



# SAFE Clinic Partners with Home At Last



## Introduction

The SAFE Clinic, Specialized Assessment of the Frail Elderly, is a specialized geriatric ambulatory care clinic within Lakeridge Health Corporation, delivering an interprofessional model of care. We provide comprehensive geriatric assessment, functional enhancement and follow up monitoring for seniors living in the Durham Region community.

The SAFE clinic evolved from the Falls Clinics, a single stream specialized geriatric clinic initiated in 2005 at Lakeridge Health Whitby. It relocated to Oshawa after the fire for a year and now operates at the Bowmanville and Port Perry sites to improve access for seniors.

HAL, Home At Last, is a program funded by the Central East Local Health Integration Network through Community Care Durham which provides settlement and transitional service for patients from hospital to home.

The goals of the SAFE clinic are to optimize function and quality of life for seniors, to support seniors to continue living safely in the community, to decrease emergency room visits, to minimize admissions and to reduce length of stays in hospital for seniors.

The goal of this Project was to develop an interprofessional and interorganizational relationship between the SAFE and HAL programs to further optimize care to support seniors living at home.

## Actions

Review of referral criteria and utilization of the SAFE clinic.

Identification of limitations, gaps and areas for improvement for the SAFE clinic.

Investigate Home At Last Program.

Liaison meetings with key partners at HAL (Cheryl MacLeod & Annemieke Dean) to determine whether SAFE patients would meet criteria to qualify for the HAL Program as they were not inpatients but rather attending an outpatient clinic.

Solidify the referral process and establish a working relationship between the two programs.

Initiated referrals to the HAL from the SAFE clinic and evaluate benefits and dual relationships.

Additional meetings between SAFE and HAL to resolve barriers and optimize communication and success.



## Results

The SAFE clinic has achieved its goals through consultation, communication, collaboration and partnership with a variety of internal and external services and programs, most specifically Home at Last.

Reduced SAFE assessments were completed due to temporary closure of the clinic due to unforeseen circumstance therefore impacting referrals to HAL program.

Staff were deployed to inpatient care settings, specifically acute care (medicine/surgery) and geriatric rehabilitation impacting SAFE referrals. This resulted in an unexpected positive ripple effect of increased referrals to the Home at Last Program from the inpatient setting.

Interprofessional educational opportunities fostered increased awareness of the Home at Last program and services within the hospital setting.

The number of referrals and settlement services to the Home at Last Program were tracked.



## Challenges

The SAFE clinic is not an inpatient unit in the hospital but rather an ambulatory clinic. Originally our patients did not meet the referral criteria to the Home at Last Program however it was evident that many SAFE patients would benefit from the services offered by HAL.

We needed to ensure that the SAFE clinic patients could access the HAL program. The collaborative spirit of the two organizations united to put seniors first initiating this project.

Due to unforeseen health human resource staffing issues, the SAFE clinic was closed for 8 weeks of operation during this project. This resulted in reduced opportunities for referrals directly from the SAFE clinic.



## Lessons Learned

### CHALLENGE THE STATUS QUO

Don't be afraid to question the service criteria for program referrals to meet the needs of your patient population!

Within the health care system there are often strict criteria for referral to programs. Challenging these limitations can open opportunities to allow access for more patients.

*"Every accomplishment starts with the decision to try."*  
Winston Churchill

### TIMING CAN BE THE DRIVER OF CHANGE

Having the right people together at the right time and for the right reasons (patient focused care) can open doors and dialogue.

The SAFE and HAL team members participating in the IP leadership project enabled collaboration and sustained momentum.

*"Success is simple. Do what's right, the right way, at the right time."* Arnold H. Glasgow

### WE DO NOT NEED TO BE THE EVERYTHING TO EVERYONE!

Look beyond ourselves and capitalize on others' successes and strengths. We can work together, reduce duplicity and address gaps in services together.

**'TEAM - Together Everyone Achieves More'**

## Knowledge Transfer

Regional Geriatric Program of Toronto Annual General Meeting  
November 19, 2009

Poster Presentation – SAFE Clinic and Interprofessional Leadership  
Poster viewing facilitated dissemination of the interprofessional, value added relationship between SAFE & HAL to meet the access needs of seniors.

*"Knowledge is of no value unless you put it into practice."*  
Anton Chekhov

## Next Steps

Now that our clinic is back up and running we will continue to identify seniors who would benefit from the Home At Last program and make referrals.

Tracking referrals from SAFE to HAL and from HAL to SAFE.

Tracking how this new partnership has improved access for seniors to the SAFE program.

Transportation gaps exploration.

Explore new opportunities to link with other organizations interprofessionally.

## Contact Information

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