HIGH IMPACT PRACTICES

Evidence-informed practices in home and community care that result in better care, better outcomes and better value.

HOME FIRST

Maximizing use of investments while creating better outcomes for seniors and reducing ALC

his High Impact Practice describes how the health system partners in the Mississauga Halton Local Health Integration Network employed two key strategies to respond to the increasing numbers of individuals designated as 'alternate level of care'. The strategies targeted the growth equation and the process for designating individuals to LTC placement.

Home First is a new philosophy used by the hospitals and the Community Care Access Centre (CCAC) in the Mississauga Halton Local Health Integration Network (MH LHIN) area borne out of the need to address significant patient flow issues within hospitals. As in many jurisdictions, too many individuals were waiting in hospital beds for 'alternate levels of care' (ALC), particularly for Long Term Care (LTC). The provincial estimate was that 75% of ALC demand across Ontario was for LTC beds. This situation created challenges in health system resource utilization and, more importantly, in the quality of life experience for individuals needing health care support.

Despite a number of investments in initiatives to enable faster discharge from hospital and/or negate the need for individuals to access the emergency room, the number of patients waiting in hospital within the MH LHIN was growing at a startling rate (the number of ALC days nearly doubled from 9.3% in 2007 to 17.5% in 2008) with no clear end in sight.

Home First leveraged the MH LHIN investments in enhanced community resources; changed workflow processes; identified roles and responsibilities for members of the health care team; and, actively promoted a shift in culture regarding the care and flow of elderly patients.

The traditional approach to hospital discharge planning was revised; the CCAC case management approach was restructured; and a concentrated approach to build and foster trust and confidence in the health care system was undertaken so that all providers would be aware of, and understand, the full range of settings and resources that are available to safely take care of the frail elderly at home in the community.

BACKGROUND

Health systems across Canada are striving to improve health care by providing the right service at the right time and place. Two key indicators of success are: 1) emergency room utilization, and 2) alternate level of care (ALC) rates. In Ontario, improving performance in these two areas is a priority for the Ministry of Health and Long-Term Care (MOHLTC) and Local Health Integration Networks (LHIN).

ALC designation is applied to a patient when s/he is occu- pying a bed in a hospital and does not require the intensity of resource/services provided in this care setting. High ALC rates mean that patients are receiving care in an inappropriate setting; and that the system is overloaded creating a backlog in emergency rooms (ER).

Leveraging system partnerships and trust, Home First is supporting seniors to successfully transition back to the community where they can make longer term decisions about how and where they wish to live.

In March 2007 the Mississauga Halton LHIN (MH LHIN) launched an 'appropriate level of care strategy' and began making significant investments in the community in order to avoid inappropriate ER utilization and enable prompt discharge from hospital. A number of programs to enable faster discharge from hospital were funded, including:

- **Wait at Home** – a program designed to facilitate hospital discharge with appropriate supports while planning and waiting for transition to long term care; supports for daily living, adult day programs, etc. An enhanced service pack- age of up to 56 hours per week of personal support worker (PSW)[1] time is provided for a sixty day period.[2] The applications for service are completed at home.
- **Stay At Home** – funding for 106 seniors at significant risk for institutionalization (with high RAI-HC3 MAPLe4 scores) and currently on 60 hrs of PSW services and waiting for LTC in the community. Clients receive a service maximum of 90 hours PSW services per month. Many clients have found this level of service sufficient to delay, or even defer need for LTC.
- **Geriatric System Navigation** – a program offered through the CCAC to which any person 75 years of age or older that has been treated and released from the ER is automati- cally referred for assessment and linkage to appropriate community resources. Allows for discussion of care options for seniors and the identification of risk factors that might have triggered a visit to the ER. The MH LHIN estimates that this program will address about 16,000 ER visits across the Region per year.
- **Adult Day Programs** - existing programs were expanded to offer greater community services to serve more of the frail elderly – those with higher RAI–HC MAPLe scores. New special- ized programs for individuals with more complex needs (i.e. Alzheimer's) have been developed and programs have been extended closer to where seniors live.
- **Supports for Daily Living (SDL)** – a service model which separates Supportive Housing and Care Delivery. The model supports an average 1.5 hours of PSW services per day delivered throughout the 24 hour period to meet clients' more frequent needs. Services are available to clients at scheduled times or as needed, anytime of the day within a 24 hour period, 365 days a year. Services are designed for clients with overnight needs or more frequent visitation than those services offered through the CCAC.

These programs produced results, but the ALC to LTC patient ratio was growing! The team realized that in order to decrease hospital ALC to LTC not only was it necessary to address the need for more services in the community but it was also necessary to address the process for designating individuals to LTC placement. The Home First initiative was created.

- **Outreach Programs** - Psychogeriatric outreach teams and Peel Halton Acquired Brain Injury Services (PHABIS) work with hospitals, CCAC and LTC to support transitions to LTC for 'hard to serve' patients. PHABIS is funded to provide on- site care in LTC (up to 8 hrs / day) and offers Adult Day Services to LTC residents with ABI. Both providers help with behaviour escalation management to support LTC staff and avoid unnecessary transitions to acute care.
- **Restore Program** - a 'sub-acute' transitional service similar to convalescent care. It is a specialized LTC unit for acute patients who require additional time (~4-8 weeks) and reactivation to enable them to go home. The patients have higher acuity than the typical LTC resident and would otherwise have been identified as ALC in hospital and put on a trajectory for a LTC facility. To date the average length of stay in the program is 44 days and 80% of patients are able to go home.
- **Nurse Practitioners in LTC** – funding to provide LTC Nurse Practitioner coverage to all 27 LTC homes in MH LHIN. The Nurse Practitioners focus on building clinical capacity within LTC homes; supporting on-site care to avoid inappropriate transfers to acute care; and assisting with timely repatriation of residents from acute care back to LTC.

IMPLEMENTATION

The Home First concept was born out of the recognition that fundamental changes to approach and process needed to be adopted. This meant that a patient designated as ALC in the hospital should not be routed to Long-Term Care. Indeed, LTC placement is a social process and it is more appropriate for this transition to occur from home.

Why waiting at home is the BEST solution:

- A reduced risk for hospital acquired infections
- A reduced risk for hospital associated de-conditioning
- Allows time to optimize functioning post-acute care prior to committing to a permanent major housing decision
- Home is the best environment to experience the significant life transition of moving to (in most situations) the patient's final residence, a nursing home.

Home First is predicated on leveraging the enhanced investments in community care services; creating operational processes to enable access to community care services; and promoting a shift in culture to committing to care options outside of hospital.

The principles are that:

- All efforts will be made to discharge the individual back home where longer term planning can happen.
- All discussions regarding LTC or other community options will occur outside of acute care.
- Clinicians will always consider home as the first option as opposed to immediately designating LTC as a solution for the individual.

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Home First was developed and launched first with the MHCCAC at Halton Healthcare Services. There was urgency because of the high level of ALC to LTC patients. Implementation occurred through the rapid cycles of improvement methodology. The first meeting to launch the initiative was with CCAC hospital case managers and discharge planners. A meeting with the physicians followed. All staff were supportive of the concept in principle. The physicians prefer to have their patients at home if they can be appropriately supported.

Changing the Culture

Historically, education and messaging around ALC within the health care team was focused on hospital utilization data including ALC days, Length of Stay and the need to reduce ER wait times and increase access to care. Home First messaging was a shift. It focused on safety and quality of life benefits for discharge home post acute-care stay.

HOME FIRST ELEMENTS

Role of Health Care Team Members

- The commitment and collaboration of the whole team is required. Many patients have complex situations and needs. Often the solutions are not easy and the plan is not a "one step" plan.
- Identify barriers that may prevent timely discharge and refer to appropriate professionals to resolve discharge related issues.
- Provide consistent messaging to the patient and family that the patient will be discharged home from hospital. A sample script for physicians was developed in order to facilitate consistent messaging about ALC but not setting LTC expectations prematurely.
- Facilitate complex discharge planning to interim care in those situations where patient needs dictate, while still communicating the ultimate goal of being discharged home.

Home First Role of the Hospital CCAC Team

- The hospital CCAC case manager assesses all options for discharge home.
- The CCAC serves as a bridge to community based solutions while application processes are undertaken and case managers use system navigation skills to connect patients with community resources available to support safety and independence at home.
- The assessment is completed and plans reported back to the team.This has not created the need for more CCAC staff as the workload is re-distributed from RAI assessments to support LTC application to assessment for in-home services.

Home First Role of the Community CCAC Team

- Once home, all clients are assessed using the RAI-HC assessment tool in order to determine the level of their ongoing care needs.
- Applications, communications, and transition plans to community support agencies are the priority. This requires the CCAC to have sound knowledge of the community support organizations and how best to leverage their services in order to ensure that the right service is provided.
- Application for LTC is completed only if needed. Many clients have been able to defer LTC placement with the enhanced community supports.

OUTCOMES

The results of the ALC Strategy continue to be closely monitored by the hospitals, CCAC and MH LHIN. A number of indicators are tracked regarding the number of ALC patients and how the partnership is working with CCAC and hospital to get patients home on community services.

At Halton Healthcare Services, the number of new referrals monthly to LTC from one hospital dropped from 25 to 14 and has been sustained at this rate. The ALC to LTC patients within this hospital dropped from 87 in September 2008 to 30 in June 2009. The acute percentage ALC in hospital which reflects patient days has dropped from 28% to 3-5% where it is sustained.[5]

"Every 10% shift of ALC patients from acute care (waiting for long term care) to home care results in a $35 million saving."6 Home First has created capacity in the hospital that has translated to improved ER utilization. In the past year, CCAC has discharged 400+ individuals home using the Home First approach. Many of those individuals would have remained in hospital waiting for a LTC placement.

Having experienced success at Halton Healthcare Services which is a community based hospital with a family practice model and a small group of hospitalists, the LHIN moved to apply Home First at Trillium Health Centre (THC). THC is a tertiary care hospital with 763 beds, over 4200 staff and 748 physicians. The implementation and staff engagement processes were different however the results were as impressive as at Halton Healthcare Services.

The health care professionals and families understand that going home is in fact best for patients, and are motivated to do what is best for the patient.

KEY SUCCESS FACTORS

- Regular meetings
- Senior management engagement and commitment – LHIN, Hospital and CCAC
- Seasoned healthcare leaders
- Education of physicians
- Creating one team approach – daily engagement and dialogue with leadership
- Willingness to trust – especially in the face of a counter intuitive approach
- Development of protocols – home first, hard to place, hard to serve
- Support from the MOHLTC staff

The investments in community based programs along with a team based focus on enabling people to go home has achieved impressive results.

CONCLUSIONS

Home First has been a big win for the hospitals and community; and especially for the frail seniors within the MH LHIN.

The MH LHIN is working collaboratively with health system providers to plan and create options for harder to serve populations. Identifying service and resource gaps such as specialized behavioural units to meet the needs of patients within the MH LHIN is an area of focus for the future. The MH LHIN, CCAC and area hospitals will continue to work with providers on right care, right place, right time.

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1 Personal Support Worker is the term used in Ontario to reflect the unregulated home health care worker, also known across Canada as Personal Care Attendant, Personal Support Aide, Home Support Aide, Home Care Attendant, Health Care Aide, Home Support Worker.
2 Initially Wait at Home was only 30 days. It was expanded to 60 days based on data from the early implementation of the improved likelihood of people successfully managing at home.
3 The RAI-HC (Resident Assessment Instrument for Home Care) is a standardized, multi-dimensional assessment system for determining client needs, which includes quality indicators, client assessment protocols, outcome measurement scales and a case mix system. (Central CCAC 2009 The Value of interRAI-HC for Planning)
4 The MAPLe (Method for Assigning Priority Levels) is a set of rules derived from the RAI-HC; it assigns clients to one of five levels (from low to very high) and provides information about their risk of adverse outcomes. Clients in the low category have no major functional, cognitive or environmental problems. They would not be at great risk of adverse outcomes and therefore would be unlikely to require admission to a LTC Faculty. Clients in the very high category are at risk of adverse outcomes based on their greater problems in cognition, ADL function and/or behaviour. The MAPLe algorithm uses 14 variables from the RAI-HC. (MOHLTC 2003, CCAC-LTC Priority Project, Fact Sheet 11)
5 There was a delay of about four months in achieving results. This is because those that are on the LTC placement trajectory prior to the implementation of the program need to be placed.
6 OACCAC, OHA, OFCMHAP, 2010. Ideas and Opportunities for Bending the Health Care Cost Curve, p12

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Canadian Home Care Association
canadienne de soins et services à domicile

The Canadian Home Care Association is a national not-for-profit membership association dedicated to ensuring the availability of accessible, responsive home care and community supports to enable people to safely stay in their homes with dignity, independence, and quality of life. Members include governments, administration organizations, service providers, researchers, educators and others with an interest in home care. The Canadian Home Care Association advances excellence in home care and continuing care through leadership, awareness, advocacy and knowledge.
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