LHINCollaborative

Sharing Best Practices: Transition Management in Ontario

Home First

Implementation Guide & Toolkit

February 2011

Ontario
Local Health Integration Network

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LHIN Collaborative (LHINC)

LHINC is a provincial advisory structure. LHINC engages health service providers, their associations and the LHINs collectively on system-wide health issues related to the LHINs' mandate.

Section I: Introduction

A. What is Home First?

Home First is an evidence-based, person-centred, transition management philosophy focused on keeping patients – specifically high needs seniors - safe in their homes for as long as possible with community supports. If/when acute hospital care is required, Home First aims to support patients to return home on discharge prior to assessment for and/or admission to a Long Term Care (LTC) home or other appropriate care setting. Under Home First, transferring patients from hospital to a LTC home is considered only after all other community options are considered.

The Home First philosophy effectively and proactively considers options for post-acute care by involving and engaging the patient and family in decision making. It requires a focus on providing the right care, at the right time, in the right setting and at the right cost to ensure successful transition back to the home/community setting. It also requires the adoption of a cultural change in health care organizations and a transformational shift within all health sectors from the traditional approach to care delivery for high needs seniors in our hospitals and communities.

Benefits of Home First

- Allows patients to stay home as long as possible
- Reduces patient risk of contracting hospital infections
- Allows patients to attain optimal functioning prior to making major decisions
- Increases acute care bed capacity
- Reduces demand for LTC beds

Provincially defined, a patient must be designated ALC (alternate level of care) by a physician or physician delegate when the patient (occupying a bed in a hospital) no longer requires the intensity of resources/services provided in that care setting. Successful implementation of Home First will result in reductions in ALC length of stay (LOS) in hospitals, avoidance of emergency department (ED) visits/hospitalization and reduced demand for LTC beds.

Why Home First?

There are significant patient flow issues within our hospitals and the rest of the health care system. In Ontario hospitals, high volumes of ALC patients and ALC days are impacting timely access for patients who need to be admitted into hospital beds from the ED. More importantly, long ALC stays in hospital have negative impacts on the patient's quality of life. In 2010, the Ontario Auditor General's Office conducted an audit of discharge practices in Ontario hospitals. In the Auditor General's report released in December 2010, it was noted that, "…staying in hospital longer than medically necessary can be bad for a patient's health." Furthermore, one of the recommendations of the same report indicated that hospitals, in conjunction with their LHINs, should educate all patients and their families on the fact that a hospital is not a safe or appropriate place for patients, particularly high needs seniors, whose condition has stabilized and/or who no longer require acute care, to wait for post-acute care given the risks of hospital-acquired infections.

There is growing evidence both nationally and internationally to support the notion of providing patient care in the home and studies have shown that when appropriately targeted and managed, care in the home can moderate the demand for more costly hospital/LTC care while also maintaining an individual's independence[1,2,3]. Providing care in the home also moderates demand for LTC homes where there are long wait lists for beds. The Ontario Association of Non-Profit Homes and Services for Seniors reports that there are currently 25,000 people on the wait list for a spot in one of 76,000 publicly funded LTC beds in Ontario[4]. The Ontario Health Quality Council has reported that the average wait for a patient on the LTC wait list has doubled from 49 days to 106 days in the past 2 years[5]. The combination of a large wait list with long waits has resulted in severe backlogs in the hospital as patients who have completed their acute care and are designated ALC are left waiting in hospital for admission to a LTC home.

Implementing Home First can help reduce the demand and wait list for LTC by properly assessing high needs seniors after their acute episode and ensuring that only those who truly need LTC are applying and being admitted into a LTC home. A study in Toronto showed that between one-third and one-half of patients who were on a LTC wait list could actually be supported either in their homes or in supportive housing in a safe and cost-effective manner[1]. Furthermore, an analysis completed by Hamilton Niagara Haldimand Brant LHIN showed that in comparison to care provided in the home setting, assisted living facilities are 1.2 to 1.8 times more expensive while LTC is 2.2 to 3.4 times more expensive[6]. Home First has also been shown to be a person-centred philosophy to providing care. A study from Veterans Affairs Canada revealed that there were high levels of client satisfaction with in-home care and in many cases, in-home care was the preferred option over institutional care such as LTC[7].

Home First was first introduced in Ontario by the Mississauga Halton (MH) LHIN in 2008 to address significant patient flow issues within hospitals that were resulting in increased numbers of individuals designated as ALC. Implementing the philosophy provided MH LHIN with an opportunity to invest in targeted community investments and transform care delivery in hospitals, the Community Care Access Centre (CCAC), LTC homes and the Community Support Services (CSS) sector to focus on providing quality care in the right place at the right time. Since then, Home First (or models similar to Home First) has been introduced in each of the 14 LHINs, with each LHIN being at a different stage of planning or implementation. Although LHINs have been conferring with each other to share knowledge and best practices around Home First, a single provincial approach to implementation of Home First was not in place. Because of the variation of practices across the province and the early stages of implementation that many of the LHINs are at, the benefit of developing this Implementation Guide & Toolkit (herein referred to as the guide) as a "how-to" manual for LHINs was identified.

B. Process

Given the priority of Home First as a transition management opportunity, the LHIN Collaborative (LHINC) was approached by the LHINs to conduct a review of current Home First practices in Ontario and develop this guide. A Home First Working Group was created with representation from the LHINs, CCACs, CSS Sector, Primary Care Sector, LTC homes, and acute care hospitals to help inform the project. Under the direction of the Working Group, LHINC developed a theme-based questionnaire that was completed by the LHINs and CCACs to understand the various Home First approaches and activities across the province. A series of interviews were then conducted with each of the 14 LHINs and CCACs, using the questionnaire as a guide to supplement the information from the questionnaire. The themes of the questionnaire were as follows:

- Philosophy & Approach
- Process & Structure
- Physician Engagement
- Engagement of Nurses, Allied Health Professionals and Other Staff
- Hospital Executive Sponsorship
- Risks and Challenges
- Communication
- Education
- Performance Measurement

The information gathered from these surveys and interviews was validated by LHIN and CCAC leadership and analyzed for commonalities and variations depending on local circumstances. The analysis was presented back to the Working Group for their review and discussion. The results of the interviews and questionnaires verified that each LHIN is at a different stage in the planning or implementation of Home First. Also, it was evident that there are a variety of approaches to Home First being undertaken in consideration of the unique, local circumstances of each LHIN. The information presented in this guide is based on the information gathered from each LHIN and CCAC through the questionnaire and interview process.

C. Purpose

The purpose and focus of this guide is on the transition management of patients from institutional care to the home setting. It is meant to act as a manual for the LHINs in implementing Home First and reflects the diversity of approaches across all LHINs. Given the unique local circumstances within each LHIN, this guide does not endorse or recommend one specific model or approach to Home First; rather, LHINs have the ability to adopt the tools described in this guide at their discretion. Specifically, the purpose of this guide is to:

- Promote a provincial philosophy of Home First
- Be a resource guide for LHINs to implement Home First
- Outline common risks and challenges associated with Home First and strategies to address them
- Provide a set of provincial performance metrics to be used across all LHINs to measure the progress and success of Home First
- Provide a set of tools and templates for LHINs to use in rolling out Home First

D. Home First Variability Factors

As previously mentioned, because of the variation in the local circumstances of each LHIN, Home First has been implemented in a variety of ways across the province. The most common reasons for variation are outlined below:

- ***Organizational Culture and Leadership***: Home First requires a major cultural shift in the behavior and mindset of all health care providers. Where previously the care process for high needs seniors was focused on identifying, facilitating and expediting their transfer to LTC homes, a paradigm shift is now required so that health care providers focus on sending these patients home with enhanced community support. Depending on the existing culture of the organization within the LHIN and their ability and openness to change, variations in the approaches used to achieve this paradigm shift are required.

- ***Existing Stakeholder Relationships:*** The relationships that exist between all the parties involved in Home First play a key role in implementing and sustaining Home First. A strong, supportive, and collaborative relationship among all parties facilitates the implementation of Home First. Where such strong relationships exist, Home First can be seen to be implemented more efficiently and effectively. Where there is opportunity for relationship building and growth, focus and attention must first be paid to stakeholder collaboration and building trust in advance of implementing Home First.

- ***Community Capacity*****:** In order to enable Home First, each LHIN requires a compliment of community and support services provided by CCAC and CSS agencies that are available beyond normal working hours to support patients in their homes. The availability and attributes of these services will differ by LHIN.

- ***Geography and Geographical boundaries:*** Each LHIN differs in geographical size, demographics (e.g. urban vs. rural population, average age) and proximity to other LHINs. LHINs that are geographically large have to provide community services over a greater area and as such the availability and response time from these services may be affected. Furthermore, LHINs that are in close proximity to other LHINs may receive a large proportion of acute-care hospital patients from areas outside their own LHIN. Therefore when the time comes to repatriate the patient there may be differences in the community care services available between the LHIN where the patient is receiving acute-care and the LHIN where the patient actually resides and will receive follow-up home care services.

It is important to note that while variation in approaches across the province is understandable, and in some cases required, the key elements of the Home First philosophy must be consistently applied across all LHINs. System partnerships do exist in all communities. While it is important to acknowledge that developing community resources to meet changing needs is an ongoing process, the philosophical shift that home is the primary destination for all patients who no longer require inpatient acute care must be adopted and understood by all. These key elements of the Home First philosophy are reviewed in detail in section II.

Section II: Key Elements for Home First

Enabling a Home First philosophy within a LHIN requires a focus on a number of key elements. LHINs do not need to have completely addressed all key elements to begin shifting to Home First and may choose to focus on one area more than another based on their local circumstances. However, it is critical that all of the following elements be addressed in some form to support the success of Home First.

In this section, each of the key elements of Home First are described to guide LHINs and their health service providers (HSPs) whether they are at the initial stages of implementation or farther along into the process. The key elements that will be described are:

A. **Philosophy**
B. **Effective Leadership and Executive sponsorship**
C. **Roles and Responsibilities**
D. **Supporting Structures and Processes**
E. **Engagement of Health Professionals**
F. **Communication and Education**
G. **Evaluation**

A. Philosophy

While the approach to implementing Home First will differ by LHIN, there are commonalities in the philosophy and principles of Home First. A province wide Home First philosophy statement will ensure that all the LHINs are striving towards the same overarching goal, while still allowing differences in implementation to exist. As such, the following provincial philosophy statement describing Home First has been developed for all LHINs and HSPs to adopt:

HOME FIRST

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

The philosophy statement is based on the following principles:

- ***Life changing decisions are better made in the home***. Home provides a patient with the most comfort for recovery along with lower levels of stress compared to hospitals. As such, it is considered the best environment in which to make potentially life changing decisions. Applying to a LTC home, if required, is a social process that should be done with family members/loved ones and is best done in a home setting.

- ***People can choose to live at risk at home and in the community.*** Often, patients and families believe hospitals are the less risky option for patients – especially high needs seniors - after acute care. It is important for patients and families to understand that there are inherent health and safety risks in every environment - whether they are in the hospital, in the community, or in their home. People do live at risk in the home; the key is ensuring that the risks do not place the individual in harm's way. Furthermore, quality of life is not necessarily correlated with risk and is often higher when patients choose their destination and can reach home in a timely manner.

- ***Institutionalized care presents risks that are not as prevalent in the home setting.*** There are risks to a patient remaining in the hospital after their acute-care episode has ended. These risks include contracting infectious disease, physical/mental deterioration and social isolation. Home First is a person-centred philosophy focused on improving the safety and quality of care where home provides a more ideal environment for post-acute care.

- ***Individuals and families have a role in partnering with health care providers to care for their loved ones.*** The onus of responsibility to care for a patient does not only rest with care providers. Families/loved ones/primary care givers also have a large role to play in partnering with health care professionals to discuss and evaluate options for a patient's post-acute care, and potentially their on-going care in home.

- ***Avoid "Ageism".*** It is important to evaluate each patient based on their needs without any bias towards age. To this end, each client regardless of their age or state of well-being should be initially assessed for discharge home.

Given that Home First is a philosophy, home must be considered as the primary discharge destination for all patients. While there are no specific eligibility criteria to evaluate patients against under the Home First philosophy, eligibility criteria may exist for the specific programs and services that enable Home First. The criteria for these programs will vary across different LHINs.

B. Effective Leadership and Executive Sponsorship

Visible and continuous executive sponsorship and leadership from the LHIN, hospitals and CCAC along with full engagement of the LTC, CSS, primary care, and community mental health sectors is a critical success factor in effectively implementing and sustaining Home First. Home First commonly uses a top down approach, where organizational transformation begins at the executive leadership level. Sponsorship from executive leadership translates into leadership bringing together staff from all levels and backgrounds, fostering collaboration and leading an organization wide shift in culture and practice. In sponsoring the philosophy and supporting the implementation, executive leadership will signal the importance and priority of Home First to staff.

C. Roles and Responsibilities

In any large, multi-stakeholder initiative such as Home First, the roles and responsibilities of each party, as well as how these different parties will interact requires careful consideration from the onset. Effective leadership from the LHIN and all of its HSPs is essential for Home First to succeed. As well, recognition and acceptance by all HSPs that ALC is a top priority given its implications on both sustainability and quality of care is also essential. Finally, all parties must take ownership for Home First given that all play an integral role in the successful implementation of the philosophy. The implications of Home First must also be fully embraced and operationalized by the parties involved.

Collaboration and Greater Integration

Successful implementation of Home First requires extensive **collaboration** between the LHIN, CCAC, hospital, LTC, CSS, mental health, and primary care sectors. Every party involved must take full responsibility for implementing and sustaining the philosophy. Working together effectively will facilitate the necessary cultural shift and process changes required to launch Home First. Collaboration can begin with informal discussions between some or all of these parties and then translate into formal committee structures as will be described further in this guide. To achieve and maintain a strong relationship, each party should clearly understand the elements of the philosophy as well as the key role that they play during its implementation. It is especially important for the CCAC and hospital to have a strong relationship since these two parties are heavily involved in operationalizing the philosophy.

Role of the LHIN

LHINs have a mandate to plan and integrate health care services. As such, the LHIN's role within Home First is to oversee the Home First strategy and provide overall leadership and garner support from all relevant stakeholders (i.e. hospitals, CCAC/CSS, LTC homes, primary care physicians) to begin discussions around Home First. This includes ensuring that Home First is a top priority for HSPs and that all HSPs are committed to reducing ALC, avoiding unnecessary ED visits/hospitalization, and reducing LTC demand. As the health system manager, the LHIN can provide contextual information around how Home First will fit in with existing related provincial strategies as well as local strategies specific to the LHIN.

LHINs are also in charge of allocating and realigning resources as required and ensuring the right care is provided in the right place, at the right time, and at the right cost. This includes ensuring there is capacity to take care of high needs seniors (i.e. those with MAPLe scores 4 or 5) through realignment of resources and priorities, and where possible, the infusion of additional funds. If not already completed, LHINs should conduct a capacity assessment of the community support sector to gain a clear upfront understanding of the ability of the community sector to support patients in their homes.

- Provide overall leadership and ensure Home First is a priority for all system partners
- Oversee strategy and communicate system objectives and expectations
- Conduct capacity assessment and promote the shift away from institutional care by increasing capacity of community sector as appropriate
- Set performance expectations for LHINs and HSPs and ensure proper monitoring and evaluation mechanisms are in place
- Promote application of standardized assessment tools (e.g RAI) as leading practices
- Allocate and align resources as required to maximize system effectiveness

LHINs must also ensure continuous monitoring and evaluation of Home First through the use of performance metrics and ensure that the necessary reporting structures are in place to take corrective action as needed. LHINs must play a role in creating more public awareness about Home First and ensuring patients properly understand the discharge process and benefits of going home. In doing this, LHINs must ensure that there is consistent messaging being provided by all HSPs with respect to Home First. In summary, the LHIN's role is focused more on providing **leadership,** along with **initiation** and **monitoring** of Home First.

Role of the CCAC

CCAC plays an integral part in the **implementation** of Home First given their role as system navigators for patients that are sent home. In order to achieve success in Home First, CCAC must gain a commitment from all staff and associated health care professionals to the philosophy and work with hospitals to assess high needs seniors before they are designated ALC.

CCAC is a key facilitator of Home First given their role in assessing patients to go home with community supports. CCAC provides a wide variety of services that enable patients to remain safely in their home. Under Home First, CCAC must realign their existing resources to increase support and capacity for high needs seniors (MAPLe scores 4 or 5) in the community. Home First partner, CCAC must be able to deliver on the services offered in order to support the success of Home First. This ability to deliver services depends on the CCAC's ability to properly plan for discharge in partnership with hospitals and other system partners.

To promote the philosophy, CCAC must provide communication and education alongside LHIN/hospital/CSS staff to demonstrate collaboration. Along with the LHIN and hospital, the CCAC must continuously monitor and report on the status of Home First

- Gain commitment to Home First philosophy by all staff
- Proactive engagement with hospitals to assess high needs seniors before ALC designation
- Assessment of patients to go home with appropriate community supports
- Use of evidence-based criteria for admission into community programs and services
- Continuous monitoring of Home First and corrective action as necessary
- Increase capacity to care for clients - specfiically high needs seniors
- Ensure all other options are considered before LTC placement and only high needs seniors are referred/admitted to LTC

initiatives to the LHIN using performance metrics. CCAC Case Managers (herein referred to as Case Managers) play a large role in championing and supporting the philosophy as a patient's care coordinator and main point of contact for patient services and enquiries. Early involvement of the Case Manager can help avoid unnecessary patient admissions from the ED.

Role of Hospitals

- Facilitate change in staff and physicians' behaviour to promote home as the primary discharge destination
- Early identification of patients' discharge date (and communication to CCAC)
- Promote proactive discharge planning and joint "integrated discharge rounds"
- Continuous monitoring of Home First and corrective actions as necessary
- Provide optimal care of patients while in hospital to reduce functional decline
- Provide appropriate community outreach programs as necessary and feasible

The hospital is the **operational** ground for Home First and the main site where a cultural shift is necessary. As such hospitals must ensure all physicians (and the medical advisory committee) and other health care professionals (e.g. nurses, allied health) fully embrace the philosophy and have robust communication and education plans in place. Health care professionals in hospitals are charged with the task of providing services to patients to meet their acute care needs, reducing their functional decline, and supporting patients to go home with community services after their acute care stay. This includes leveraging the use of complex care, rehabilitation beds and other resources to improve a patient's functional status and transition patients to go home.

While current practices tend to promote institutionalized care, Home First challenges health care professionals in hospital to undergo a cultural shift and recognize that home is the best place for people to recover and rehabilitate. To do this, hospitals must work with community partners to proactively plan a patient's discharge and identify patients' discharge dates as soon as possible. Hospitals must also work with LTC homes and community providers to develop outreach programs (e.g. psycho geriatrics) as needed.

Along with the LHIN and CCAC, hospitals must also continuously monitor and report on Home First performance and identify where any corrective action may be necessary. Hospitals working collaboratively and creatively to examine processes with other system partners will ensure successful implementation of Home First as these partnerships are of key importance throughout the planning process to get patients back home.

Role of the CSS Sector

The CSS sector provides many services to **support** patients to remain comfortably at home. As such this sector must be an integral and equal part of the team to successfully implement Home First. There is an opportunity to further leverage CSS services to achieve greater community capacity and LHINs need to ensure there is capacity in the CSS sector to take care of high needs seniors in their homes. Readiness of CSS agencies and building capacity in the CSS sector to take care of high needs seniors in their home/community is critical to the success of Home First. CSS agencies must work with LHINs to transform their practices and support the use of evidence-based assessment tools to ensure high needs seniors (i.e. MAPLe 4 and 5) are being appropriately placed and served. LHINs and CSS agencies must also work together to increase service hours of care (where feasible) beyond normal working hours (i.e. weeknights and weekends) to ensure patient services are available when needed.

The value of CSS services is continuing to gain recognition among LHINs and HSPs and these services should be continually developed to reach their full potential. Through active collaboration with CSS agencies, HSPs must become fully informed of services available by CSS agencies in their catchment areas thereby ensuring opportunities to leverage these services further. Because the CSS sector encompasses a variety of agencies providing a wide spectrum of services, it can be difficult to engage the sector as a whole (although some LHINs do have a centralized point of access). Using a representational model where a point person(s) or organization(s) is identified to speak on behalf of all CSS agencies in the LHIN helps facilitate engagement and keeps all CSS agencies informed and engaged in Home First. These points of contact should be involved at the onset of planning for Home First and in discharge planning to act as the liaison for proper patient referral to other CSS agencies. The capacity of the CSS sector does vary from one LHIN to another and as such, this will impact the magnitude of their involvement in Home First.

Role of the Primary Care Sector

Primary care physicians are often the first contact for patients with an undiagnosed health issue and also provide continuing care for various medical conditions. They can exert great influence on patient choices and experiences as patients tend to heavily rely on and trust in the advice and recommendations of their physician. As such, physician support for Home First is critical. During the course of a patient's stay in hospital and especially during discharge planning, physicians must work with the patient, family, and interdisciplinary care team to determine the most appropriate care plan to facilitate discharge home and refrain from having premature discussions about LTC with their patients. Physicians can also play a key role in alleviating any fears patients may have about receiving care in their home and must reassure their patients about the benefits of going home.

Community physicians must also actively monitor their patients while they are recovering and receiving care at home to ensure timely recovery and avoid unnecessary visits back to the hospital. Careful monitoring of Home First patients is enabled if hospitals and case managers ensure community physicians receive timely discharge summary notices (i.e. 24 to 72 hours after discharge) providing clear information on the patient's status and expected care plan (e.g. medications, services being received) within the home setting.

Role of LTC Homes

LTC homes provide many services that can support seniors to stay at home, and delay or eliminate the need for LTC homes. Some of these services include: respite care beds to provide support to caregivers, and convalescent care beds to relieve pressure on the hospital sector and prepare patients to go home. With the introduction of Home First, the LTC sector needs to work closely with LHINs to ensure LTC homes are able to provide the services required to manage high needs seniors and close any potential gaps in services.

Many seniors and families think of LTC homes when they are struggling with staying at home or when a senior is admitted to hospital. Many LTC homes are part of a strong community that meet the specific cultural and religious needs of their community. Therefore, seniors and families will, at times, approach LTC homes to get more information on how to get assistance. LTC staff can provide support through educating seniors and their families on services offered by their CCAC and CSS agencies that would assist the senior (and their caregivers) in staying at home.

Given that many high needs seniors currently reside in LTC homes, the LTC sector should be well informed of the Home First philosophy and how it may impact their processes. Once LTC staff are brought into and understand the philosophy, they can play a critical role working in conjunction with the LHIN to ensure that only those who truly need LTC are currently in LTC homes. LTC can also partner with hospitals to help avoid/minimize the transfer of LTC residents to hospital EDs.

D. Supporting Structures and Processes

Structures

LHINs must ensure there is an effective and dedicated Home First committee that will bring together individuals from various disciplines and backgrounds and provide a forum for knowledge and experiences to be shared in an effort to formulate the most suitable approach to implement Home First. A Home First committee, whether at a higher management level or an implementation/operational level, should be in place at the onset of Home First to plan, oversee and coordinate the implementation. The individuals involved in such a committee are an essential resource in the launch of Home First as they can then educate and communicate back to their respective teams and colleagues about the philosophy. A dedicated Home First committee can also help maintain momentum during implementation.

Processes

Home First will impact roles and processes within the hospital, CCAC, and other community sectors. Changes to the Case Manager role and the hospital discharge process are two commonly impacted areas and are in fact essential to facilitate a cultural shift and make Home First more visible. The changes in roles and processes require a great deal of planning and execution. The discharge process should be mapped out clearly to identify where the necessary changes need to occur and where the Case Manager role will be impacted. Any changes to processes and roles will largely depend on the current discharge process followed in the hospital.

E. Engagement of Health Professionals

To effectively realize a cultural shift, those who will be most impacted by the shift must be engaged throughout implementation.

Physicians

Physicians in the hospital and the community should be targeted separately due to their direct involvement in patient care and planning. Physician support is critical since they are the gate keepers when it comes to patient care and can therefore heavily impact the adoption of the Home First philosophy. In many hospital processes, the physician is the steward amongst the interdisciplinary team in regards to decision making and as such, the change in process or culture must be adopted by the physician in order to be accepted and embraced by the rest of the interdisciplinary team.

Nurses

Nurses are often the health care providers that spend the most time with patients, therefore it is critical that the nursing team is fully aware and supportive of the Home First philosophy. Nurses are also a key point of contact for the patient and family. They can respond to their questions and reassure them of their ability to manage at home. In working with patients, nurses can also identify barriers and challenges and work with colleagues to identify potential solutions. Nurses often serve as a link between physicians, allied health professionals and the CCAC and CSS providers. They are a conduit for knowledge transfer, and their ability to provide information as well as provide support should be capitalized.

Allied Health Professionals

While allied health professionals is a broad term that includes many health care professionals, for the purposes of this guide, allied health professionals refers primarily to physiotherapists, occupational therapists and social workers, as they are the allied health professionals most involved with Home First processes. Allied health's engagement is essential since they are an important part of the health care team and are often involved in patient assessments for discharge home and patient care in the home. Furthermore, the Home First philosophy can be applied to other types of care including rehab, mental health and convalescent care where allied health practitioners may act as primary care givers.

Clinical Leadership

Clinical leadership's support for the philosophy is required to effectively engage physicians and allied health professionals hospital wide. Clinical leadership can provide advice on how to best reach clinical audiences and can also be at the forefront of physician and allied health communication and education.

F. Communication and Education

Communication and education are at the core of launching Home First in order to establish and sustain the cultural shift required for its success. It is therefore extremely important that these two elements are carefully considered at the onset and comprehensive plans are formulated before any initiatives are launched. Consistent messaging on communicating when things do not go as planned must also be part of the plan. When establishing communication and education plans for Home First, the following needs to be considered:

- Target audiences
- Key messages that must reach those audiences
- Mediums to be used
- Timelines for roll out

For the purposes of this guide, the key target audiences for which communication and education tools are discussed are hospital, CCAC staff and physicians; CSS and LTC staff; patients and their families; and the public at large.

Hospital, CCAC Staff and Physicians

Hospital, CCAC staff, and Physicians is an overarching category which may involve any or all of the following: unit managers, physicians, nursing, allied health professionals, patient flow managers, discharge planners, CCAC staff and any other staff who may be involved in implementing Home First and/or interact with patients and families. A comprehensive communication and education plan will facilitate staff and physicians' clear understanding of Home First and its goals, as well as how it impacts their current role and responsibilities. In order to support their engagement and on-going support, physicians and health care staff may need to be convinced that Home First is in the best interest of the patient. Therefore communication and education should also focus on successes of Home First and building confidence levels for both physicians and health care staff.

CSS and LTC Staff

As previously mentioned, the CSS and LTC sectors must be involved in planning for Home First as these sectors are important parts of the patient's journey through the health care system. Because these sectors will most likely involve multiple organizations, broader communication on a regular basis is required to ensure the messaging reaches all staff and they are continuously engaged.

Patients and Families/Loved Ones

Through communication and education, patients and families/loved ones can better understand the rationale and benefits behind Home First so they do not feel as if they are simply being forced out of the hospital. They can also gain the knowledge necessary to empower them to manage their own post-acute care and be more involved in their own recovery.

Public at Large

An understanding of the Home First philosophy within the public domain supports better understanding of the health system and the approach of health care providers within the system. It is important that the public do not feel that patients are being forced out of the hospital in order to alleviate pressures, but rather recognize Home First as the person-centred philosophy that it is. Public communications and marketing of Home First will educate the public and help prepare them in the event that one day they (or a loved one) may require intervention.

G. Evaluation

It is critical to continuously monitor and evaluate Home First to assess the impact on desired goals of the philosophy and quantify the benefits of the philosophy to the health care system. LHINs and their partner organizations will require an evaluation plan in place to regularly monitor and report on Home First using both process and outcome performance metrics. While there are a number of benefits to Home First for healthcare providers, the outcome of Home First is a reduction in ALC, reduction in unnecessary ED visits and/or hospitalization, and reduced demand for LTC homes. As part of the evaluation plan, LHINs and their partner organizations will need to establish a method of monitoring process measures to monitor the culture change as it happens (i.e. quantifying that all patients are being assessed for discharge to home).

Section III: Implementing Home First

This section is intended to provide guidance to LHINs in implementing Home First based on the key elements described in Section II. Using an adaptation of the Ontario Public Service (OPS) guide to project management as a framework the phases of implementation for Home First have been identified and are described below. A collection of approaches and tools to use in adopting the elements of Home First described in section II are also provided within this section. LHINs may adopt the tools from each of these elements to suit their individual needs and circumstances.

Phases of Implementation

A checklist is provided at the end of this section summarizing the key steps to be followed under each of the phases of application.

A. Current State Assessment

The purpose of this phase is to enable LHINs to recognize the benefits of the philosophy (as described in section I), the extent of existing pressures (i.e. high ALC volumes/LOS) the associated need for change (i.e. need for a transformational change in the way care is provided), and determine what needs to be accomplished when implementing Home First. This includes reviewing past performance (using provincial metrics as described in Section V) to understand where efforts may need to be focused. During this phase, LHINs also should conduct a capacity assessment (if not already completed) to properly assess the ability of the community sector (i.e. CCAC, CSS) to support high needs seniors in their homes.

Finally, executive sponsorship (and collaboration) must be established, and supporting structures need to be defined and developed.

Executive Sponsorship and Collaboration

As system managers, the endorsement of Home First and the importance of collaboration from LHIN executives are both essential to foster active participation and collaboration amongst all other parties. As described in section II, it is especially important for hospital and CCAC staff to effectively collaborate in implementing Home First. The visibility of hospital and CCAC executives as partners is important in that it illustrates the significance of collaboration between the two parties. This is especially important in the early stages of Home First. A visible collaboration between CCAC and hospital executives will increase the likelihood of collaboration amongst their respective staff when process changes involving both parties need to occur. Executive sponsorship can be achieved and recognized in the following ways:

Involvement in Home First Committees

Executive involvement in Home First steering committees is required to oversee and monitor the progress of implementation. To demonstrate collaboration, co-chairs for committees can be designated from different organizations (e.g. hospital and CCAC co-chairs). Where only implementation committees exist (at the operational and/or staff level), executive leadership can play a key role in monitoring the progress of Home First through other existing reporting structures and serving as a Home First champion to those staff involved in leading and facilitating the implementation.

Informal Involvement

Through Home First events, communications, or informal conversations, executives should directly communicate their support and sponsorship of Home First to staff to increase staff buy-in and support of the philosophy. To support staff, executives can provide opportunities for staff to raise any concerns or discuss areas for improvement as well as ensure that staff have the necessary resources for a successful implementation. Supporting staff becomes especially critical when challenging patient/family situations arise and a lack of cooperation from parties is exhibited in regard to the Home First philosophy and approach of the hospital (e.g. patient/family refusal to go home). In such situations, consistent, firm decisions by the hospital executives that support the organization’s position on Home First are essential. Furthermore, executives must provide their signatures together on staff communications. Without such support from executives, staff dedication to the philosophy may waver in conflict situations, making it difficult for the organizational culture to change.

Supporting Structures

There are many different committee structures to consider when implementing Home First and different factors to consider in setting up these structures. These factors include:

- Existing relevant LHIN-wide steering committees (e.g. ED/ALC committee) which include representation from LHIN, CCAC, Hospital and CSS that can be leveraged
- Implementation Timelines: Stringent and short timelines versus flexible and longer timelines allocated to implementation for change management within organizations
- Number of hospitals within the LHIN

Representation from the hospital, CCAC and CSS will most likely make up the majority of LHIN-wide or hospital-based Home First committees since these parties will be predominately involved in implementation. As part of all the structures presented, sub working groups can also be formed to focus on certain elements of Home First including evaluation and planning for communication and education.

B. Stakeholder Engagement & Committment

During this phase, it is important for the established Home First steering committee to clearly define specific goals, objectives and deliverables of Home First. While provincial performance goals for Home First are reducing ALC LOS, ED visits/hospitalization and demand for LTC homes, if there are any additional local goals or outcomes, these should be outlined and clearly defined in this phase. By defining the goals, objectives and deliverables, it will then be possible to outline the expected or estimated costs associated with Home First.

During this phase, it is also necessary to identify all the stakeholders involved in Home First (beyond the steering committee), their respective roles and responsibilities (as discussed in Section II), and how each will be engaged. This is in addition to ensuring that the roles and responsibilities of the parties described in section II (i.e. LHINs, CCACs, hospitals etc) are clearly understood and adhered to. Any formal agreements (e.g. accountability agreements, memorandum of understanding) should also be developed and put in place.

Formal agreements (outlining expectations, roles and responsibilities and share goals) in the form of a partnership agreement, accountability agreement or a memorandum of understanding may serve to formalize the partnership in some LHINs.

C. Readiness to Implement

During this phase, the philosophy will begin to become visible through changes to supporting processes (i.e. discharge planning), planning for the actual launch of Home First, and the development of communication and education plans.

Supporting Processes

Along with a shift in mind set, processes may need to be altered to support a shift in culture. The case management model and the discharge process may need to be examined when implementing Home First; required changes to these structures are discussed below.

Home First Case Management

ALC patients who are discharged home are often high needs seniors who require more intensive case management to ensure the necessary supports are in place to maintain their health and safety at home. This requires more in-depth assessments, frequent follow-ups of patients at home and enhanced/resource-intensive service packages. To change the case management model in this way, Case Managers must have the capacity to provide this level of service.

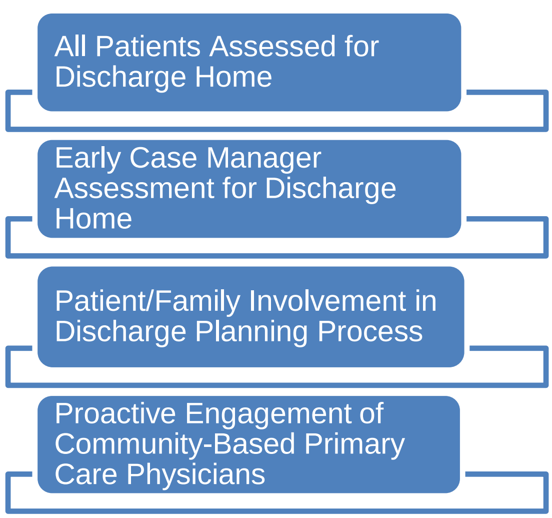
As system navigators, the Case Manager must also work with CSS agencies to determine which CSS services are required and connect with CSS agencies early on to allow adequate time in securing those services. To ensure the patient receives all the services they require, the Case Manager must either have a comprehensive knowledge of all CSS services/processes and/or coordinate with CSS agencies as required (through a representational model).

Since the Case Manager's role can be significantly changed in many ways, it is imperative to ensure both the interdisciplinary team and Case Managers themselves understand their role. Appropriate mechanisms must be in place to allow a smooth transition to new roles and processes. This can be achieved by regular team meetings involving everyone impacted by the changes where successes and challenges can be discussed.

Integrated Discharge Planning Process

Whether the Case Manager is situated at the CCAC office or in the hospital, a key aspect of their role is their early involvement in the discharge process. Once a patient is identified as a potential ALC risk, the Case Manager should begin to assess them for discharge home. Through their early involvement, the Case Manager must determine potential issues in sending patients home (specifically high needs seniors) and address these early on in the process, thereby avoiding complications when the patient is actually ready to leave the hospital. It should be noted that under Home First, all patients should be assessed for discharge home at some point during their stay. The Case Manager will need to work closely with the interdisciplinary team including hospital staff and CSS agencies to determine discharge options and service plans for each patient (based on what kind of supports are available in the community) and then (in partnership with hospital and CSS staff) proactively secure the necessary community services required by the patient. This can become a contentious issue when patients/families do not agree with service plans or even being discharged at all from hospital.

When patients are discharged home, it is critical that their primary care family physician be notified in a timely manner (i.e. 24 to 72 hours after discharge) so that he/she is aware of the patient's current status and location. This includes sharing the physician discharge summary completed by physicians in the hospital so that the community based physician is appropriately aware of all relevant information including the patient's medications and the community services in place to support the patient at home.



In keeping with the Home First philosophy, LTC should not be a part of the initial discharge planning discussion and should only be considered after all other options have been exhausted. Premature discussion around LTC (i.e. prior to CCAC assessment) can create false expectations for patients and families about a patient's discharge destination and possible conflict when the patient is ready to be discharged. Furthermore, as mentioned, the LTC application process is a social process that should be completed in the comfort of home as opposed to a hospital bed.

A patient's family/loved one(s) is a part of the care team and must be involved in discharge planning by playing a role in creating the patient's post-acute care plan. This will ensure their buy-in of the care plan and can be valuable since they can provide advice related to caring for the patient, or even offer to provide some support in addition to the community supports being offered.

Communication & Education

Continuous and consistent communication and education begins in the planning phase but is also critical throughout the implementation to not only ensure that everyone is working towards the same goals and deliverables but also to ensure that staff do not revert back to old habits. In planning communication and education, one of the first steps is to determine the target audiences along with the mechanisms and messages to employ in reaching those audiences. After this is determined, Home First committees can then develop plans and templates to be used. Common messaging related to Home First will ensure a clear understanding of the philosophy by all staff and avoid any confusion that may arise when multiple parties try to communicate the same message. Duplication of effort is also avoided when one entity is charged with communication planning.

It is important to present Home First to committees and teams that include management before moving on to staff level committee structures as management can help create staff buy-in. Given that specific Home First events will not be able to reach all staff, it is important to leverage existing meeting structures and minimize any additional meetings staff are asked to attend when communicating with staff,. During these meetings a clear, concise and consistent presentation should be used along with fact sheets/brochures for attendees to take with them to ensure the message remains with them. Videos are another medium that can be used.

Although there are many target audiences that must be considered for communication and education, these audiences can be grouped into three broad categories: hospital and CCAC staff, CSS and LTC staff, and patients and families. Communication methods and tools are described in the following section by audience. It should be noted that given the number of audiences as well as the importance of communication and education, LHINs can establish sub-committees to focus solely on communications and education as needed.

Hospital and CCAC Staff

Communication and education tools described here can be used for any and all staff in the hospital and CCAC setting.

Education Sessions/Presentations

Multiple in-house communication and education sessions (both broad and targeted) can be used to ensure that all staff understand the Home First philosophy and have an opportunity to raise and discuss questions or concerns. These sessions should be conducted before, as well as after Home First has been launched. Providing education and communicating to staff early on will ensure staff understand the philosophy, are provided with an opportunity to be involved, provide feedback, and are ready to make the necessary shift in culture when Home First is launched.

Use of Staff and Patient Testimonials

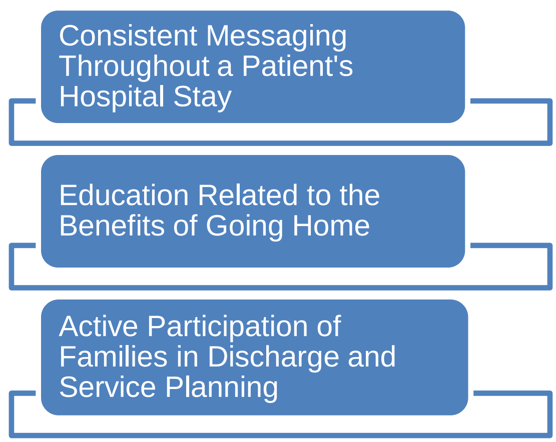
Stories and testimonials from staff and patients are powerful tools to illustrate the success and positive impact of Home First. To facilitate this, all parties involved need to monitor and record the positive experiences and stories of Home First from both the staff and the patient's perspective. Where possible, staff/patient success stories and testimonials should be incorporated into communication tools (e.g. newsletters, fact sheets, brochures and/or videos) to build the credibility of the philosophy. Staff testimonials, while creating more buy-in from peers, also allow staff to reflect on their experiences and how Home First has improved the patient experience and hospital operation, further supporting the philosophy.

Continuous Reinforcement of the Home First Philosophy

Broadly launching Home First is only the first part of the communication process. Because the philosophy requires a change in mindset and practices, staff may find it easier to return to their old habitual ways after a period of time. Thus, the philosophy must be continuously reinforced through any of the communication mediums discussed above. The type and frequency of communication and education required can be determined based on the results of monitoring and measuring Home First. Specifically, communications should be delivered more frequently at the initial stages of the launch to reinforce the cultural shift. It is important to provide staff the opportunity to reflect on their experiences through reoccurring meetings to allow them to share lessons learned and ensure issues are addressed as they arise.

Patients and Families

Below are some methods and tools that can be used to ensure patients (and their families/loved ones) properly understand the decisions made around their care as a result of Home First.



Consistent Messaging throughout a Patient's Hospital Stay

Given that Home First may be a relatively new concept within the hospital and patients may be receiving communication from multiple sources, messaging around Home First should be both continuous and consistent through the patient's hospital stay. From the moment they walk through the hospital doors, patients and their families should understand that home is the first and best discharge option for the patient, even if they are to eventually apply for LTC placement. All hospital staff that come in contact with the patient, even those not involved in their treatment (i.e. housekeeping, food services staff) must relay the same philosophy. Reinforcement of such messaging from everyone minimizes confusion when patients are about to be discharged. The health care team can also assign one point person (e.g. from the interdisciplinary care team) to continuously communicate with the patient to maintain consistency in messaging. To ensure consistent messaging, health care providers may need to review current communication materials in use (e.g. on discharge planning) and change existing information to reflect Home First language.

Education Related to the Benefits of Going Home

Most patients and families are accustomed to thinking that the hospital is the safest and best place to stay even after the acute care phase has ended. Patients and families may feel more comfortable having a doctor in the vicinity to attend to the patient if/when the need arises. Patients and families may also not be fully aware of the existing community services in place to support the patient when at home. Key messages to communicate to patients and their families to solicit their support of the philosophy are noted below. These can be verbally communicated to patients/families as well as provided through fact sheets or brochures (either from the individual hospital or from the LHIN).

- There are a number of community services available to patients to support their stay at home.
- Home is the best place for patients to make life changing decisions and to optimize independence and function.
- Staying in a hospital for prolonged periods of time makes a patient more susceptible to hospital acquired infections and further physical deterioration. This can be avoided if the patient is sent home when their acute care needs have been met.
- Patients can be managed safely in the community since a patient's health can be monitored in the comfort of their own home in a manner similar to the way it is monitored in a hospital setting.
- There are risks to the patient both in hospital and in the home. The interdisciplinary team will evaluate the acceptable level of risk to the family to incorporate the appropriate level of services to support the patient at home.

Active Participation of Families and Loved Ones in Discharge and Service Planning

Families and loved ones play a pivotal role in service planning. The interdisciplinary team should include patients' families when discussing discharge options. Early family involvement ensures that there is clarity on the level of support the family can provide and that all support options for the patient are investigated. The family should understand the importance of their role and how they can help support the patient. Often, the Case Manager and the interdisciplinary team can hold meetings with the family in person or via teleconference to discuss the patient's options and the family's role.

Planning for Roll Out

To prepare for implementation, the steering committee (in conjunction with any operational committees) must plan how Home First will be launched and subsequently implemented. There are many factors that need to be considered before deciding on a launch approach including:

- Number and size of hospitals in the LHIN
- Existing or new timelines from senior management to launch and implement Home First (i.e. are there any imposed deadlines?)
- Available financial and human resources to launch and implement Home First
- Existing initiatives at the hospital site that can be leveraged (ex. LEAN/Six Sigma events)

Consideration of the above factors will assist LHINs in determining whether the launch should begin at a specific site, a small number of targeted sites, or be rolled out across all HSPs in the LHIN at once. Each of these options is described in more detail below:

Launch at one target site

If this option is chosen, then the most appropriate site(s) must be determined. In selecting the site, it is important to consider existing organizational culture and the ability of the organization to implement a major transformational change within a short amount of time. Beginning at one site can be more effective and manageable than launching the philosophy to all hospital sites within the LHIN simultaneously. This approach also allows for lessons learned to be documented and then used by other sites in later launches. In addition, experienced hospital and CCAC staff can share the knowledge they obtained from the first site to other sites that are just beginning implementation to obtain quicker buy-in from staff, who may otherwise be hesitant to this new approach.

Launch at a small number of hospitals

The considerations for launching at a small number of hospitals are similar to launching at one specific site (e.g. existing organizational culture at targeted sites). The benefits of this approach are also similar as it is a more manageable approach where lessons learned at each site can be documented and used during the launch at remaining sites. The main benefit of this option is that results from multiple sites can be analyzed for commonalities and lessons learned will have more validity given the large sample size versus launching at a single site.

LHIN wide roll out

This approach can be executed in scenarios where the LHIN has only a small number of hospitals and/or timeline pressures exist and therefore do not permit a longer, more staggered approach. A LHIN wide roll out requires a pre-existing strong working relationship among the parties involved (more so than in other situations). With a LHIN wide roll-out, it can be challenging to share lessons learned within the LHIN when all hospitals are implementing the philosophy at once, however the LHIN can still adopt leading practices and lessons learned from other LHINs who are further along in implementation.

When choosing the launch approach, it is important to consider that many hospitals in Ontario are currently engaged in process improvement initiatives (e.g. ED performance improvement, lean/six sigma initiatives) to eliminate inefficiencies and improve patient flow. Therefore, regardless of the launch approach used, coupling the launch with any on-going process improvement activities can create efficiencies for hospitals and staff in terms of time and resources required to launch Home First. Through a coupled approach, Home First processes may not be perceived by staff as additional workload, but rather a change in how they currently do their jobs.

After choosing a launch approach, the committees need to establish timelines for roll-out (e.g. when Home First will be rolled out at each site) and milestones along the way. An evaluation plan must also be developed containing the provincial Home First performance metrics (see Section V) and any other additional metrics. Committees should also proactively identify any risks or challenges they may encounter and brainstorm mitigation strategies. More details are provided in Section IV about some of the common risks and challenges that can accompany the implementation of Home First as well as their mitigation strategies.

D. Commence Implementation

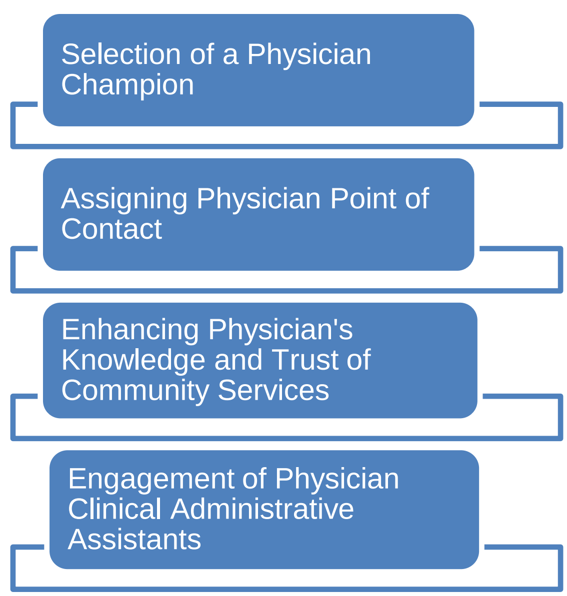
After ensuring that all components of the previous phases are completed, and that there is appropriate community capacity (i.e. CCAC/CSS services) to care for high needs seniors in their homes, LHINs and their HSPs can begin *implementation*. This means activating communication and education plans and implementing changes to supporting structures and processes as described above to promote the discharge of patients home with community supports.

Furthermore, it is important to continuously monitor the uptake of the philosophy and evaluate all aspects of Home First. This is done through regular reporting of performance metrics as well as regular verbal or written updates that should be provided to the overall steering committee. While this is especially critical during the initial stages of implementation to ensure that the philosophy is properly understood and achieving the desired benefits, constant and continuous monitoring and evaluation is also critical to success. In addition, during implementation ongoing engagement of health professionals as well as continuous communication and education are critical to success. Tools for the ongoing engagement of health professionals are described in more detail below.

Engagement of Health Professionals

Physicians

There are a number of common tools to engage physicians which are described below. However, in addition to the tools described here, LHINC's recently published Resource Guide and Toolkit entitled "Engaging Primary Care Physicians in LHIN Processes: Primary Care Physician Engagement Resource Guide & Toolkit" also provides a wealth of information and resources on engaging physicians. This guide can be found at www.lhincollaborative.ca.



Selection of a Physician Champion

A designated physician champion (e.g. Chief of Staff or other champion) from within the field of practice should be identified to facilitate physician engagement and buy-in. The physician champion must be well-educated on Home First and be a trusted physician amongst his/her peers. The champion should also have visible leadership qualities to effectively motivate others. He/she should also take charge of monitoring and reporting on the uptake of the Home First philosophy by physicians and be in a position to handle or escalate any issues related to physician non-compliance in supporting the philosophy.

Assigning a Physician Point of Contact

To ensure physicians achieve and maintain a change in mindset, physicians will need sufficient and continuous support as well as a venue to raise issues and concerns. This can be provided by assigning an individual at the hospital (e.g. Case Manager) to be the sole contact for physicians when they require assistance or have specific questions related to Home First and related processes. This individual should possess adequate knowledge of the philosophy as well as the supporting CCAC and CSS services and also be easily accessible by all physicians on site.

Enhancing Physician Knowledge and Trust of Community Services

Physicians should be constantly educated with regard to the community services available and their capacity to support a patient at home. A community services fact sheet is a tool that can ensure information regarding community services is easily accessible to all physicians. In addition, the point of contact individual mentioned above can also facilitate physician awareness of community services and how they can be utilized. Physicians' trust of community services may be enhanced through their positive experiences with Home First or by hearing about successes from physician colleagues at other hospitals. To facilitate the latter, successes should be acknowledged by monitoring patients that are sent home under Home First and keeping the physician informed of their status. Peer to peer communication amongst physicians within the same hospital and across different hospitals should be encouraged and facilitated through physician specific events to allow physicians with positive Home First experiences to share their stories with their colleagues.

Engagement of Physician Clinical Administrative Assistants

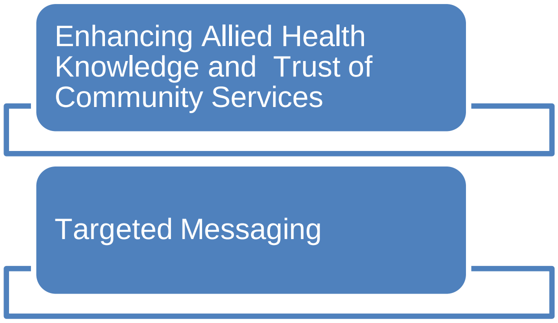
While physicians' clinical administrative assistants coordinate physicians' calendars and organize patient charts, they can also facilitate communications to physicians about Home First. Their buy-in and involvement also informs the Home First implementation team of the realities in physicians' practice that may support or impede implementation of the philosophy. When clinical administrative assistants understand the philosophy and its impact on discharge process, they can become advocates for Home First and constantly remind physicians of the changes required for Home First to be effective.

Allied Health Professionals

Allied health professionals are a key group of health care providers that must be continuously engaged in Home First. Their support is also critical to success. The following tools can be used to engage them:

Enhancing Allied Health Knowledge and Trust of Community Services

Where there are opportunities to enhance and further expand allied health professionals' knowledge and trust of community services, hospitals and CCAC must examine ways to assist further growth and development. One way is to create opportunities for allied health to connect with peers in the community who are serving hospital patients that were discharged home. This will provide allied health professionals with insight on the continuity of community care, quality, and capacity available to support patients safely in their home. Community based allied health professionals can also provide hospital based professionals with insight on community services



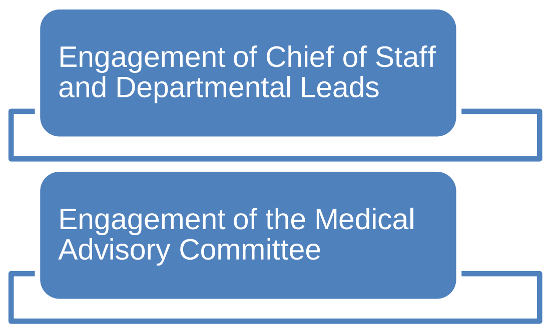
and their true quality and capacity. Through this peer to peer interaction, allied health professionals in the hospital setting will feel more comfortable about sending patients home.

Allied health can also be exposed to community services by shadowing a health care professional based in the community. This type of learning experience can serve to increase the understanding of community services amongst allied health as well as allow dialogue between hospital based and community based staff. Alternatively, a different model can be applied whereby the same in-hospital allied health professionals provide care for their patient in the community. In this case, allied health will be well versed in both hospital and community services and processes.

Targeted Messaging

Due to many factors, allied health professionals may be misinformed about the level of risk associated with sending patients home (versus staying in hospital or going to alternative institutional care), objectives and goals of Home First, and the capacity of community services. Messaging around Home First should emphasize the importance of not allowing a small number of cases where Home First did not realize intended benefits to affect the overall perception of the effectiveness and benefits of the philosophy that have been realized by the broader population.

Clinical Leadership



It is critical that all clinical leadership be continuously engaged in Home First. Their support and buy-in to the philosophy will result in support from the rest of their teams/departments. Clinical leadership can be engaged using the following tools:

Engagement of Chief of Staff and Departmental Leads

The Chief of Staff and Physician Departmental Leads should be informed of the philosophy at the very onset when informal discussions are being initiated. This recognizes the important role that physicians and physician leaders play in facilitating Home First, and will support broad physician engagement. To be effective in initial engagement efforts, clinical leadership should be engaged by executives (e.g. CEO) of the organization.

Engagement of the Medical Advisory Committee

Given demanding schedules, it can be difficult to coordinate meetings with physicians to discuss Home First. As such, pre-existing bodies such as the Medical Advisory Committee (MAC) can be leveraged to communicate with physicians, educate them on Home First and solicit feedback for engaging other physicians within the hospital. Furthermore, MAC endorsement of the philosophy facilitates buy-in from other physicians and MAC members can also spread the message to their colleagues in the hospital.

Section IV: Home First Risks and Challenges

As with any paradigm shift, there are common risks and challenges that can accompany the implementation of Home First.

A. Resistance to the Philosophy

When first beginning to implement Home First, LHINs and HSPs may experience resistance from staff. Physicians and allied health professionals may not be aware of the capacity of the community sector to support patients in home. This includes the capacity of CCAC/CSS agencies to provide services and the quality and timeliness of these services. This lack of awareness about the community care sector can impact the level of trust between hospital care providers and community care providers and lead to apprehension on the part of hospital care providers to discharge patients home.

Mitigation Strategies

To minimize resistance to Home First, it is important to have a robust communication and education plan detailing the philosophy, the benefits, and the implications on staff. This includes educating staff on the availability, quality and effectiveness of services provided by both CCAC and CSS agencies. These education sessions can be formal meetings or informal conversations where staff are encouraged to share their Home First knowledge and experiences with their peers in one-on-one conversations. Where necessary, education sessions can be complemented by home visits by hospital-based clinical professionals to alleviate concerns about safety in the home. These may be especially useful for allied health professionals to facilitate their understanding of the standards and services of community-based care. Where certain parties/individuals are especially resistant, it may be useful to involve them in formal committees developed to implement Home First. This will help them understand the rationale and decision-making processes behind Home First, as well as provide a forum to have questions or concerns addressed.

As with any change, it is important to continuously communicate the positive results of the philosophy. This can take the form of quantitative data (e.g. ALC rates) or qualitative client testimonials demonstrating satisfaction with the philosophy. Where ethical dilemmas present themselves, an ethicist can be engaged to ensure that all health care professionals in the hospital are comfortable with discharging patients home in a manner that does not breach ethical standards.

B. Sustaining the Cultural Shift

As mentioned, Home First requires a major transformational change in the way staff operate in health care organizations. Initially achieving this culture shift can be a challenge and requires considerable effort. However after organizations begin to see the required culture shift, it is critical to focus on sustaining the change to ensure that staff do not revert back to old habits.

Mitigation Strategies

In order to both achieve the culture shift at the beginning of implementation and sustain the changes that occur, it is important that all partners in Home First continuously reinforce the philosophy and supporting principles. This can be achieved through continuous communication and education on Home First. If staff begin to shift away from the Home First philosophy and revert back to old habits, it is important to be cognizant of this shift at its onset in order to mitigate it. This can be done by monitoring and sharing process metrics associated with Home First to ensure everyone is doing their part to make the necessary changes. Monitoring attendance at education sessions can also ensure that staff are attending the courses provided to understand the Home First philosophy. Although Home First communication and education should be continuous, there will be a need to have more frequent sessions at the onset and additional refresher courses if the shift in culture starts to revert back. Furthermore, when staff begin to revert back to old habits it may also be necessary to examine any potential barriers to implementing role changes and accountabilities. This includes examining all policies and procedures that are currently in place to ensure that staff are empowered to send patients home and the messaging they receive is clear and consistent.

Section V: Home First Performance Metrics

Developing an evaluation plan to monitor the performance of Home First with a combination of process and outcome metrics is critical to the success of Home First. A set of provincial Home First performance metrics have been developed for all LHINs to use to monitor Home First and must be included in the evaluation plan. These metrics were developed with input from each of the LHINs as well as the Health System Indicator Steering Committee.[1] Adopting a common set of metrics will allow for performance comparisons across LHINs and enable better sharing of success stories. Although the provincial metrics are anchored by Home First, there may be other factors that affect their performance (e.g. Average LTC LOS). As such, it is important that Home First is not implemented in a silo, but rather as one component of a system wide approach to creating positive change.

Each LHIN and their HSPs must adopt the provincial Home First metrics however they may also choose to adopt additional metrics as they feel necessary. The provincial Home First metrics are outlined in the table below (appendix L illustrates examples of the data from some of these metrics).

#	Provincial Home First Metrics	Rationale
Outcome Metrics		
1	Percentage ALC days	This measure indicates whether hospitals are creating fewer ALCs with proactive discharge planning of seniors and

[1] The Health System Indicator Steering Committee (HSISC) was established by and is supported by the LHIN Collaborative. The key mandate of this LHIN-led group is to develop a coordinated, system-based approach to indicator development, maintenance, and monitoring by allowing all health system providers to work together to achieve a high quality, sustainable health system

		improving their functional state while in hospitals. LHINs should see a *reduction* in percentage ALC days.
2	Number of ALC-LTC days	To assess how patients are flowing through the system, it is important to monitor ALC-LTC days. With successful implementation, LHINs should see a *reduction* in this metric over a period of time.
3	Percent change in LTC Waitlist (Demand for LTC)	In order to ensure Home First is mitigating demand for LTC and patients are being assessed for discharge home, percent change in LTC waitlist must be measured.
4	Annual change in clients with MAPLe scores 4 or 5 living in the community supported by: a) CCAC b) CSS (where RAI scores are available)	This metric assists LHINs in monitoring whether CCAC and CSS agencies have shifted to supporting more high needs seniors in their homes (e.g. by providing care beyond normal working hours).
5	Proportion of new admissions to LTC homes from MAPLe scores 4 or 5	This metric will allow LHINs and HSPs to monitor LTC admission and ensure that only those who need LTC are being admitted to LTC homes. This metric can be monitored annually.
Process Metrics		
1	Number of applications to LTC from Hospital	This metric will measure the uptake of the philosophy as it is being rolled out by identifying how many patients are still being sent to LTC from the hospital
2	60-day ED readmission rate	It is recommended that LHINs monitor this metric as it provides a balance to ensure that Home First is not causing negative impacts on other areas of the health care system.

Technical Specifications (including data sources) will be developed for each of the above metrics. While there are multiple outcome and process metrics, as part of the evaluation plan LHINs will need to determine a way to measure the process changes and ensure the philosophy is spreading (e.g. measuring that all patients are assessed for discharge home).

APPENDICES

Appendix A – Staff Fact Sheet Template

Staff fact sheets can be used as a supporting tool in many communication events. The information below can be used as a starting template when creating a staff fact sheet.

1. **Home First Philosophy**

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

2. **Benefits to organization and system**

   List the benefits of Home First to the organization including:

   a. *Improved integration and effectiveness in discharge planning*
   b. *Reduced ALC patients in acute care beds and shorter ED length of stay*
   c. *Better access to system resources such as hospital and long term beds for patients in need*

3. **Benefits to patients (same as those listed under patient fact sheet)**

   List the benefits of Home First to patients and their families. These can include:

   a. *Ensuring patients receive the most appropriate care in the most appropriate setting*
   b. *Allowing patients to live safely and comfortably at home as long as possible*
   c. *Avoiding life changing decisions while in hospital (e.g. LTC decision)*
   d. *Avoiding hospital acquired infections and de-conditioning due to prolonged, unnecessary hospital stays*
   e. *Optimizing patient's function and quality of life*

4. **Change in process**

   Describe the changes in discharge process and other related processes

5. **Role of staff**

   Describe role of each staff member as it relates to the changes required in discharge processes and other processes related to Home First. This should include:

   a. *Change of mindset required: Each staff member needs to think "What do I need to do to facilitate a discharge home?"*
   b. *Describe collaboration required amongst health care team, including the CCAC Case Manager where applicable*
   c. *Describe how CCAC Case Manager will be involved in the discharge planning process*

Appendix B – Patient/Family Fact Sheet Template

Patient fact sheets can be used to facilitate communication to patients/families about Home First during the patient's stay in the hospital. The information below can be used as a starting template when creating a patient/family fact sheet.

1. **Home First Philosophy**

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

2. **Benefits to the patient and family**

   List the benefits of Home First to patients and their families. These can include:
   a. *Ensuring patients receive the most appropriate care in the most appropriate setting*
   b. *Allowing patients to live safely and comfortably at home as long as possible*
   c. *Avoiding high-pressure life changing decisions while in hospital (e.g. LTC decision) when the patient is sick*
   d. *Avoiding hospital acquired infections and hospital de-conditioning due to prolonged, unnecessary hospital stays*
   e. *Optimizing patient's independence and function*

3. **Examples of supports (CCAC, CSS, hospital) available to patients at home**

   List some or all of the services (including the organization that provides those services) that can be used by the patient while at home

4. **What to expect throughout patient stay**

   a. *Describe when discharge options for home will begin to be considered and by who*
   b. *Describe the role of the CCAC Case Manager/discharge planner:*
      i. *Describe who will be predominately working with the patient/family in discussing discharge options and services available to patient*
   c. *Describe role of the patient/family:*
      i. *Describe what is required from the family to secure the required services and support (e.g. Family may have to act as back-up for the services provided or provide some level of support)*
      ii. *Encourage patient/family to be actively involved in discharge discussions early on*

5. **Contact information**

   Provide contact information for key individual/organization that can answer any patient questions regarding Home First.

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The following members of the Home First Working Group are acknowledged for their input and collaboration in developing this Implementation Guide & Toolkit.

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	Heather Reid – Director of Patient Flow & Utilization, Lakeridge Health Corporation
Long Term Care	Maria Elias - CEO, Belmont House
Primary Care Sector	Dr. Tim Nicholas – Primary Care Physician

We would like to acknowledge the following organizations for their specific contributions to the Appendices:

- Mississauga Halton LHIN, for pages 49, 50, 51, 52, 72 and 73; and
- Mississauga Halton CCAC, for pages 53, 54, 59, and 61; and
- Hamilton Health Sciences, for page 48; and
- Halton Healthcare Services, for page 74; and
- Society of Hospital Medicine, for page 60.

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