The Access To Care Approach

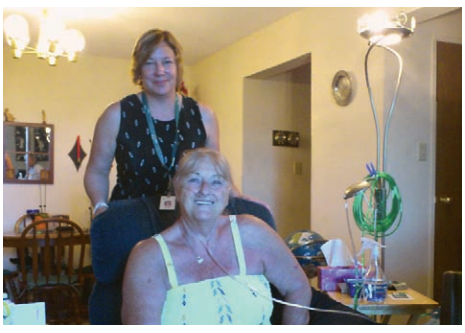
Access to Care | Right Care | Right Time | Right Place

Check us out at
www.southwestlhin.on.ca
> Current Initiatives
> Access to Care for news
and resources.

Volume: 1 Issue: 3 Date: 09 / 25 / 12

Individual commitment to a group effort – that is what makes a team work, a company work, a society work, a civilization work."

— Vince Lombardi



Moira with her CCAC case manager Peggy.

Moira's Experience with Access to Care

Recently, you may have read about Moira Beaune in the London Free Press or viewed her interview on CTV. At the age of 67, Moira knows first-hand the benefits of Home First. Diagnosed years ago with both Cystic Fibrosis and Muscular Dystrophy, Moira and her husband, Larry were able to manage her health until she fell in her apartment and acquired pneumonia.

To read more, click here

South West Partners: Committed to Improving Access

Kelly Gillis, Senior Director, Planning, Integration and Community Engagement, South West LHIN

Sandra Coleman, CEO South West Community Care Access Centre

The vision of right care, right time, right place for seniors and adults with complex needs in the South West LHIN is ambitious. To realize this vision, every health care professional in every health service organization must come together to study how our system of care works and how we can work together to improve upon the care that we deliver. To declare Access to Care "a complex project" would be an understatement.

To read more, click here

Developing Solutions Together For Improved Access

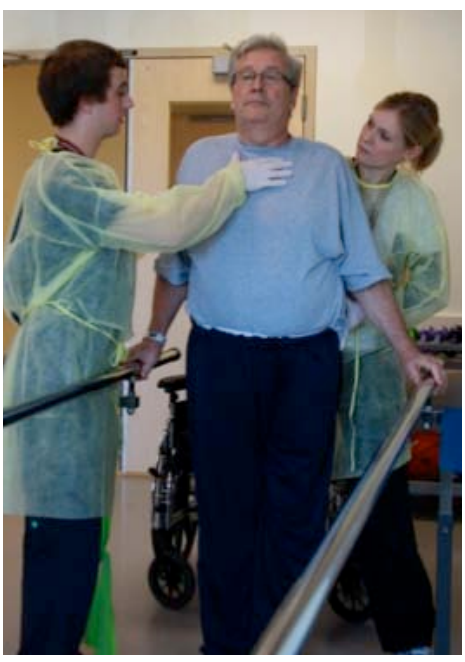
Partners across the South West have demonstrated their support for the Access to Care strategy through their actions. From committee participation to stakeholder engagement, these people and organizations have provided valuable input and significant time in consideration of the recommendations and have further committed to supporting the implementation of these recommendations. As an example, hospitals, the CCAC and community support service agencies have collaborated to implement common discharge principles, strengthen community support services and develop a coordinate single point of access. All of which will ease transitions for clients as they access the various services that will best meet their needs and support the sustained success of the Access to Care work.

To read more, click here

Why is Access to Care Important?

Seniors and adults with complex needs have not been well supported to choose home as the preferred destination following a stay in hospital. While waiting in hospital for a destination supportive of their health care needs, (often for more than 50 days), these people are at risk of mental and physical decline of 5% per day. Too many seniors are unnecessarily transitioning to long-term care instead of home, and are experiencing unnecessary waits in hospital before transitioning to long-term care.

To read more, click here



Ron, a patient in the Rehabilitation Unit at Woodstock General Hospital (WGH) works with team members Jenny (PT) and Andrew (PTA, OTA).

How will Coordinated Single Point of Access help?

Coordinated Single Point of Access (CCAC Enhanced Role) is a well-established process in the South West, where the CCAC has worked in partnership with long-term care facilities for more than 15 years to efficiently support clients in accessing long-term care. To facilitate applications to long-term care homes, CCAC Case Managers work with clients and their families to determine a client's eligibility for long-term care and to research which long-term care homes clients wish to apply to.

To read more, click here

IN THE NEWS

- South West LHIN exchange
- LHSC Press Release – Home First, Moira's Story
- Inside LHSC

PERSPECTIVES

View client stories here.

- **Floyd**
- Catherine
- Janet

REPORTS

Recommended Reports

- Assisted Living, Supportive Housing, Adult Day Programs Report
- Complex Continuing Care and Rehabilitation Report

TOOLKIT

- CCAC Expanded Role and Coordinated Single Point of Access

To find all of the information below and more click here.

Access to Care
- Fact Sheets
- Organizational Structure
- Oversight Structure

Home First
- Fact Sheets

Assisted Living, Supportive Housing, Adult Day Programs
- Fact Sheets

Complex Continuing Care, Rehabilitation
- Fact Sheets

- June 12, Webcast for Health Service Providers

FEEDBACK

To receive future issues of the *Access to Care eNewsletter* click here.

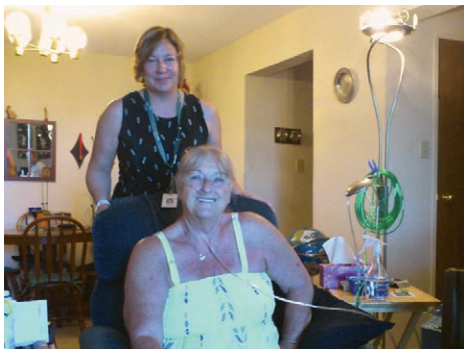
FREQUENTLY ASKED

To view FAQs click here.

Ontario
South West Local Health Integration Network

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

Volume: 1 Issue: 3 Date: 09 / 25 / 12



Moira with her CCAC case manager Peggy.

Moira's Experience with Access to Care

Recently, you may have read about Moira Beaune in the London Free Press or viewed her interview on CTV. At the age of 67, Moira knows first-hand the benefits of Home First. Diagnosed years ago with both Cystic Fibrosis and Muscular Dystrophy, Moira and her husband, Larry were able to manage her health until she fell in her apartment and acquired pneumonia.

Soon after she was admitted to London Health Sciences Centre, Moira was identified by the medical staff as a possible Home First candidate. The hospital team connected with the CCAC and together they began working with Moira on a discharge plan that would prepare her to return home before making any decisions about her future health care needs. While in hospital, doctors, nurses, occupational therapists and physiotherapists, among others, worked to ensure Moira's physical abilities would contribute to her successful recovery at home.

When Moira arrived home on that first day, her CCAC Case Manager, Peggy Callaghan had her Intensive Hospital to Home Care Plan already in place. 24 hour a day care consisting of nursing, personal support worker, occupational therapist and nurse practitioner care, along with all of the appropriate equipment (ie: a hospital bed) were already in place to provide Moira with the care that she needed. During those first few weeks, Moira and her team worked together to fine tune the right mix of services to best meet Moira's needs, gradually decreasing services as Moira's health improved.

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

As Moira considered her recent experiences, she commented, "Being at home with my husband, and all the things that are familiar to me, well, it makes all the difference."

Volume: 1 Issue: 3 Date: 09 / 25 / 12

South West Partners: Committed to Improving Access

Kelly Gillis, Senior Director, Planning, Integration and Community Engagement, South West LHIN

The vision of right care, right time, right place for seniors and adults with complex needs in the South West LHIN is ambitious. To realize this vision, every health care professional in every health service organization must come together to study how our system of care works and how we can work together to improve upon the care that we deliver. To declare Access to Care "a complex project" would be an understatement.

Sandra Coleman, CEO South West Community Care Access Centre

Over the past year, partners from organizations across the continuum of care in the South West have come together, as a team to take a hard look at the health care system. Their goals are to determine where the system can be improved for patients, clients and health care professionals and to develop recommendations to implement those improvements to the system.

The work has not been easy, but with the support of many, the Access to Care team has been able to celebrate some early successes!

- We have worked together to identify solutions to many of the issues facing seniors and adults with complex needs.
- We have built a solid partnership between hospitals and community service providers to implement the Home First philosophy of care at London Health Science Centre (University Hospital and Victoria Hospital), St. Thomas Elgin General Hospital, Tillsonburg District Memorial Hospital and at Grey Bruce Health Services (Owen Sound Hospital). Early results have been promising and have contributed to a 70% decrease in Alternate Level of Care – Long-Term Care (ALC-LTC) designations, which has also supported the overall decline in Alternate Level of Care designations.
- The Coordinated Single Point of Access through the CCAC has been adopted at select sites across the South West, with positive feedback from both clients and service providers .

The Access to Care Approach eNewsletter is intended to provide you with an update on the progress of this exciting initiative. We ask you to support the Access to Care vision by connecting with project team members and your colleagues about how Access to Care will impact your ability to provide the right care, at the right time, in the right place here in the South West LHIN.

Volume: 1 Issue: 3 Date: 09 / 25 / 12

Developing Solutions Together For Improved Access

Partners across the South West have demonstrated their support for the Access to Care strategy through their actions. From committee participation to stakeholder engagement, these people and organizations have provided valuable input and significant time in consideration of the recommendations and have further committed to supporting the implementation of these recommendations. As an example, hospitals, the CCAC and community support service agencies have collaborated to implement common discharge principles, strengthen community support services and develop a coordinate single point of access. All of which will ease transitions for clients as they access the various services that will best meet their needs and support the sustained success of the Access to Care work.

Often praised for their outstanding care and compassion, health care professionals from personal support workers to occupational therapists to primary care physicians, derive great satisfaction from providing excellent care for their patients and clients. Individually, health care providers are working diligently to provide patients and clients with the care that they need, but the question remains: does the system make it possible for people to access the right care easily when and where they need it?

Together, we are achieving results! This year, we have assisted 170 people to go home and be supported in their community who last year would have had long-term care as their only choice for care.

The following organizations have dedicated their time and energy to participate in the Access to Care Initiative:

Alexandra Hospital
CarePartners
Canadian Red Cross
CBI Home Health
Cheshire
Closing the Gap Healthcare Group
Crest Support Services
Dale Brain Injury Services
Grey Bruce Health Services
Home and Community Support Services of Grey Bruce
Huron Perth Healthcare Alliance
London Health Sciences Centre
London Regional Aids Hospice
McCormick Home
Middlesex Hospital Alliance
One Care Home and Community Support Services
Pace Homecare Services
Participation House Support Services
Participation Lodge Grey Bruce
Saint Elizabeth
St. Joseph's Health Care London
Spruce Lodge
St. Thomas Elgin General Hospital
South West CCAC
South West LHIN
thehealthline.ca
Tillsonburg District Memorial Hospital
VON Canada
West Elgin Community Health Centre
Woodstock and Area Community Health Centre
Woodstock General Hospital

Volume: 1 Issue: 3 Date: 09 / 25 / 12

Why is Access to Care Important?

Seniors and adults with complex needs have not been well supported to choose home as the preferred destination following a stay in hospital. While waiting in hospital for a destination supportive of their health care needs, (often for more than 50 days), these people are at risk of mental and physical decline of 5% per day. Too many seniors are unnecessarily transitioning to long-term care instead of home, and are experiencing unnecessary waits in hospital before transitioning to long-term care.

Detailed analysis of the health care system in the South West and the people who are accessing care confirms that services are not consistent across the South West; a person's ability to access services may be limited depending on their community, local programming, fees and funding, among other variables. Furthermore, the South West analysis shows that many people have care needs that would be better met through a different type of care:

- 37% of people in Complex Continuing Care beds
- 30% of people accessing Assisted Living services
- 20% of people in Long-Term Care
- 1,000 more people could benefit from Adult Day Programs

Year one outcomes included the implementation of Home First at London Health Science Centre (LHSC), St. Thomas Elgin General Hospital (STEGH), and the development of detailed recommendations to support seniors in accessing services in the community and in hospital settings. In Year two,

- Home First has been launched at Tillsonburg District Memorial Hospital (TDMH) and Grey Bruce Health Services (GBHS);
- Health Service Providers in each area of the South West have committed to supporting the Local Transition teams to support individuals who require an alternate level of care than they are currently receiving;
- Groups including the South West LHIN Hospital CCAC Leadership Forum, along with the Assisted Living and Supportive Housing Network and the Adult Day Program Network have committed to providing guidance in the finalization of the recommendations and throughout implementation.

Care in the Community and Post Acute Care Settings - The recommendations included in these reports reflect broad changes to the health care system in the South West and, in some instances, will result in significant change for some organizations and communities. As such, stakeholder participation in the development of the recommendations has been a priority and further stakeholder engagement has been built into the Access to Care work plan, prior to finalizing and implementing changes. The full reports and recommendations can be reviewed on the South West LHIN website, under Current Initiatives, Access to Care: CCC/Rehab Bed Draft Final Report—June 12 (CCC/Rehab Final Draft Report) and Assisted Living/Supportive Housing/Adult Day Programs Draft Final Report (AL SH ADP Draft Final Report).

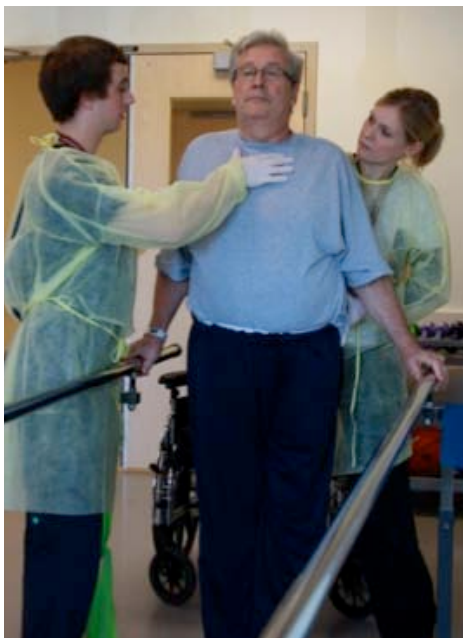
Acute Care, Home First Implementation - When a patient enters the hospital with an acute episode, every effort is made to ensure adequate resources are in place to support the patient in returning home upon discharge rather than being designated Alternate Level of Care. Significant investment in process and professional practice changes have been made in hospitals to adopt this philosophy, but care coordination assistance and robust community services are equally important to support patients upon their return home. The CCAC has established Intensive Hospital to Home Service Plans, adjusted case management practices to provide system navigation support and contracted in-home service providers with the expertise and the flexibility to provide these intensive services. Community Support Service Agencies who provide Assisted Living, Supportive Housing and Adult Day Programs have also been identified as key components of individualized care plans that support seniors to remain in their home.

How will Access to Care impact people?

Right Time, Right Care, Right Place

• Consistent elegibilty criteria • Coordinated access through the CCAC
• Standard definitions, services and programming
• Local transitions with strong links to primary care physicians

Volume: 1 Issue: 3 Date: 09 / 25 / 12



Ron, a patient in the Rehabilitation Unit at Woodstock General Hospital (WGH) works with team members Jenny (PT) and Andrew (PTA, OTA).

How will Coordinated Single Point of Access help?

Coordinated Single Point of Access (CCAC Enhanced Role) is a well-established process in the South West, where the CCAC has worked in partnership with long-term care facilities for more than 15 years to efficiently support clients in accessing long-term care. To facilitate applications to long-term care homes, CCAC Case Managers work with clients and their families to determine a client's eligibility for long-term care and to research which long-term care homes clients wish to apply to.

Throughout the process, home care is provided for the client while they remain in their own home. Both clients and long-term care homes benefit from this process as it is fair and equitable throughout the region. The CCAC has a close partnership with long-term care homes with the CCAC determining eligibility and individual long-term care homes approving applications based on their home's ability to meet the needs of the client.

The Coordinated Single Point of Access is already in place for many other services across the LHIN, including many Adult Day Programs, Transitional and Restorative Care Units, and Sakura House Residential Hospice. In March, the process was implemented at Woodstock General Hospital, with the opening of the Rehabilitation Unit.

In early March 2012, the CCAC Case Manager formally joined the Woodstock General Hospital (WGH) interdisciplinary Rehabilitation and Complex Continuing Care teams and is currently coordinating admissions for the Rehabilitation unit.

An integral member of the team, the CCAC Case Manager's role is to:

- accept referrals from "sending hospitals"
- complete initial assessment to determine eligibility for admission
- collaborate with the broader team to determine suitability for admission
- monitor and manage waiting lists
- develop discharge plans for patients

By mid-August, 54 people had been admitted to Woodstock General Hospital's Rehabilitation Unit using the Coordinated Single Point of Access system. During this time, the unit has experienced nearly 100% occupancy.

There have been multiple referrals to the WGH's Rehabilitation Unit who were identified by the team as not appropriate candidates for rehabilitation, using the standardized criteria and referral form. Examples of the reasoning include:

- patient's condition had plateaued, admission to rehab would not be beneficial
- the patient still required acute care (e.g. specialized wound care)
- patient experienced arthritis complications that required medication adjustments
- able to be discharged home with CCAC support

Wendy Abbas, Director of Rehabilitation at Woodstock General Hospital is extremely pleased with the results, "Brenda, the CCAC Case Manager is truly part of our team. She has been successful in working with the team to facilitate admissions from London, Stratford, Tillsonburg, Ingersoll and Woodstock."

This work supports a high performing system that focuses on: reducing wait times and improving utilization for CCC and Rehab beds and reducing the number of clients/patients designated as Alternative Level of Care in hospital beds.

The CCC/Rehab initiative will focus on ensuring that patients/clients across the South West LHIN have equitable access to Complex Continuing Care and Rehabilitation services through a coordinated single point of access. To achieve this goal of equitable access, the development of consistent admission, assessment and eligibility criteria is necessary. Clear admission criteria have been developed by the system partners and will be utilized by South West CCAC Case Managers to assess if an individual's care needs can be met by one of these services. As CCC and Rehab services are available in a few hospitals only, consistent processes are important to ensure that patients from all hospitals in the geographic region have easy access to the service.