Report of the President & CEO to the Board of Directors

Date: October 2011

"In any moment of decision the best thing you can do is the right thing, the next best thing is the wrong thing, and the worst thing you can do is nothing."
Theodore Roosevelt

This past month I was invited by the Rotary Club of Windsor (1918) to make a presentation entitled "HEALTHCARE: Where We Were: Where We Are: Where We Are Headed."

I focused the presentation on the many patient safety and quality improvements you all have made at Windsor Regional Hospital. The fact that the creation of our Strategic Plan in 2008 guided our daily activities for the past three years has resulted in some amazing outcomes for the benefit of your community and healthcare.

I also focused on the fact that close to 50% of our Provincial spending is in healthcare. Most project it will increase to over 50% in the next 3-5 years. Currently, healthcare spending in Ontario stands at a staggering $46 billion dollars per year.

In a recent pre-election Report on Ontario's Finances[i] the Ontario Auditor General stated:

> The government's 2005 projection was that, over the long term, these factors would drive up health-care costs by 5.9% annually, while more recent estimates indicate that these factors will result in annual increases in the 6%–7% range. A May 2011 report by the Health Council of Canada noted that annual health spending across Canada increased by 6.7% between 2004 and 2010.

The Report states further

> The pre-election report projects an average annual increase in health-care expenses of only 3.6% over the 2011/12–2013/14 period, or about half the average annual growth of 7.1% over the last eight years.

The Auditor General then goes on in his Report to question the ability of ANY Government to bridge the difference between historical healthcare cost increases of 7.1% and what is being projected by the government – only 3.6% - without making "cuts" to the system.

Office of the Auditor General of Ontario

Figure 6: Actual and Projected Growth in Expenditures for Five Areas of the Health Sector

Source of data: Ministry of Finance

		Average Annual Growth in Expenditures (%)	
Area	Estimated Expenditures 2010/11 ($ billion)	Actual 2003/04–2010/11	Projected 2011/12–2013/14
hospitals	15.6	6.0	3.3
Ontario Health Insurance Plan (OHIP)	11.9	8.0	3.9
drug programs	4.3	6.7	3.5
long-term-care homes	3.5	8.6	4.2
Community Care Access Centres	2.0	7.2	2.3
Total	**37.3**		

Before we jump to cuts I proposed that we could look at certain possible changes that could not only reduce expenses BUT at the same time increase patient safety and quality. I proposed the following:

1. Shared administrative staff at local hospitals. Whether this will result in massive financial savings is questionable. However, we have to look at it from the patient/family experience. That is the focus of the discussions between Credit Valley Hospital and Trillium Health Centre voluntary merger. The goal is to have the identical exceptional experience for the patient no matter what facility they attend. Having a shared administrative staff/approach is a major step towards accomplishing that goal.

2. Electronic Medical Records. The time staff spend dealing with the current glut of paperwork is taking away time they could be spending at the bedside with the patient. In addition, electronic medical records have been proven to increase patient safety and quality by reducing mistakes and reducing costs. We need to overcome this "e-health scandal issue" and press ahead with a Provincial Electronic Medical Record as currently mandated by the Obama Administration in the United States of America.

3. Ambulatory Care services outside of the Hospital setting. We have all seen it: Ambulatory Care, either pre or post operatively, or Medical Ambulatory clinics. Do they need to be in the hospital? Could they be provided outside of the hospital more cost effectively? In addition, should we not be looking at reducing the traffic within a hospital as a result of infections?

4. Pay for Performance. Very shortly OHIP payments to physicians will consume close to 40% of our healthcare budget. Currently, there is little, if any, performance/metrics/targets attached to these payments. This creates very difficult situations where hospital funding is tied directly into wait times (i.e. Emergency Department) but physician payments are not. In fact, if we hit or exceed the targets we are prohibited from providing any bonus payments to the Physicians. Does that make sense? How can we ensure we are all rowing in the same direction? In the United States Medicare/Medicad payments will be rejected if a patient returns to a hospital within 30 days of discharge for the same medical issue. We need to look at this.

5. Detroit Hospitals. We want to make Windsor/Essex unique? Why not create a very unique medical learning opportunity for healthcare professionals? We have some of the finest medical schools and healthcare systems in North America 15 minutes away. Why not team up with them to provide a unique International Medical School teaching experience to draw not only students to the area but some valuable research dollars as well.

6. Co-pay for ER visits. Currently, we have co-pay for many hospital services. Complex Continuing Care services to name one. Why not the ER? Based upon your income level why not charge a small fee for people to attend the ER? Would this help with possible abuse?

I am only scratching the surface on this discussion. I am not saying we need to implement all of the above or that they will result in increased patient safety, quality and reduced costs. There probably are many more. I am suggesting we need to appoint a Royal Commission on the Future of Healthcare in Ontario. They need to examine how we can improve and sustain healthcare into the future for our children and grandchildren. We have a great system. However, we have to continually change it to improve it.

Strategic Direction – Embed Patient Quality and Safety in Our Culture

Windsor Regional Hospital Breaks its Own Record

- In November 2011 Windsor Regional Hospital will have 11 out of the 53 Leading Practices displayed at this year's Ontario Hospital Association International Health Care conference. They are as follows:

Improving Blood Flow: Reducing Laboratory Morning Turnaround Times – Jeff Booth *and Team*

The Laboratory has enhanced the Patient Experience by dramatically improving our morning turn around times to support the Hospital's Mission, Vision and Values. A timely result leads to timely treatment decisions and improved Patient outcomes.

WRH has also set discharge times as a priority to improve the Patient Experience. The Laboratory's role in this goal is pivotal to ensure results are available when and where it is needed by our customers.

To accomplish these goals, the Laboratory employed the Lean theory of 'one piece flow' of samples to and through Laboratory processes, leveled the morning collection workload to reduce the amount of work pushed through processes and fully utilized new technology to ultimately decrease turn around times to meet customer demands.

Early Ambulation in the ICU – Cary Bedard and Team

Developed an early Ambulation protocol in the ICU to be integrated with all patients on a ventilator and not. There has always been reluctance to ambulate patients who are on a ventilator due to safety concerns re: extubating them and we have started walking some of these patients using the interdisciplinary team (RN, RT, Physiotherapy).

Hospital -Wide Fall Prevention Program Sustains High Reliability – Gina Bulcke and Team

Falls are a significant risk for patients when they are hospitalized. Injuries resulting from falls can result in pain and suffering, prolonged hospital stays, loss of independence and quality of life and sometimes death. At Windsor Regional Hospital we believe in providing *Outstanding Care No Exceptions* and embarked upon a mission to reduce the numbers of falls and falls with injury to zero. Since starting the program in 2009 we achieved:

- Engagement and empowerment of the entire health team in change management and quality improvement;
- Development of a process map utilized for falls prevention and other safety initiatives; and
- A 74% reduction in falls with injury hospital-wide (670 acute and non-acute beds) where 3% of total falls result in injury.

Elements of Success:

*Senior leadership engagement in an organizational culture of quality and safety and an environment focused on learning.
*Staff engagement to take the time up front to identify staff champions, provide education and training, tools and evaluation of best practices.

*Establish burning platform to create an urgency for change.
*Communicate results often to ensure ongoing flow and reporting of up-to-date data.
*Develop new forms and communication tools.
*Redesign the structure of accountability for leaders and staff to contribute to sustainability.
*Engage patients and families in the process, get their feedback and input into education materials, communication strategies and nursing care.
*Measure results frequently, track and analyze the data. Look at individual results as well as overall trends. Conduct root cause analysis and utilize case scenarios to support lessons learned and develop strategies for ongoing improvement.
*Use external resources and collaborate with other organizations to share knowledge and ideas.

From Boardroom to Bedside: Engaging the Entire Organization to Reach New Levels of Patient Safety and Quality – Linda Morrow and Team

Charting the Safe Course - Strategies for Recognizing and Reducing Drift "to Maintain Patient Safety Outline of current activities related to awareness of drift, recognizing when and where it occurs and strategies for minimizing impact."

Using Lean Tools and Techniques to Maximize Opportunities for Direct Patient Therapy – John Norton and Team

LEAN tools and techniques to map the patient's day, locate waste and non-value added activities, and identify improvement opportunities. Interdisciplinary working groups then applied rapid cycling testing to improvements and developed innovative solutions to extend therapy opportunities beyond the traditional work day.

Breaking the Silence: Making the Workplace Safe for Victims of Domestic Violence - Joanne Barbera-Sheehan, Patty Kerr, Corry Saunders and Team

In response to a need for a safe workplace, the Sexual Assault Treatment Centre initiated a program to address domestic violence that may occur in the workplace. Occupational Health and Safety and Bill 168 have increased the need for policy and programs to address the safety of all employees. The Violence in the Workplace initiative received strong corporate support and provides ongoing education for staff regarding domestic violence. In addition, two nurses specialized in the treatment of domestic violence are available to assist employees at any time.

A number of innovative services have been implemented for staff members who have required this initiative. As part of the initial screening, the staff member is administered a standardized tool to formally assess overall risk levels. All staff identified as having a risk are provided with a safety plan that is coordinated with their department and hospital security. In addition, through close collaboration with the local police and judicial system, the hospital sites are incorporated into restraining orders. Staff without access to a cellphone can also access an emergency phone.

A Problem with Parts was Part of our Problem: A Specimen Safety Initiative - Neelu Sehgal, Jeff Booth and Team

Full disclosure of irreplaceable specimen errors and a proactive approach ensure safe quality care for all parts of the patient, thereby promoting the reduction of irreplaceable specimen errors. Specimen handling is an error prone process that must be clearly defined in any organization. Irreplaceable specimen errors are defined as specimens that would be difficult or impossible to recollect. Eliminating irreplaceable specimen errors will result in the right outcome for the right patient, leading to timely treatment, accurate diagnosis, reduced waste, and less time spent correcting errors.

Bug Patrol: A Proactive Approach to Outpatient Screening - Neelu Sehgal, Jen Cameron and Team

It has been estimated that one hospital acquired infection can cost an organization over $14,000; yet there are a limited number of studies that clearly validate measures for preventing outpatient surgical infections. Approximately 75% of all elective surgery is performed in the Ambulatory, same-day, or outpatient setting. Prior to October 2010, no standardized or reliable method for screening outpatient surgical patients for transmission based infections: Methicillin-Resistant Staphylococcus Aureus (MRSA), Vancomycin Resistant Enterococcus (VRE), and Clostridium Difficile was established at our facility. We formalized the outpatient screening process to match our existing, rigorous inpatient screening protocol. Using a risk assessment questionnaire/tool during their pre-assessment visit, patients deemed to be at higher risk for infection were swabbed. Relevant departments were notified of any positive laboratory results; thereby, ensuring the appropriate infection prevention and control practices were used on the day of surgery (including hand hygiene, protective personal equipment, and environmental disinfection).

Navigating toward a Common Goal: The Undertaking of a Length of Stay (LOS): Improvement Planning Process (Patient Safety & Quality) - Corry O'Neil, Matthew Grayson and Team

This abstract will describe the LOS planning process undertaken in 2010 at WRH. The process was aimed at reducing both the LOS for the department's 3-5 top CMGs while improving clinical outcomes for patients. There was a common understanding that clinical providers were in the best position to improve patient care processes while implementing strategies to decrease LOS and costs per case. Researching best practices and creative thinking, teams implemented strategies such as changes in patient flow processes; development of order sets, new admission criteria and set new LOS goals for their selected CMGs.

An Integrative Management Approach to the Divestment of Specialized Mental Health Beds to Windsor Regional Hospital – Gina Bulcke and Team

In the fall of 2011, 59 Specialized Mental Health beds will be divested to Windsor Regional Hospital. The divestment to Windsor Regional Hospital was part of the directions issued to St. Joseph's Health Care London and the Ministry of Health by the Health Services Restructuring Commission to coordinate the transfer of inpatient programs currently at the London Psychiatric Hospital and the St Thomas Psychiatric Hospital. The divestment will allow for residents of Windsor-Essex and Chatham Kent counties to receive Specialized Mental Health Services closer

to home by allowing patients to remain connected to their local community supports, thereby improving the quality of care and the patient experience. Windsor Regional Hospital has taken a coordinated and integrated approach to the management of this transfer. In addition to ongoing steering committee meetings that include the senior leaders at Windsor Regional Hospital, St. Joseph's Health Care London/Regional Mental Health Care, and the LHIN's, project teams were established to complete project deliverables and achieve goals and objectives using specialized expertise to deal with people and organizational change challenges. Project Teams meet regularly and make recommendations to WRH's Specialized Mental Health Steering Committee who report to the CEO and Board of Directors who are responsible for decision-making and the oversight of scope. Project Teams include: Community Partners and Engagement, Clinical Program Development and Coordination, Psychiatry and Medical Staff Support, Human Resources, Finance, Communications, Education and Orientation, and Facilities and Support. Participation on project teams has included management, program staff, and community providers to ensure system coordination and optimal patient care.

- Once again CONGRATULATIONS to all of you in achieving another record. We do not create these programs to win awards. We create them to enhance patient safety and quality. To be recognized as a result of these improvements and to share them with the world to benefit others is amazing.

Strategic Direction – Cultivate an Environment of Accountability and Transparency

<u>Temporary Closure of Oncology to Admissions</u>

- Last month we had to temporarily close Oncology to admissions as a result of the unfortunate spread of infections to other patients in the hospital.

- The index cases came from the community with their infections. However, we did not, as a team, take the necessary initial precautions (hand wash and use of personal protective equipment) to eliminate the transmission of the infection to other patients.

- During the identification of the cluster on oncology, many elements worked together to reduce the impact of the cluster from turning to an outbreak. Early detection of the cluster and early implementation of cluster control measures may be the only reason that this cluster did not turn to an outbreak. Leadership and teamwork were of great values especially during the lack of beds through the organization. Early communication to the public and other internal and external stakeholders ensured the containment of the cluster to only the oncology program and limited the spread of MRSA/VRE through the hospital.

- Some of the elements identified through the cluster management are the lack of routine practices (hand wash and use of personal protective equipment). Environmental cleaning of patients who were positive after discharge was an issue since the bed is already occupied with a new patient.

- The learnings from this event have been shared with staff in order to reduce/eliminate the possibility of it occurring again.

Strategic Direction – Build and Sustain Financial Health

Comprehensive Men's Health Program Announced

- This past month, the Ministry of Health and Long Term Care through the Minister of Finance, the Honourable Dwight Duncan, announced operational funding for the Comprehensive Men's Health Program (CMHP).

- The program will result in "one stop" shopping for men. The CMHP is much more than buying a machine. It will create "one-stop" care for men struggling with prostate issues. Instead of having a man attempt to navigate through the system by himself, it brings the system to the man. The Urologist, Pathologist, Oncologist and Surgeon will all be a team, meeting with the individual patient and his family to discuss his options and agree upon a clinical course of action. By bringing all of these clinicians together, we will reduce the wait time from over 30 weeks to less than 16 weeks.

- Why are we so certain? Because we have done it before with the Women's Breast Health Centre and the Lung Diagnostic Assessment Program. The CMHP will provide the opportunity for earlier detection and resolution that will save lives. The current system allows men to do what they do best, ignore their health problems as soon as the pain subsides. This results in delay to treatment and additional complications arising due to the delay and cost to the system.

- It will result in the purchase a DaVinci Robot by the Windsor Essex Cancer Centre Foundation. The DaVinci machine will perform prostate surgeries. These machines have been proven to reduce recovery times, allow for better outcomes and reduce rate of infection. The Ministry of Health and Long Term Care has agreed to provide the operational funding for the machine.

Expansion to the Metropolitan Campus Announced

- This past month, the Ministry of Health and Long Term Care through the Minister of Finance, the Honourable Dwight Duncan, announced the needed renovation and expansion of the Metropolitan Campus. The project will start in the 2014/15 fiscal year. Between now and then a lot of planning needs to take place to ensure the project meets the current and future needs of patients, families and staff. There will be in total 21,800 additional square feet.

- It will result in a new and renovated state of the art **laboratory** which will result in the consolidation of the pathology services at WRH as required by the Investigator's report. It will include 20,000 square feet being renovated plus 7,000 new square feet added.

- There will be new construction for the **medical school** students. This will result in 4,000 square feet of new space and 10,000 square feet of renovated space.

- State of the art renovation of **Diagnostic Imaging** space – 2,000 new square feet plus full renovation of existing space.

- **Emergency Department (ED)** – 9,000 new square feet will be added. ED has over 70,000 visits a year. This will result in WRH`s ED being one of the largest EDs in the Province.

- Starting shortly, we will be commencing the planning that will result in detailed drawings that will support the tendering process.

- Please note that this announcement does not change the long term (10-15) plan that Windsor Regional Hospital has to look elsewhere to adequately accommodate the needs of its patients, community and staff. The above described plan is termed a "bridging plan" to that eventual new site.

65 bed Specialized Mental Health Hospital

- On September 22, 2011, we officially "cut the ribbon" on the new 65 Bed Specialized Mental Health Hospital at the Western Campus of Windsor Regional Hospital. It will be named after the Toldo Family. As you are aware the Toldo family has donated some $5 million dollars towards healthcare capital and operating needs at Windsor Regional Hospital in recent history.

- The 65 beds will be separated into pods that include 17 Geriatric Psychiatry, 16 Mood and Anxiety Treatment, 6 Dual Diagnosis, 16 Psychosis and 10 Assessment beds.

Geriatric Psychiatry Program

- ✓ Provide specialized care to individuals with severe and persistent mental illness and late onset psychiatric disorders, whose care exceeds the capacity of secondary level programs; treatment and care has been complicated by problems related to aging or have dementing illness, complicated by difficult behaviours and/or other psychiatric symptoms.
- ✓ Patients in this unit would be 65 years and over; however, bed demand may require admission of persons as young as 55 years of age if clinically appropriate for the model of care.
- ✓ LOS will average 4 to 6 months.

Mood and Anxiety Treatment Program

- ✓ Provide specialized care for individuals whose level of functioning in their social, occupational, and familial lives is severely impaired by symptoms of mood and/or anxiety.
- ✓ Treat medically stable adults 16 to 64.
- ✓ LOS will average 3 to 4 months.

Dual Diagnosis Program

- ✓ Provide specialized treatment to developmentally disabled individuals who also suffer from a severe and persistent mental illness.
- ✓ Treatment will improve psychopathology, global level of functioning, behavioural impairment and severity of mental illness and lessen misdiagnosis, inappropriate treatment, over-reliance on psychopharmacological intervention, and repeated admissions to hospital.
- ✓ Treat medically stable adults 16 and over.
- ✓ LOS will average 4 to 6 months.

Psychosis Program

- ✓ Provide specialized treatment to individuals with Schizophrenia and related disorders (not drug induced) who require care that cannot be managed in less intensive settings due to the persistent instability, complexity, and lack of responsiveness to treatment.
- ✓ The diagnosis of psychosis must be the primary diagnosis and the illness must be present longer than 2 years.
- ✓ Treatment includes medical management, skills assessment, rehabilitation readiness assessment, cognitive behavioural therapy and rehabilitation, psycho educational programs and adherence management in accordance with the individuals needs.
- ✓ Treat medically stable adults over the age of 16.
- ✓ LOS average 6 months.

Assessment Program

- ✓ Provide assessment on individuals who have had multiple attempts at secondary treatment that have been unsuccessful and individuals who have not been diagnosed or misdiagnosed despite numerous attempts and where medication review is required in a controlled setting.
- ✓ This unit will properly assess, diagnose, and refer for the most appropriate treatment unit.
- ✓ Treat medically stable adults 16 to 64.
- ✓ LOS maximum 1 month.

- ➢ Over the next couple of months we will start equipping the facility with the necessary equipment and supplies for the patients.

- On November 15, 2011 we will be accepting our first patient from London. For patient safety and staff orientation we will be accepting patients on a systematic basis over the months following November. We have learned from other facility openings that you do NOT want to rush opening all 65 beds overnight. That is NOT safe for patients or staff. In addition, we are concerned that some of the staff applying for the new positions will need to be backfilled from their current positions. That will take time.

- More information will be forthcoming over the next couple of months on the various job postings, site visits and orientation. Keep an eye out for some exciting announcements.

Family Learning Place Pressing Ahead

- We have made very good and positive progress marching toward a "in the ground" commencement on the Family Learning Place/Gym Pool Replacement.

- The architect, in very close consultation with Family Learning Place staff, is well on his way to completing the contract documents that will be issued for tendering.

- The pre-qualification process to select contractors and sub-contractors to bid on the project has commenced. We are hoping and indeed expecting that many of our local contractors will participate and bid on this work.

- We are targeting a February 2012 start for construction. Between now and then we have a few key milestones and they are as follows:

  - Pre-Qualification of General and Sub-contractors October 17th.
  - Site plan control completion with the City of Windsor November 1st.
  - Approval of overall design and drawings from Ministry of Child and Youth Services November 15th.
  - Tender issued to qualified contractor November 21st.
  - Tenders close January 9th.
  - Construction February 6th.

- Construction is expected to take approximately 10 months and we would hope to have the new facilities ready for use before the end of the 2012 calendar year.

Strategic Direction – Enhance our Status as an Employer of Choice

Undercover Boss

- I once again ask team members that would like me to spend a couple of hours with them while they support the exceptional care we are providing to our patients, to please contact me at david_musyj@wrh.on.ca, 519-995-2966 (cell), (519) 254-5577 ext. 56018 (office) or (519) 726-5617 (home).

- The feedback I am getting from those of you that have participated to date has been very positive. I have thoroughly enjoyed it myself. You can never stop learning.

Strategic Direction – Distinguish Ourselves through Superior Performance, Innovation and Exceptional Customer Service

Parking at the Metropolitan Campus

- As previously announced we are getting ready to proceed with the changes to parking at the Metropolitan campus to better serve our patients and families. These changes are to convert the existing staff parking lot located at the east end of the Lens lot to patient/family parking.

- Since Windsor Regional Hospital has been informed that it needs to look to an external site within the next 10-15 years building and operating a parking structure is NOT financially possible.

- Windsor Regional has expanded its offsite parking on Kildare in order to accommodate all staff that wish to park offsite. This work has been delayed as a result of weather conditions. This will then result in Windsor Regional Hospital being able to maximize its onsite parking for its patients and families.

- **We are planning a "go live" date for the changes for Tuesday November 1, 2011. There will be more announcements between not and November 1, 2011.**

Windsor Regional Hospital on International Map Once Again

- Windsor Regional Hospital was chosen as a presenter during a plenary session at the 2011 Annual Meeting of the Society for Developmental and Behavioral Pediatrics occurring September 16-19 in San Antonio, TX. The Society for Developmental and Behavioral Paediatrics is an international interdisciplinary organization dedicated to improving the health of infants, children, and adolescents, by promoting research, teaching, and clinical practice, in developmental and behavioral paediatrics. The society strives to promote an understanding of the social, educational, and cultural influences on children. The presentation will focus on the differences found in children with mild intellectual disabilities.

  Birds of a feather do not flock together: Subtypes of Intellectual Functioning in Children with Mild Intellectual Disabilities
  Nikhil Koushik, Ph.D., MetroHealth Medical Center, Cleveland, OH
  Andrew Taylor, Ph.D., Windsor Essex Community Health Centre, Windsor, ON
  Cory Saunders, Ph.D., Ozad Institute/Windsor Regional Hospital, Windsor, ON
  John Strang, Ph.D., Ozad Institute/Windsor Regional Hospital, Windsor, ON
  Joseph Casey, Ph.D., University of Windsor, Windsor, ON

Subtypes of intellectual functioning have been established in children with learning disabilities (Saunders et al., 2006) but little research has examined subtypes of functioning in children with intellectual disabilities. We explored the presence of cognitive subtypes in children with mild intellectual disabilities and externally validated the subtypes using their academic achievement and daily functioning. Analysis generated four subtypes in this population: children with primarily language strengths, nonverbal strengths, automatic processing strengths, and children who exhibited global deficits. Significant differences between these groups were found in academic achievement and activities of daily living. Paediatricians involved in the care of children with mild intellectual disabilities need to advocate for appropriately modified interventions that target the unique patterns of cognitive, academic, and daily functioning found in this population rather than making assumptions of homogeneity in this population.

- Congratulations to the team on this fine clinical work and once again placing Windsor Regional Hospital on the International map!

Strategic Direction – Strengthen our Relationships with External Partners

Windsor Regional Hospital supports Home First[ii]

- Windsor Regional Hospital is teaming up with the Erie St Clair Local Health Integrated Network (LHIN) Community Care Access Centre (CCAC) to participate in the Home First Program. Over the next few months you will be hearing more about this much needed program to relieve pressure to the system and support patients being able to go back home where they want to be.

What is Home First?

It's an approach that helps hospital patients to continue their recovery safely at home while receiving enhanced home-care services for up to 60 days. These patients are often frail seniors who have completed their acute-care treatment. It's an approach that helps hospital patients to continue their recovery safely at home while receiving enhanced home-care services for up to 60 days.

Who organizes the Home First Program?

The Home First program is coordinated by CCACs and is being rolled out in all 14 LHINs across Ontario. Between July 2010 and March 2011, the Home First program was launched by the Champlain CCAC in all acute-care hospitals of the Champlain region. The Champlain CCAC is funded by the Champlain LHIN, an agency of the Provincial Government.

What services are offered?

Services can include intensive case management, nursing, personal support, physiotherapy, occupational therapy, speech therapy, social work, dietetics, equipment and supplies.

What are the main benefits for clients and families?

Clients can recuperate in a familiar environment, reducing the risk of losing strength from lack of mobility while remaining in hospital.

There is no cost for eligible services provided through the CCAC.

Seniors have more time to improve their health status prior to making a major decision about their future care needs.

What are the main benefits for the health system?

The Home First program, by helping people get better at home, relieves pressures on hospitals. For example, more beds are made available for patients who require surgery.

Preventing premature admission to long-term care homes results in greater access to these beds for individuals who require a more intensive level of care.

When appropriately managed, care in the home can moderate the demand for more costly health-care options while maintaining a person's independence.

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[i] http://www.auditor.on.ca/en/reports_en/2011pre-election_en.pdf

[ii] http://www.youtube.com/watch?v=Pnnsa8WGKDM