

Celebrating *Home First*

August 22, 2011 - Health service providers and partners gathered early this summer to celebrate *Home First* and the impact this new philosophy has had on seniors' care in Thunder Bay.

Home First is grounded in the belief that people go into hospital for needed care and should go "home first" once the acute phase of their hospital stay is complete – and before any longer-term decisions are made about future care. The North West LHIN has worked with partners in the City of Thunder Bay to align community programs to be able to support *Home First* such as transitional supportive housing, respite care, supports for daily living, adult day services, and home care.

By applying this philosophy, the number of Alternate Level of Care (ALC)* patients in Thunder Bay hospitals decreased by 49 percent (between September 2010 and May 2011).

At the *Home First* event on June 29, 2011, the partnerships and efforts involved were highlighted by speakers from Thunder Bay Regional Health Sciences Centre and St. Joseph's Care Group, while client stories were shared by front line staff at the North West Community Care Access Centre (CCAC) and Jasper Place supportive housing.

The client stories were compelling like the *Home First* experience of CCAC client, Mr. B:

On November 4, 2010, Mr. B was found on the floor of his apartment unresponsive and incontinent. Once at hospital, he was diagnosed with hypoglycemia – the same condition that caused him a trip to the emergency department just a month before.

While being treated at the hospital, Mr. B was assessed as requiring long-term care. A meeting was called between the client, his caregiver, a social worker and a Community Care Coordinator to discuss plans for his discharge. It was apparent the caregiver, who did not reside with Mr. B, was experiencing stress and burnout with her role of taking care of him. She was resistant to the idea of discharging Mr. B from the hospital while he waited for a long-term care bed because, she said, "he can't take care of himself – he doesn't eat or take his medications properly". Nor was he able to shower without assistance.

The Community Care Coordinator explained to the caregiver that services could be arranged to support him to live at home and help decrease her care giving role. Arrangements would include home support to prepare meals; nursing to assist with his medication and a home maker to assist him with showers for safety.

Mr. B agreed to go home assisted with these supports while he waited for a long-term care bed and was discharged in mid-November. Since his discharge, Mr. B had no further emergency visits or hospitalizations. He remained at home comfortably with nursing and home support until his admission to long-term care in June 2011.

The North West LHIN has provided education to service providers across Northwestern Ontario about *Home First*. Planning for the implementation of this philosophy has already started with key stakeholders in Kenora and will continue with other communities across the northwest over the coming year.

* These are patients who have finished the acute stage of their stay, but wait in hospital for the next level of care, whether it's long-term, rehabilitation or home with supports.

