Access to Care | Right Care | Right Time | Right Place

Home First

"The way I looked at it, if I had a chance to come home and be with my family, I'd take it and enjoy whatever time I had." - Faye

HOME FIRST

When a patient enters the hospital with an acute episode, every effort is made to ensure adequate resources are in place to support the patient to return home on discharge.

ACCESS TO CARE

Access to Care is an approach focused on supporting people, specifically seniors and adults with complex needs, in their homes for as long as possible, with community supports.

ACCESS TO CARE LEADERSHIP

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Julie Gilvesy, Senior Executive Leader/Chief Nursing Executive, Tillsonburg District Memorial Hospital

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Access to Care in the South West

Access to Care in the South West is a unique initiative that is changing many facets of the health care system to support seniors and adults with complex needs in their homes for as long as possible. Home First as a philosophy is one of those changes. Others are Coordinated Access to Assisted Living, Supportive Housing, Adult Day Programs, Complex Continuing Care, Rehabilitation and realignment of resources across the South West to improve access to services. Executive sponsors from the South West LHIN and CCAC are true champions of change and along with the patients and their families, are the inspiration to make courageous decisions.

Access to Care has a structural oversight that includes a Core Operations group that makes and supports key decisions that require broad input and support. There are Steering Committees for each of the change initiatives; Assisted Living/Supportive Housing/Adult Day Programs, Complex Continuing Care/Rehabilitation, and Home First. The teams that are leading the change on site with patients and families are co-lead by staff skilled in change management as well as having experience in one or more of the sectors involved in the change. For example, Home First is co-led at each hospital by a hospital and CCAC leader. This has been identified as a key indicator of success for Home First.

Principles of Home First Implementation

In the South West, Home First has been grounded and successfully implemented based on four key principles:

1. Identifying patients at risk
2. Promoting home as the primary discharge destination
3. In general, LTCH applications are not completed in hospital
4. Strengthening the basket of services in the community

These principles are anchored in the work done provincially to launch Home First. Home First implementation teams in both hospital and community were essential in developing the various tools and strategies outlined below. Over the course of the last year and a half since implementation, tools and strategies have been tested, evaluated and improved. The tools and strategies outlined below under each of these four key principles have been developed in partnership between the CCAC, Hospital, and community partners.

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Ontario
South West Local Health Integration Network
Réseau local d'intégration des services de santé du Sud-Ouest

Connecting you with care
Votre lien aux soins
South West CCAC Community Care Access Centre
CASC Centre d'accès aux soins communautaires du Sud-Ouest

Home First

Identifying Patients at Risk

There is a subset of individuals, who enter hospital for an acute care episode that are at risk of having a complex discharge, and are therefore at risk of staying in hospital and becoming ALC. Identifying patients at risk ensures earlier discussions between health care team members, CCAC, clients and their family to ensure that everyone is working together to facilitate a return home with appropriate supports once acute care is no longer required.

After returning home from hospital, Bernice is happy to be able to make her own decisions about her care.

The process for identifying these patients is now supported through the use of the **Complex Discharge Screening Tool** that has been developed for use within the South West. The Complex Discharge Screening Tool was developed based on a comprehensive review of several screening tools currently in use across the province used to identify clients at risk of complex discharge. In almost all other Home First implementations across the province, some form of a screening tool is used. In the South West, the tool is administered by hospital staff at the time of admission to hospital, and if positive, generates an automatic electronic referral for a CCAC Assessment. Extensive analysis of the tool and validation of the accuracy of the results have been completed to ensure it is appropriately identifying complex clients.

Multidisciplinary communication at daily bullet rounds and use of associated visual cues such as white boards which identify complex clients have also proven to be valuable tools to support this process. Completion of the screening tool continues to be tracked to ensure compliance. Identification of complex clients and response time metrics including the percentage of referrals on day of discharge from Hospital, and percentage of clients contacted within 2 days of referral are reviewed monthly to ensure early involvement of team to facilitate discharge planning and monitor the impact of the process change.

Home First eEnablers

E-Health Enablers have been developed primarily to assist in identifying patients at risk of a complex discharge early on in their hospitalization.

E-Notification for common clients between CCAC and Hospital

E-notification is a system of care integration between the hospital CERNER system and the CCAC CHRIS system. When a person enters hospital and registers using their health card, identifying information will be sent from the hospital to the CCAC to determine if the person is a current CCAC client. If they are, this information is provided to hospital, and their hospitalization status is provided to the CCAC. This means that hospital staff will accurately know if a patient is receiving CCAC services in the community, and the CCAC will know that one of their clients has been to hospital.

Complex Discharge Screening Tool

When a patient screens positively, it is likely that they are at risk of having a complex discharge requiring extensive discharge planning, family conferences, and extensive CCAC and community services will be needed to facilitate a discharge. Some individuals that screen positively are at risk of requiring alternate living supports, such as Long-Term Care. Processes have been developed related to the screening tool results including prioritization of allied health and CCAC assessments, and results are integrated with current bullet rounds and white board practices used in discharge planning. The electronic tool is completed by hospital nursing staff at the time of admission to hospital.

E-referral from Hospital to CCAC

A positive screen generates an automatic e-referral to CCAC, and the CCAC becomes involved in the patients care and planning very early on in their hospital admission.

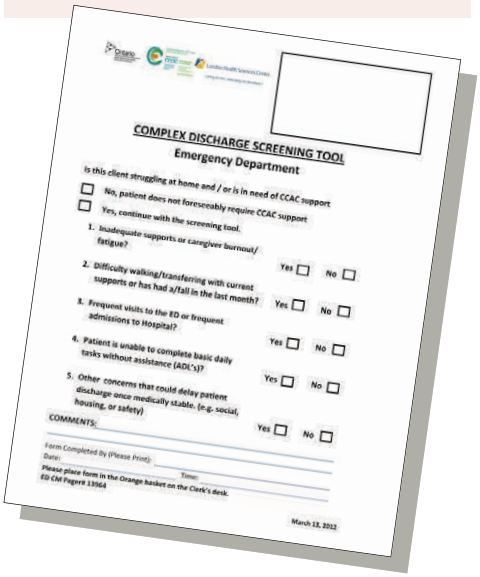
Complex Care Coordination

When clients with complex needs are discharged home from hospital, they require a high level of care coordination which is provided through CCAC Complex Care Coordinators.

To ensure that Complex Care Coordinators have the ability to address the needs of these clients, provincial guidelines are in place to limit Complex Care Coordinators' caseload sizes, and to increase the number of home visits and assessments the client receives.

Complex Care Coordinators work closely with the clients' and their community and primary care teams to connect clients with the most appropriate community resources to support continued recovery in their homes.

As clients are recovering in their homes, Complex Care Coordinators will help clients to determine what services they will require in the future, (ex. long-term care, assisted living, supportive housing, adult day programs etc.) and will support their transitions to the most appropriate services and/or location.



COMPLEX DISCHARGE SCREENING TOOL
Emergency Department

Is this client struggling at home and / or is in need of CCAC support

☐ No, patient does not foreseeably require CCAC support
☐ Yes, continue with the screening tool

1. Inadequate supports or caregiver burnout/ fatigue? Yes ☐ No ☐
2. Difficulty walking/transferring with current supports or has had a/fall in the last month? Yes ☐ No ☐
3. Frequent visits to the ED or frequent admissions to Hospital? Yes ☐ No ☐
4. Patient is unable to complete basic daily tasks without assistance (ADL's)? Yes ☐ No ☐
5. Other concerns that could delay patient discharge once medically stable. (e.g. social, housing, or safety) Yes ☐ No ☐

COMMENTS:

Form Completed By (Please Print):
Date: Time:
Please place form in the Orange basket on the Clerk's desk
ED CM Pagers 13064

March 13, 2012

"As Clinical Leader, I have seen a change in discussions during daily bullet rounds. The interdisciplinary team is embracing 'the possible,' especially when it comes to complex discharges. The team is talking about Home First instead of Long Term Care and identifying what can be done to get the patient strong enough for a safe discharge sooner than we used to. Confidence is building within the teams seeing what can be accomplished for best outcomes for our patients."
-Sharon Wojtkowiak, Clinical Leader, Tillsonburg District Memorial Hospital

Home First

Promoting Home as the Primary Discharge Destination

STEGH Home First Team, promoting Home First among their colleagues.

Promoting home as the primary discharge destination involves collaboration and communication between Physicians, Hospital and CCAC staff and requires a number of process and behavior changes in post-hospital care planning to ensure everyone is working together to deliver the message of 'Home First'. Facilitating change in culture and behaviour involves early and frequent communication.

A repository of Home First power point presentations have been developed by Implementation teams, tailored to specific target audiences and stakeholders including Physicians, Nursing, Allied Health, CCAC , Hospital Boards and advisory committees. Presentations have provided opportunities to educate, reinforce key Home First messages, answer questions and also provide a forum to report on Home First implementation and progress.

Home First fact sheets for staff designed to educate both hospital and CCAC staff have proven to be effective tools and have been disseminated via Intranet, pay stubs, and email.

Patient education is also vital to promoting home as primary discharge destination. Home First Patient fact sheets highlighting the benefits of Home First, what clients can expect and how Home First works have been developed and used in a variety of ways: posters, handouts, patient guides to educate patients and their caregivers. Community and staff newsletters have also been published to share Home First information and profile patients and their stories as they transition from hospital to home (E.g. STEGH's community newsletter, CCAC's Community paper insert, CCAC's primary Care Bulletin).

To monitor the change in practice of promoting home as the primary discharge destination, the number of new ALC-LTC designations are reviewed on a weekly basis to monitor the impact of this change. As well, a review of CCAC Care Coordinators, Allied health and Physician documentation can also be used as evidence of the cultural shift in behavior and the adoption of the Home First philosophy.

Home First supports the principle that life changing decisions, (ie: moving to a Long Term Care Home), are better made at home. Implementation of this approach has resulted in a process change that has shifted the completion of many LTCH applications to the community. The Home First approach supports the practice that generally, application for LTCH's will not be started in Hospital for patients who are identified for discharge home with supports. To track this change in practice, new ALC- LTC designations are monitored. As well, in some sites, new processes have been developed and tested to ensure that all discharge options have explored and ensuring 'Home First' is promoted as the primary discharge destination.


In the months leading up to Mr. M's death, his wife and family valued the time he was able to remain in his home.

Mr. and Mrs. M were able to make difficult decisions from the comfort and stability of their own home, with support from family, friends and their care team.

Strengthening Services in the Community

Strengthening the basket of services in the community to support safe transition planning is critical to Home First implementation. The CCAC has improved capacity to care for high-needs clients in the community. Along with other robust service plans, the CCAC has developed a new level of intensive service plan to support appropriate complex seniors and adults to go home from hospital: The Intensive Hospital to Home Service Plan, a "bridge" plan designed to stabilize clients for 2-4 weeks in the home providing them the opportunity to return to familiar surroundings, and stabilize at home prior to making life changing decisions around future living arrangements.

Pre-Discharge care conferences are critical to ensuring smooth transitions home, and involve multidisciplinary hospital teams, community care providers and clients/families. The pre-discharge care conferences are supported with a host of tools *The Complex Client Case Conference Template, My Health Management plan to be Safe at Home*, *Teleconference checklist*, *Intensive Hospital to Home Service plans* that have been developed and are used by Care Coordinators to support safe transitional care planning for these complex clients.

Once home, complex clients are supported by a CCAC Intensive Care Coordinator in the community. Intensive Care Coordinators have smaller caseload sizes, are able to conduct frequent home visits, and will contact the complex client within 24-48 hours of discharge from hospital; all key success factors to a successful transition home from hospital. Hospital Care Coordinators are creative and work along with the client/family to "right size" the service plan to fit the client need. With a focus on returning the client home after their acute care episode, they ensure safe transition planning from hospital to home and utilize robust CCAC service plans, Community Support Services, family and informal community supports.

In addition to pre-discharge care conferences, weekly debriefing teleconferences attended by hospital and community teams (including hospital staff, CCAC staff, and Service provider staff) are conducted as part of each home first implementation. During these debriefing teleconferences, clients who have been discharged the previous week on an Intensive Hospital to Home service plan or other complex clients supported on robust service plans are discussed. This debrief teleconference provides opportunities to review processes in order to improve transitions for clients, share client progress and build relationships and trust between stakeholders.

Home First

Home First Impact for Clients

Moira's Experience - Soon after she was admitted to London Health Sciences Centre, Moira was identified by the medical staff as a Home First candidate. The hospital team and the CCAC worked with Moira to develop a discharge plan that would prepare her to return home before making any decisions about her future health care needs.
When Moira arrived home, her CCAC Care Coordinator had her care plan in place with 24 hour a day care consisting of nursing, personal support worker, occupational therapist and nurse practitioner care, and all the appropriate equipment (ie: a hospital bed) to support Moira. During the first few weeks, Moira and her team worked together to fine tune the right mix of services to best meet her needs, gradually decreasing services as Moira's health improved.

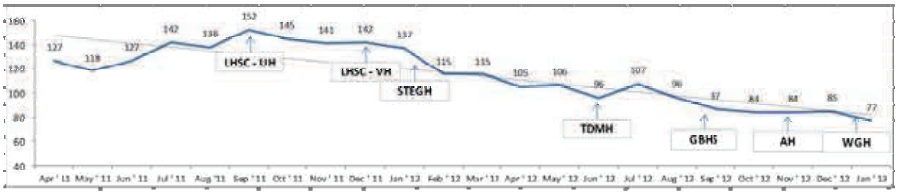
Today, Moira is still home with Larry and their dog Sandy. The Beaune's have realized that long-term care is not necessary right now, but that they do need additional support to remain independent. "Supports for Daily Living" provided by Cheshire, (a Community Support Service Agency) is an ideal fit for Moira's current lifestyle and health care needs. Through this program, Moira is able to direct her own care, through scheduled attendant services to meet her predictable and unpredictable needs.

"Being at home with my husband, and all the things that are familiar to me, well, it makes all the difference."

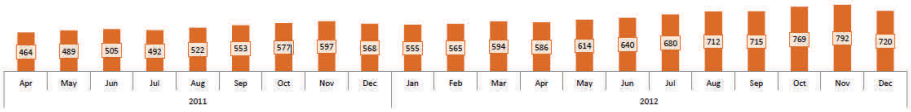
Moira Beaune, Client with CCAC Intensive Care Coordinator, Margaret Callaghan

Home First Results

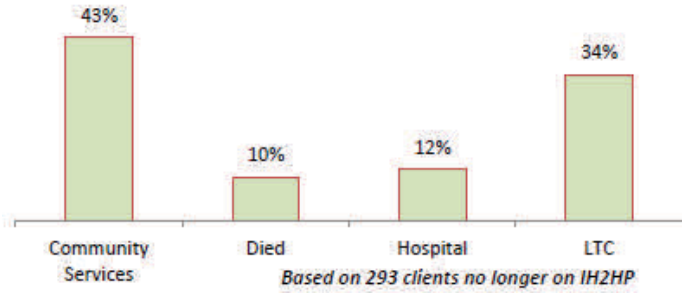
There are less people waiting in hospital for Long-Term Care.



There are more people in the community on robust "CCAC" Home First plans.



Clients, who would have previously waiting for Long-Term care in hospital, when supported at home, with intensive CCAC supports, stay home.



Additional Indicators

- There is a significant increase in the number of clients with complex needs who require support in the community.
- 40% increase in referrals to Adult Day Programs
- Long-Term Care homes are receiving applications from higher acuity patients.
- Hospital and CCAC employees report job satisfaction with the focus of giving frail, elderly patients/clients the opportunity to return home.

Home First Timeline and Co-leads

July 2011
Jennifer Fazakerley
Regional Client Services Manager

September 2011
Sherri Lawson
Director, Medicine
Natalie Berkiw
Project Lead

January 2012
Jodi Edwards
RN, Manager AMU-4
Sandra McDonald

July 2012
Kelly Verhoeve
Executive Leader
Patient Services

August 2012
Elaine Burns
Senior Director, Rural Health & Chronic Disease Management
Carla Crowther, Client Services Manager, CCAC

December 2012
Kathy Ellis
Resource Nurse
Inpatient Services
Lisa Gardner,
Director of Patient Services/Chief Nursing Officer

January 2013
Andrea McPherson
Patient Flow Coordinator