MEMO

DATE: September 28, 2022

TO: Doctors Manitoba
    College of Physicians and Surgeons of Manitoba
    College of Family Physicians of Manitoba
    Community Health Agency Partners
    Site Medical Leads
    PC Team Managers
    WRHA Community Area Directors

FROM: Dr. Shawn Thomas
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      Primary Health Care, Home Care and Community Integration

SUBJECT: The 60/40 Project

The 60/40 project is a collaborative effort that looks to shift the paneling process to prioritize paneling clients to Long Term Care (LTC) directly from community. A target has been set for 60% of clients being placed to PCH come directly from community as opposed to hospital. The project mandate is to ensure the Home is Best philosophy is present in policies and processes within all key areas of the health care system (Acute Care, Community and Continuing Care).

For 60/40 to be successful, improving system access and flow needs to be a priority. The main goals are to reduce alternative level of care (ALC) bed days for those admitted to hospital and facilitate better flow from emergency departments and urgent care for those requiring admission.

While many providers are aware of home care services, providers are not always aware that the Home Care Program and the Long Term Care (LTC) Access Centre are distinct programs with distinct roles and responsibilities within the paneling process.

**Home Care:** Home care is a supplemental service that is progressively increased in an effort to keep clients safely at home for as long as possible. If a patient requires a reassessment, providers can contact the patient’s Case Coordinator (CC) directly to discuss. The CCs direct contact information is located in eChart (on the preview screen); for those with no eChart access to the CC can be reached through the Central Intake Line (204-788-8330).

Additional Information: [https://home.wrha.mb.ca/old/prog/homecare/files/ce_homecaregeneric.pdf](https://home.wrha.mb.ca/old/prog/homecare/files/ce_homecaregeneric.pdf)
LTC Access Centre Once a patient is no longer able to be safely supported in community the Home Care Case Coordinator will consult with the LTC Navigator to discuss paneling. The role of the LTC Navigator is to determine eligibility and disposition within LTC. If you have questions related to the paneling process, you are encouraged to contact the LTC Access Centre (204-940-8670).

What does this mean for providers?

- Be supportive that all areas in the health system have adopted the Home is Best philosophy
- Support clients and families understanding that if medically stable, clients should reside within their homes (*if clients have a residence or home)
- Home care is a supplemental service and should complement other supports in keeping clients at home safely
- If concerned about a client’s safety in community consult with the Case Coordinator

How can providers help?

- Avoid prescribing Long Term Care or PCH placement for clients
- Support family to understand the process into LTC (the CC will consult with the LTC Navigator)
- Support the LTC Navigator as the decision maker to determine LTC eligibility and disposition

We are excited at the prospects of attaining the 60/40 goal. Thank you for your time and attention and for all that you do in providing quality care for your patients every day. If you have further questions or require clarification on any raised points, please let us know.