Tillsonburg Transitional Programs

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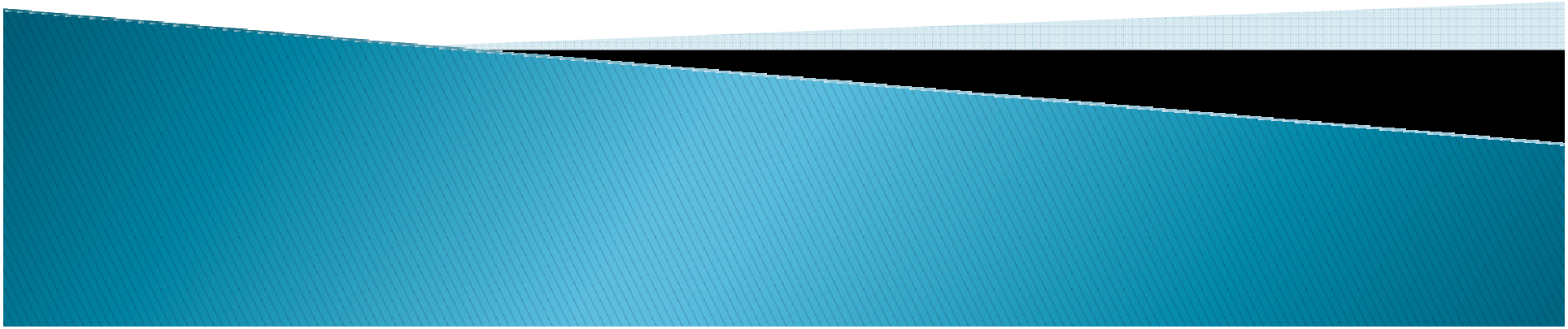


Past

- 72 yr old female admitted to acute care
- Difficulty with ADLs, depressed, decreasing mobility
- Designated ‘ALC’
- LTCH placement trajectory
- Husband = caregiver
- Family lives outside

Current

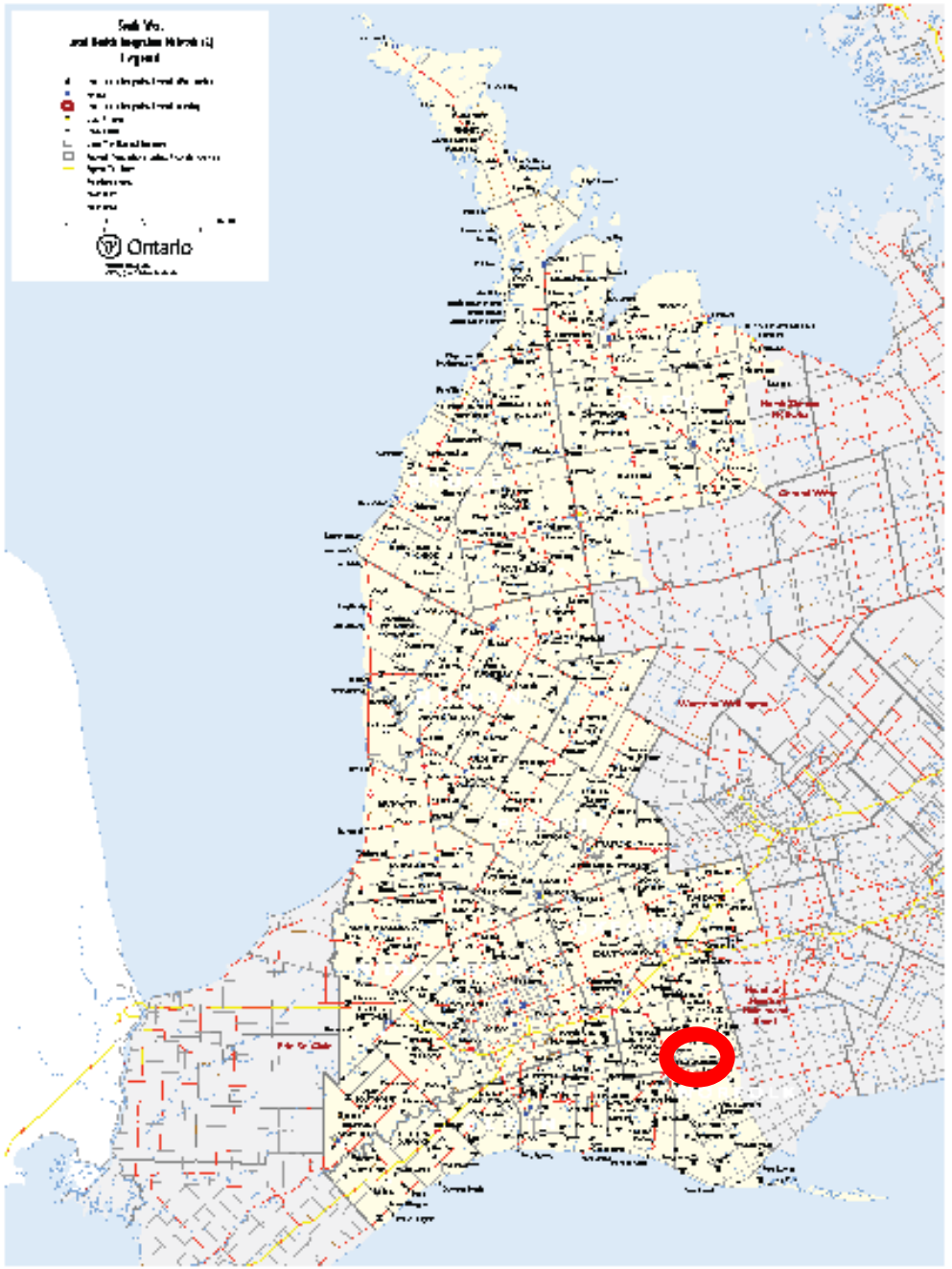
"This is a wonderful program and it has given my wife and I
a
new lease on life!"

Our Partnership

- Tillsonburg District Memorial Hospital (TDMH)
- South West Community Care Access Centre (SW CCAC)
- Tillsonburg & District Multi-Service Centre
- Maple Manor Nursing Home
- South West Local Health Integration Network (SW LHIN)

Tillsonburg

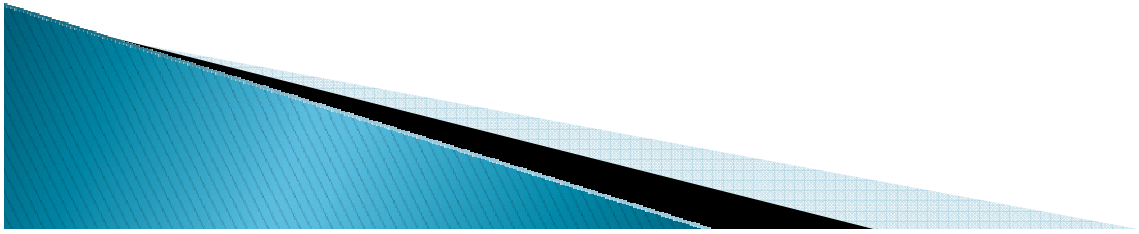
- "*A place to build your future*"
  - promoted as a retirement community
- Growth rate of 5.5%
- Age 65-74 = 11.10%
- Age 75-84 = 9.24%
- Age 85+ = 1.58%



The first inkling….

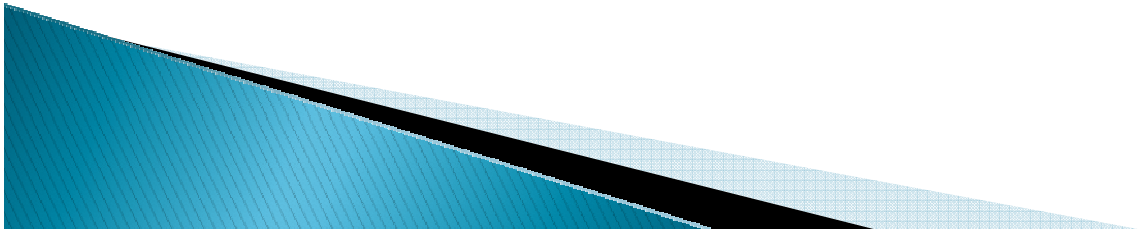
Further Evidence

- Anecdotal evidence from inpatient unit
- Physician perceptions
- CCAC validates patient needs



The Broader Hospital Environment

- $1M recurring one-time funding dries up
- Need to cut costs on $20M budget in order to balance the budget



Enablers

CCAC expanded services in the home including:

- Advanced Home Care Team
- Safe at Home
- Wait at Home
- New Service Maximums

The Challenge Becomes the Opportunity

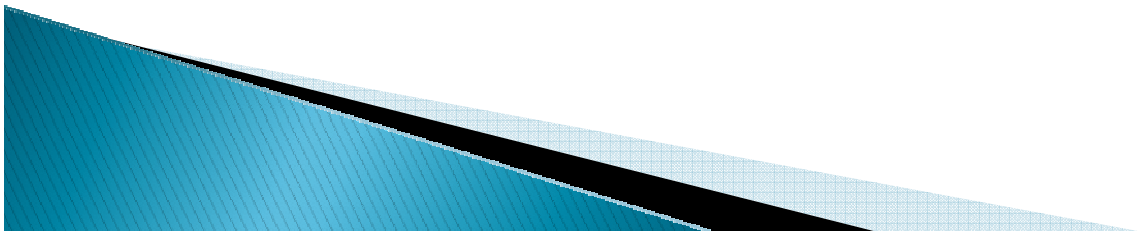
- Partners developed proposal for Transition Program
- SW LHIN participated in development of proposal
- AAH Funding allowed the ability to respond to this need

Purpose

- To assist seniors to remain in their homes and receive care and support
- To take pressure off of ER department and inpatient care beds
- To facilitate the reduction in Complex Continuing Care Beds at TDMH and a concurrent expansion of Assisted Living in the community (ALCom) program

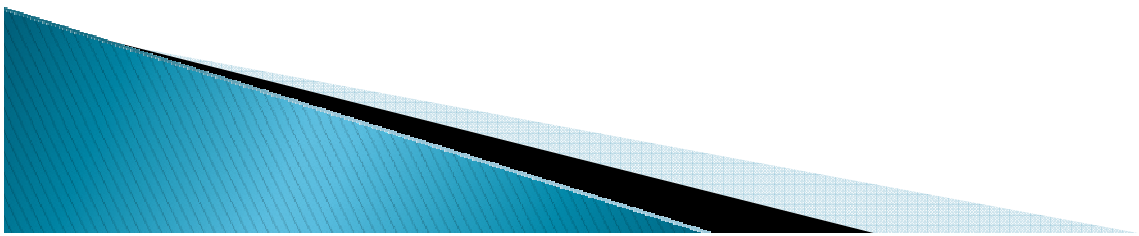
Enablers

- Oversight Group that monitors/champions processes
- Learning from Flo Collaborative at another site in South West



Enablers

- Education for the community and all partners, including phsycians
  - change in culture, focus on community support / resources rather than hospital admission
- Ongoing evaluation of the success of the program



Program Components

- CCAC Case Management in hospital and ER
- Expansion of current Assisted Living in the Community Program
- Social Work
- Interim Long Term Care Beds

Transition Case Manager Role

- Facilitate flow of Alternate Level of Care (ALC) clients and/or clients at risk
- Education / information/ care connection – review of all options, i.e. ALCom, Safe@Home, Wait@Home, Home at Last, community support services
- Develop plan with client/family and team for most appropriate discharge destination and target date
- Liaise with physicians and hospital leadership
- Addition of weekend Case Management has resulted in 31 clients being seen in ER and diverted from hospital admission from Feb-May

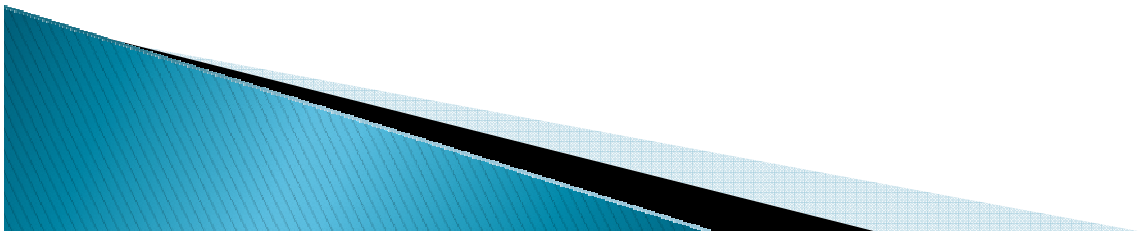
ALComH

- Multi Service Centre expansion of the current ALCom program by 12 spaces (for TDMH referrals) – these additional spaces referred to as ALComH
- New model of Supportive Housing for people in their current home instead of requiring them to move
- To date – 8 admissions and 1 discharge

Social Work

- Social Work resources to work with clients and families at TDMH

- Social Work provider with current contracts with CCAC, see clients in hospital and in the community, enhancing continuity during transitions



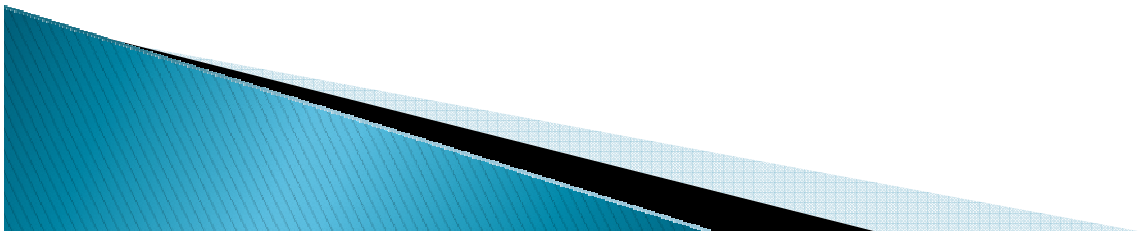
Interim Long Term Care Beds

- Interim LTCH beds at two local facilities
- Enhance capacity in system during transition
- CCAC as care connector into these beds

"The pessimist sees the difficulty in every opportunity; the optimist, the opportunity in every difficulty."

Experience to Date

- Successful reduction of beds, savings targets met
- Increased bed turnover, patients with discharge plan in place
- Built strong relationship among partners



Experience to Date

- Enhanced role of case manager very helpful
- The intangible benefits from role clarity, improved partnership and improved client outcomes are very important
- Ongoing communication about program capacity
- Sustainability is the challenge going forward

Successful Change

- Client focused
- Partnerships – ‘synergy’
- Believed that ‘status quo’ was unacceptable
- ‘Can Do’ Attitude

Community
Support
Organizations

Long
Term
Care
Homes

Connecting you with care
Votre lien aux soins

South West
CCAC
Community
Care Access
Centre

CASC
Centre d'accès
aux soins
communautaires
du Sud-Ouest

Ontario
South West Local Health
Integration Network