The Access To Care Approach

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

In This Issue

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Faye, Oxford County's First Home First Client

The first person to return home in Oxford County, guided by the Home First philosophy was Faye. Having experienced a fall in her home, Faye was admitted to hospital. During her three months in hospital, Faye lost considerable weight, felt disoriented, and missed her home in the country, her knitting and her computer.

When the possibility of trying to return home first was raised, Faye and her daughter Robin did not hold out much hope, but they were determined to try. With her arm in a sling and multiple medical concerns, Faye had 24 hour care from personal support workers, as well as scheduled visits from occupational therapists, physiotherapists and nursing care, but those first few weeks were not easy. At the end of the second week Faye and Robin made the decision with their CCAC Case Manager, Nancy to move forward with Faye's long-term care application.

Faye, at home with her Care Coordinator Nancy, PSW Betty and daughter, Robin

About the start of the third week, however, Faye's health improved remarkably when the sling on her arm was removed. Both Faye and Robin were surprised when she started using her arm out of habit, without experiencing pain. From that day on, Faye's outlook and health has continued to improve. Her CCAC Case Manager, Nancy remains involved, as she still requires daily support from a Community Support Service Agency to help her with her personal needs. At this time, Faye has no plans to move to a long-term care home. To learn more about Faye's experience, click here.

Home First in the South West Recognized at HealthAchieve!

It was an honour to be recognized in Pat Campbell's closing remarks at the Ontario Hospital Association's HealthAchieve 2012 in November, with only two other provincial projects. Read the entire speech by clicking here.

"This initiative shows the power and importance of close collaboration in improving patient experiences, and everybody—from front line hospital staff to policy advisors at the Ministry of Health—should take the lessons learned through Home First, particularly about collaboration, to heart. Well done, LHSC, the South West LHIN and CCAC…and to all of the participants in Home First projects across Ontario!"

- Pat Campbell, OHA President and CEO

QUESTIONS TO PONDER

Hospitals are undergoing major changes in funding mechanisms as well as accountability for quality of care and partnerships. What strategies need to be considered in order for a successful reallocation of complex care and rehabilitation services to take place?

IN THE NEWS

- South West LHIN announces additional funding for community services (under New Releases—top right)
- South West CCAC: Increasing Public Awareness Newspaper Insert

FREQUENTLY ASKED

- Common Access to Care (ATC) Acronyms
- Definitions of eScreening, eReferral, and eNotification

REPORTS

Recommended Reports

- AL/SH/ADP
- CCC/Rehab

FEEDBACK

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

Access to Care
356 Oxford Street West
London, Ontario N6H 1T3
519-474-5693
Sue.McCutcheon@sw.ccac-ont.ca

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

Ontario South West Local Health Integration Network

South West CCAC / CASC Community Care Access Centre

Ron, a rehabilitation patient speaks with Stacey Sim, Charge Nurse at Woodstock General Hospital

Access to Care in Oxford County

Home First has been implemented at a number of hospital sites with successful outcomes for more than 250 people who have been discharged home on a CCAC Intensive Hospital to Home service plans and has reduced the Alternate Level of Care – Long Term Care (ALC-LTC) designations in the South West LHIN. Home First was implemented at Tillsonburg District Memorial Hospital in July 2012 and at Alexandra Hospital, Ingersoll in November 2012.

Access to Care however, is about so much more than just Home First. This initiative will strengthen support for people while they live in their homes, minimize the negative effects of acute episodes and maximize post-acute health to ensure people are able to make optimum decisions about their lives. In Oxford County, work has begun to support people throughout the system.

The Tillsonburg Implementation Team is taking action to implement the recommendations detailed in the Assisted Living, Supportive Housing and Adult Day Programs report. To date, the team has reviewed existing Adult Day Program eligibility tools, referral processes, wait list, and caseloads. Testing updated versions of these tools is well underway to determine what additional revisions will be required to best serve clients. The team is now repeating this process for the Assisted Living and Supportive Housing.

The team's work will involve a review of the services that each client is receiving to ensure that the right combination of services are in place, based on each client's individual needs. Further, the team will consider the needs of people being served by the CCAC to determine if they could benefit from Assisted Living, Supportive Housing or Adult Day Programs. The work is intensive but necessary to ensure fair and equitable access to services.

At Woodstock General Hospital, (WGH) Coordinated Access to the Rehabilitation Unit has been in place since March 2012, with improved access for patients from Oxford County and the surrounding communities. To learn more about Coordinated Access at WGH, click here. In mid-December, Home First planning will start at WGH with plans to extend the Coordinated Access process to Complex Continuing Care in the New Year. On November 22, 2012, **Alexandra Hospital (AH) in Ingersoll launched both Home First and Coordinated Access** to their Complex Continuing Care unit.

These exciting shifts in the way we serve people, in keeping with the Oxford County Master Aging Plan, will positively impact quality of life for Oxford County seniors and adults with complex needs. The rest of the South West LHIN will also benefit as a result of the valuable learning in Oxford County as we all work together to utilize our health care resources to the greatest benefit. To read Oxford-County's Master Aging Plan, click here.

South West LHIN, Oxford County

Access to Care: Studies Continue

Mary Jo Dunlop

Mary Lynn Priestap

The AL/SH/ADP report concentrated on the needs of seniors in the community and recommended that the same consideration be applied to adults living in the community with Special Needs. The CCC/Rehab report identified the need to consider Restorative Care/Convalescent Care opportunities. These studies are expected to bring forth recommendations in the spring of 2013. **We are pleased to advise that Mary Jo Dunlop, Attendant Service Manager, Cheshire has agreed to lead the review of the Special Populations report, while Mary Lynn Priestap, Co-Lead of the CCC/Rehab report has agreed to lead the study of Restorative Care/Convalescent Care.**

Home First at St. Thomas Elgin General Hospital, *Sustaining the Home First Philosophy*

Recently, the Home First team at the St. Thomas Elgin General Hospital (STEGH) reached a significant milestone with the 50th patient to be discharged home with a CCAC Intensive Hospital to Home service plan, as a result of the Home First philosophy of care. Since implementing Home First as a philosophy of care in January 2012, the Hospital and Community teams have contributed tremendous time and energy to the initiative, building strong relationship during this process.

"I feel that the Home First is performing very well and it has served two purposes. Firstly, our number of ALC/Awaiting Placement patients has significantly decreased. Our longest length of stay on the CA (Clinical Associate) teams is consistently below 30 days, which is an impressive improvement from previous years. Secondly, I feel the message regarding the inappropriateness of admitting family members for awaiting placement is starting to permeate through the community. I feel this is directly related to the work of CCAC and our team to get these patients home quickly once medically stable." ~ Dr Terry Evans, STEGH Hospitalist & ER Physician, July '12

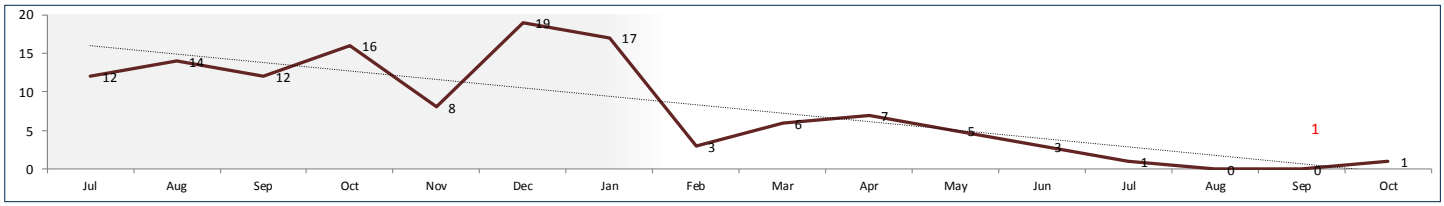
Bernice, returned home from STEGH during the summer as a result of Home First.

Since Home First was initiated, the team has identified and worked to understand the professional practice changes required for the Home First philosophy to become truly ingrained in the STEGH culture. The Hospital Implementation team was established as an interdisciplinary team to represent the diverse Hospital community. Communication with Hospital employees was identified early as a key success factor and team members made it a priority to ensure that the Home First message was repeated often, with multiple opportunities for employees to learn more.

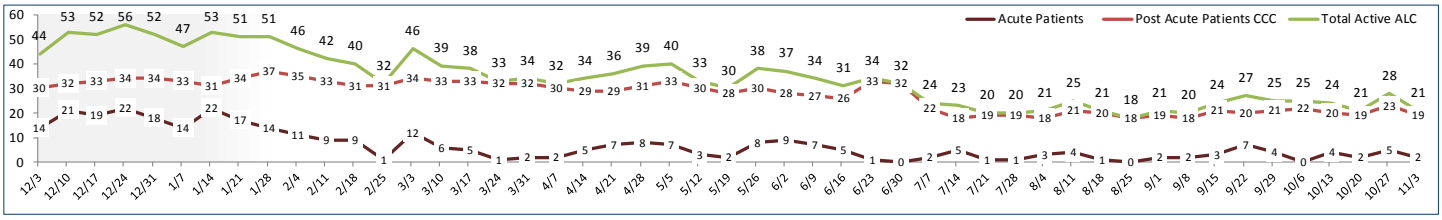
As importantly, the Home First message was shared with patients and their families early and often. From the moment a patient arrived in Hospital, they were reassured that all members of their care team were working together, with the CCAC and community partners to help get patients home, quickly and safely to make future decisions. To read STEGH's information for patients, click here.

STEGH Home First Metrics - click here to read the STEGH Home First October 2012 Report

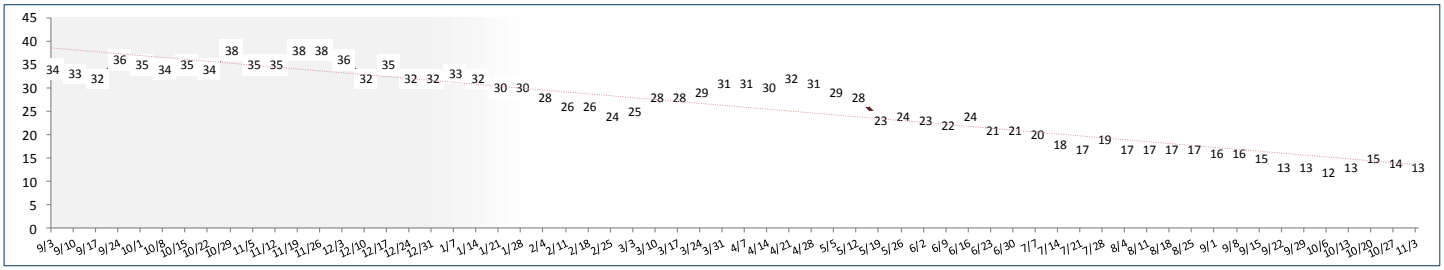
Number of Newly Designated ALC-LTC Patients per month



Total Number of Active ALC Designated Patients



Total Number of ALC Clients Waiting for LTC



Congratulations on a job well done!

While there have been many activities during the last year that have contributed to the success of Home First in Elgin County and in the broader South West LHIN, a few key activities include:

- An in depth review of how ALC designations were applied and subsequent changes to support the consistent use of ALC designations.
- A detailed review of all Alternate Level of Care – Long Term Care (ALC-LTC) patients, when Home First was initiated:
  - ⇒ to determine if they could be discharged home with the Intensive Hospital to Home care plan and
  - ⇒ to ensure that they had identified a minimum of three long-term care homes on their applications.
- The STEGH discharge planning policy was updated to include the Home First philosophy.
- Hospital employees increased referrals to CCAC for patients not requiring intensive service in their homes, but who would benefit from CCAC services.
- Joint testing of eEnablers with LHSC
  - ⇒ eScreening
  - ⇒ eReferral
  - ⇒ eNotification
- Development of an ALC-LTC designation sign off process to ensure that all options have been considered prior to applying the ALC-LTC designation.

Early Days—The St. Thomas Elgin General Hospital Team working together in January 2012 to implement Home First.

" I feel the shift happening already but it will take us time to change everyone's thinking."
-STEGH AMU Nurse Clinician Nancy Berman

Community Implementation Team

Anita Cole, Regional Client Services Manager, SWCCAC
Barb Modesto, Client Services Manager SWCCAC
David Heaton, Closing the Gap
Diane Dodge, Intensive Case Manager, SW CCAC
Eileen Cunningham, St. Elizabeth Health Care
Jean Bennett, St. Elizabeth Health Care
Jennifer Fazakerley, Home First Lead, SW CCAC
Jennifer Jackson, Client Services Manager, SW CCAC
Kim Irwin, Business Intelligence, SW CCAC
Maureen White, St. Elizabeth Health Care
Nupee Hardeep Sandra, Regional Quality Manager, SW CCAC
Sandra McDonald, Home First Lead- Elgin SWCCAC
Sherry Fletcher, Regional Client Services Manager, SW CCAC
Tracy Matheson, St. Elizabeth Health Care
Yvonne Either, Client Service Manager Closing the Gap

Hospital Implementation Team

Brenda Emre, Nurse, ED, STEGH
Cathy Fox, Communications, STEGH
Jen Hilt, RN Clinical Informatics Specialist STEGH
Jennifer Fazakerley, Home First Lead, SW CCAC
Jodi Edwards, Home First Lead, STEGH
Kathy Court, Occupational Therapy STEGH
Kathy Kinsella, Social Work STEGH
Laurie Browne, Case Manager, SW CCAC
Lisa Martens, Social Work STEGH
Lori Clifton, STEGH
Mike Lalonde, Physiotherapy STEGH
Nancy Berman, Nurse Clinician STEGH
Sandra McDonald, Home First Lead-Elgin, SW CCAC,
Sherry Fletcher, Regional Client Services Manager, SW CCAC
Suzen Cornell, Case Manager, SW CCAC

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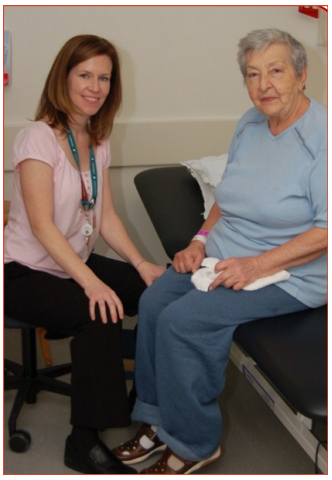
Coordinated Access

Patients in transition from one level of care to another need to understand all of the care options available to them and how best to access services in relation to their individual circumstances. Partners across the continuum of care are responsible for working together to provide patients/ clients with the best possible information with which to make their decisions.

Coordinated access is the phrase used to describe the new admission process to assisted living, supportive housing, adult day programs, complex continuing care and inpatient rehabilitation. Individuals, their families and health care providers (including their family physician) will access these services by contacting the CCAC Care Coordinator and then working together to get needed services in place.

- Patients/clients, their families and care teams are empowered by this process. Having access to all of the information and resources that they need enables them to make informed decisions and participate more fully in their care.
- Health and Community Service Providers benefit by caring for patients/clients who need their respective levels of care, enabling them to work to their maximum level of profes- sional skill and expertise.



Rose, a patient at the Woodstock General Hospital Rehabilitation Unit discusses her care with Physiotherapist Jillian.

How do team members work together using Coordinated Access?

Referral ⬇	• An individual is identified as potentially benefitting from specialized service or community care • Referral is made to the CCAC by a health care professional in the hospital or in the community, a friend/family member or the individual themselves.

Assessment and **Reassessment** ⬇	• A CCAC Care Coordinator will work collaboratively with the individual, their family and hospital/primary care team to assess the individual's needs through active listening and discussion and to develop a plan of care that will outline:
	  ◦ type of service
	  ◦ length of time
	  ◦ Health and/or Community Service Provider
	• Jointly, the Health and/or Community Service Providers and the CCAC Care Coordinator review the individual's abilities and needs with respect to the eligibility criteria and consider resources that are required to meet the individual's specific needs (including specialty equipment)
	• The CCAC Care Coordinator monitors the patient/client's progress to ensure that the care plan is effective and will reassess as scheduled or as needed

Admission ⬇	• The Health and/or Community Service Provider accepts or declines (with rationale) the individual as a patient/client and determines how best to provide care for the patient/client utilizing their respective expertise
	• *If the appropriate service is not available or the client is deemed an inappropriate candidate for the intended service, the CCAC Care Coordinator will work with the individual to explore alternatives which may include*
	  ◦ *receiving service in a different community, or*
	  ◦ *deciding to wait for services to become available*
	  ◦ *considering alternate health or community service*

Ongoing Services and/or **Discharge**	• The Care Coordinator maintains contact with the patient/client, their family and care team to ensure that the care plan is meeting the needs of the individual • In cases, where the care plan is only available for a limited time, the care coordinator will work with the patient/client and their care team to reassess the patient/client's need

To review the Coordinated Access Fact Sheet, click here.