HOME FIRST –
THE CENTRAL EAST JOURNEY

PRESENTATION TO THE
Central East LHIN BOARD
July 24, 2013

Drivers for Change

- ALC rate was continuing to grow in Central East LHIN – by definition, these patients are not receiving care in the right place at the right time

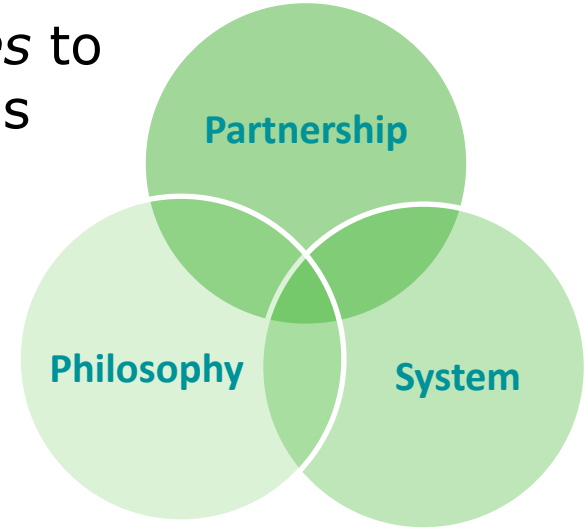
- Home First is a proven and effective philosophy of care that is being delivered in hospitals across Ontario

- Studies have shown that extended periods of time in hospital can have significant negative consequences on patients

- A mechanism was required to facilitate safe and timely transitions back to home.

What is Home First?

- A *philosophy* that promotes safe and timely care, services and supports to meet healthcare needs of patients and families in the most appropriate setting – it applies to all patients
- A partnership among Central East LHIN, hospitals, CECCAC and Community Support Services to prevent the creation of ALC-LTC cases
- A system of *people, processes and services* to '**pull**' patients back into the community…as opposed to creating more '**push**'



What are the Benefits to Patients?

1. Patients are in their own home where they want to be.

2. Patients and families are able to make life-changing decisions related to future living accommodations from the comfort of their own home – returning back into the community.

3. Patients' health, independence and well-being are maintained longer.

4. The risk of patients getting a hospital acquired infection, or suffering from functional decline is reduced.

5. Patients and caregivers are able to receive the benefit of services offered by CECCAC and community support agencies.

Overall Tenets of Home First

"Every patient admitted to the hospital should expect to be discharged home at the end of the acute period of care."

- Decisions about major changes in lifestyle should be made from home, not from hospital.
- CCAC is the 'destination determiner' & 'system navigator' for all patients in need of community services on discharge.
- Consistent messaging about discharge from anyone in contact with the patient.
- The guiding principles included that the philosophy provided a client centered approach.

Managing Expectations

Home First WILL

✓Reduce patient deconditioning in hospital

✓Reduce ALC designation rate in hospital

✓Reduce LTC applications completed in hospital

✓Prevent avoidable admissions to hospital

✓Remove barriers to patient discharge

Home First will NOT

×Affect patients currently on ALC - LTC wait list in hospital

×Create new LTC capacity

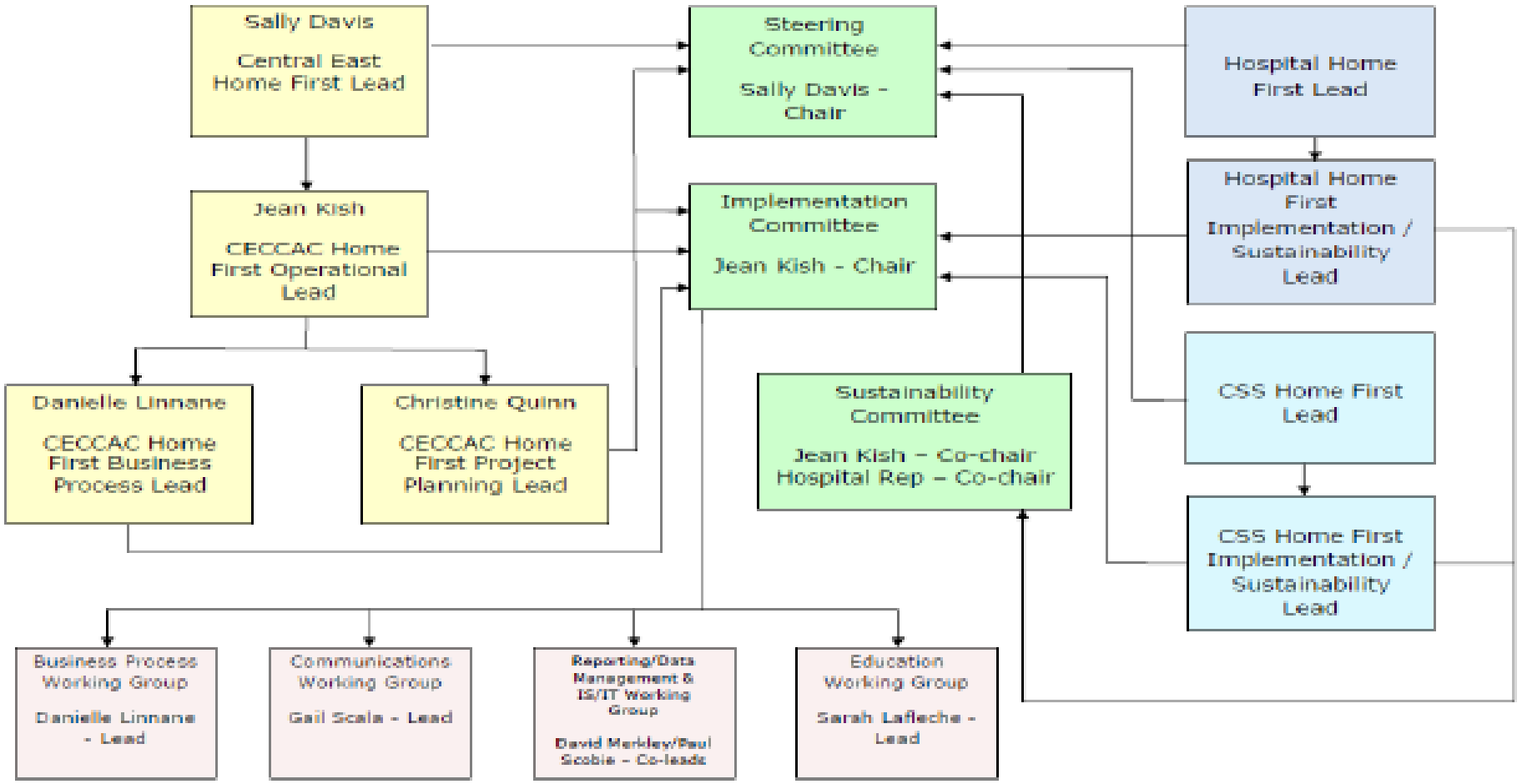
×Reduce services available to clients currently in community

×Prevent all ED re-visits

×Prevent all hospital re-admissions

* Except for the 2-week pre-launch period

Home First Committee Structure



Working Groups Overview

- **Business Process - Danielle Linnane, Lead**
  - Creation of current and future state process maps
  - Facilitate understanding of the process to address barriers to discharge
  - Identify current methods of communication between partners and opportunities for improvement

- **IS/IT & Data Management/Reporting – David Merkley, Lead**
  - Creation of tunnel and common table to share data, alerts, and notifications
  - Sharing of Outcome, Process, and Balancing Indicators

- **Communications - Gail Scala, Lead**
  - Update the Communication Plan template in regards to tactics, timelines, and stakeholders
  - Development of on-going internal communication vehicles

- **Education - Sarah Lafleche, Lead**
  - Creation of collaborative education package to be rolled out to all staff within partner organizations
  - Support internal education roll-outs with representation from all partners to answer questions
  - Development of on-going education for new and current staff to support sustainability

- **Project Management - Christine Quinn, Lead**
  - Development and updating of project workplan
  - Identification of any roadblocks and determination of resolutions/workarounds.

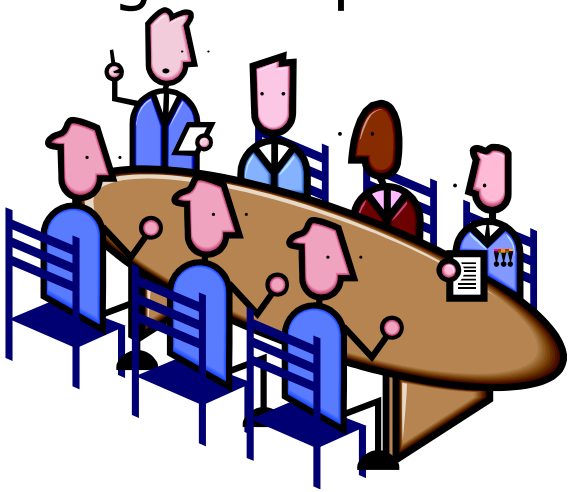
Home First Governance Structure

LHIN-wide

Sustainability Oversight Committee

Metrics group

Costing Group



Per hospital

Implementation Team

- Working Groups

Sustainability Oversight Committee

Operations Committee

Root Cause Analysis Team (TRAC)

Home First Enablers: Pre-Launch

- ✓ Comprehensive Communication and Education re: new processes and philosophy
- ✓ Engagement of CSS Agencies
- ✓ Pre-Implementation ALC patient review and Priority 1 status
- ✓ Data sharing tunnel
- ✓ Establishment of Working Groups

Home First Enablers in Hospital

- ✓ Ongoing Communication & Education
- ✓ Information Management (Real time data/notification)
  - Automated notification of common clients
  - Automated screening of patients for discharge delay risk
  - CCAC to Assess through Order Entry
  - Automated ALC Alerts
- ✓ Patient Activation Initiatives
- ✓ Interdisciplinary Teams
  - Bullet rounds
  - Discharge Support & ALC Root Cause Analysis processes
- ✓ Early Engagement of CCAC/CSS

Home First Enablers in Community

- ✓ Enhancement of CCAC Personal Support Services
  1. PSW support in excess of normal service maximums
     - 15-56 hours per week for a 2 week period, transitioning over a 4 week period to a maximum of 60 hrs/monthly
     - Early pull of clients into the community (up to 5 days earlier service)
- ✓ Enhancement of Community Support Services
  1. One-time interventions
     - Construction of wheelchair ramp, payment of utility bills, delivery of wood, etc.
  2. Services related to IADL (Instrumental Activities of Daily Living)
     - Transportation, settlement, PSW, home maintenance, etc.
     - Over and above services already provided by CSS

Early Engagement of Community Support Services (CSS)

✓CSS Enhanced Care Coordinator (ECC) on-site at hospital (when required).

- Early engagement through an electronic notification system (eForm).
- Participation on the Discharge Planning and Root Cause Analysis Team (TRAC) meetings where required.

Early Engagement of CECCAC

- ✓ Participation in ***daily discharge rounds*** and updates on the ***unit whiteboard***
- ✓ Dedicated CECCAC Care Coordinator Manager in the ED
- ✓ Electronic Notification to CECCAC Care Coordinator

- **Common Client**
- Patients who are at risk for **Discharge Delay**.
  75 > with 2 or more Risks:
  1. History **or** evidence of cognitive impairment
  2. Difficulty walking/transferring **or** recent falls
  3. ED use in previous 30 days **or** hospitalization in previous 90 days
  4. Lives alone **or** no available caregiver
- Notification for "**CCAC to Assess**"
- **ALC Alerts**

The start of the Home First Philosophy

- The official launch of Home First occurred on September 7th, 2010 and spread out across all other Lakeridge Health sites during the month of September.
- The Home First approach created a collaborative hospital and community process to improve care for clients and families.
- This approach provided enhanced coordinated community services early in the admission process to directly impact the creation of Alternative Level of Care (ALC). The goal was to *optimize the use of existing community resources* to achieve a successful implementation of the Home First philosophy.

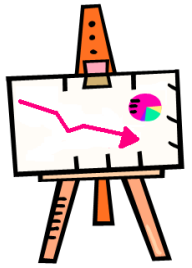
Home First Implementation Schedule

1. Kick-off Meeting
   5 weeks pre-launch
2. 8 weekly Implementation Team meetings
3. Soft Launch/Priority 1 status
   Two week ALC patient review
4. Hard Launch
5. Post Go-Live Debriefing Meetings by teleconference
   - Daily for week one, Monday/Wednesday/Friday for week two
6. Bullet Rounds Support Plan
7. Process Review and Root Cause Analysis team (TRAC) established
   - Planning meeting
   - TRAC Meetings
8. Operations Committee Meetings ongoing

OUTCOME AND METRICS

Tangible

- 10 hospital corporations and 15 sites launched
- Approximately 20,000 clients discharged on enhanced services to date
- Reduced ALC designation rate



Intangible

- Improved working relationships among CCAC, CSS, and hospitals
- Impro

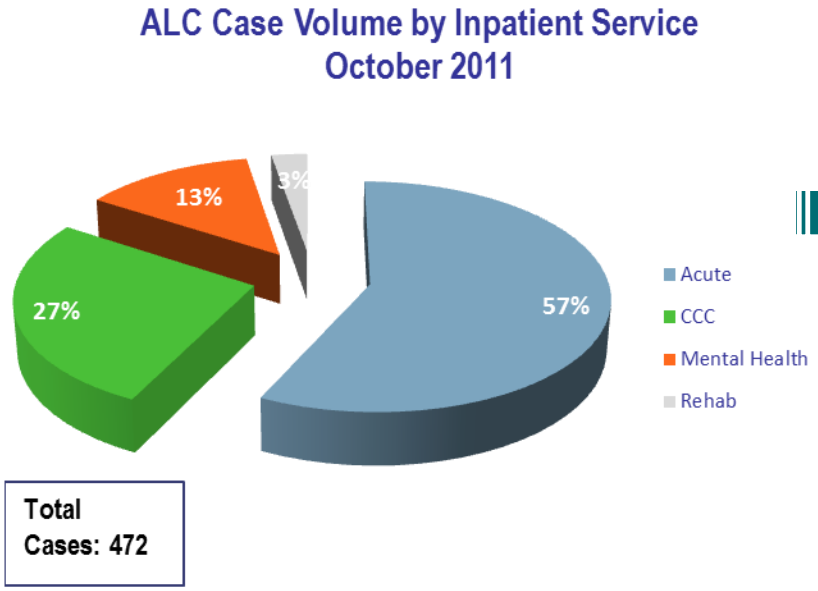
Home First Metrics

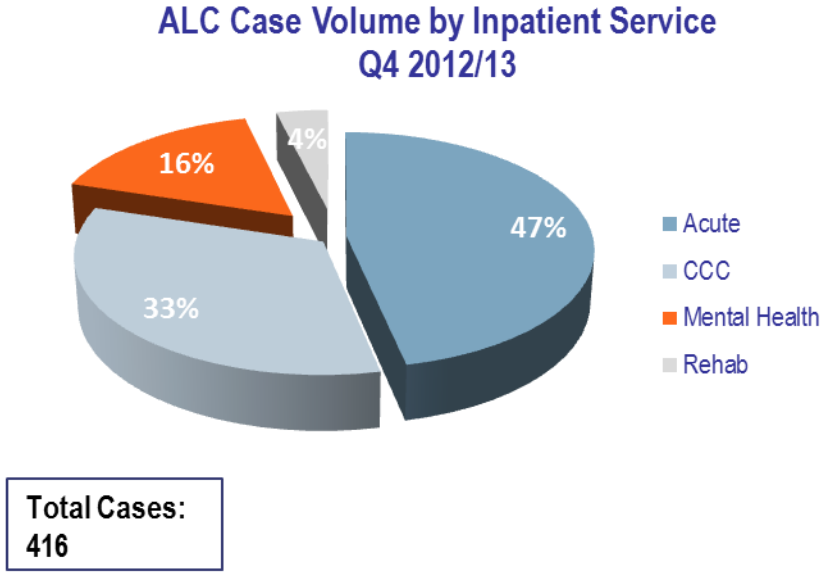
- Total Patients Designated ALC
- Total Patients Designated ALC-LTC
- ALC Designation Throughput Ratio
- Total New ALC Designations
- Total New ALC-LTC Alerts
- Total New ALC-TBD Alerts
- ALC Designations Within 48 Hours of Admissions to Hospital (NB. This metric is currently suspended as we are no longer able to access the data from WTIS and are awaiting confirmation from the Oversight Committee whether to retire the metric or have hospitals submit data manually to CCAC)

Home First Metrics

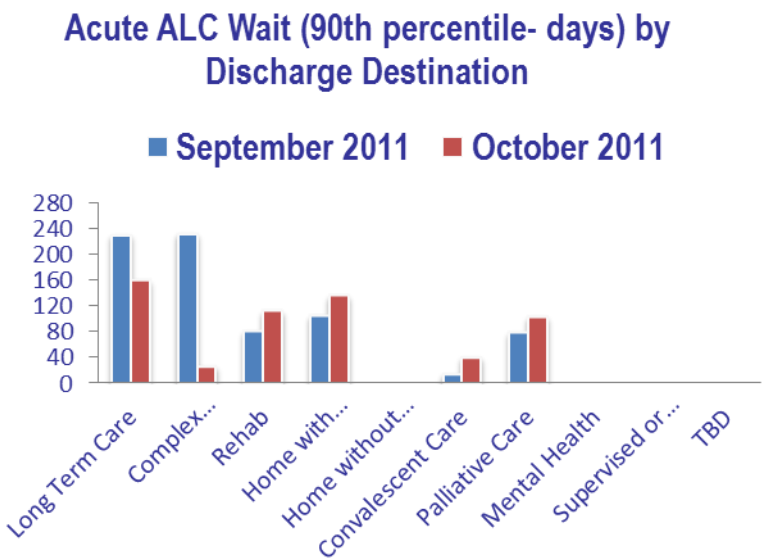
- Average Length of Time from CCAC Notification to CCAC First Contact with Patient
- Average Length of Time from CCAC First Contact to Early Engagement of CSS
- Number of Patients Discharged to Home on Enhanced CCAC Services
- Number of Patients Referred to CSS for Early Engagement
- Number of Patients Referred to CSS that were Assessed to be Eligible for CSS Enhanced Services
- Number of Patients Discharged from ED with New or Changed CCAC Services
- Number of Crisis Placements of Enhanced Services Clients
- Number of CCAC Enhanced Services Clients on LTCH Wait List with Crisis Status
- 7 Day ED Revisit Rate for CCAC Enhanced Services Clients
- 7 Day Inpatient Readmission Rate for CCAC Enhanced Services Clients

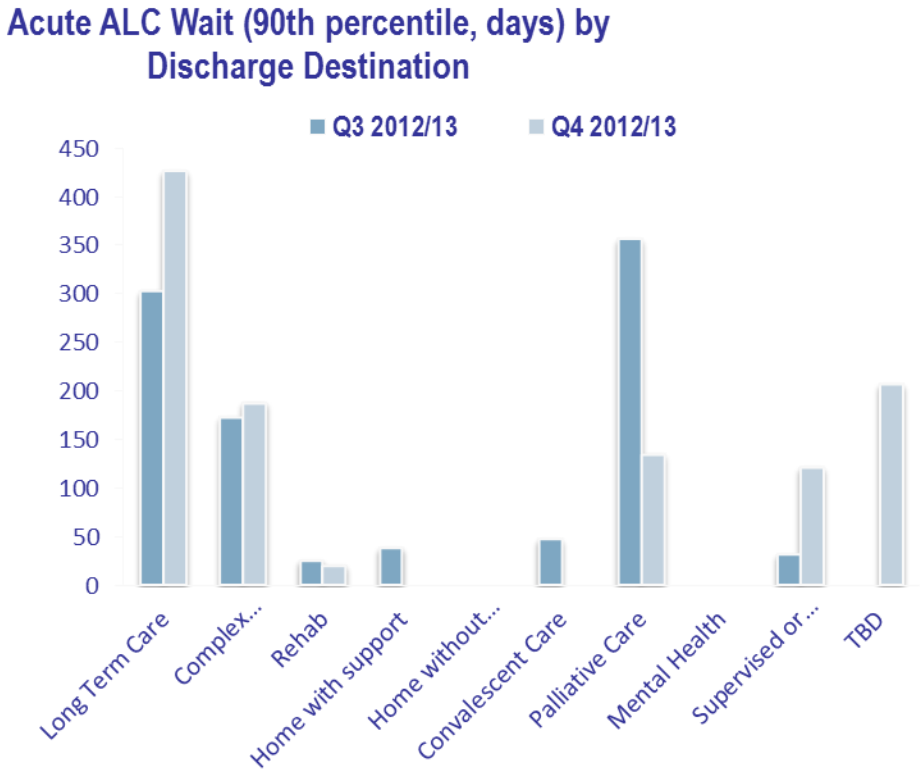
OVERALL NUMBER OF ALC CASES





ALC Wait (Days)

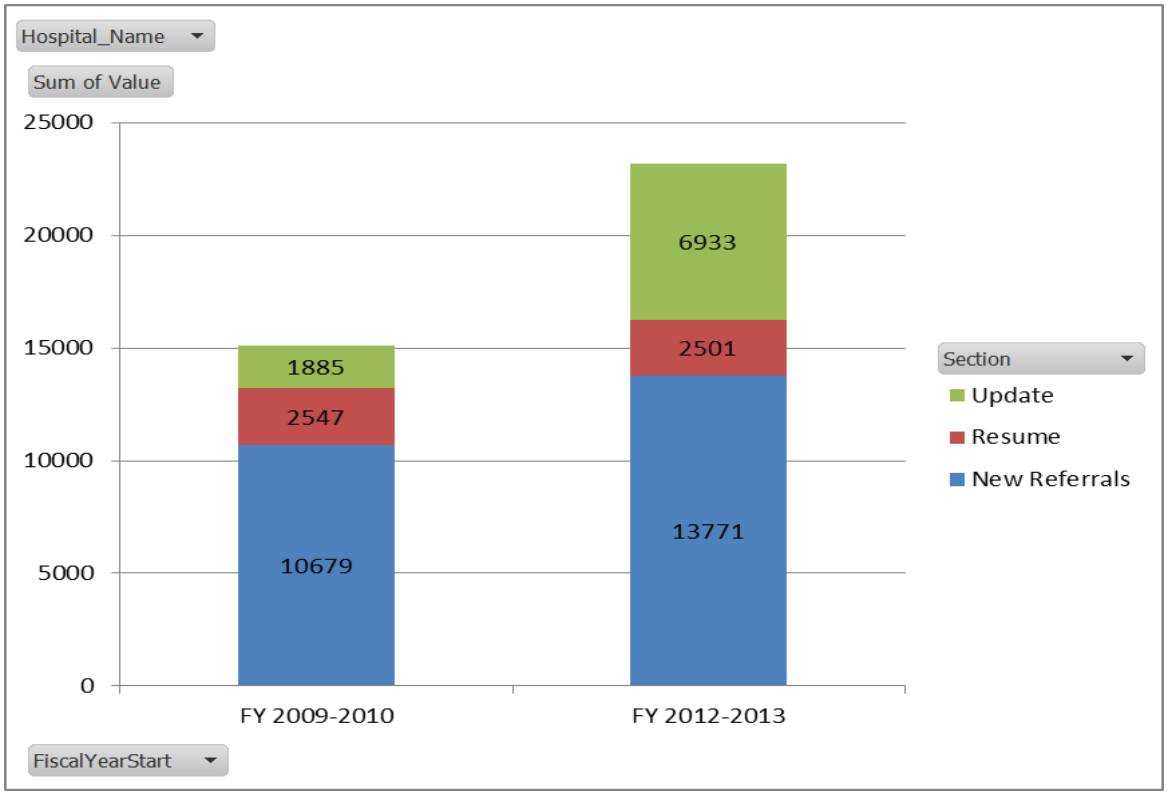




CECCAC SERVICE VOLUMES

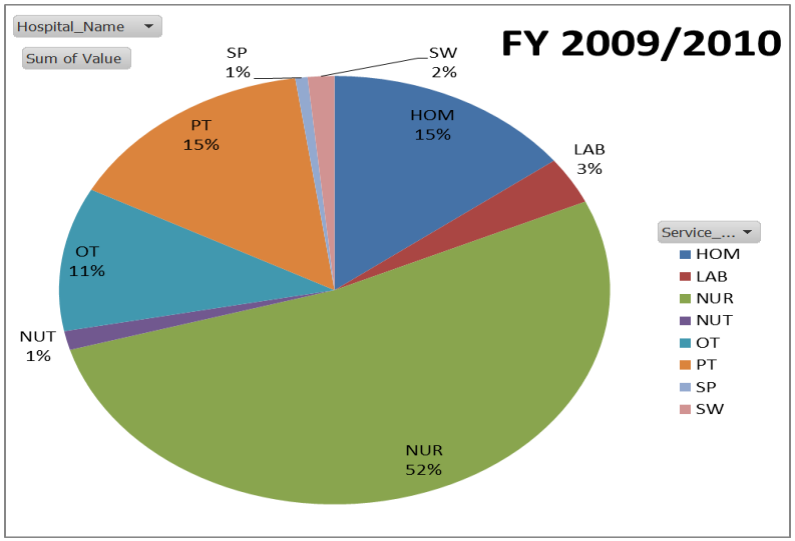
	New Referrals	Resume	Update	Grand Total
FY 2009-2010	10679	2547	1885	15111
FY 2012-2013	13771	2501	6933	23205
Grand Total	**24450**	**5048**	**8818**	**38316**

New Referrals	29%
Total Activity	54%

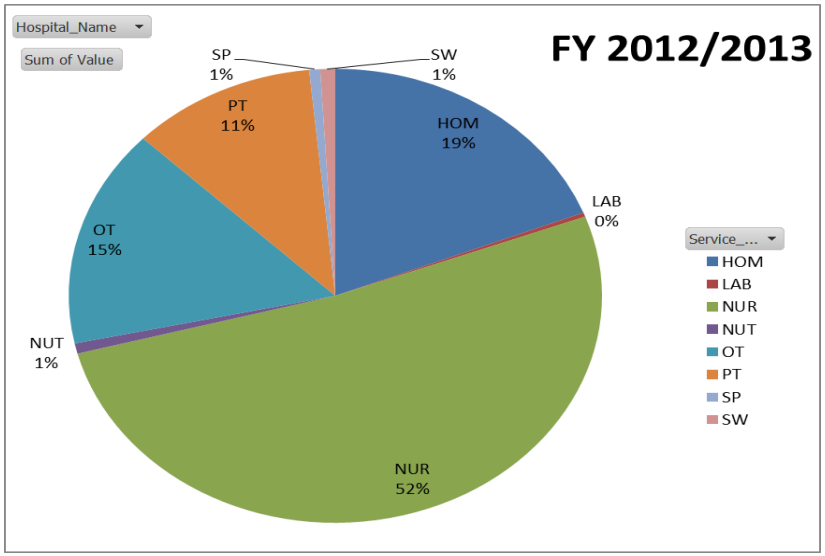


CECCAC SERVICE NUMBERS

	Sum of Value
HOM	3172
LAB	767
NUR	11302
NUT	310
OT	2344
PT	3230
SP	156
SW	338
Grand Total	**21619**



Row Labels	Sum of Value
HOM	4238
LAB	66
NUR	11482
NUT	163
OT	3464
PT	2504
SP	147
SW	202
Grand Total	**22266**



Patients Designated ALC-LTC Pre and Post Home First

Hospital Corporation	ALC - LTC Pre Home First	ALC-LTC as of May 31, 2013	% Decrease
CMH	**9**	**4**	**55%**
HHHS	**3**	**1**	**67%**
LH	**133**	**89**	**55%**
MSHU	**5**	**2**	**60%**
NHH	**7**	**7**	**0%**
OS	**64**	**23**	**64%**
PRHC	**106**	**42**	**60%**
RMH	**33**	**22**	**23%**
RVHS	**84**	**58**	**31%**
TSH	**73**	**30**	**59%**
CE Total	**517**	**278**	**54%**

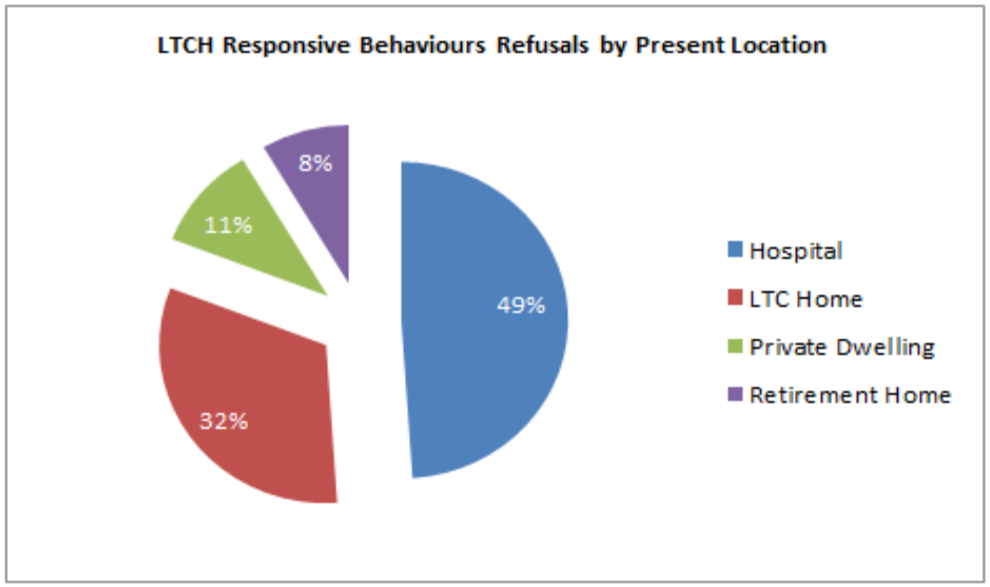
* ALC-LTC Pre Home First were counted as each hospital corporation initiated the Home First philosophy

Community Care Referrals from Supportive Referral Coordinator (SRC) and Hospital Enhanced Care Coordinator (ECC)

April 2012 – March 2013		
Home First Referrals	ECC	2,927
Community Referrals	SRC	1,695

LTCH RESPONSIVE BEHAVIOURS REFUSALS BY PRESENT LOCATION JUNE 2013

Present Location	UnqiueReferralCount	Percentage
Hospital	23	49%
LTC Home	15	32%
Private Dwelling	5	11%
Retirement Home	4	8%



SUSTAINABILITY

Central East Home First Sustainability Oversight Committee

PURPOSE:

To provide a venue for cross organizational review of region wide trends, issues and the sharing of best practices related to sustaining the changes resulting from the implementation of the Home First philosophy.

Objectives

- Ensures the operational culture of each partner; Central East Community Care Access Centre (CECCAC), Hospital, and Community Support Service agencies (CSS) supports the Home First philosophy;
- Ensure individual organization initiatives and strategic priorities are aligned with the Home First Philosophy.
- Reviews performance trends which include Home First outcome process indicators.
- Recommend system wide improvements based on the identified trends.
- Facilitates communication between partners;
- Provides a forum for problem solving and decision-making,
- Promotes continuous improvement through the sharing of best practices.

Home First Operations Committee

- Purpose is to monitor the operational metrics and review results of Root Cause Analysis Team (TRAC) meetings.
- Identify trends/opportunities that are required to be brought forward to the Central East LHIN Home First Sustainability Oversight Committee meetings.

Lessons Learned

- The success of Home First relies on joint ownership and collaboration. The process is about putting the patient first and look for opportunities for improvement. It is about a solution focused approach versus culpability.
- Once the Central East LHIN informed the hospital and community partners that Central East CCAC was the lead for the deployment the project progressed as this provided clarity to allow the CCAC to progress the project.
- Better understanding of the internal environment within each hospital, and how this impacts their readiness for change. This would better identify hospitals whose internal environment would set the stage for success
- Better understanding on the Hospitals capacity to assist in the development of the electronic enablers
- Hospitals where Senior Team embraced joint ownership for implementation of the Home First Philosophy together were more successful with the culture shift

Lesson's Learned (cont'd)

- Those hospitals who embraced a senior friendly culture including Patient Activation demonstrated greater improvements
- Dedicated CCAC secondment was critical for the progress to deploy such a philosophy in a short timeframe.
- In order to ensure sustainability, the philosophy needs to be incorporated into new staff orientation processes
- Hospitals that continue to focus on the sustainability processes created with Home First (TRAC, Operations) see better results
- When CCAC and/or hospital identify other opportunities for improvement, consideration on the need to align with Home First philosophy and processes is required to optimize success
- Model utilized (working groups) was an effective model for successful implementation within a challenging time frame
- The importance of all partners changing the "language" when talking to patients and families.

ccac Community Care Access Centre
casc Centre d'accès aux soins communautaires

Questions?