Ontario Health

Operational Direction: Home First

ISSUED TO:	Ontario Hospital CEOs, Ontario Health atHome CEO, Ontario Community Support Services and Community Mental Health Services Health Service Provider CEOs and Executive Directors
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Ensuring patients across Ontario receive the right care, in the right place at the right time remains of paramount importance. We thank you and your teams for the work you do every day to support Ontarians by providing compassionate and dignified care to thousands of people across our provincial health care system every day.

It is critical that we continue to focus effort on reducing the number of patients in hospital designated as alternate level of care (ALC), particularly given rising demand for long-term care (LTC) and the seasonal surge in respiratory illnesses anticipated this fall. As such, we are leading a province-wide effort to enhance ALC throughput and reduce ALC volumes by 10% by the end of September 2024.

Across the province there are more than 5,000 people with an ALC designation waiting in hospital beds, with approximately 46% waiting for LTC. Fifty percent of older adults experience functional decline and increased dependency during prolonged hospitalization. To optimize patient outcomes and system capacity it is imperative that we shift away from an “LTC-first approach.”

Home First is an approach whereby every effort is made to ensure adequate resources are in place to support patients to remain at home whenever possible, and ultimately return home upon discharge from all bedded levels of care (i.e., acute, rehab, complex continuing care, mental health).

This operational direction is intended to provide sectors with specific actions and approaches that will support patient flow and overall system efficiency, with a focus on supporting patients at home and returning patients home with the appropriate supports. This direction highlights and builds on key elements from *The Transitions Between Hospital and Home Quality Standards* (QS) and *The Alternate Level of Care (ALC) Leading Practices Guide: Preventing Hospitalization and Extended Stays for Older Adults* (ALC LP) that support and reinforce the implementation of the Home First approach.

Ontario Health regional teams will continue to work closely with your teams to identify strategies to address gaps based on your local context and support you with the implementation of these directives in advance of the anticipated fall/winter surge and respiratory season.

Thank you for all that you are doing to provide care for the people of Ontario.

Home First Guiding Principles:

1. Patients have the right to choose to live at risk in their own home with the right level of supports. There is recognition that patients no longer in need of inpatient care are at risk of further decline when remaining in a hospital setting (i.e., hospital-acquired infection, functional decline, etc.).
2. Major decisions, such as going to LTC should be made from home, since patients are most comfortable and better able to make decisions about next steps in their care journey in the home environment.
3. Care provided in hospitals enables and supports patients to return home. Patients' care plans should include early mobilization to further avoid functional decline that may prevent the return home.
4. Supporting patients and caregivers to return home enables caregivers to contribute to care delivery in partnership with service providers, creating opportunities for better health outcomes. Challenges, barriers, and concerns patients and caregivers are experiencing are always considered throughout discharge planning.
5. Services and supports are available in the community to enable patients to return home, including primary care and organizations that support access to Indigenous Healing Practices for culturally safe care.
6. Building on the *Operational Direction: Priorities for Spring/Summer 2024*, Home First applies a focus on collaborative discharge planning that is patient-centered and ensures all services and supports in the community are explored and exhausted before considering a LTC referral. LTC is not an appropriate alternative for patients requiring affordable housing and should not be considered as an expedited discharge destination.

Operational Direction

A. Direction for acute care hospitals:

1. All older adults (i.e., 65 years or older) in the emergency department (ED) are screened for early identification of "at-risk" adverse outcomes and ALC designation, and a follow-up plan is developed as needed. [ALC LP B.1]
    - Tools such as *The Identification of Seniors at Risk (ISAR)*, *Blaylock*, *Clinical Frailty Score (CFS)*, etc. can be leveraged. Compliance with the use of screening tools is audited quarterly by the ED management team and/or patient experience/quality team.
2. Patients are assessed by an inter-professional team (including patient, family, caregiver(s), substitute decision maker [SDM], Ontario Health atHome care coordinator, geriatric specialists such as Geriatric Emergency Medicine [GEM] nurses, allied health, etc.) to inform admission decisions and identify appropriate community services for patients not requiring an acute care admission. Work to ensure after hour/weekend coverage. [ALC LP B.3/QS 2] Admissions should be considered only after all community resources to ensure a safe return home have been exhausted.
    - For patients in the ED that are already enrolled in a Hospital to Home (H2H) program, or clients that are already receiving home care from Ontario Health atHome, connect with the appropriate care coordinator (i.e., H2H coordinator or Ontario Health atHome care

coordinator) to confirm additional supports can be arranged to support the patient to return home.

B. Direction for acute and post-acute care hospitals:

1. Within the first 48 hours of admission:
   - ❑ Initiate and complete a comprehensive patient assessment by interprofessional team for all older adults (i.e., 65 years or older or otherwise considered frail) who are identified as "at risk", including assessment for frailty, delirium, and dementia as this may impact the estimated discharge date (EDD). Develop a plan for follow up services as needed. [ALC LP C.4.b/QS 2]
   - ❑ Assign a hospital discharge planner for each patient identified as "at-risk" to coordinate transition planning, communicate contact information with patient and caregiver, and submit referral to Ontario Health atHome. [ALC LP C.11/QS 6]
     - Provide early and consistent messaging to patients and families about options and set the expectations regarding discharge planning. Communicate that the goal is to ensure services are in place to return home, while addressing any related concerns.
   - ❑ Identify, document on patient's chart, and communicate with the patient/family/ caregiver(s)/SDMs the estimated date of discharge **within 48 hours of admission to acute care and within 4 days of admission to post-acute.** [ALC LP C.8/QS 3-4]
2. Initiate plan for a return home with the appropriate supports based on the EDD, including for patients waiting for LTC at home. Ensure Ontario Health atHome care coordinator and/or hospital discharge planning team arranges community-based supports prior to discharge. This may include: CSS, transitional bedded capacity, H2H programs, behavioural supports, mental health and addictions (MHA) care, remote care monitoring (RCM), etc. [ALC LP C.12/QS 3-4]
   - ❑ Leverage expertise of Ontario Health atHome care coordinators and engage Ontario Health Team (OHT) partners to identify and refer to community partners offering appropriate services in the community. *Note: OHT maturity varies. OHT leads may serve as a liaison between hospital and CSS sector, depending on local context.*
   - ❑ For patients requiring admission that are already enrolled in a H2H program, or clients admitted that are already receiving home care from Ontario Health atHome, connect with the appropriate care coordinator (i.e., H2H coordinator or Ontario Health atHome care coordinator) to ensure additional supports can be arranged to support the patient to return home.
3. When barriers or safety concerns cannot be resolved, further consultation is sought through complex discharge rounds held with hospital, Ontario Health atHome, and CSS representation, with escalation to program leadership. Regional service resolution tables, or similar, are leveraged when necessary. Patients should not be designated ALC to LTC unless all community resources have been exhausted and the patient cannot safely return home. [ALC LP A.13]
4. Hospital leadership, in collaboration with Ontario Health atHome leadership, approves ALC designation to LTC and reviews/approves any referrals to LTC prior to submission, leveraging the LTC Escalation Template (see appendix 1*)* to validate that all necessary steps have been taken to explore alternatives to LTC. Prior to ALC designation: [ALC LP C.4a-f]
   - ❑ Screening for early identification and risk-stratification completed as soon as possible.

- ❑ An interprofessional team continues the comprehensive assessment.
- ❑ A comprehensive geriatric assessment is completed.
- ❑ Functional goals and restorative potential are determined.
- ❑ Barriers to transition are identified.
- ❑ Referrals to home and community care programs/services are completed.

5. Hospital discharge planners engage patient/family/SDM/caregiver(s) and provide a written transition plan 2 days prior to discharge and ensure they have the information and services they need to manage their needs at home. [ALC LP C.19]
6. Conduct a weekly review with Ontario Health atHome of all patients designated ALC to LTC with a Home First lens to identify if there are potential pathways to return home while they wait for LTC. [ALC LP C.14-15]
7. Following discharge: [QS 8]
   - ❑ Provide discharge summaries to primary care and home and/or community care providers within 48 hours of discharge (coordinate with Ontario Health atHome care coordinator).
   - ❑ Follow-up with primary care is scheduled within 7 days of discharge by hospital team. Leverage outpatient clinics for those unattached to a primary care provider.
8. Hospital leadership team to regularly engage with Ontario Health atHome and CSS leadership to strengthen partnerships.

C. Direction for Ontario Health atHome:

1. Community-based clients are regularly assessed every 3 months for risk identification/functional decline. Scale services and/or refer to CSS as needed.
2. Establish appropriate support of care coordination for patients in each hospital.
3. Care coordinators support discharge planning by:
   - ❑ Engaging with patient/family/ caregiver(s)/SDM within 2 business days of receipt of referral.
   - ❑ Maximizing attendance and participation in patient-level unit rounds when they occur and participate in early discharge planning with interprofessional discharge planning teams.
   - ❑ Collaborating with hospital discharge planner to determine the most appropriate transition plan and assess patients' LTC eligibility as soon as possible once patient is stable, if appropriate/required. LTC should not be explored unless all community resources have been exhausted and the patient cannot safely return home.
     - For patients with lower MAPLe scores (i.e., 1,2, and 3), appropriate home care professional services and/or community services are identified, and referrals to CSS are submitted in collaboration with hospital discharge planner. For patients with MAPLe scores of 3, also consider transitional units until the patient can return home.
     - For patients requiring LTC (i.e., with high MAPLe/Crisis Risk scores and inability to return home), work with patient/caregiver/SDM to complete LTC application and conduct weekly follow-up. Reason(s) for LTC application process delays are identified and communicated with hospital.

- For patients requiring LTC but able to wait at home, build transition plan to home (incl. Ontario Health atHome and/or CSS supports/services, H2H services) and complete LTC application (i.e., identify choices, submit applications) as soon as possible once client is home.

- [ ] Collaborating with hospital discharge planner to ensure plan and services for home and/or community support are arranged *prior* to discharge. Plan collaboratively with patient and caregiver to proactively address any concerns.

4. Manager(s) attend complex discharge and ALC rounds to work with hospital team to identify potential discharge options, and appropriately identify/designate patients requiring LTC that cannot safely return home.

5. Director(s) review/approve a crisis designation and referrals to LTC prior to submission.
    - [ ] Share updates regarding LTC waitlist with hospital partners weekly.

D. Direction for community support service and community-based mental health & addictions (CMHA) organizations:

1. Ensure organizational practices reflect the principle of keeping clients at home.
    - [ ] Complete screening for early identification of individuals at risk of decline without appropriate supports in the community. Leverage tools such as the *InterRAI Community Health Assessment (CHA)*.
    - [ ] If functional decline is observed, submit a referral to Ontario Health atHome for assessment.
    - [ ] Regularly re-assess clients for risk-identification.

2. Develop and disseminate information sheet outlining services offered, eligibility criteria, and referral pathways with system partners, including OHTs, hospitals and Ontario Health atHome.
    - Ensure public listings of CSS are up to date.
    - Ensure awareness of hospital discharge planners and Ontario Health atHome care coordinators re: supports and services offered.

3. Review current HHR capacity and current/forecasted demand to support service needs in the community. Adopt innovative models of care, where needed.

4. Implement capacity reporting tool as directed by your Ontario Health region.

5. Enhance and formalize partnerships with acute/post-acute hospital partners and Ontario Health atHome.

6. Designate a representative from your organization to participate in hospital rounds for complex discharges. Explore regular participation in hospital rounds to support discharge planning, if practical within local context.

7. Expand service hours of care, where feasible, beyond normal working hours (i.e., weeknights, weekends) to ensure patient services are available when needed and unnecessary after-hours ED visits are avoided.

Components for implementation:

1. Governance and Accountability:
    a. All organizations to designate an executive lead to oversee and drive implementation of the Home First operational direction.
    b. Hospitals to identify an engaged physician champion to support implementation, messaging, and monitoring of Home First.
    c. Designate an implementation team – ideally, an interdisciplinary team (which should include clinical leaders with geriatric expertise, quality improvement staff and individuals focusing on transitions and flow as part of their core portfolios) would take the lead in championing the operational direction by working across the organization.
    d. Outline an evaluation framework in partnership with your Ontario Health region.
        i. Develop and implement a process for monitoring and measuring Home First in your organization, in alignment with the provincial performance monitoring framework (*in development*).
    e. Embed the Home First approach, measurement and monitoring in organizational committees (e.g., division meetings, steering committees, staff meetings, etc.).
2. Implementation Structures and Supports:
    a. Conduct organizational assessment against operational direction and set priorities and develop an action plan to address gaps moving forward for ongoing implementation, monitoring and assessment.
    b. Consider the inclusion of Home First in the organizational strategic plan, operating plan, corporate goals/objectives, and/or Quality Improvement Plan (QIP).
    c. Implement a comprehensive internal communication and education plan (both broad and targeted) to ensure staff understanding of the Home First approach and rationale, including:
        i. At onset of launch.
        ii. During new staff (incl. physicians for hospitals) on-boarding, hospitals to consider utilizing the Medical Advisory Committee (MAC), or similar structure for physician engagement, education and reinforcement.
        iii. Annual refresher training.
    a. Provide educational tools/resources to staff (incl. physicians), and patients/families outlining the Home First approach, including but not limited to, Home First Launch event, scripts (terminology, consistent messaging), print material (i.e., pamphlets, booklets, newsletters, fact sheets, frequently asked questions, etc.), screen savers, posters (including in the ED), webinars, and information and resources on organizational website.
    b. Ensure guiding documents (e.g., policies, standards, procedures, guidelines, care pathways, etc.) reflect the Home First approach.

APPENDIX 1: Example LTC Escalation Template

Patient Details
Patient Initials:
Date of Admission:
Health Card:
CHRIS Client # (if known):
Hospital ID #:
Unit/Bed #:
Age:
Assessment tool (e.g., Blaylock) Score:

Admitting Diagnosis:

Summary of Patient Needs:

Does this patient require any of the following:

- ❑ Mechanical lift
- ❑ Two person assist
- ❑ RTLS
- ❑ Feeding Assistance
- ❑ Feeding Tube
- ❑ Dysphagia
- ❑ Secure (wandering)
- ❑ Secure (behavioural)
- ❑ Suctioning
- ❑ Trach

Admitting Location (e.g., home, RH, AL, etc.):

Home Care (including OH atHome) supports in place before admission:

Discharge Options (please demonstrate why all have been ruled out for the exception of LTC):

Barriers to going home:

Supports available? If no, why?

RH/Assisted Living appropriate? If no, why?

Transitional Care Bed appropriate? If no, why?

Does patient require a secure site?

Behaviours present? If yes, explain.

BSO charting details:

Is the patient capable?

If deferring, then to who?

If patient is not capable, who is the Substitute Decision Maker or Power of Attorney?

Convalescent Care **before requesting convalescent care, home discharge must not be viable**
***complete barriers to going home and support available, in section above, page one.*

Are any of these idle CCP beds available? (if not idle, please include expected wait time for bed).

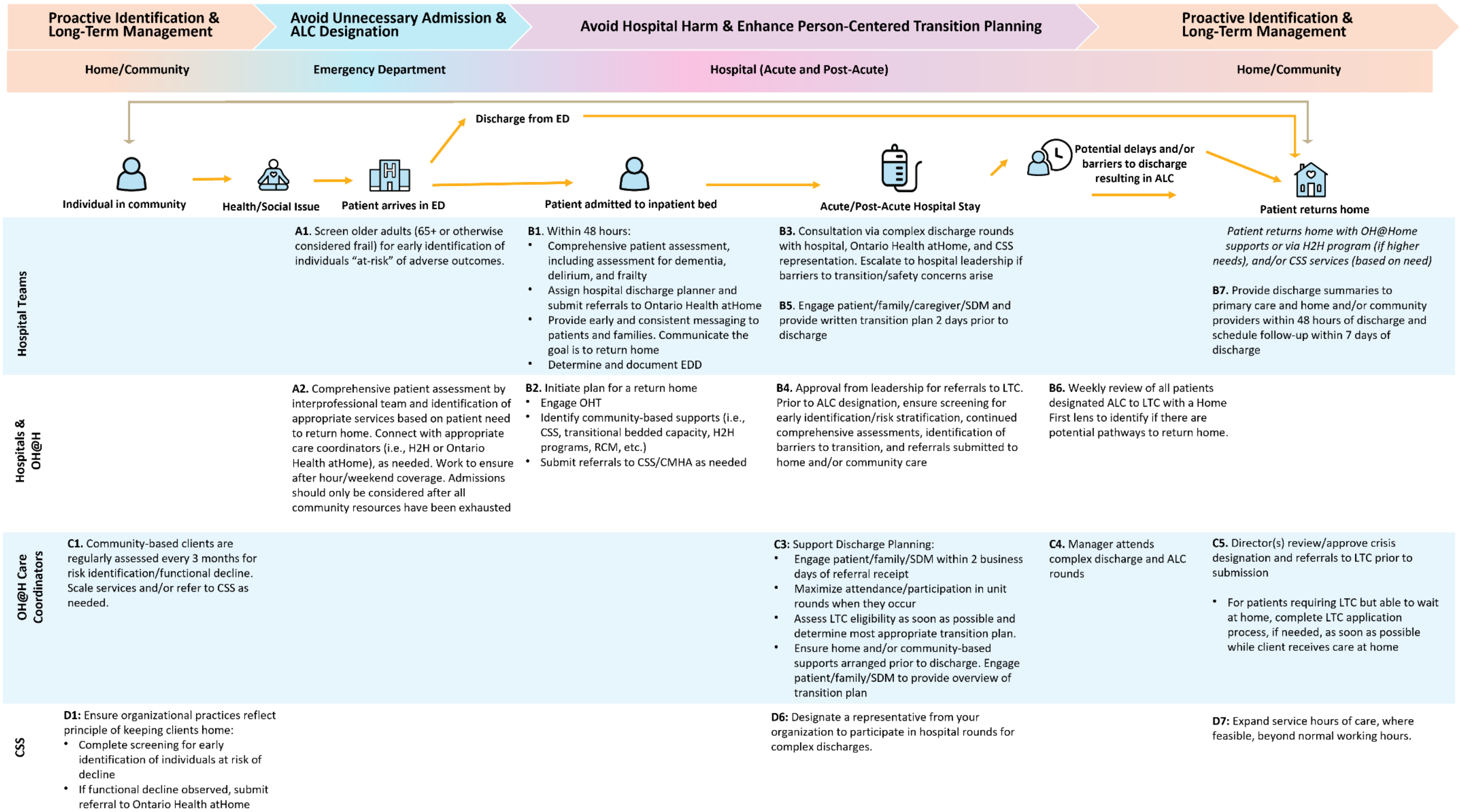
TCB/LTC/CCP Discharge Plan
Provide details if able – e.g., choices, accommodation, local or OOR, PG&T involvement, etc.).

If available:
Ontario Health atHome RAI Ax Characteristics:
RAI-HC Date:
Personal Support Care Group:
Crisis Risk Score:

Reviewed by Ontario Health atHome Manager:
Home not viable (Y/N):
Reason why home not viable:

Date submitted:
Submitted by:

APPENDIX 2: Patient Journey – Home First Operational Direction



Text description: The figure is a flow chart with each step in the patient journey linked by arrows. Each step incudes information on the operational direction for each sector that aligns with each step, as well as the goal and location where applicable. Here the flow chart is described as steps in which the possible next steps are listed beneath.

1. **Individual in Community**
   Proactive Identification & Long-Term Management

Home/Community
OH@H Care Coordinators: C1. Community-based clients are regularly assessed every 3 months for risk identification/functional decline. Scale services and/or refer to CSS as needed.
CCS: D1. Ensure organizational practices reflect principle of keeping client's home:

- Complete screening for early identification of individuals at risk of decline
- If functional decline observed, submit referral to Ontario Health atHome

a. forward to Health/Social Issue
b. forward to Patient Returns Home

2. **Health Social Issues**
   a. forward to Patient arrives in ED

3. **Patient arrives in ED**
   Avoid Unnecessary Admission & ALC Designation
   Emergency Department
   Hospital Teams: A1. Screen older adults (65+ or otherwise considered frail) for early identification of individuals "at-risk" of adverse outcomes.
   Hospitals & OH@H: A2. Comprehensive patient assessment by interprofessional team and identification of appropriate services based on patient need to return home. Connect with appropriate care coordinators (i.e., H2H or Ontario Health atHome), as needed. Work to ensure after hour/weekend coverage. Admissions should only be considered after all community resources have been exhausted.
   a. forward to Discharge from ED
   b. forward to Patient Admitted to inpatient bed

4. **Discharge from ED**
   a. forward to Patient returns home

5. **Patient admitted to inpatient bed**
   Avoid Hospital Harm & Enhance Person-Centred Transition Planning
   Hospital (Acute and Post Acute)
   Hospital Teams: B1. Within 48 hours:
   - Comprehensive patient assessment, including assessment for dementia, delirium, and frailty
   - Assign hospital discharge planner and submit referrals to Ontario Health atHome
   - Provide early and consistent messaging to patients and families. Communicate the goal is to return home
   - Determine and document EDD

   Hospitals & OH@H: B2. Initiate plan for a return home:
   - Engage OHT
   - Identify community-based supports (i.e., CSS, transitional bedded capacity, H2H programs, RCM, etc.)
   - Submit referrals to CSS/CMHA as needed

   a. forward to Acute/Post-Acute Hospital Stay

6. **Acute/Post-Acute Hospital Stay**
   Avoid Hospital Harm & Enhance Person-Centred Transition Planning
   Hospital (Acute and Post Acute)
   Hospital Teams: B3. Consultation via complex discharge rounds with hospital, Ontario Health atHome, and CSS representation. Escalate to hospital leadership if barriers to transition/safety concerns arise. B5. Engage patient/family/caregiver/SDM and provide written transition plan 2 days prior to discharge.
   Hospitals & OH@H: B4. Approval from leadership for referrals to LTC. Prior to ALC designation, ensure screening for early identification/risk stratification, continued comprehensive assessments, identification of barriers to transition, and referrals submitted to home and/or community care OH@H Care Coordinators: C3: Support Discharge Planning:
   - Engage patient/family/SDM within 2 business days of referral receipt
   - Maximize attendance/participation in unit rounds when they occur
   - Assess LTC eligibility as soon as possible and determine most appropriate transition plan.
   - Ensure home and/or community-based supports arranged prior to discharge. Engage patient/family/SDM to provide overview of transition plan

   CCS: D6: Designate a representative from your organization to participate in hospital rounds for complex discharges.
   a. forward to Potential delays and/or barriers to discharge resulting in ALC

7. **Potential delays and/or barriers to discharge resulting in ALC**
   Hospitals & OH@H: B6. Weekly review of all patients designated ALC to LTC with a Home First lens to identify if there are potential pathways to return home.
   OH@H Care Coordinators: C4. Manager attends complex discharge and ALC rounds
   a. forward to Patient Returns Home

8. **Patient Returns Home**
   Proactive Identification & Long-Term Management
   Home/Community
   Hospital Teams: *Patient returns home with OH@Home supports or via H2H program (if higher needs), and/or CSS services (based on need).* B7. Provide discharge summaries to primary care and home and/or community providers within 48 hours of discharge and schedule follow-up within 7 days of discharge
   OH@H Care Coordinators: C5. Director(s) review/approve crisis designation and referrals to LTC prior to submission
   - For patients requiring LTC but able to wait at home, complete LTC application process, if needed, as soon as possible while client receives care at home

   CSS: D7: Expand service hours of care, where feasible, beyond normal working hours.

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