The Access To Care Approach

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

Volume: 1 Issue: 4 Date: 11 / 08 / 12

"When you live alone, it is just nice to have someone to say good night to."
— Audrey, Assisted Living Client

Audrey's Experience

Audrey, who is 90 years old, has lived in or around Tillsonburg for most of her life and enjoys all of the benefits of living in her own home. Knowing that a personal support worker will be there twice a day, morning and night has provided Audrey and her family with peace of mind and the people who support her have contributed to her quality of life.

Audrey's face lights up when she talks about the people in her life. While these people certainly include her friends, children and grandchildren, they also include the home care workers who support her. They help Audrey get dressed in the morning, bathe, fix light meals and prepare for bed, among the other necessities of her daily life.

Recently, Audrey fell while getting out of bed one morning. Although she was not hurt, she was unable to get up off of the floor. Because Audrey knew that a personal support worker would arrive within minutes for her scheduled visit she was able to wait patiently without the added stress of wondering when she would be found.

Without Assisted Living services, Audrey believes that she would not be able to remain in her home.

South West LHIN Investment in the Community Sector

Access to Care released reports in June 2012, available at www.southwestlhin.on.ca that recommended more adult day program spaces be made available, that 'Home First' continue to be spread within the South West, that a 'urgent needs' fund be established to ensure that money was not a barrier in transition to community programs, and to explore enhancement of transportation and home help services. Consistent with these recommendations the South West LHIN Board approved the following:

- Expansion of home first to Tillsonburg, Owen Sound, Woodstock and Ingersoll
- Implementation of a Community Support Service Urgent Fund
- New Adult Day Program spaces in London and Grey Bruce
- Enhanced transportation programs in London and Middlesex
- More Home Help in Elgin, London and Middlesex.

QUESTIONS TO PONDER

What is the impact to the client and their caregiver when there is a perceived lack of communication between providers?

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

FEEDBACK

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

FREQUENTLY ASKED

To view FAQs click here.

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

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

Assisted Living, Supportive Housing and Adult Day Programs Help People, Like Audrey, to Stay in the Community

Assisted Living, Supportive Housing and Adult Day Programs (AL/SH/ADP) can be described as the services that wrap around clients to support their decisions to live independently in the community. For clients and their family members and caregivers, the significance of these services and the organizations that deliver them is fundamental to living life as fully as possible.

VIEW THE VIDEO

Tanya Bowman of Tillsonburg and District Multi Service Centre (MSC) describes how Assisting Living helped one couple stay together on their farm.

It was with careful consideration of the lives of individual clients and the detailed analysis of statistics that the AL/SH/ADP Committee developed recommendations to:

- realign and enhance community capacity in assisted living, supportive housing and adult day programs to meet the needs of our region
- implement the Community Care Access Centre's (CCAC) coordinated single point of access role to coordinate equitable access to these important services for all clients
- implement a common assessment tool for Community Support Services, to ensure that all clients receive consistent, high quality assessment

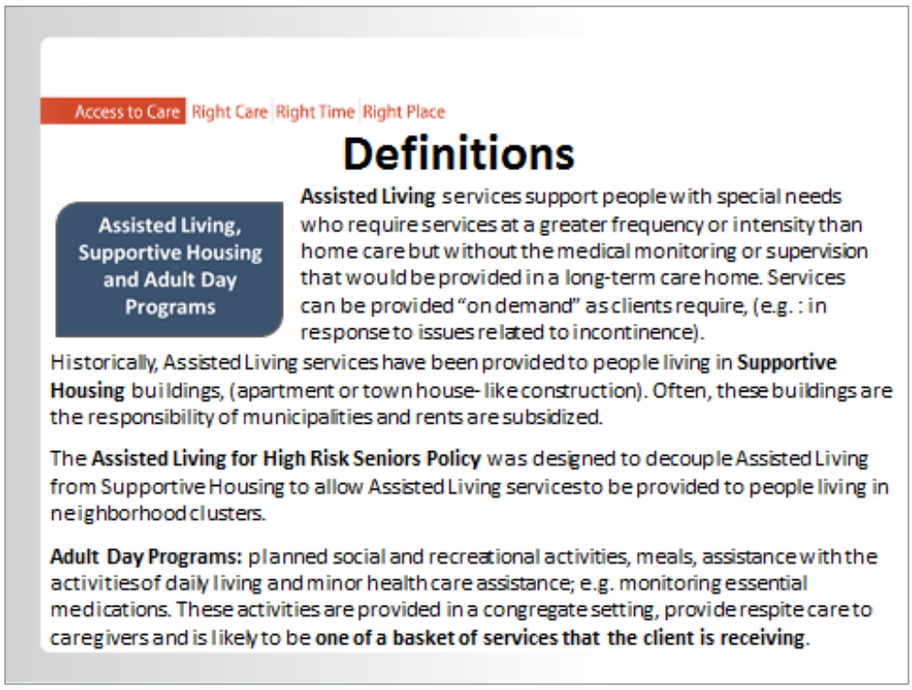
The recommendations can be grouped into four main themes:

- formalization of Assisted Living/Supportive Housing and Adult Day Program Networks
- implement CCAC Role to coordinate access to these services
- increase Adult Day Program spaces
- alignment of individual care needs to the services available

Among the benefits of reaching these goals, more clients will be able to live safely and comfortably in the community. They will experience easy and seamless transitions across the health system and will require decreased Emergency Department visits and hospitalizations.

Since the report was submitted the province has released a revised ALS_HRS Policy, and work is underway to determine how this policy will impact residents of the South West.

To read the AL/SH/ADP report, click here.



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Helping People Return Home

What has changed for a patient who presents at a Hospital in the South West which has implemented the Home First approach?

"It is exciting to see the transformation occurring. I see first-hand, the collaboration between team members, hear them speak of the benefits of the Home First approach to care for our patients and our system as a whole. Having the opportunity to hear about our patient's journey, their successful transitions home and their positive feedback has really added value and meaning to our work as well." – STEGH Employee

VIEW THE VIDEO

Dr. Amelia McCabe of St. Thomas-Elgin General Hospital talks about the advantages of Home First for clients.

At St. Thomas Elgin General Hospital (STEGH), patients, family members and employees have all been impacted with the adoption of the Home First philosophy of care. From the moment a patient arrives at the hospital, everyone works together on a discharge plan that will enable the patient to return home, safely and as quickly as possible. Upon returning home, the patient is supported with a care plan, appropriate to their individual needs, prior to making any decisions about moving from their home to long-term care or alternate destinations.

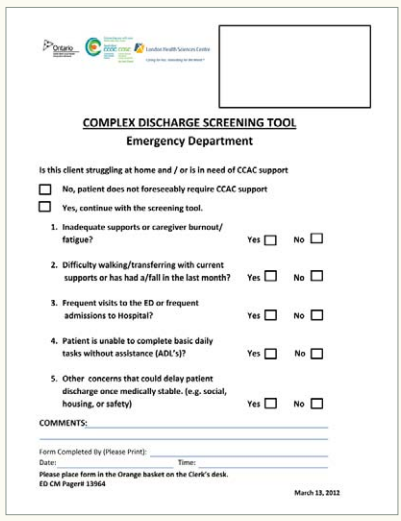
At STEGH, the Home First philosophy has been widely embraced by hospital staff, including Dr. Amelia McCabe.

The impact of the Home First culture shift will continue to be closely monitored as new processes and electronic tools are established to support the philosophy. Examples include:

- Metrics are compiled on a weekly and monthly basis to understand the Home First impact. Inconsistencies in the data are quickly identified and researched, while patient journeys are reviewed in detail to understand pivotal events.
- Work is ongoing to refine an Alternate Level of Care (ALC) sign off process to ensure that team members consider all options for discharge home before a patient is designated ALC – long-term care.
- eScreening is an electronic tool that prompts hospital staff to ask patients key questions to assess their need for a CCAC referral.

< Please see the "paper versions" of the Complex Discharge eScreening tools to the left.

COMPLEX DISCHARGE SCREENING TOOLS



COMPLEX DISCHARGE SCREENING TOOL
Emergency Department

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

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

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

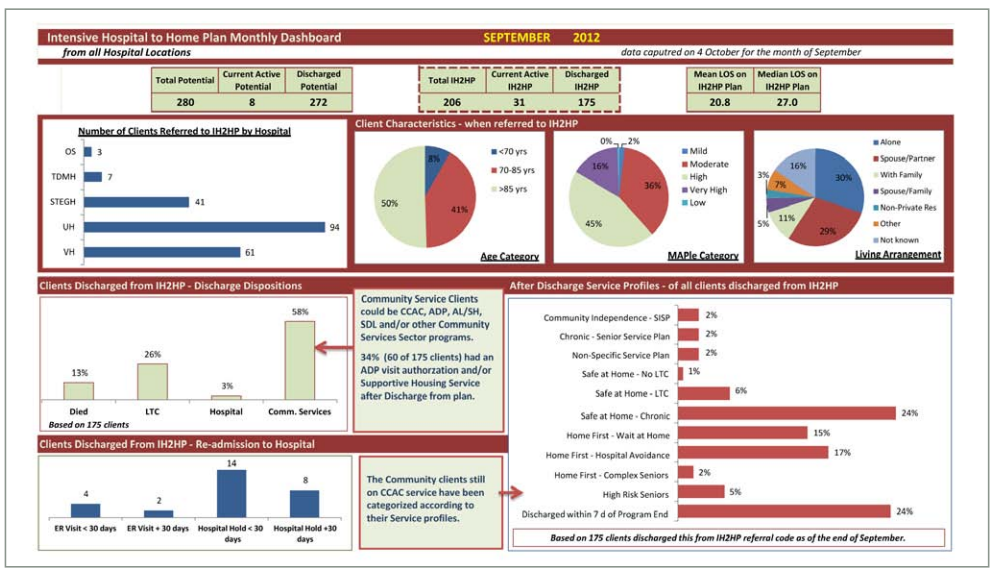
COMMENTS:

Form Completed By (Please Print):
Date: Time:
Please place form in the Orange basket on the Clerk's desk.
ED CM Page# 13964
March 13, 2012

To view the Complex Discharge Screening Tool - ED click here.

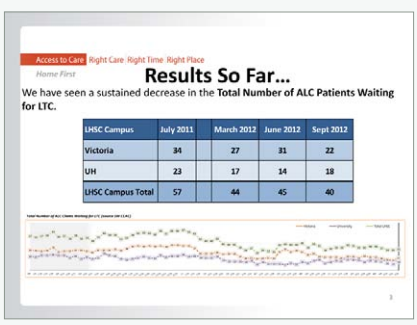
To view the Complex Discharge Screening tool - Inpatient click here.

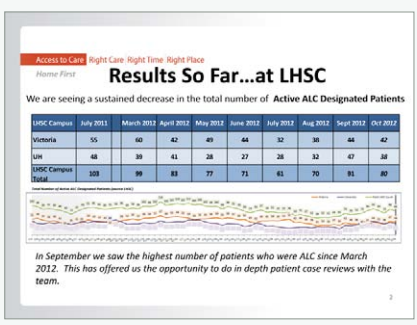
INTENSIVE HOSPITAL TO HOME PLAN MONTHLY DASHBOARD

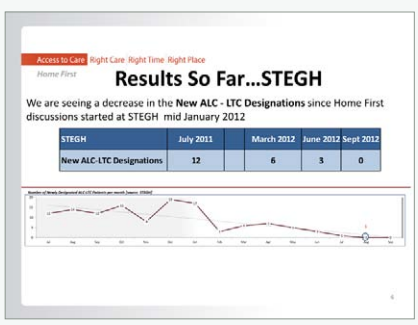


To view the Intensive Hospital to Home Plan Monthly Dashboard click here.

HOME FIRST METRICS - OCTOBER 2012







To view the Home First Metrics in detail click here.

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Sherry Frizzell

Angela McMillan

Kristy McQueen

Thank you and best wishes

Sherry Frizzell (Co-lead, CCC/Rehab), Angela McMillan (Co-lead, AL SH ADP) and Kristy McQueen (interRAI CHA Project Manager, AL SH ADP) have each demonstrated incredible commitment to the Access to Care project. Without exception, these individuals have contributed compassionate perspectives, professional expertise and strong analytical skills in supporting the development of recommendations to improve health care delivery for clients in the South West.

It is with the greatest respect that we acknowledge their Access to Care work and wish them all the best as they continue to provide leadership in their respective organizations. We know that they will continue to make a difference in the lives of the patients and clients they serve. Thank you!

Asha Rawal

Margo Collver

Welcome to the Access to Care team

Welcome to Margo Collver, (AL SH ADP Co-Lead) and Asha Rawal, (CCC/Rehab Co-Lead)

Asha Rawal has been a social worker in London for the past 12 years. She graduated with her Bachelors in Social Work in 2000 from UWO King's Colleges and a Masters in Social Work from Wilfrid Laurier in 2002. Currently employed at LHSC with the acute medical care teams, she is passionate about supporting patients as they navigate and understand the healthcare system. To have the opportunity to learn more about health care from a holistic systems perspective is very exciting.

"Health care today is undergoing many changes and challenges; to be a part of a team which looks to understanding the patient and his/her journey along their illness and supporting them in their homes or in other organizations which best meets their needs is good work being done." – Asha Rawal

Margo Collver is a Registered professional social worker with over 15 years experience working within the Long-term Care and Community Support Sectors in Middlesex and Elgin Counties, and the City of London. For the past 5 years, Margo has worked with VON Canada as a Care & Service Manager, overseeing both Assisted Living and Adult Day Programs in Middlesex County. Margo participated in the planning and implementation of the Behavioural Supports Ontario overnight respite beds within the South West LHIN, and was instrumental in the development of the Supports for Daily Living cluster model pilot in the Ailsa Craig community. A history of working in community health care and supporting aging relatives has given Margo the desire to be part of the positive change that is occurring with the Access to Care work.