Southlake@home

GUIDE

Better experience, better outcomes, better value

MARCH 4, 2020

Produced in partnership with

HEALTH COMMONS SOLUTIONS LAB

SOUTHLAKE REGIONAL HEALTH CENTRE

Leading edge care. By your side.

“Patients and families are at the CORE of Southlake@home. Their knowledge and ideas have steered us from the beginning, and they continue to shape and improve the program every day.”

INTRODUCTION

In early 2019, Southlake Regional Health Centre launched a unique, integrated home and community care model – the first of its kind in Ontario.

A year later, Southlake@home has helped close to 270 patients transition home successfully and reduced average ALC-to-home days by more than 12 days.

Unlike most hospital-to-home bundled models, Southlake@home took a population-based approach focused on complex populations at highest risk of becoming ALC. The model **redefines how homecare services are integrated**, and **includes mechanisms to incorporate social, community supports, and primary care**.

This guide captures and shares what we learned from our first year in operation as a guidepost for other hospitals or OHTs across the province that are considering similar population-based integrated models of care.

WHY THIS GUIDE?

At a time when most OHTs and hospital leaders are exploring homecare opportunities, Southlake@home offers an important example of emerging population-based bundled community care models.

Southlake@home is fast becoming a model for other transitional care programs across Ontario aimed at integrating home and community care for high-need populations. This guide is a must-read for any team considering integrated community care or homecare partnerships aimed at reducing hallway healthcare pressures.

- **For your senior leadership,** it outlines the overall vision and rationale for community integration and highlights the critical foundation for securing funding and partnerships.
- **For the implementation team,** it lays out a simple step-by-step approach to design, plan and launch an @home program that includes tools, templates and examples to get started.

Print. Share. Adapt. Discuss.

Like so many other transformation initiatives, Southlake@home has ultimately been about developing new relationships and trialing new ways of working together. There is no single blueprint for success, and we have much to learn.

We encourage you to **adapt what you need from these tools, and share your own experiences about what works - and what doesn't!**

LET'S GET THE CONVERSATION STARTED! We have as much to learn from you as you do from us. Get in touch if you have questions or want to share your story.

You can reach us any time at homewithsouthlake@southlakeregional.org or by phone at 289-221-0482.

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PROGRAM LEADS AND STAFF, THESE SECTIONS MAY INTEREST YOU MOST

@HOME AT A GLANCE

WHERE SOUTHLAKE STARTED

Southlake@home grew out of a need to get at the root cause of our ALC-to-home pressures. Too many people are spending longer in hospital than they needed. These patients often decondition and can face an increased risk of hospital-acquired conditions, falls and infections.

We could see from our data that our ALC-to-home patients are mostly medically and socially complex seniors that required significant support through transition; many lived in the same neighbourhoods.

This is where we started.

What would it take to reduce our ALC-to-home days to ZERO?

To create a clear pathway home for these patients, we knew the program would need to directly address the barriers to transition, through:

TRUST – building patients' confidence in a reliable, dependable home and community care system that provides a safe and supported transition home

CUSTOMIZED, HOLISTIC CARE PLANS – where every care plan starts with understanding a patient's care needs

HIGH TOUCH TRANSITIONS – hands-on integration model that delivers collaboration at the point of care

NO ELIGIBILITY CRITERIA – making it easy for frontline staff and physicians to refer their patients – any patient can be referred that lives within the geographic area

HOMECARE TEAMS WORKING AT THEIR FULL SCOPE – shifting focus from a task-based homecare models to one that allows everyone on the care team to work at their full scope of practice to provide comprehensive care

A RELENTLESS FOCUS ON OUTCOMES – where patient outcomes are measured and accountability is shared among all our partners

EXPERIENCE

> **There was far more coordination of care, far more care options, and far more timely care.**
> – Patient partner

CREATING A CLEAR PATHWAY HOME

Fundamentally, Southlake@home is about transitions of care. We have shown that better clinical outcomes, improved patient and staff experience, and reduced costs to the system are possible by redesigning the pathway home for those with complex medical and social care needs.

A 'whole health' approach to IDENTIFICATION

Patient flagged in the ED or at admission*

@home Coordinator notified, team mobilized to begin planning and complete required assessments

@home Coordinator works with patient, family, and discharge planner to develop transition care plan

Care Plan

Describing who is coming to the home, when they will arrive, and how they can help

*Southlake continues to innovate new models for early identification, including case-finding and diversion clinics

Supported, dependable TRANSITIONS HOME

Transportation and settling in from community support provider

24/7 phone support as needed

24hr
1st home visit by a registered health professional

Individual care plan developed by the provider including social care supports

Daily contact from a registered health professional for first week

day 7
Primary care follow up

Provider connects with PC to arrange 7-day follow-up after transition home

Daily huddles / virtual rounds — **16wk**

Homecare team manages day-to-day care planning and delivery.
@home Coordinator facilitates integration and plans for future care needs

Comprehensive, inclusive CARE IN THE COMMUNITY

HOMECARE SERVICES

- Nursing (RN, RPN)
- Personal Support/ Homemaking
- Occupational Therapy
- Physiotherapy
- Speech Language Therapy
- Dietetics Services
- Social Work
- Medical Supplies and Equipment

COMMUNITY SUPPORT SERVICES

- Home Help/ Personal Care
- Caregiver Support
- Respite Care
- Adult Day Programs
- Meals On Wheels
- Social And Wellness Programs
- Community Transportation

PRIMARY CARE SERVICES

- Pharmacy Services
- Medication Reconciliation
- Post acute Follow Up
- Patient Education/ Health Literacy

ESSENTIALS FOR AN @HOME MODEL

Southlake@home is more than just bundled care, it is a whole new approach to integrated care. Through collaboration and common-sense problem-solving, Southlake@home is about working together differently – within the hospital and across multiple partners and sectors.

POPULATION FOCUS

- Define a "population" that shares a broad set of characteristics (e.g. frail older adults with complex needs living in this neighbourhood), not a single clinical condition
- Understand comprehensive needs of your target population and factors that impact their experience – social, geographic, and clinical
- Prioritize activation and restorative care

"There was far more coordination of care, far more care options, and far more timely care."
– Patient partner

FINANCIAL MODEL THAT DRIVES INTEGRATION AND BETTER OUTCOMES

- Single pool of funding deployed across multiple providers to achieve a shared set of outcomes
- Financial model that balances economies of scale with the value of having multiple providers
- Built-in incentives for quality care outcomes, including gain and risk sharing among providers
- Focus on outcomes tied to cost, rather than process measures and a set price

"As a clinician it gives you so much more control over the quantity and quality of service you can provide."
– Community Partner

HOSPITAL LEADERSHIP FOR INTEGRATION

- Building internal expertise in home and community care and provider management
- Investing in a core hospital-based team for active care management and provider management
- Visible and active engagement of physicians and frontline teams

"I've noticed personally a decrease in readmissions of some patients I've sent home who would otherwise have been back to the emergency department."
– Hospitalist Physician

'ONE TEAM' COMMITMENT FROM PARTNERS

- Patients see providers as 'one team' working from a single care plan customized to meet patient needs
- Providers have mutual trust and shared accountability for outcomes
- Providers working at their full scope of practice to meet patient needs
- Team demonstrates real-time issue management and the agility to adjust care plan as needs change

"It takes a village to help ensure that a patient feels safe and confident that their care needs are going to be met when they return home."
– Registered Nurse

OUTCOMES

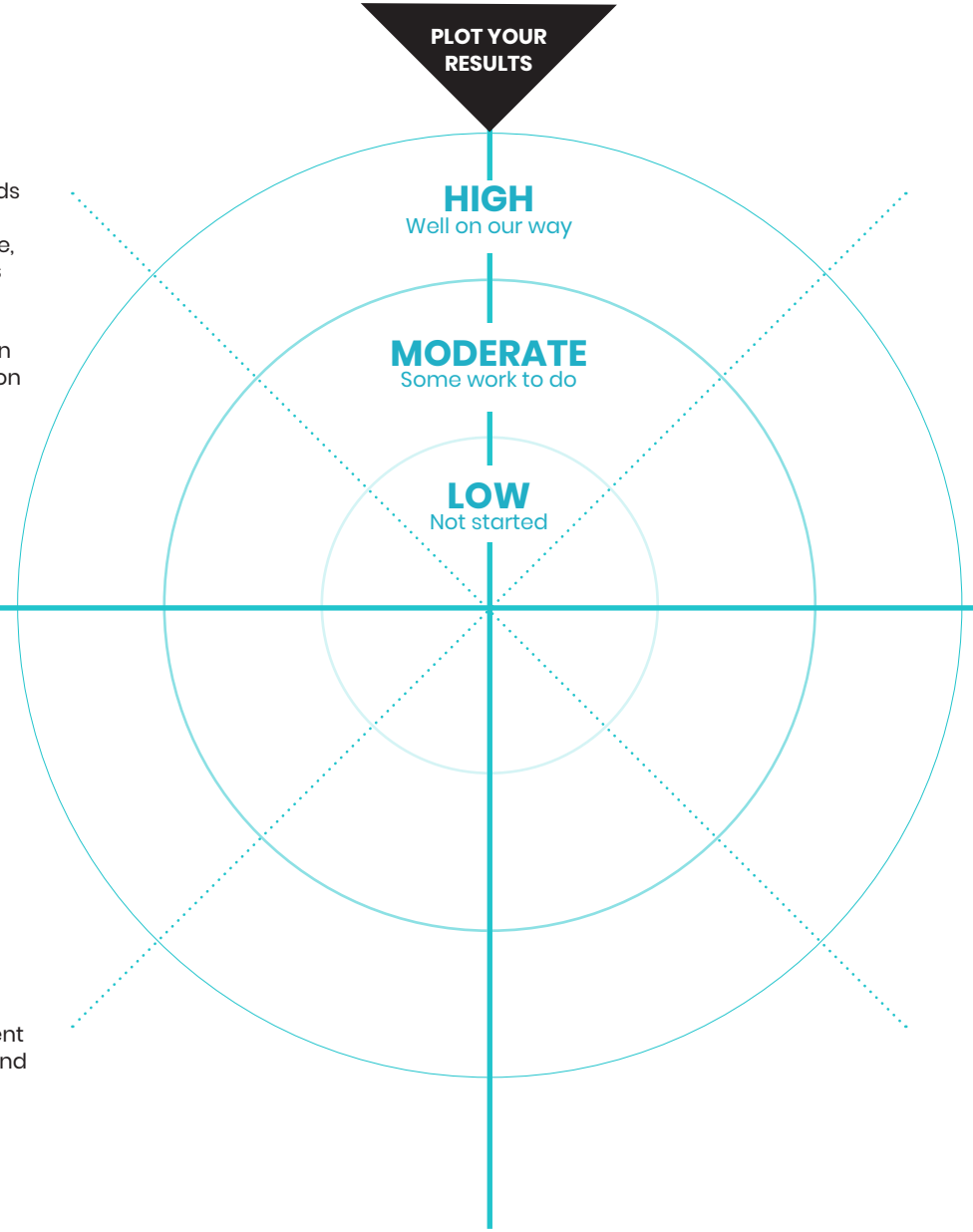
“We wanted to move quickly to improve. We knew we needed an outcome-focused model that went beyond incremental change – we wanted to fundamentally REWIRE how we work together with our partners.

Using human centred design methods helped us GET STARTED FAST and kept us focused on what patients actually need.”

BEFORE YOU START

WHERE ARE YOU STARTING FROM?

To understand what @home takes, assess how ready your hospital and community team is today, and determine what to focus on. On each domain, score your level of progress as HIGH, MODERATE, OR LOW.



POPULATION FOCUS

1. Define a system problem to be solved and target population needs
2. Understand the patient experience, services available and pain points
3. Engage with patient family/ caregiver representatives who can participate in designing the solution

ONE TEAM

1. Build relationships with one or more homecare agencies and CSS providers who can serve this population at home
2. Establish relationships with community-based Primary Care providers who can play an active role
3. Partner with Ministry of Health and Local Health Integration Network to enable the hospital's new role in homecare and system integration

FINANCIAL STRUCTURES

1. Gain familiarity with bundled care model administration
2. Develop costing for a bundle of services to serve the target population
3. Establish financial and procurement structures for provider payment and performance management

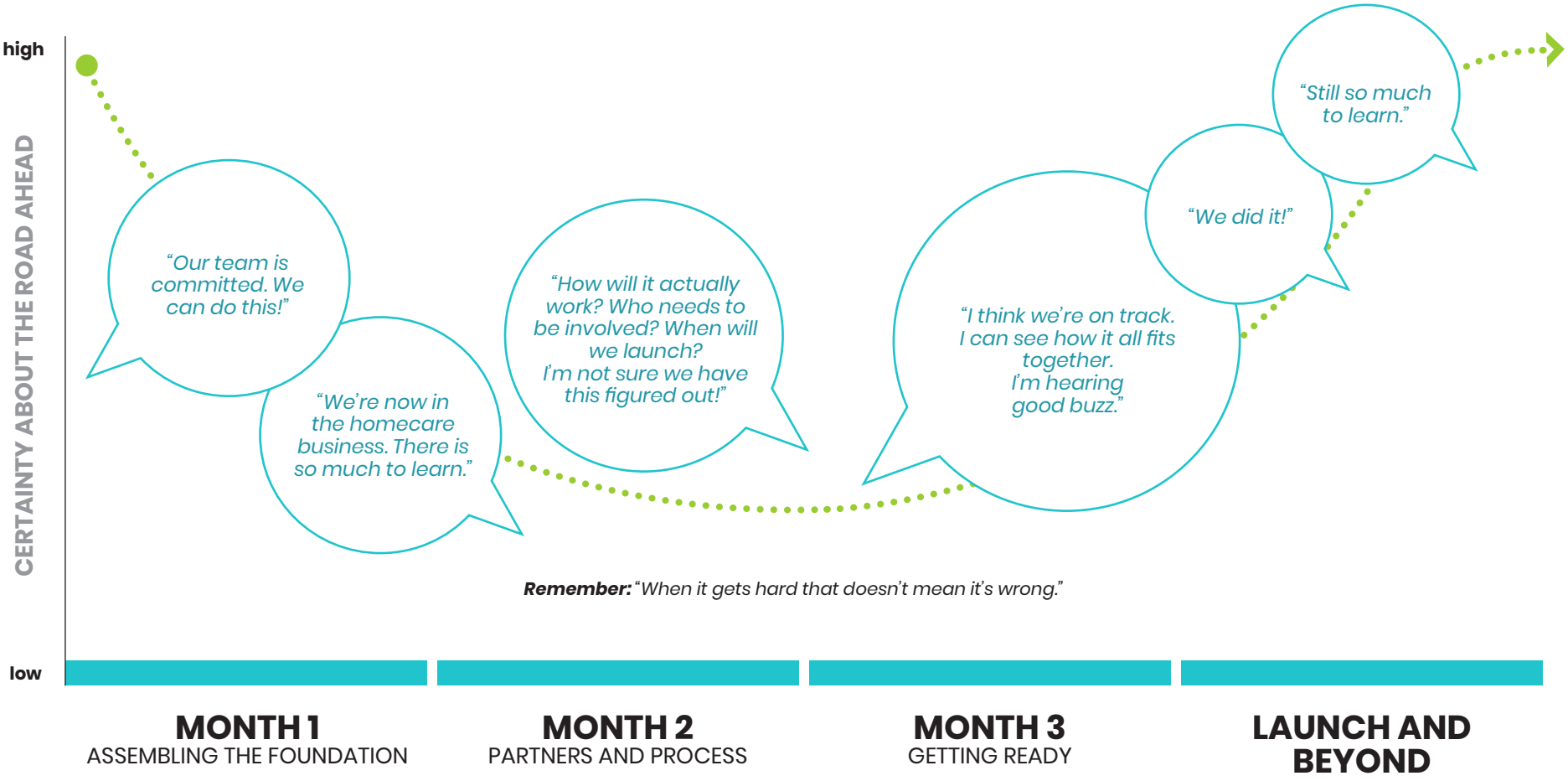
HOSPITAL LEADERSHIP

1. Identify hospital lead who understands homecare intimately or is willing to become a homecare 'expert'
2. Ensure hospital executives willing to drive integration across sectors by challenging conventional roles and functions
3. Support from hospital leadership willing to work through ambiguity and learn as they go

THE JOURNEY AHEAD

To bring @home to life, estimate approximately 12 weeks from planning to first patient, although it may take longer or shorter at your site.

Here's how your journey might feel



GETTING TO LAUNCH

SNAPSHOT OF THE WORK AHEAD

Defining your patient population

OUTCOMES

- Clear description of the problem you're trying to solve (pressures/ key indicators)
- Patients and families involved in developing a profile of the target population (health, socio-demographic)
- Consider geography – where the patient population lives will inform planning for homecare services
- Map of current patient experience through transition (pain points, bottlenecks, etc.)
- Working model of what services will be needed in the community based on patient profile

WHAT YOU'LL NEED

- Analysis of hospital pressures, root cause and patient profiles
- Continuous focus on the patient population and their needs
- Awareness of the basket of services available in home and community

Building hospital support & care team

OUTCOMES

- Hospital leadership is bought into their new role as homecare provider and integrator of services
- Identified physician and staff champions – understand their needs and pain points
- Core operating team assembled; outcomes defined and actions assigned
- Patient committees, advocates and volunteers are engaged
- Raising awareness with business intelligence and decision support (data requests), finance (new contract and billing relationships) and IT (patient information, coding)

WHAT YOU'LL NEED

- Established leadership tables to build buy in
- Understanding roles for team members
- Executive/ board briefing
- IT considerations

Licenses and approvals

OUTCOMES

- Secure Ministry of Health (MOH) funding (bundled care, hallway healthcare, etc.)
- MOH approved homecare license
- LHIN approved Community Support Services license to reduce duplication and avoid waits for service
- Request LHIN access to centralized homecare electronic health record (CHRIS) or another mechanism e.g. access to drug cards
- Internal procurement approval for homecare provider

WHAT YOU'LL NEED

- Business case for funding and required approvals
- Costing for bundled payment
- Get to know homecare licensing and legislation

Choosing the right partners

OUTCOMES

- Homecare: procure one or more providers with sufficient capacity to cover required services, geography and expected volume
- CSS: partner with one or more agencies with sufficient capacity to cover required services, geography and expected volume
- Primary care: identify partners with capacity to take unattached patients (based on patient demographics or geography)

WHAT YOU'LL NEED

- Considerations for selecting home and community partners
- Criteria and questions for prospective partners
- Contracts or other agreements describing partner activities and outcomes

Designing the program

OUTCOMES

- Patient experience and key touchpoints from referral to transition home and ongoing care
- Reporting and service expectations for homecare visits and follow up services
- Care coordination/ care planning roles, protocols and tools
- 24/7 care coordination and navigation support
- Processes for rapid care plan changes
- Oversight and reporting structure

WHAT YOU'LL NEED

- Process map of end-to-end patient touchpoints and related team roles and structures
- Screeners, assessment tools, care plan templates
- Engage the LHIN about the plan for transition home and ongoing care

Getting to launch

OUTCOMES

- Frontline staff understand the program and how it relates to their patients
- Referral processes and tools allow staff to connect their patients to the program
- Materials and processes available to communicate to patients and families
- Core team protocols in place for case management, care planning, quality improvement, provider management
- Partners are working as 'one team'

WHAT YOU'LL NEED

- Communication plan
- Referral tools and frontline staff education
- Patient communication materials
- 'One team' templates, tools and resources - daily huddles, provider meetings, etc.

Measuring success

OUTCOMES

- Demonstrated improvement on priority hospital indicators (ALC, avoidable ED, readmission)
- Demonstrated improvement on patient experience and activation
- Active oversight of provider outcomes for ongoing quality improvement
- Patient and provider feedback informs program development

WHAT YOU'LL NEED

- Comprehensive performance management
- Executive reporting tool/ scorecard
- Homecare monitoring indicators and utilization reporting tools
- Patient and provider survey tools

Iterate and Learn

OUTCOMES

- Work with patient, families, caregivers and other partners to continuously learn and refine your program design

WHAT YOU'LL NEED

- Feedback from patients and families to guide quality improvement
- Data and feedback from partners to monitor outcomes
- Ongoing checkpoints with partners to share learning and problem-solve together
- A team culture that welcomes transparent dialogue about what's working well and could be improved

COMPASSION

“We didn’t start or end with a process map. We took the time to EMPATHIZE – partnering with patients and families to understand what they’re actually experiencing and plan for the most important touchpoints.

We also took the time to understand what staff experience and what could improve, ultimately creating a better program for patients.”

SOUTHLAKE@HOME SPOTLIGHT

KNOW YOUR PATIENTS

@HOME STARTS WITH THE PATIENT NEED

We **MADE A COMMITMENT TO CUSTOMIZE CARE FOR EVERY PATIENT** considering all their medical and social needs

We **CHANGED HOW WE DESIGNED PRACTICE** to meet those needs, looking at the full range of assets available in the community

We are **CONSTANTLY REVISITING AND REFINING OUR UNDERSTANDING** of patients and their needs, and how they use hospital and homecare services

WE DEFINED OUR TARGET POPULATION BROADLY ENOUGH TO REFLECT THE FULL DIVERSITY OF PATIENTS AT RISK OF ALC.

For Southlake this is patients who:
- Live within the geographic area
- Are frail and medically complex, experiencing social health challenges
- Need multi-service home and community care
- Need socialization and social connection

And possibly:
- Mild to significant cognitive impairment
- Multiple chronic diseases
- More than 5 medications
- Are at risk for non-durable discharge or at risk for future unplanned ED visits

WE IDENTIFIED BOTH MEDICAL AND SOCIAL CARE NEEDS THAT SERVICES IN THE COMMUNITY MUST SUPPORT, FOR PATIENTS WHO:

- Frequently live alone or have tenuous informal support
- Require assistance with activities of daily living
- May require typical in-home treatments (wound care, urinary catheter, etc.)
- May need socialization or social connection supports
- May need nutrition or housing security
- May have mobility issues
- May require assistance with transfer or environmental modifications to aid with transfer
- May require assistance with toileting and may be incontinent
- May need support with feeding
- Experience pain and/or depression, limiting participation in activity

SOUTHLAKE@HOME SPOTLIGHT

BUILDING BUY-IN, BUILDING THE TEAM

Hospitals need to build buy-in to the value of the program and acknowledge its growing role in community care

Executive Sponsorship

CEO and executives ensure alignment to hospital priorities and promote the program through internal and external channels

Physician, Staff and Volunteer Champions

Champions raise awareness across the hospital and support co-design on key areas for improvement

Program Oversight

Steering Committee provides a collaborative forum for providers, hospital staff and physicians, financial reps and patient advisors

Executive / Program Lead

Oversight and leadership for overall provider relationship and management; oversees program design and implementation

Manager

Day to day management to support implementation and ongoing operations, risk/issues management and reporting

Care Coordinator

Direct patient care to coordinate referrals and support care planning; follow-up with patients and providers throughout journey

Success is all about bringing these structures to life. Southlake's impact has in large part been due to:

Visible leadership from CEO & executive team

Active 'Champions Table' – a huge return on investment

- Keeps the program relevant and top of mind
- Solution-focused eyes and ears on the units to funnel ideas and drive quality improvement
- Supports education on prinicples and objectives

Hands-on leadership with deep knowledge of home and community care, program design and performance management

Responsiveness to hospital operational priorities (finance, IT, etc.) throughout implementation; critical bridge between hospital and provider teams

Direct support for patients and families, facilitating referrals, coordinating transition plans, and building trust among frontline teams

HOMECARE LICENSE AND LEGISLATION

UNDERSTANDING YOUR RESPONSIBILITY AS A LICENSEE

Unlike physician services and hospital care, homecare is not considered an insured health service by the *Canada Health Act* and is governed under provincial legislation. As a license holder, a hospital is required to comply with applicable legislation and its regulations.

Who needs to know?

- Executive Leadership/ Program Lead
- Corporate Counsel
- Finance/ Human Resources Leads

GET TO KNOW THE LEGISLATION

WHERE TO LOOK: Publicly-funded homecare is governed by the *Home Care and Community Services Act (HCCSA), 1994 and Regulation 386/99*

WHY IT MATTERS: The *Act* sets out a **bill of rights for patients**, lists **permitted services**, locations where care can be provided (i.e. in-home, congregate or group setting) and outlines **requirements for a care plan** for each patient; regulation sets out the **eligibility criteria** and **service maximums** for homecare services

UNDERSTAND HOW LHIN HOMECARE WORKS

WHERE TO LOOK: LHIN funded homecare includes approximately 160 for-profit and not for profit providers offering services in a given geography; healthcareathome.ca maintains a full list of providers in each region

WHY IT MATTERS: Providers have long term contracts with the LHIN based on volume and market share expectations, billing on a **pay-per-visit model** that often rewards volumes over outcomes. Patients are assessed for **eligibility by a LHIN coordinator** and services are ordered and scheduled through a **centralized patient record and billing system** (CHRIS)

UNDERSTAND COMPLIANCE AND REPORTING REQUIREMENTS

WHERE TO LOOK: Contract agreements and approvals with the Ministry of Health and LHIN

WHY IT MATTERS: Financial and statistical information related to approved services are managed through the Ministry reporting system (the Ontario Financial and Statistical System (OHFS); LHINs may have additional reporting requirements

THINGS TO THINK ABOUT

Hospital Care Coordination Role: HCCSA requires that the organization which holds the license determines the need for homecare services; this role cannot be transferred to the contracted provider

Service Maximums: In 2018, government amended homecare service maximums to permit up to 120 hours of combined homemaking and personal support in any 30-day period in 'extraordinary circumstances'

Local Pricing: There are no set billing rates for services, with the exception of personal support, which was recently harmonized across the province at a price of $34.05 per hour

Labour Impacts: Any new program should carefully consider human resources and labour implications

SHIFTING MINDSETS

FROM FEE-FOR-SERVICE TO BUNDLED PAYMENTS

ESTIMATING COSTS IN THE BUNDLE – 3 COMPONENTS

1 DIRECT CARE COSTS: Based on a reasonable estimation of average per-person costs per day, recognizing that actual patient costs at an individual level may vary

=

AVERAGE HOMECARE SERVICE NEED
PSW, nursing, rehab, @home care coordinator

×

AVERAGE NUMBER OF HOURS A WEEK
and estimated number of weeks needed

×

ESTIMATED COST PER HOUR
based on best knowledge of LHIN homecare pricing

2 EARMARKED FUNDS FOR COMMUNITY AND SOCIAL CARE: Southlake's budgeted earmarked per patient funds that could be used to purchase additional community health or social care (e.g. meal delivery, congregate dining, etc.)

3 INDIRECT COSTS: Including evaluation, spread and scale, program design, quality assurance, as well as internal resource commitments (program leadership, operations, facilities, etc.)

THINGS TO THINK ABOUT

Developing a back-of-the-envelope ROI: While a detailed ROI analysis may be onerous, consideration should be given to estimated cost offsets; for example, costs recovered from reduced ALC bed days

Risk and gain-sharing: The @home budget model is similar to a health spending account where patients' care needs determine the amount, type, and duration of service

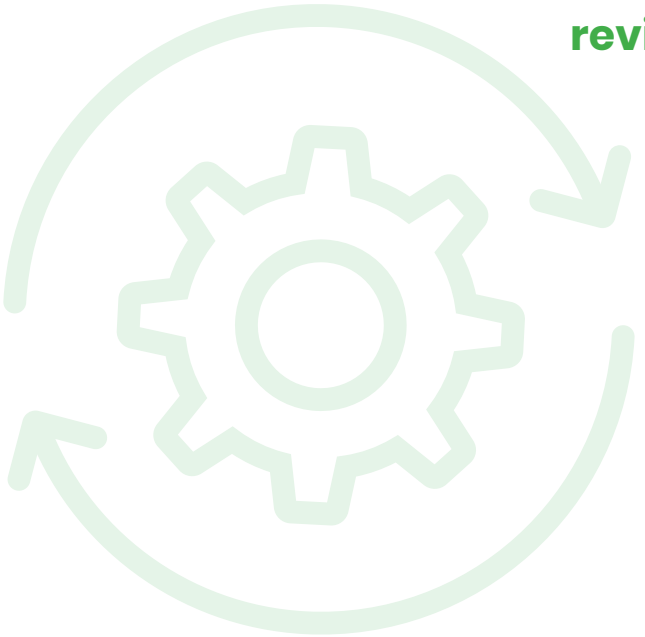
- While it may take time to implement, a set outcome-based rate per patient creates incentives to leverage (lower cost) community services where appropriate and introduce virtual care
- Risk sharing is fundamental to the model where the full care team – hospital, CSS and homecare – shares responsibility for the experience and outcomes of each patient

PERSON A	PERSON B	PERSON C
$7000	$9000	$5000

Working with your internal financial and IT partners: Once the program is underway, detailed operational processes will need to be mapped with internal finance and IT teams, including patient coding, tracking and billing

ITERATION

“We didn’t simply move from left to right. Many things needed to happen at the same time, and that helped us CONTINUOUSLY LEARN AND ADJUST as we went. We constantly revisited the ‘how’ but never the ‘why’.”



TRUSTED RELATIONSHIPS

PICK PARTNERS WHO GET IT

@home is about rethinking how partners work together. Home and community care partners need to deliver the services your patient population needs, communicate and work with a diverse team, adapt to new ways of working, be comfortable with shared accountability and working through ambiguity – and adapt care plans based on changing needs.

START BY UNDERSTANDING THE ASSETS IN YOUR COMMUNITY

ASK PROSPECTIVE HOMECARE AND COMMUNITY PARTNERS

- How have you worked with hospital and CSS partners in an integrated team?
- Can you deliver consistent staff coverage in the geography where our patients live?
- Can you take the lead in coordinating team-based care that changes over time?
- Can you adapt to an outcomes and needs based care model rather than hourly billing (which might require a salaried or assured hours model for your staff)?
- Do you have clinical leads who can support your staff 24x7?
- Can you participate in daily team huddles, monthly provider meetings, and Champions meetings (virtually or in person)?
- Are you willing to adapt quickly in response to new learnings, and commit to continuously improve?
- Do you have technology solutions that support information sharing within a blended team?
- Are you comfortable working through ambiguity?

WORK WITH PRIMARY CARE CHAMPIONS TO UNDERSTAND:

- What types of practices serve our patient population (FHTs, solo physicians, etc.)?
- What would make @home attractive to local primary care practices?
- Which medical orders and pre-work would be essential for practices to receive a new patient from our target population?
- How can we engage practices as active partners in designing @ home?

MAKE THE LHIN AN ACTIVE PARTNER

The LHIN has an important role to play:

- Approving the hospital as a CSS provider
- Request access to CHRIS
- Connecting some patients to LHIN Home and Community Care services after @home
- Issuing drug cards for patients that don't have them

PARTNERS

“We selected two homecare providers and assigned each a unique geography.

Turns out, we LEARNED MORE by having two different organizations caring for the same population.”

SOUTHLAKE@HOME SPOTLIGHT

WHAT GOES IN THE HOMECARE CONTRACT?

Trust is built on clear expectations and confidence in each partners' role. Working through a contract is an important step in codifying how you work together. .

Staff Required

disciplines and coverage

Ensure the provider can deliver the full range of personnel required to care for your target population (nursing, personal support, social work, etc.). If there are gaps, ensure they can be filled before launch.

Patient Population

profile and characteristics

As a population-based program, the needs of a typical target patient profile are critical.

Consider:

- Level of cognitive and physical impairment
- Living situation and level of caregiver support
- Requirements for assistance with activities of daily living
- Mobility and transfer assistance
- In-home medical care (wound, catheter, etc.)

Outcomes

expectations for care team

@home is outcomes-focused rather than process-focused.

Be explicit about:

- Care team members and consistent ways of working in a geography with this population
- Care planning, continuity, and rapid response to changes
- Communication frequency among the care team (daily huddles, etc.)
- Use of technology to enhance communication and care experience

Deliverables

service area, care plans, bundled care

Set clear expectations about how the provider is expected to deliver the services.

Consider:

- Personal support services, professional services, medical equipment and supplies, pharmacy, virtual care, etc.
- Service geography
- Medical supplies and equipment (included in the bundle for Southlake @home)
- Continuous iteration and improvement processes
- Autonomy of provider to allocate service bundle to meet outcomes
- Dynamic updating of care plan in real time
- Use of technology (e.g. virtual care) and reporting

Reporting

indicators and frequency

Indicators the provider is expected to report on, at least monthly.

Consider:

- Value and efficiency
- Patient outcomes
- Patient and provider experience

Pricing

reimbursement rate for services

Describe the bundled rate of reimbursement for the basket of services.

USING DESIGN METHODS

TO BRING THE @HOME PROGRAM TO LIFE

1 MAP PATIENT PATHWAYS BEFORE, DURING, AND AFTER @HOME

Include roles and activities of each provider, including referral forms and electronic communications.

- Think about the patient touchpoints and experience.
- *what are patients hearing, feeling, doing?*
- *What are the design constraints that will limit your choices?*
- Remember @home is outcomes-driven, not process-driven. Strip out any non-value adding processes.

2 DEFINE ROLES AND SERVICE EXPECTATIONS OF @HOME

How will your team operationalize the unique service expectations of every @home model?

- Same-day / next-day homecare visit, 48-hour prescriptions filled
- 7-day primary care visit, zero missed visits
- Rapid response to care plan changes
- Real-time quality debrief when there is a quality issue (ideally within 48 hours)

"If a process or tool doesn't meet the needs of an end-user or an outcome – it's a waste. Eliminate it."

3 DESIGN PROCESSES FOR FLEXIBLE AND FLUID TEAM OPERATIONS

How will the core team operate in an agile, responsive way to identify and problem solve? Care plan changes in real time? Course correct as needed?

- Daily One-Team huddles in person or virtually
- Weekly Core Team meetings
- Monthly Provider meetings
- Time and space for real-time debrief when things don't go as planned

MAP PATIENT TOUCHPOINTS

PATIENT FLOW THROUGH THE PROGRAM

Patient flagged in the ED or at admission*

@home Coordinator notified, team mobilized to begin planning and complete required assessments

@home Coordinator works with patient, family, discharge planner to develop transition care plan

Care Plan
Describing who is coming to the home, when they will arrive, and how they can help

Transportation and settling in from community support provider

24/7 phone support as needed

24hr
1st home visit by a registered health professional

Individual care plan developed by the provider including social care supports

Daily contact from a registered health professional for first week

day 7
Primary care follow up

Provider connects with PC to arrange 7-day follow-up post-discharge

Integrated care conference with family to discuss patient needs and goals

Southlake continues to innovate new models for early identification, including case-finding and diversion clinics

Daily huddles / virtual rounds

Homecare team manages day-to-day care planning and delivery. @home Coordinator promotes integration and plans for future care needs

KEY METRICS USED AT SOUTHLAKE

- ALC days avoided
- Improved patient satisfaction
- Before leaving hospital, patients received the information they needed to be supported at home
- Daily provider touchpoints for first 7 days
- No wait times for community care
- No missed visits
- Discharge prescription filled within 48 hours
- Primary care contact within 7 days
- Care team reported to primary care about patient's care need
- Number of patients with acute readmission within 7 days of discharge from @home

If needed, Southlake@home Coordinator initiates touchpoints with LHIN Home and Community Care preparing to help the patient achieve the level of function needed to remain at home

Wk8
Southlake @home Coordinator touchpoint with team, patient and family to determine long term plan

Wk12
Southlake @home Coordinator schedules touchpoint and initiates transition/ discharge

Wk16
Patient transition to appropriate destination

- **Patient transitions to self care**
  With ongoing social supports
- **Patient transitioned to other place of care**
  LTC, family, etc.
- **Patient transitioned to LHIN Home and Community Care Services**
  Warm hand off

Daily huddles / virtual rounds

@home care Coordinator provides leadership to regularly revisit care needs and adjust as needed

KEY METRICS USED AT SOUTHLAKE

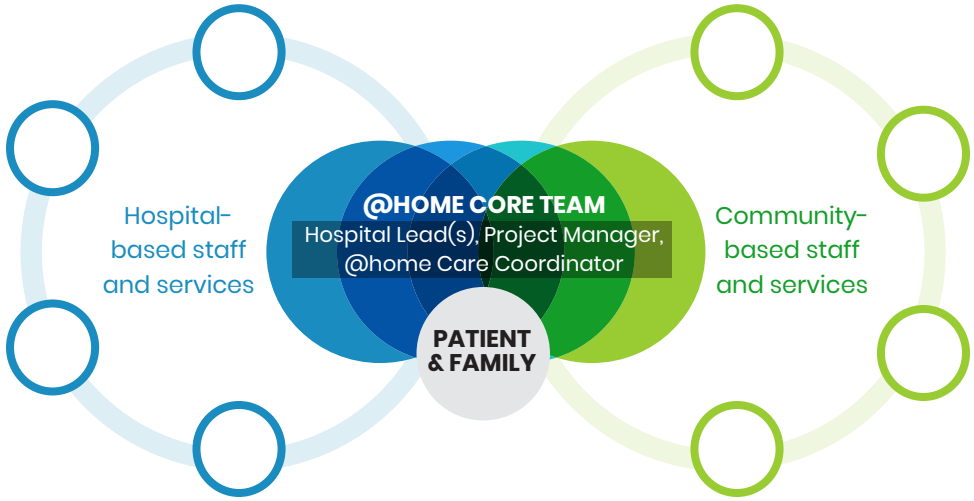
- Patients received the support they needed at home
- Patients were able to work with the care team to adjust care as needed
- Patients' overall satisfaction with Southlake@home
- When patients called, they were satisfied with the response
- Patient knew who to call if they needed to contact their care team
- Provider staff would recommend Southlake@home to a friend looking for a job
- Provider staff have the flexibility to schedule visits to meet the patients' needs

BRIDGE TO THE COMMUNITY WITH A HOSPITAL-BASED CORE TEAM

THE HOSPITAL-BASED CORE TEAM SERVES AS A BRIDGE bringing knowledge about the community into the hospital and supporting the patient's transition back into the community.

Having support from a person in real-time reduces the need for detailed forms and eligibility criteria and reduces delays. Investing in the team helps patients avoid time spent in a hospital bed.

The core team helps patients feel confident they can go home safely from the hospital, supported by a home and community care system that's there when they need it.



The hospital-based Core Team helps @home succeed through:

- Active coordination and quality improvement among the care team
- Active patient management and customization of care plans
- Active provider management and support
- Quarterbacking daily One-Team huddles
- Day-to-day oversight of the program, including identifying quality improvement opportunities
- Issues management and problem-solving
- Continuous iteration and improvement of @home protocols
- Transition out of the program

The hospital-based @home Coordinator brings critical thinking and advance planning skills, to:

- A hands-on, high-touch way of working with patients and staff
- Assisting hospital staff with case finding and transitions
- Providing clear answers to hospital staff on the appropriateness of referrals
- Providing a central point of contact for patients, families, caregivers and staff

COMMUNICATION IS ABOUT BUILDING TRUST AND CHANGING PRACTICE

@home is new and it takes a team – hospital staff, community partners, physicians, patients and families. Referral guidelines and care plans are fluid by design, making communications and education essential. Design your communications tactics recognizing that this could feel a bit confusing for your audiences if key messages aren't well defined. *Just get started – many staff learn best by doing.*

@HOME KEY MESSAGES

@home offers patients a clear path home from hospital with follow-up care within 24 hours

Hospital and community teams work together to meet the health and social needs of patients returning home

@home is a better patient experience, reducing the time patients spend waiting to go home, and the time spent waiting for homecare to arrive

It's a win for patients, health care providers, and the health system

At a minimum, @home key messages for each audience should answer these questions.

	For patients and public	For home and community care provider partners	For hospital staff and physicians	For primary care
WHAT	• How is this good for patients? • What's different from usual care? • Will my care team change? • Who do I call with questions?	• How is this different from our usual process? • Who is responsible for the client? • Who's on the team? What staff will I need? • Where do my staff go with questions?	• Which patients to refer and how? • Who's on the team? Who's in charge? • How does this fit with other options?	• How does this help my practice? • Who do I call when my patients need something? • How does this fit with other options?
HOW	*Patient brochure, welcome letter from hospital CEO, blog, website, newsletter, video testimonial, local newspaper story*	*Staff in-service, presentation, staff email, team meetings*	*Face-to-face briefings, intranet page, staff email, rounds/huddles, message from hospital CEO*	*Face-to-face visits with letter from hospital CEO, referral tip sheet, program brochure*

TARGET YOUR AUDIENCES

PATIENTS, STAFF, PROVIDERS AND PUBLIC

Tip from Southlake

Don't start with communications. *Start by understanding what patients and partners actually need, then incorporate that learning into designing your own material.*

FOR PATIENTS, FAMILIES, CAREGIVERS

Patient brochure, welcome letter, care plan

FOR HOSPITAL STAFF AND PHYSICIANS

Care transition form, referral guide

FOR THE PUBLIC

Blog post, video testimonial

Tip from Southlake

Think about branding. How will you refer to this program? For example Southlake@home, Kingston@home

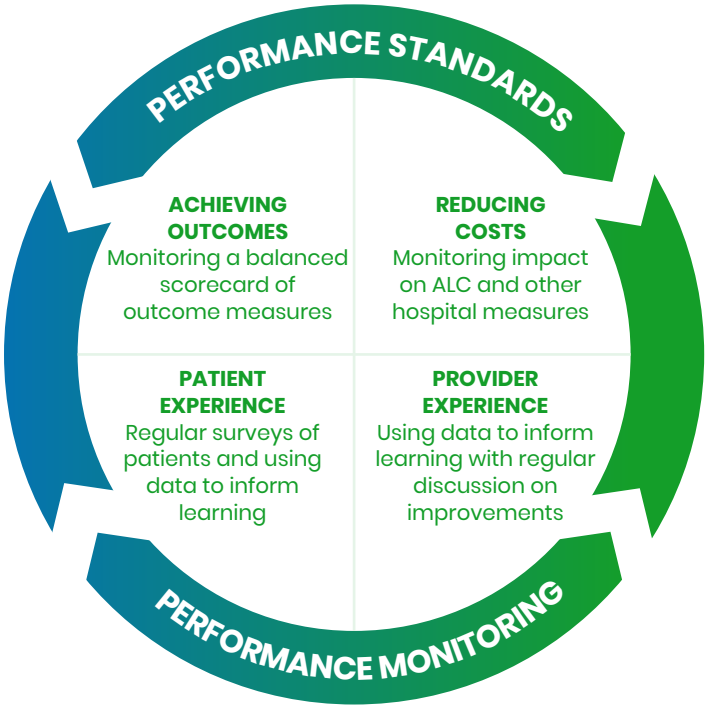
MONITORING PERFORMANCE

GET SERIOUS ABOUT OUTCOMES

Good data strengthens relationships and equips the team with critical feedback to adjust and grow the program. A comprehensive performance framework will help get the most out of available data, and make sure that all the partners have near real-time information to inform their work.

EIGHT TOOLS SOUTHLAKE USES TO KEEP FOCUSED ON OUTCOMES

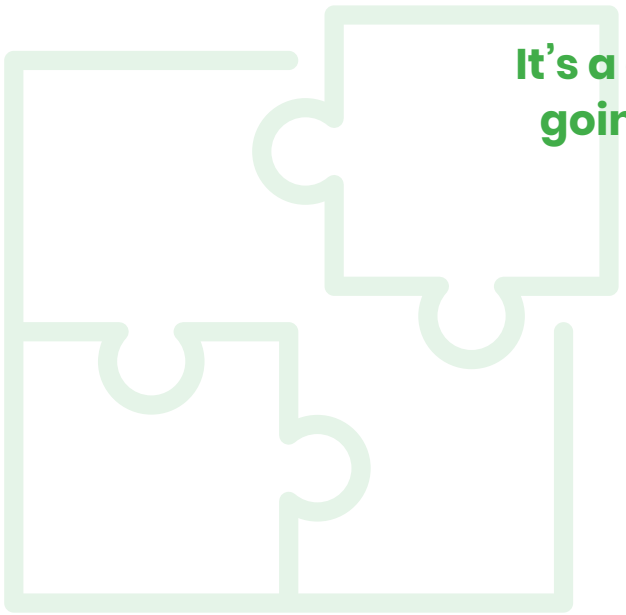
1. **TRACKING CLINICAL OUTCOMES** – reduced ALC days, ED visits, hospital deconditioning; improved collaboration with primary care
2. **BALANCED SCORECARD** – top-line dashboard to focus leadership on clinical outcomes, patient experience, provider satisfaction, and cost
3. **PROVIDER REPORTING** - minimum data set for provider reporting on core homecare and community care indicators
4. **SERVICE UTILIZATION AND COSTING** - active clients, types of services received, duration of service, monitoring per-patient bundled care costs
5. **POST-TRANSITION PATIENT SURVEY** – a telephone survey to be asked of the patient and or the caregiver within the first 2 weeks post-hospital-to-home transition
6. **DISCHARGE PATIENT SURVEY** – a telephone survey to be asked of the patient and/or the caregiver within the first 1-2 months post-transition from the program
7. **QUALITY AND RISK MANAGEMENT** – monthly provider meetings to narrow in on performance and emerging issues
8. **PROVIDER SURVEY** – regular check ins with provider teams on their experience with the program



PROBLEM SOLVING

“We use daily team huddles to round on all current and referred patients, talk about what’s top of mind today, HOLD EACH OTHER ACCOUNTABLE, share wins and solve problems.

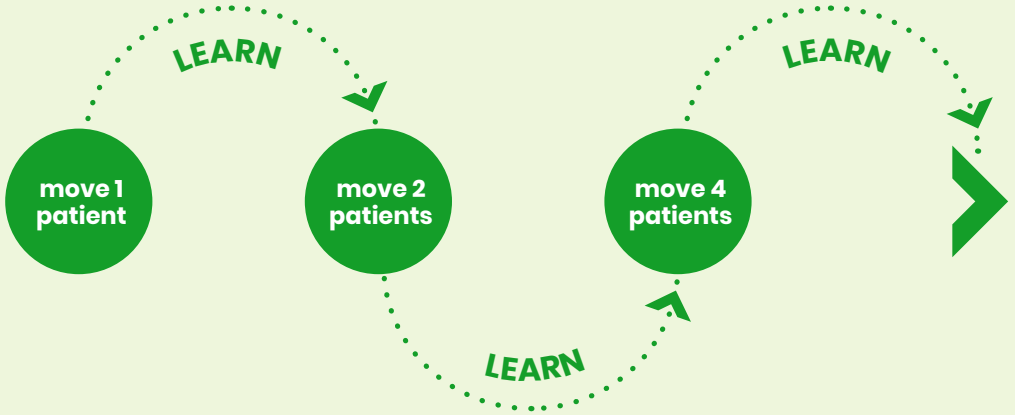
It’s a great way to keep the momentum going and understand what needs to change or improve.”



TREAT LAUNCH AS A BEGINNING

Launch is not a destination. @home is designed to rapidly iterate on what's being learned in real-time, with the Core Team continuously learning from each cycle and adapting the program.

Treat the launch as a starting point for deep learning and iterating. Plan for a soft launch for the first few patients followed by reflection and learning, before an 'official' launch is broadly communicated.



PRE-LAUNCH CHECKLIST

Ensure your team has covered the operational details before the first @home patient intake:

- ◯ Patient population understood, including needs and assets in community
- ◯ Hospital leadership, frontline staff, and champions aware and bought-in
- ◯ Licenses and approvals from MOH and LHIN
- ◯ HomeCare and CSS partners selected and ready
- ◯ Core hospital project team has clear roles and activities to manage patients and providers
- ◯ One-Team structure and processes in place, including homecare partners
- ◯ Communications plan and tools are in the field
- ◯ Program designed around patient experience and intended outcomes
- ◯ Mechanisms in place for data gathering, feedback from patients and staff, and continuous improvement
- ◯ Plan for soft launch and full launch

WHAT'S NEXT

STARTING CONVERSATIONS

Southlake@home has improved the experience for at-risk patients and made significant gains in reducing our hospital ALC rates. We will continue to build on what we have learned and keep innovating on how we deliver care.

STRENGHENING OUR HALLWAY HEALTHCARE STRATEGIES
Finding new ways to work together to tackle hallway healthcare pressures

HELPING OUR PATIENTS THRIVE IN THE COMMUNITY
Convening partners in the community to serve patients closer to home

PROMOTING NEW PARTNERSHIPS
Translating our partnerships into a broader home and community care strategy

CHANGING MINDSETS
Demonstrating the potential of community partnerships and where there are opportunities to rethink how we design, fund and deliver integrated services

Join our community. Share what you're learning.

Working together we can get further, faster. Our goal is to foster a community of hospitals and OHTs implementing @home or testing other similar integrated and bundled care models. We encourage you to document your learning and reach out to other @home partners to share what's working and what's not.

You can reach us any time at homewithsouthlake@southlakeregional.org or by phone at 289-221-0482