Capital Health's ALC Strategy

Jill Robbins

Director, Integrated Continuing Care, Capital Health

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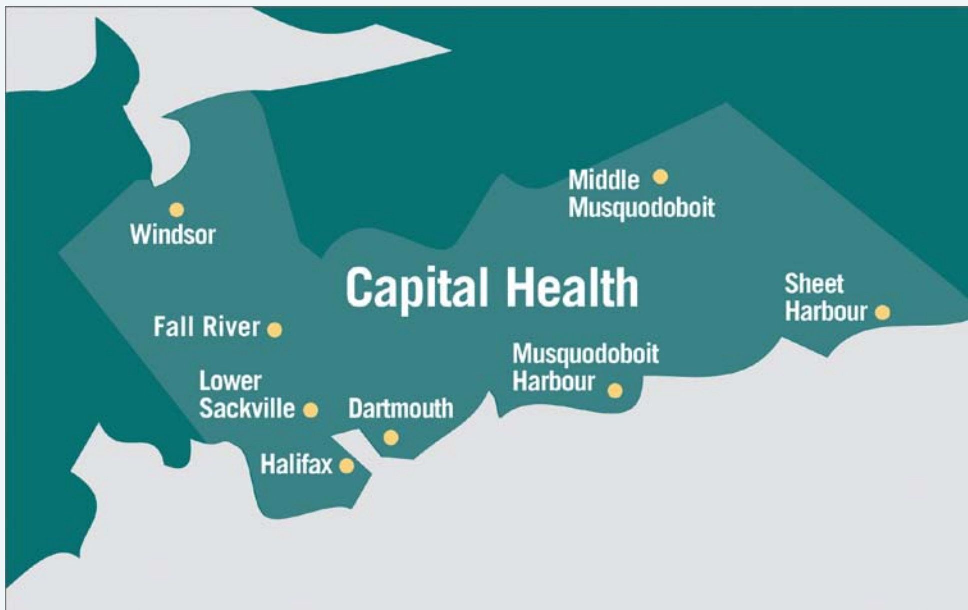
A different today. A better tomorrow.

About Capital Health

- Is one of nine District Health Authorities (DHAs) in Nova Scotia.
- Is Nova Scotia's largest DHA serving 450,000 citizens in Halifax and surrounding areas.
- Served 8,201 continuing care clients in 2010/2011.



Capital Health's ALC realities

- 150 - 175 total 'ALC' patients in hospitals every day.
- 60 -100 'ALC' not including Mental Health patients.
- A wait list for home care (5,000 hours outstanding)
- A wait list for long term care beds (we have total of 2,500+ LTC beds in our district.)
- *Aging At Home* strategy in Ontario has specific Home First program funding supported by their ministry. Our Provincial Home Care Program, Long Term Care, and ED Quick Response Program are ALC programs funded by the government. All other programs in Capital's ALC strategy are funded by Capital Health.

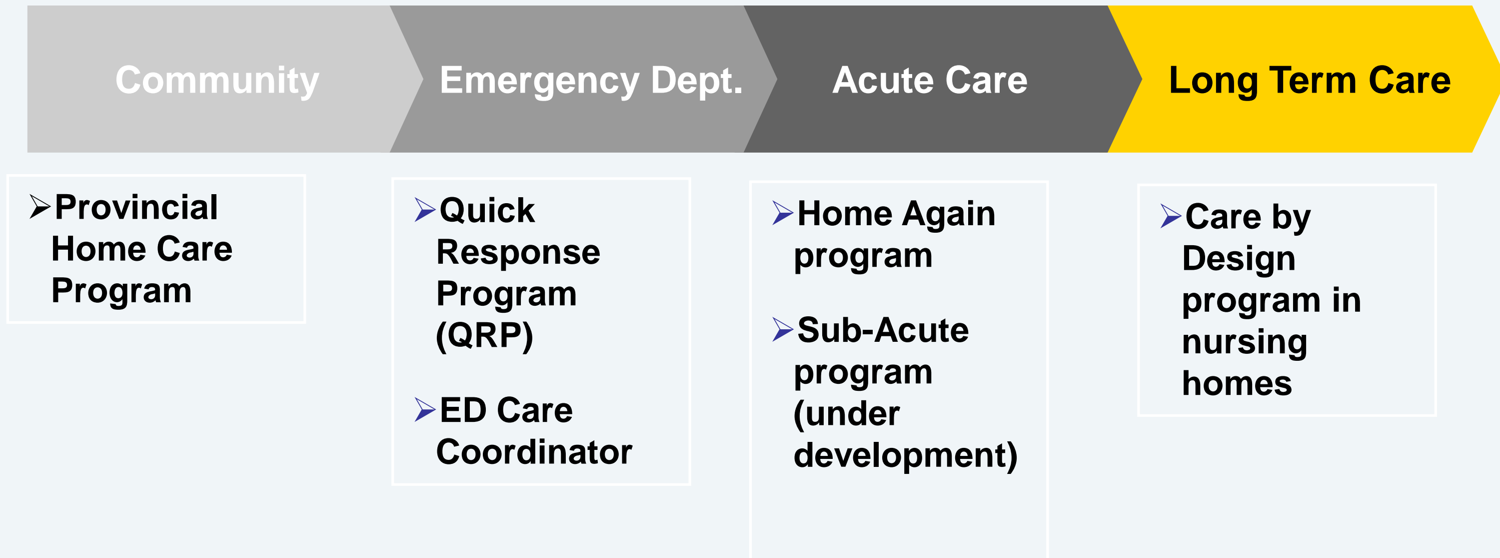
ALC strategy guided by the 'Home First' philosophy

- Capital Health has adopted Ontario's 'Home First' philosophy to guide its ALC strategy & programs.
- The goal is to give clients the opportunity to make decisions about their long term care in their homes / in the community.
- Principles: a) Give people the opportunity to go home whenever possible, b) In hospital, 'ALC' to 'LTC' should be considered a last resort, c) There should be community options to meet their needs.

"At home, my husband was the person I knew again."

- Jean Pattison, wife of client Clive Pattison

Our 'Home First' ALC programs



- Provincial Home Care Program

- Quick Response Program (QRP)
- ED Care Coordinator

- Home Again program
- Sub-Acute program (under development)

- Care by Design program in nursing homes

Provincial Home Care program

- Personal Care services
- Home Support services
- Respite services
- Nursing services (through VON)
- Home Oxygen service
- Bed Loan (through Red Cross)
- Palliative Care
- Community OT & PT
- Provincial financial support programs

QRP (Quick Response Program)

- For patients in two of Capital Health's Emergency Departments.
- Quick set up and delivery of short-term home care services for a maximum of up to 24 hours/day for 5 days to avoid hospital admission.
- Client's eligibility is determined in Emerg. by Hospital Care Coordinator, Social Worker & Discharge Planner.
- Based on the 'home first' philosophy - that home, when possible, should be considered as the first option before admission to hospital.

Emergency Dept. Care Coordinator

- In 2011, Capital Health decided to dedicate one of its 67 Care Coordinators to work in the Emerg. Dept.
- Once a patient is deemed stable, the Emergency-based Care Coordinator assesses the client for Continuing Care services, with an emphasis on getting the client ‘home first’.
- Goal is to find more suitable options to being admitted to hospital or being immediately placed on a LTC wait list.

Home Again - background

- In 2009, Capital Health identified the need to close an 'ALC' hospital unit with 42 beds.
- In two weeks, Continuing Care placed all of these patients in long term care facilities.
- The $200K from closing this unit was acute care money that was re-invested to launch the Home Again program to give ALC patients enhanced home care. **Dollars from acute care to continuing care in the community!**

Home Again – the program

- Enables certain eligible ‘ALC’ admitted hospital patients to return home to decide about their long term care.
- Up to 60 days of home care services (up to 56 hours per week), enhanced beyond the provincial Regular Home Support program.
- Use of CCA and non-CCA workers to provide care.
- Home care is provided by five home care agencies.
- Cost is equal to that which client would pay in the Regular Home Care program, which is lower than the ALC rate in hospital.
- Program has capacity to accept 15 clients at a time.

Home Again eligible client:

- Hospital inpatient, medically stable & deemed ALC
- Has a home to return to
- Agrees to complete an application for LTC incl. financial assessment
- Can be classified for LTC placement
- Has capacity to direct care/has a Substitute Decision Maker
- Has Physician support in the community
- Agrees to participate in the program

Home Again services:

- Intensive case management by a Capital Health Continuing Care Coordinator
- Home support services: up to 56 hours/week x 7 days/week, for a maximum of 60 days
- Home support services through established agencies
- VON Nursing services as required
- OT & PT community team assessment & follow up

Capital Health

30 clients in Home Again to date

Outcome	Clients
Re-admitted to hospital for LTC wait	2
Required no further home support	1
Reduced to Regular Home Support	16
Still in program	8
Home with private care	1
Deceased	1
Self Discharge	1

No clients have gone immediately from Home Again to a LTC facility

Home Again - client outcomes

- 21 clients to date have completed the program
- **76%** of clients who have completed the program actually remained at home and *reduced* their amount of home care, instead of moving to a LTC facility.
- N.S. government and other DHAs are impressed – looking at how programs can expand provincially.

Lessons learned

- Culture change – we need to change physician and healthcare professionals' perception that going home is riskier.
- Family involvement is crucial to 'home' being a success.
- Need to explore the idea of 'home' with the client and family at an early stage in the process.
- Client and family's reluctance to complete the Long Term Care application to be eligible for Home Again.
- The use of both CCA and non-CCA designated HSW is necessary due to client wait list.
- Using five home care agencies limits relationship building, so RFP for one single provider is being developed.

Care by Design

- Transforming care for residents in 17 nursing homes by bringing a collaborative team on-site to provide enhanced primary health care services.
- 66 physicians make weekly visit to 1 floor/unit of a nursing home to see the same residents.
- EHS Paramedics work with physicians and facility nurses to provide extended care. They respond to non-emergency calls in nursing homes to assess/treat patients on site. This reduces the need for patients to go to hospital via ambulance and wait in the ED. **To date 72.5% of patients have been treated on-site!**
- Care by Design has helped Capital Health **reduce the # of nursing home transfers to ED from an average of 44/month to 32/month, a drop of more than 25%.**

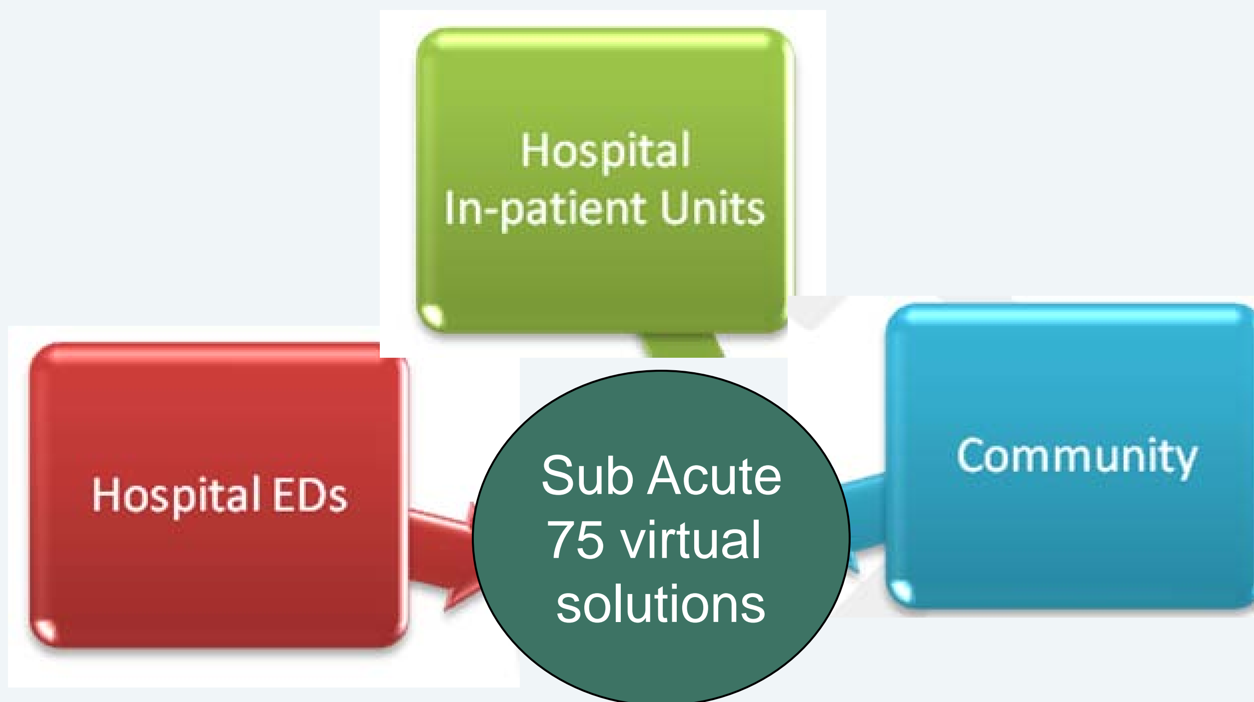
Care by Design - the vision

High quality care for residents

- Geriatric Assessment Tool
- Physician Coverage By Floor
- Interdisciplinary Education
- Mobile X-ray
- Performance Monitoring
- Coordinated Orthopaedic Care
- Palliative Care
- Extended Care Paramedic
- Mental Health

What's next: Sub Acute program

- Develop a community based program that carries a Home First culture and expansion of programming.
- Taking lessons from Home Again, and Restore programs.



What's next: Sub Acute Program

- The Sub Acute Community Based Program will be a mix of hospital beds and community programs (i.e. our Home Again program is 15-25 beds of the 75 planned).
- The sub acute program will be co-lead by:
  Jill Robbins, Director of Integrated Continuing Care & Dr. Stavros Savvopoulos, Medical Director of Family Practice