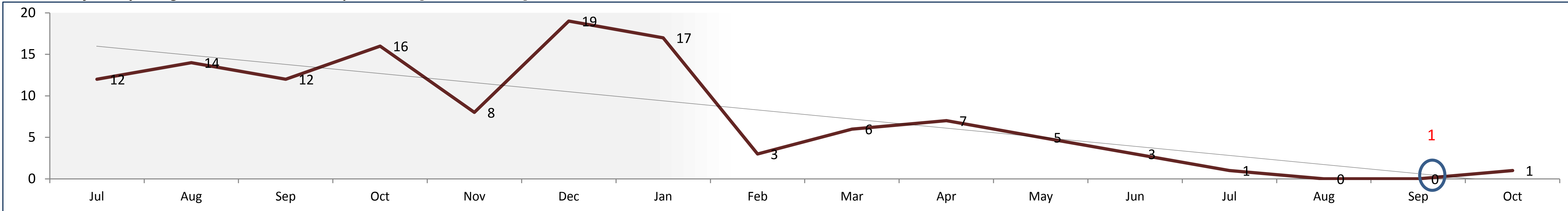
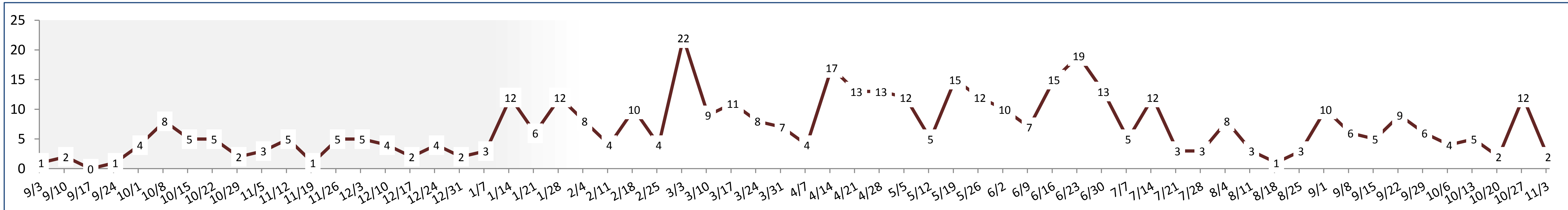
HOME FIRST MONTHLY PROGRESS REPORT- October 2012

Hospital and Community Implementation - St. Thomas Elgin General Hospital

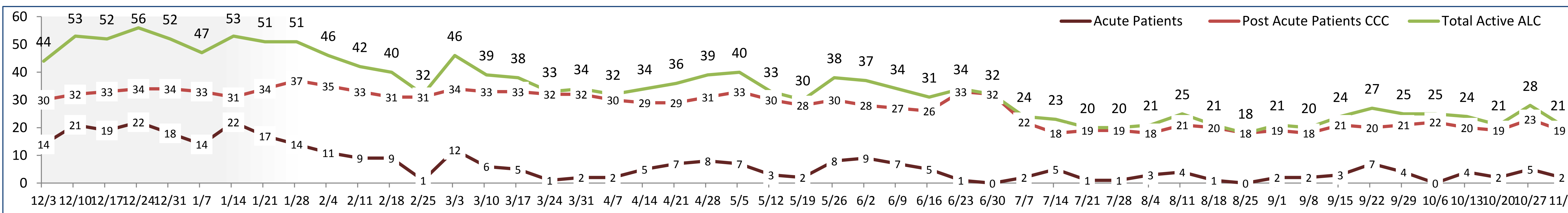
Number of Newly Designated ALC-LTC Patients per month [source STEGH]



Number of Newly Designated ALC Patients per week: All Categories [source IPORT STEGH]



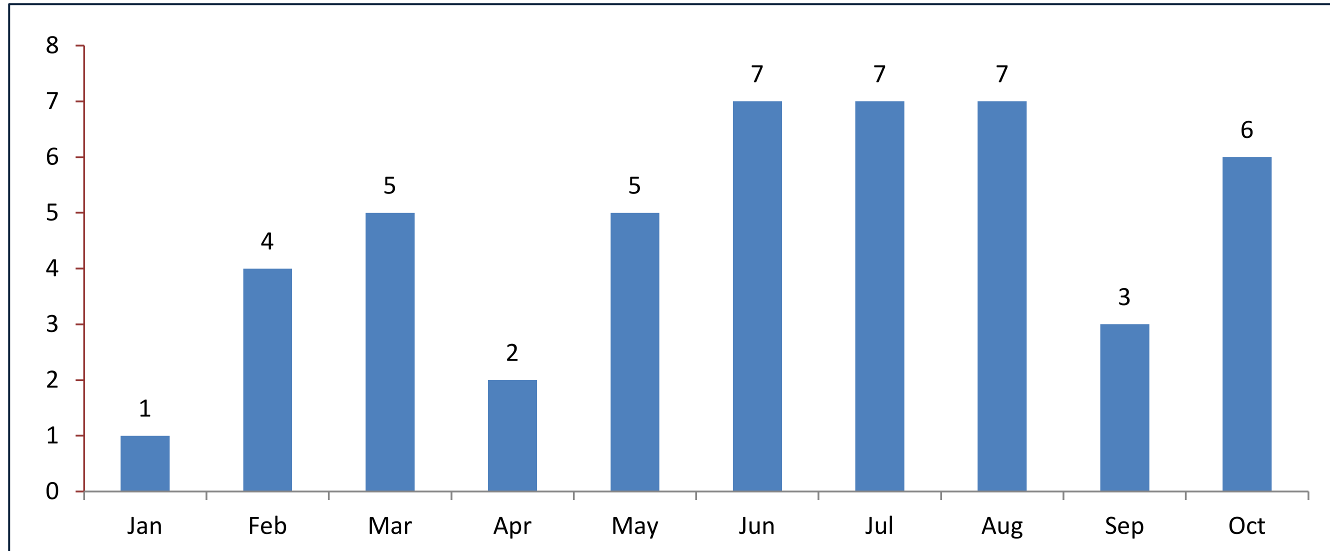
Total Number of Active ALC Designated Patients [source I PORT STEGH]



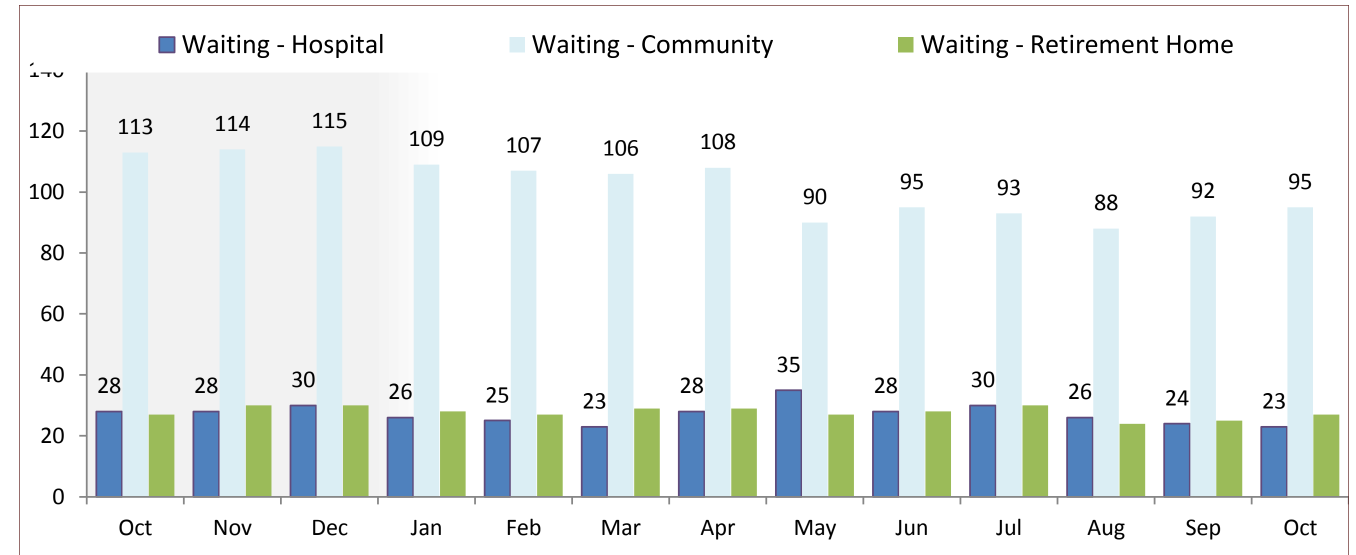
HOME FIRST MONTHLY PROGRESS REPORT- October 2012

Hospital and Community Implementation - St. Thomas Elgin General Hospital

Number of Clients Referred to Intensive Hospital to Home Plan [source SW CCAC] n=47

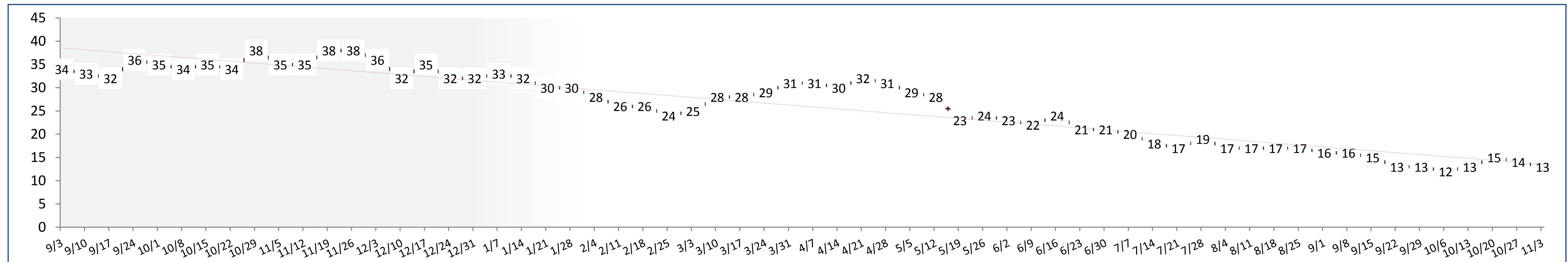


Number of LTC Clients Waiting - Elgin [source SW CCAC]



This graph reflects any client waiting with an open placement file based on clients' location as at the first of the month.

Total Number of ALC Clients Waiting for LTC [Source: SW CCAC]

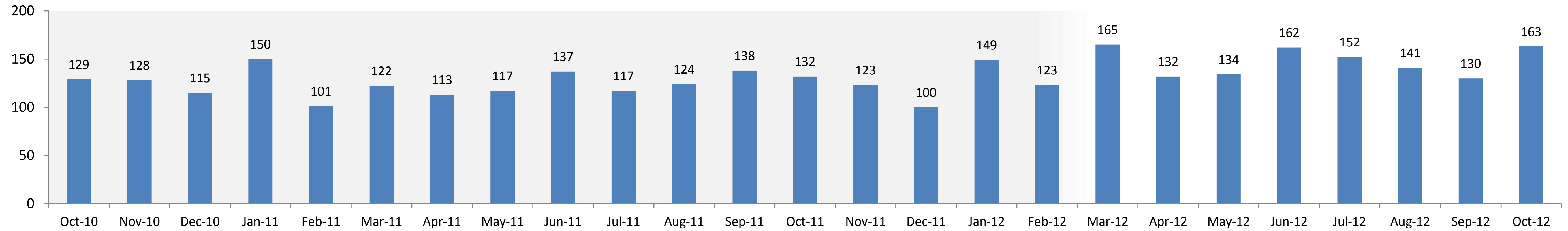


HOME FIRST MONTHLY PROGRESS REPORT- October 2012

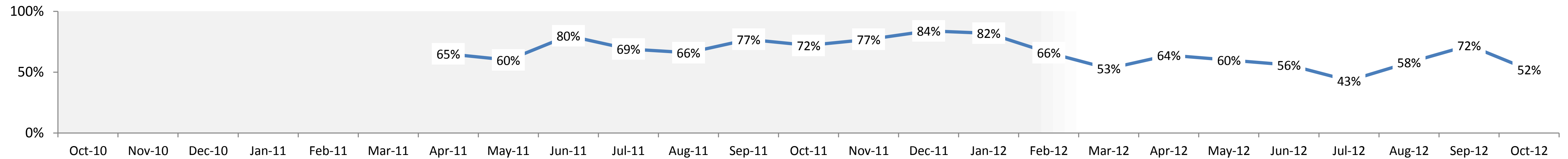
Hospital and Community Implementation - St. Thomas Elgin General Hospital

Number of Referrals from STEGH [source SW CCAC]

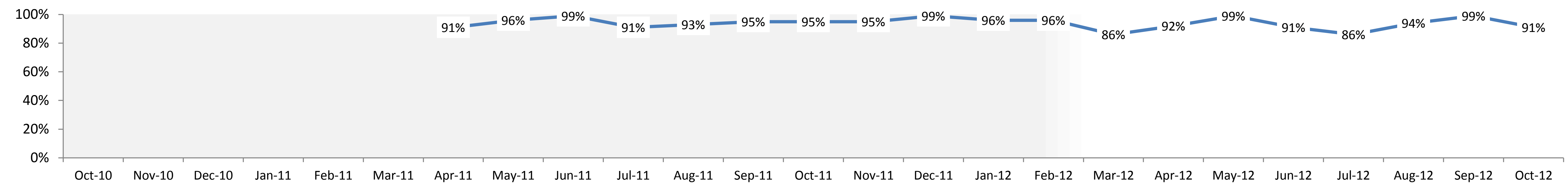
note: not distinct clients



Percentage Referrals on the Day of Discharge from Hospital [source SW CCAC]



Percentage of Clients Contacted Within 48 hours of the Referral by Hospital [source SW CCAC]



Executive Sponsors

- Sandra Coleman, CEO, SWCCAC
- Donna Ladouceur, Sr. Director, Client Services, SWCCAC
- Paul Collins, CEO, STEGH

Home First Leads

- Jennifer Fazakerley, Regional Client Services Manager, SWCCAC
- Jodi Edwards, RN, Manager AMU-4, STEGH
- Sandra McDonald, CSM, Home First Lead- Elgin, SWCCAC

Home First Governance Structure

LHIN steering committee meets monthly.

Project Implementation Team Structure

Home First Hospital Project Implementation Team STEGH :
focus on the process redesign and cultural shift related to Home First on the grounds of STEGH.

Home First Community Project Implementation Team- Elgin:
focus is on process redesign and cultural shift related to Home First as a patient is discharged from hospital to the community and is then supported in the community.

Communications Update

- Visit the link for the September Access To Care Approach eNewsletter: http://www.southwestlhin.on.ca/uploadedFiles/Public_Community/Current_Initiatives/Access_to_Care/ATC%20Newsletter%20Sept%202012.pdf
- Multiple ATC presentations have been made to community organizations and individuals.
- Access to Care Lead Sue McCutcheon will be meeting with municipal leaders around the region to profile all Access to Care initiatives
- Access to Care was discussed at the OMA South West LHIN Physician Engagement Sessions taking place from Late October to Mid November.
- Municipal Engagement activities are continuing and presentations to stakeholder organizations are ongoing.

Metrics Update

- We note a sustainment in the process for determining ALC-LTC. There was one patient added to the LTC waiting list this month after successful application of the ALC- LTC sign- off process.
- We continue to see higher referral rates on the day of discharge. This is confusing from a data perspective as most discharge planning referrals are being determined at the time of admission. We need to continue to break up this data to determine the accuracy and understand the data. Perhaps the e-referrals received for services on the day of discharge continue to skew this data.
- Total number of patients in waiting in STEGH for LTCH placement continues to decline.
- We are noting consistency developing in the number of clients admitted onto the Intensive Hospital to Home service plan on a monthly basis. As you recall, in Sept there were 5 clients who were ready for discharge home on the Intensive Hospital to home plan, however, two transitioned directly to LTCH as they received a bed just prior to their discharge home.

IT Update

E-notification Update:
E-notification will notify hospital and CCAC of common clients. Hospital will receive notification in CERNER that patient being registered is current CCAC client. CCAC will receive notifications through CHRIS at three possible points: 1. when client has presented at ED, 2. when client has been discharged from ED, or 3. when client has been admitted to an inpatient unit. E-notification in the CERNER system will to go live in late November. and will be able to be utilized by CCAC and hospital staff within LHSC. CCAC teams are working internally to look at when to turn on the CHRIS elements of the system.
Next Steps:
CERNER side of e-notification will go live late November at LHSC, and this will benefit both hospital and CCAC staff . CHRIS side of enotification will proceed after internal workgroups have developed appropriate workflows, meetings set for early December. Preparation for implementation at STEGH will be based on the learnings of LHSC Go Live.

Complex Discharge Screening Tool and E-Referral to CCAC for Assessment
The application of the tool appears to more appropriate. Auditing continues to ensure compliance and accountability with results increasing.
Other units have begun to utilize the screening tool as well and we are auditing for compliance on these units.
E-Referral for Specific CCAC Services Update:
E-Referral for specific CCAC services at STEGH continues to be used well throughout the organization.

Hospital Updates

Highlights:

- Work continues on testing the ALC designation process (including a sign off process)to ensure all options for discharge are exhausted before client is designated ALC-LTC. An escalation process has been developed and continues to be trailed along with ALC-LTC sign -off document.
- Roll out of accountabilities to unit managers began in October..
- Hospital implementation meetings as well as co-lead meetings will now be monthly

- **Next Steps:**
- continue to focus on Sustainability
- develop implementation plan for ED notification

Patient / Client Updates

Summary:

- The Client Characteristics Dashboard (see Dashboard Tab) is attached. This tab gives a breakdown of several client demographics including age, living arrangement, MAPLe score. This dashboard also has a breakdown of readmission data, both ED visits and hospital readmissions, and a breakdown of client destinations post-discharge from Intensive Hospital to Home.
- As of October 31, we have supported 47 patients on the Intensive Hospital to Home Service Plan when coming out of STEGH.
- Clients continue to thrive in there own home, and not occupy acute care hospital beds waiting for Long Term Care placement!

Community Updates

Highlights:

- Community Implementation team meetings continue monthly to address processes changes and issues that arise as we spread to Middlesex, Elgin , and Oxford counties and the city of Owen Sound in Grey Bruce
- **Next Steps**
- Evaluate ongoing client profile of clients going home from hospital with Intensive Hospital to Home as this population is becoming increasingly complex.
- Develop strategies for maximizing community services sector support for complex clients in the community
- Continue to monitor hospital readmission data, and eventual destination of clients who "graduate" from Intensive hospital to Home.
- Monitor volumes of Intensive Hospital to Home clients.

Hospital Implementation Team

Jodi Edwards, Home First Lead, STEGH
Sandra McDonald, Home First Lead-Elgin, SW CCAC,
Jennifer Fazakerley, Home First Lead, SW CCAC
Sherry Fletcher, Regional Client Services Manager, SW CCAC
Laurie Browne, Case Manager, SW CCAC
Suzen Cornell, Case Manager, SW CCAC
Kathy Court, Occupational Therapy STEGH
Mike Lalonde, Physiotherapy STEGH
Kathy Kinsella, Social Work STEGH
Brenda Emre, Nurse, ED, STEGH
Nancy Berman, Nurse Clinician STEGH
Lisa Martens, Social Work STEGH
Lori Clifton, STEGH
Jen Hilt, RN Clinical Informatics Specialist STEGH
Cathy Fox, Communications, STEGH

Staff Quotes- 'The Cultural Shift Sustained'

Home First gives the patient the opportunity to go home to their natural environment with the supports that they require to keep them safe in a timely manner.
Christine Thompson STEGH Manager AMU- 5th

Community Implementation Team

Jennifer Fazakerley, Home First Lead, SW CCAC
Sherry Fletcher, Regional Client Services Manager, SW CCAC
Sandra McDonald, Home First Lead- Elgin SWCCAC
Barb Modesto, Client Services Manager SWCCAC
Anita Cole, Regional Client Services Manager, SWCCAC
Nupee Hardeep Sandra, Regional Quality Manager, SW CCAC
Diane Dodge, Intensive Case Manager, SW CCAC
Yvonne Either, Client Service Manager CTG
Jennifer Jackson, Client Services Manager, SW CCAC
David Heaton , Closing the Gap
Kim Irwin, Business Intelligence, SW CCAC
Tracy Matheson, St. Elizabeth Health Care
Jean Bennett, St. Elizabeth Health Care
Eileen Cunningham, St. Elizabeth Health Care
Maureen White, St. Elizabeth Health Care

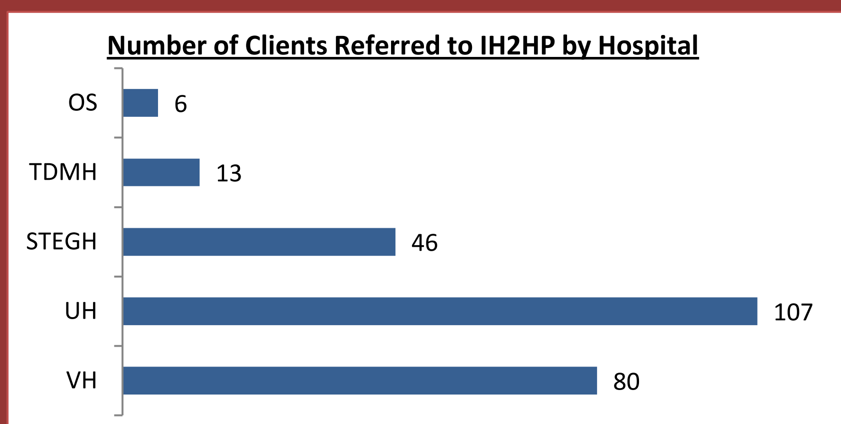
Intensive Hospital to Home Plan Monthly Dashboard October 2012

from all Hospital Locations *data caputred on 6 November for the month of October*

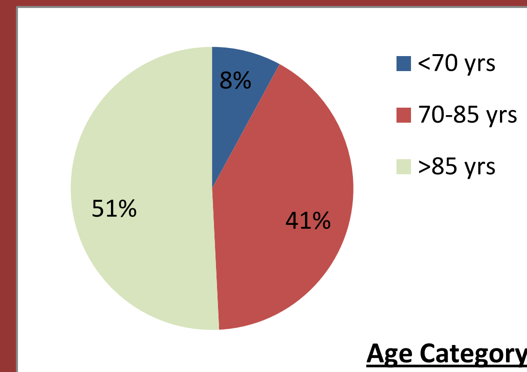
Total Potential Referred	Current Active Potential	Discharged Potential
280	5	275

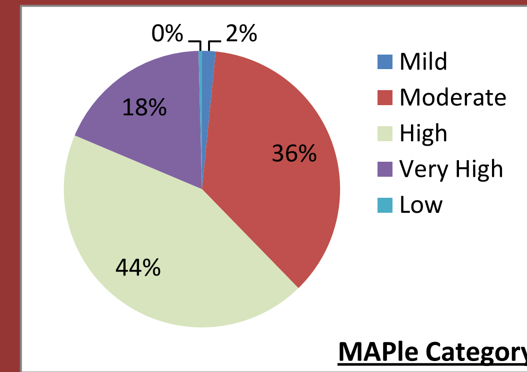
Total IH2HP Referred	Current Active IH2HP	Discharged IH2HP
252	42	210

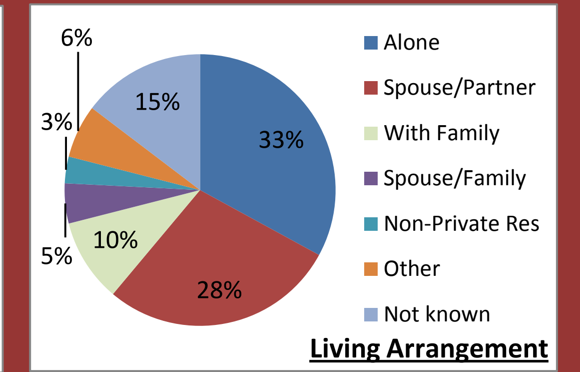
Mean LOS on IH2HP Plan	Median LOS on IH2HP Plan
20.8	27.0



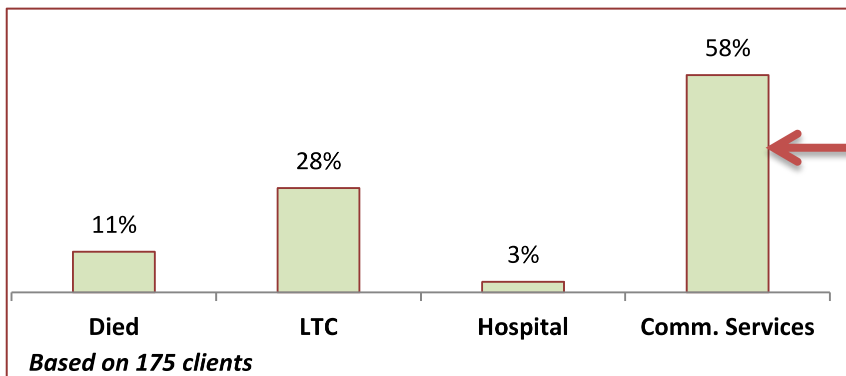
Client Characteristics - when referred to IH2HP







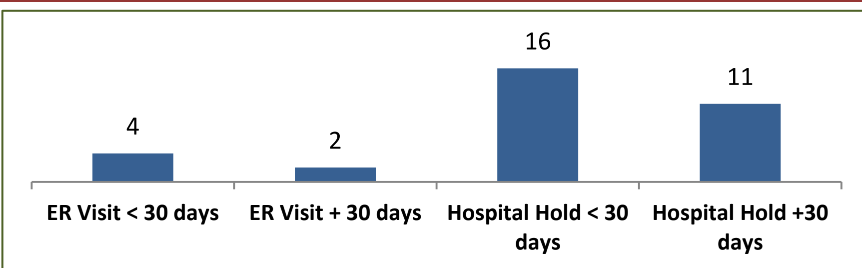
Clients Discharged from IH2HP - Discharge Dispositions



Community Service Clients could be CCAC, ADP, AL/SH, SDL and/or other Community Services Sector programs.

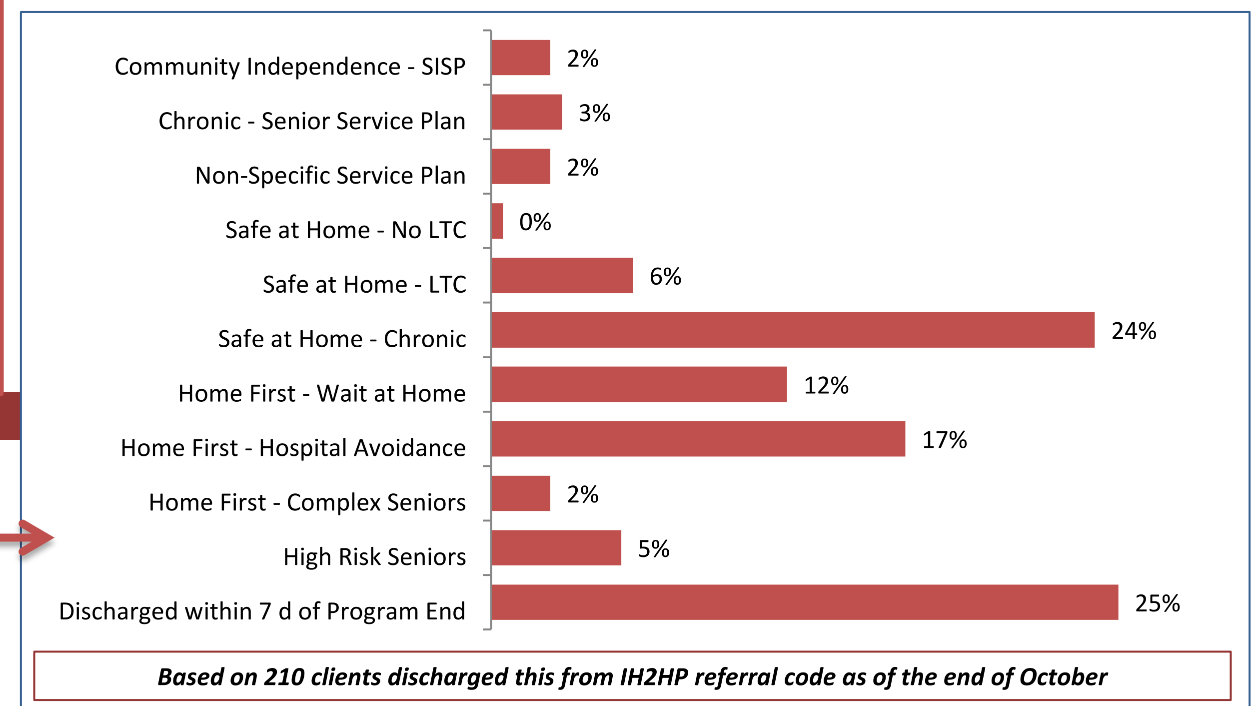
40% (83 of 210 clients) had an ADP visit authorzation and/or Supportive Housing Service after Discharge from plan.

Clients Discharged From IH2HP - Re-admission to Hospital



The Community clients still on CCAC service have been categorized according to their Service profiles.

After Discharge Service Profiles - of all clients discharged from IH2HP



Based on 210 clients discharged this from IH2HP referral code as of the end of October

Created by Krista McMullen, Data Analyst, SW CCAC Business Intelligence

Intensive Hospital to Home Plan Monthly Dashboard - descriptions / definitions

Total potential is all the clients who have an active or inactive IH2HP Potential Client referral code.

Current **Active Potential** is all clients who have an active IH2HP Potential Client referral code.

Discharged Potential is all clients who have an inactive IH2HP Potential Client referral code.

Total IH2HP is all the clients who have an active or inactive IH2HP referral code.

Current Active IH2HP is all clients who have an active IH2HP referral code.

Discharged IH2HP is all clients who have an inactive IH2HP referral code.

The **Mean Length of Stay** is the mean number of days between the IH2HP referral start date and the IH2HP referral end date.

The **Median Length of Stay** is the mid point between the highest and lowest number of days between the IH2HP referral start date and the IH2HP referral end date.

Number of Clients referred by hospital location is the total number referred to the IH2HP Plan based on Referring Hospital location.

MAPle of all clients referred to the IH2HP Plan as of the start date of the referral.

Living Arrangement of all clients referred to the IH2HP Plan as of the start date of the referral.

Age Category of all clients referred to the IH2HP Plan as of the start date of the referral.

Readmission - Discharged Clients, mutually exclusive first instance of either a hold or ER referral code; having a hold before 30 days or after 30 days of discharge from IH2HP; displaying an ER referral code 30 days before or after discharge. Please note: this captures only CHRIS clients where readmission data has been entered.

Destination / Dispositions - Based on clients discharged from the IH2HP Plan, the discharge disposition; not mutually exclusive as one client could be in multiple categories.

After Discharge Service Profiles - active clients that have been discharged from IH2HP referral code - based on program analysis logic - mutually exclusive. In order to appropriately categorize clients into Service Profiles, the logic follows a specific order of operations. If the client does not meet the criteria for the first category, the logic is designed to automatically review the clients using the next operation until a match is found. The category order is: 1) Home First – IH2HP; 2) Peritoneal Dialysis; 3) Home First – Wait at Home; 4) eShift; 5) Safe at Home – LTC; 6) Home First – High Risk Seniors; 7) High Risk Seniors; 8) Safe at Home – no LTC; 9) Hip and Knee; 10) Home First – Hospital Avoidance; and, 17) Safe at home – Chronic. The categories used in this report are defined as follows:

Home First - Hospital Avoidance - referred from a Hospital or as a result of Hospital Hold. Greater than the average 1 hr./d Combined Homemaking following Admit / Hold End date. Within 28 days following Admits / Hold End Date. Not meeting the criteria for other service profiles.

Home First - Wait at Home - clients with an Active placement with a 1 or 1A crisis priority. Not meeting the criteria for other service profiles.

Home First - Complex Seniors - Clients with a RAI score > 16, over the age of 65, with an SRC of 93,94,95 and a MAPle of Very High. Not meeting the criteria for other service profiles.

Safe at Home - Chronic - Clients with a RAI score 11-16 and an SRC of 93,94,95. Not meeting the criteria for other service profiles.

Safe at Home - LTC - Clients with a RAI > 16, with an SRC of 93,94,95 and an Active LTC Referral. Not meeting the criteria for other service profiles.