South West HOME FIRST FACT SHEET

What is *Home First*?

A new way of providing patient/client care. The central idea is that when a person enters the hospital, hospital and CCAC staff members, family members and others work together to get him or her home upon discharge, if at all possible. Research has shown that this is the best way to manage transitions from hospital.

Home First is central to the South West's Access to Care initiative. It's about providing the right care at the right time in the right place. It's about ensuring that our hospitals and long-term care homes are there for those who need them most. It's about everyone involved in care asking, "What can I do to help this person get home?"

What will *Home First* look like in the South West?

Initially the project involves London Health Sciences Centre (University Hospital followed by Victoria Hospital), the South West Community Care Access Centre (CCAC), community partners, and the South West Local Health Integration Network (LHIN). Over time, this approach will be rolled out across all hospitals in the South West.

What are the benefits of *Home First*?

For patients and clients, *Home First*:

- Empowers them to participate in their care.
- Gets them home sooner, minimizing the risk of hospital-acquired infection and functional decline.
- Enables them to live safely and comfortable at home for as long as possible.
- Enables them to make life-changing decisions, such as a move to long-term care, from their own homes.

For hospitals, the CCAC and the local health system, *Home First*:

- Improves the effectiveness of discharge planning.
- Reduces the number of Alternate Level of Care patients.
- Shortens Emergency Department length of stay.
- Provides better access to hospital and long-term care for those who really need it.

How will South West *Home First* work?

- Dedicated CCAC case managers will work with hospital staff to identify high-needs patients and assess them soon after admission to hospital for discharge home, before long-term care or ALC or any other options are discussed. Patients and their families will be partners in the process.
- Hospital staff and physicians will promote home as the primary discharge destination. Generally, applications for long-term care will not be completed in hospital.
- The CCAC will have more capacity to care for high-needs patients in the community, through intensive case management and enhanced service plans.
- Community support services, mental health and addiction services, and primary care will help ensure that high-needs patients are well served in the community.
- All stakeholders will measure performance and evaluate success.
- Other Access to Care initiatives will involve changes to the way assistive living, supportive housing, adult day programs, complex continuing care, and rehabilitation services are made available across the South West, helping support people in the community.

For more information, contact the Project Leads:

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London Health Sciences Centre

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