The Access To Care Approach

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

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Welcome to Access to Care!

A Message from Kelly Gillis, Senior Director, Planning, Integration and Community Engagement, South West LHIN, and Sandra Coleman, CEO, South West CCAC

Ontario's health care system is one of the best in the world. There's no doubt, however, that it faces serious challenges. According to renowned economist Don Drummond, health care could consume 80% of the provincial budget within 20 years. Mr. Drummond writes: "Canadian health systems are designed to focus on patching up people after a health problem has struck rather than taking a broader approach that might have prevented the problem

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or at least have mitigated the effects. But health matters are switching to chronic issues, in good part because the population is ageing. For much of chronic care, focusing on home care is more efficient and provides better quality."

Access to Care is a province-wide strategy focused on helping people move out of hospital and into homes and community settings quickly, smoothly and safely. Designed to address some of the challenges identified by Mr. Drummond and others, the Access to Care strategy is about ensuring that people get the right care at the right time and in the right place.

In the South West LHIN, the Access to Care strategy will improve the quality and experience of care for our patients and clients, particularly seniors and adults with complex needs.

Support from health care professionals across the LHIN will be required to successfully implement the following initiatives:

- Home First, based on the idea that when a person enters hospital, everyone will work together to get him or her home upon discharge, if at all possible.
- Assisted Living/Supportive Housing/Adult Day Program, focused on enhancing equitable access across the LHIN and implementing a new application process through the CCAC.
- Complex Continuing Care and Rehabilitation, focused on ensuring the most appropriate distribution of beds across the South West LHIN and implementing coordinated access through the CCAC.

There will also be a measurable impact on the efficiency of our health care system by reducing:

- Alternate Level of Care (ALC) days and hospital lengths of stay
- Emergency Department (ED) visits, lengths of stay, and wait times
- Long-Term Care demand

In this issue of *The Access to Care Approach*, you'll meet some of the outstanding health care professionals who have been recruited to lead these critical initiatives. You will also have the chance to read about first steps, including some early successes from Home First, which has already been initiated in London hospitals. In future issues, we'll keep you updated on each initiative and share the experiences and lessons learned.

Check out our website at www.southwestlhin.on.ca for the latest news and resources.

Home First: Up and Running in London

The Home First approach to care is based on the philosophy that when a person enters hospital, everyone will work together to get him or her home upon discharge.

Initiative co-leads Jennifer Fazakerley, Regional Client Services Manager (South West CCAC), Natalie Berkiw, Project Consultant (LHSC), and Sherri Lawson, Director (LHSC), are working to make it possible for patients with complex needs to return safely to their homes. Fazakerly, Berkiw and Lawson lead project implementation teams in both the hospital and in the community that are mapping out new processes to support Home First. Several sub-groups have collaborated to develop a screening tool for automatic referrals to the CCAC, monitor outcomes, strengthen communication, and identify and implement information technologies in support of the process.

(l to r): Natalie Berkiw, Sherri Lawson and Jennifer Fazakerley

Home First discharge planning begins when the patient is admitted to hospital. Everyone involved in the patient's care assumes that home is the destination. To support clients with high needs, the CCAC provides robust service plans, including a short-term stabilization Intensive Hospital to Home Care Plan, which can involve round-the-clock care.

Home First discharge planning begins when the patient is first admitted to hospital, and everyone involved in care assumes that home is the destination.

"Working on this initiative has really heightened my awareness of the need to talk about discharge from the point of admission," says Lawson. "It has also reminded me of the value that CCAC case managers bring to the discharge process. It's important to engage the CCAC and everyone involved to get patients home. When we do that, there are more hospital beds for those who need them most."

Berkiw says changing processes can be challenging. She and her co-leads are making an effort to involve all stakeholders, especially frontline staff members. "They live and breathe this work, so who better to redesign it?" Berkiw says. "And when staff members are involved, they own the changes."

Early metrics have shown a drop in the number of individuals designated ALC because they are waiting for a long-term care bed. There are also many anecdotal success stories. Fazakerley is delighted with the feedback so far. "Every week case managers tell us stories about clients who were able to go home, despite complex challenges. It's not easy to organize these discharges, but it's very satisfying to see patients reunited with their families and pets. When I hear those stories, I think, 'This is what it's all about.'"

Implementation of Home First began at University Hospital in September, at Victoria Hospital in December, and at St. Thomas Elgin General Hospital in January, with plans to roll out to other hospitals across the South West LHIN in 2012-13.

Jane's Story

Jane*, who lives with her daughter and son-in-law, has mild dementia and was admitted to hospital after experiencing congestive heart failure, which necessitated a pacemaker. While in hospital, Jane's recovery was delayed by gastrointestinal problems. During her month-long stay in hospital, Jane became very confused and agitated, at one point not recognizing her son-in-law. Jane's daughter became concerned about her ability to care for her mother at home.

Jane's CCAC case manager was able to support Jane and her family by developing a special CCAC care plan that included overnight care with three hours of care during the day. Within days of returning home, Jane's acute confusion and agitation lessened while her general health and quality of life improved greatly. Her CCAC case manager has since transitioned Jane's care plan to two hours per day and Jane is once again attending her Adult Day Program.

With complex physical health challenges and dementia, Jane could have been discharged from the hospital to the care of a Long-Term Care home. Because of the Home First approach to care, Jane and her family can now take the time to explore future care options for Jane without the added pressure of a medical crisis.

**Jane's name and identifying details have been changed to protect her privacy.*

Introducing the Assisted Living/Supportive Housing/ Adult Day Programs (AL/SH/ADP) Initiative

Participants of The Salvation Army - Adult Day Program

Assisted Living (AL), Supportive Housing (SH) and Adult Day Programs (ADP) are community services that enable seniors and adults with complex medical needs to live independently in their own homes and communities. These programs provide supervised social activities, meals and personal care while their caregivers receive much needed breaks. These critical services, however, are not always easy to access as they are not available equitably across the South West.

The AL/SH/ADP initiative will make recommendations about the realignment and enhancement of community capacity and, in keeping with the Community Support Services Common Assessment Project (CSS CAP), the initiative will introduce standardized assessment for community support services. Co-leads Angela McMillan, Manager of Administration and External Relations (VON), Mary Jo Dunlop, Attendant Services Manager (Cheshire Homes of London), and Shirley Koch, Regional Manager (South West CCAC), are collaborating with providers across the region to develop a comprehensive action plan.

Noting that the South West CCAC case managers will take on an expanded role in providing coordinated access to these services Koch explains, "We're engaging with providers to explore whether there are ways to work together that would make a better experience and a more complete service for our clients."

It's a complex initiative that includes many caregivers across the region, and Dunlop knows it won't be easy. "Realigning resources is tough work, but very important," she says. "I want to be part of positive change."

The co-leads have solicited information, using a variety of methods, from community partners to develop a current state assessment. As an example of their approach, more than 30 stakeholders came together in December to participate in a Value Stream Mapping (VSM) exercise. "A VSM shows a process from beginning to end with time values," says Dr. Timothy Hill, the Quality and Process Improvement Coach who led the process. "VSMs can help identify bottlenecks and duplication. They can point the way to improvement, even transformation."

(l to r): Shirley Koch, Angela McMillan and Mary Jo Dunlop

McMillan sums up the reason for the initiative: "As a result of this initiative, more clients will be able to live safely and comfortably in their homes and in the community."

What is ALC and why does it matter?

The Access to Care Strategy has several goals, including the reduction of ALC days in hospital.

Patients in acute hospital beds should be there because they need acute care services, (i.e. intensive illness treatment or recovery from surgery or injury). There are, however, a number of individuals who become "stuck" in these beds because they are awaiting services such as long-term care, complex continuing care, or rehabilitation. In other words, these patients are waiting for an Alternate Level of Care (ALC).

The more patients who are designated as ALC in a hospital, the fewer beds there are available for people who need acute care services. Moving people from the hospital and into the appropriate care settings will also help reduce wait times.

More importantly, evidence shows that seniors' health declines the longer they stay in hospital as a result of complications, lack of activity and infections, which reduces their chances of returning home and regaining their health and independence.

ATC Transitioning Team Members

It is with sincere appreciation that we recognize the contributions of Interim Project Lead, Marg McAlister and Communications Consultant, Pat Morden, who have done tremendous work leading and supporting the early stages of the ATC project.

Sue McCutcheon

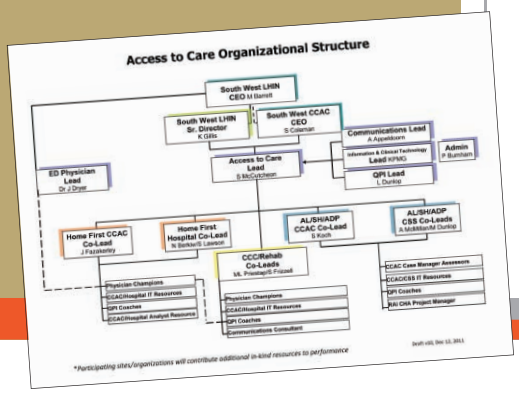
We are also delighted to welcome Sue McCutcheon as Director of the ATC project. Sue is a familiar face across the South West, having held various positions with Grey Bruce Health Services (GBHS) since 2000. Most recently, Sue was the Vice President of Clinical Services at GBHS. We look forward to benefiting from Sue's strong leadership and team-building skills.

New team members also include:

- CCC/Rehab Co-lead, Sherry Frizzell
- ATC Communications Lead, Andria Appeldoorn

WHO'S WHO?

Meet the South West Access to Care team visit www.southwestlhin.on.ca, Access to Care and click on "Organizational Structure"



Introducing the Complex Continuing Care and Rehabilitation Initiative

Mary Lynn Priestap and Sherry Frizzell

"Ultimately, the CCC/Rehab initiative is about a better quality of life for our clients and patients," explains Mary Lynn Priestap, recently retired South West CCAC Regional Manager. Priestap, a co-lead of the CCC/Rehab initiative continues, "Currently there are more CCC and rehab beds across the central and south portions of the LHIN. The objective of this initiative is to balance the need for access to these services regionally with the need for consolidated expertise to care for medically complex patients."

Fellow co-lead Sherry Frizzell, Nursing Practice Consultant at St. Joseph's Health Care, London, says the team will engage with all partners throughout the change process. "Our inclusive approach shows our commitment to developing a system that everyone is involved in shaping and feels good about." Response to this approach has been positive; requests for information have been met with enthusiasm and a willingness to share best practices and areas of concern.

The consulting firm, Optimus SBR will conduct an analysis of current CCC/Rehab resources, while working closely with the co-leads to conduct engagement and planning sessions with leaders and frontline staff members in both hospital and community settings across the South West LHIN. The team will also coordinate their efforts and share information with consultants from Healthtech, who are undertaking a Resource Matching and Referral study in four Ontario LHINs. The ultimate result will be concrete recommendations to meet future needs and implement coordinated access through the CCAC. Recommendations will be developed by March 2012.

At the same time, a new interprofessional system of assessment and referral to CCC and rehab beds will be developed and tested at Woodstock General Hospital, beginning in March 2012. The full plan will be implemented during 2012-2013.

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For more information, contact the Project Sponsors:

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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