Policy Title	**Client Access Policy**	
Policy Type	**Home & Community Care**	
Department	**Home and Community Care - Care Coordination**	
Division	**Information and Referral**	
Policy Number	**HCC - 263**	
Supersedes	**N/A**	**Approval Date: November 2018**
Approved by	**VP, Home and Community Care**	**Next Review Date: June 30, 2021**

1. Introduction

The Toronto Central Local Health Integration Network (Toronto Central LHIN) is committed to providing. clients with equitable and timely access to home and community care services. Once a referral is received by the Toronto Central LHIN, we will determine a client's eligibility and best efforts will be taken to consider the client's availability and preferences while meeting our service delivery standards.

This policy will outline the actions required to process a referral for home and community care services in the Toronto Central LHIN including non-admits and accompanying procedures for consistent and understandable communication to clients and caregivers about their home care services.

2. Purpose/Scope

The purpose of the policy is to provide consistent processing of service referrals and clear communications to clients regarding the Toronto Central LHIN service delivery standards to allow equitable and timely access to home and community care services.

All Toronto Central LHIN Home & Community Care staff will adhere to this policy when considering services for eligible clients.

3. Policy

3.1 General

- Wait time targets are established by Ministry-LHIN Accountability Agreements (MLAA) and are as follows for clients who are eligible for service:
    - For all referrals originating from community, an in-home service provider first visit will occur no more than 21 days from date of receipt of the referral.
    - For all nursing and complex PSW services, the first in-home service provider visit will occur no more than five (5) days from the date of service authorization.
    - For all referrals originating from hospital, an in-home service provider first visit will occur within seven (7) days of the date of hospital discharge.
- Changes to a service delivery plan, resulting in the potential or actual delay of in-home service delivery occurring within the aforementioned time frames will be documented and actioned in CHRIS. All

communication related to a patient's wait time for service provider services will be considered significant and documented in accordance with the documentation policy.

3.2 Community Intake

- In all instances, all reasonable efforts will be undertaken to reach new patients in order to establish a service delivery plan and timeline for service delivery:

    1. Intake staff are responsible for making a minimum of three (3) attempts to reach a referred patient within five (5) days of the referral being received by the TC LHIN. Each attempt should be documented.

    2. If a patient cannot be reached and there is no call-back within the five (5) days, the patient and their circle of care shall be notified in writing of such, and the file closed as "non-admit".

3.3 Hospital Intake

- In all instances, all reasonable efforts will be undertaken to reach new patients in order to establish a service delivery plan and timeline for service delivery:

    1. Intake staff are responsible for making a minimum of (3) attempts to reach a referred patient within (5) days of discharge from hospital, if patient was not assessed in hospital prior to discharge. Each attempt should be documented.

    2. If a patient cannot be reached and there is no call-back within the five (5) days, the patient, most responsible physician, and their circle of care shall be notified in writing of such, and the file closed as "non-admit".

3.4 Community Service Ordering and Coordination

All Home & Community Care staff are responsible for the timely delivery of home and community care services within the Ministry of Health and Long Term Care established targets:

3. An eligibility assessment by a Care Coordinator for the purpose of authorizing home and community care services shall be completed within 10 calendar days of the date of receipt of the referral.

4. If a patient cannot be reached by the most responsible Care Coordinator to complete an assessment within (10) calendar days of the date of receipt of the referral, the patient is to be notified in writing of such and the file closed as "Other".

5. Care Coordinators and Team Assistants are responsible for requesting the first in-home service provider visit takes place within five (5) days of the relevant assessment leading to the authorization of complex PSW or nursing services.

6. Care Coordinators and Team Assistants are responsible for requesting the first in-home service provider visit takes place no later than (21) days from the date of receipt of the referral.

7. Upon discharge from hospital, following the relevant assessment leading to the authorization of all non-nursing home and community care services, Care Coordinators and Team assistants are

responsible for requesting the first in-home service provider visit takes place no later than (6) days from the date of discharge.

8. The Patient Availability Date in CHRIS shall always be selected to reflect the date of the first planned visit or frequency when ordering home and community care services.

9. If a patient requests, or service provider organization reports, a change to the first in-home service provider visit date as a result of patient preference, the Patient Availability Date shall be adjusted by the party receiving the request to reflect the new first visit date.

10. All requests for in-home service initiation beyond (10) days from the date of assessment, for reasons of patient preference, will be closed as "Client/Family preference" and re-admitted at the time of client preference.

3.5 Re-Admission

- To support patient flow and access, reasonable efforts will be made to minimize impact to clients:

1. If a patient was previously deemed eligible for home care services, the patient shall be assigned to the most appropriate caseload, without full intake assessment, within 30 days of discharge should the reason for the discharge be patient preference and availability.

2. A patient may also be readmitted within 30 days of discharge, without full intake assessment, if it is determined that there has been no significant change to their care needs since the time of their last assessment and admission.

Responsibility	Action

Care Coordinators	• To complete home care assessments, establish goals of care, and implement service plans within the established timelines:
	  ○ Complete an initial home care assessment and develop a service plan within 10 days of referral
	  ○ Follow up, as appropriate, to determine that an initial in-home nursing and complex patients receiving PSW service visits are delivered within 5 days of authorization
	  ○ Support the delivery of initial in-home service visits within 21 days of referral from the community, and 7 days from hospital discharge
	• Order services by selecting a Patient Availability Date
	• Document any changes to the service delivery time requested by the patient in CHRIS

Community Team Assistants	• To support Care Coordinators by contacting or following up with clients and/or referral source and booking home visits
Managers	• To monitor and performance manage their staff for compliance with the implementation of this policy • Monitor program and organizational wait times and participate in efforts to reduce wait times for clients
Contracts	• Investigate issues and Performance Manage Service Providers who are not meeting all wait time metrics

Responsibility	Action
	• Require Service Provider Organizations to notify LHIN when there is a delay for first visit due to client preference
Service Provider Organizations	• Schedule visits for clients within 5 days of authorization (referral) • Where client preference delays first visit (or when clients cancel a scheduled 1st visit), notify the LHIN so that patient available date can be updated.
Intake Team Assistants	• Complete registration and intake of community referrals within established timeline guidelines • If unable to complete intake, follow the non-admit process

4. Definitions

Term	Definition
Assessment	For the purpose of this policy, assessment refers to the determination of need completed by a Care Coordinator leading to the authorization and initiation of service, including: RAI-CA, RAI-HC, PAT, and Child & Family assessment tools. This assessment may be completed face-to-face or over the phone.
Complex PSW	Patients with the sub-population code of "Complex" who are receiving PSW services from the TC LHIN
In-home	For the purpose of this policy, in-home includes all service types delivered in a patients residence as well as services delivered in school and in TC LHIN provider nursing clinics
Ministry	Ministry of Health and Long-Term Care
Nursing	Includes in-home, clinic, Mental Health And Addiction Nursing, and Rapid Response Nursing
Patient Preference	Personal preference not linked to a clinical need for a service to begin on a specific date, such as vacation
Days	For the purpose of this policy, days refers to calendar days.

5. Related Forms/References

Home and Community Care Practice Standards

Care Planning Information- Personal Support Services, Nursing, Nursing Clinics

8. Review and Revision History

Reviewed by (title)	Consulted With (title)	Modification(s)	Date
VP, Home and Community Care	**Director, Operational Support**		**November 18, 2018**