## Alternate Level of Care - the New Wait Time



Not too long ago, several health care board members, physician leaders and executives from Southeastern Ontario discussed the alternate level of care (ALC) issue with wait time czars Dr. Alan Hudson and Dr. Peter Glynn following a particularly prickly meeting in Belleville. Not wishing to restate the obvious, we expressed hope that the provincial government would hear the sound of the health care system straining under the ALC pressures in sentinel regions of the province like Northeastern, Champlain and Southeastern Ontario.

This does not mean that the placement of no-long-acute elderly patients is the only thing challenging our health care system. But the aforementioned hope was that the Ministry of Health and Long-Term Care (MOHLTC) would invest the same level of zeal and opportunity for creativity and innovation to the table.

Unfortunately, this has not yet been the case. Regretfully more regions in the province are beginning to experience the system capacity issues that have been part of daily operations in our hospitals for some time. This was predictable.

To allocate some credit, the MOHLTC did create an expert panel co-chaired by former assistant deputy minister Mary Kardos Burton and Champlain LHIN CEO Rob Cushman. The report – due to be released at the end of 2006 – has not yet been made public. Prior to that, local area planning committees were established under the aegis of the MOHLTC's Long Term Care Planning and Renewal Branch. This was the vehicle that allowed for the identification of 352 new long-term care beds across our region (albeit they will not be

operational until 2008-09). Surprisingly, the uptake on the request for proposals has not been as robust as expected.

As much as these beds are needed, in isolation they will not solve the issue. A comprehensive plan addressing the entire continuum of care from enhanced in-home personal support to supportive housing alternatives short of large long-term care facilities must also be considered. A quick scan of models suitable for potential adoption in our area could include:

- Capital Health's CHOICES program (Edmonton)
- Programs for All-inclusive care of the Elderly (PACE) such as the *On Lok* program (San Francisco) or the PACE CNY (Syracuse)
- Maimonides Geriatric Centre's accredited home and intermediate resource programs (Montreal)

Each was developed to provide long-term care to the frail elderly in non-acute care environments. Instead of depending on the approval of large long-term care facilities, these options were established to provide a more nimble and quality of life oriented response.

The province's initial positive response to the regional surgery service proposal demonstrates that it is prepared to consider innovation in Southeastern Ontario. These options are at least as equally worthy of our investigation and trial - and of provincial support.

## Ontario's e-Health Agenda Needs Focus

Ontario's Smart Systems for Health Agency, the group that has spent some \$458 million of taxpayers' money since its inception to put in e-Health systems, has serious problems. This is the conclusion of an operational review conducted by Deloitte Consulting that was recently released. The review was ordered by the health ministry following accountability and performance issues surrounding the agency that surfaced last year.

Deloitte's report says there is "nebulous understanding" of the agency's role which has mushroomed with the impetus behind the e-Health agenda. Its activities have ranged from setting data and technology standards, to establishing web portals such as OntarioMD, and building a secure email service. It has also been involved in the development of electronic health records (EHRs). However, Deloitte says the agency has achieved "little or no meaningful progress" on this front. Deloitte says the agency has suffered from a lack of direction from government, but the pending approval of an e-Health strategy will greatly help matters.

A copy of the complete report can be found at the following URL:

[http://www.health.gov.on.ca/english/public/pub/ministry\\_reports/ssha\\_06/ssha\\_oper\\_review.html](http://www.health.gov.on.ca/english/public/pub/ministry_reports/ssha_06/ssha_oper_review.html)

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### Meetings Attended by Managing Director - January 2007

<u>January 3</u> Regional Hospital Clinical Leaders	<u>January 16</u> Regional CEO Committee
<u>January 4</u> TEN DI-r/PACS Briefing Session	Incident Management Committee
<u>January 5</u> Regional Capacity Meeting (KGH)	<u>January 18</u> Healthline Initiative (SE CCAC)
<u>January 8</u> Southeastern Ontario Integration Project - Human Resources Team	<u>January 19</u> Liaison Committee
Southeastern Ontario Regional Infection Control Network	<u>January 22</u> OHA Region 2 AGM Conference Planning
<u>January 9</u> Information Technology & Communications Steering Committee	Rural Health Science Network Chronic Disease Management Initiative - Leadership Team
<u>January 10</u> Joint Regional CEO & Southeastern Ontario Integration Project Supply Chain Briefing Session	<u>January 25</u> PSFDH Leadership & Partnership Team
<u>January 11</u> Palliative Care Integration Project	<u>January 29</u> HCNSEO Board Meeting
<u>January 15</u> Joint Ontario Telemedicine Network/SE CCAC meeting	



Brockville General Hospital

