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South West CCAC / CASC
Community Care Access Centre
Centre d'accès aux soins communautaires du Sud-Ouest

STAFF BULLETIN
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in this ISSUE:

Reducing the Risks for High-Risk Seniors

A pilot project explores the impact of Supports for Daily Living

An 82-year-old with COPD has been living in an apartment with his elderly wife. He is hospitalized with pneumonia. Ready for discharge but still weak and showing early signs of dementia, where does he go when released from hospital?

In the past, many people in this situation might have moved into a long-term care home permanently. Or they might have gone home, only to return to the hospital a few days or weeks later when the situation proved unmanageable. A new project at the South West CCAC explores what intensive case management and at home supports would enable these high-risk seniors to stay safely in their own homes and communities.

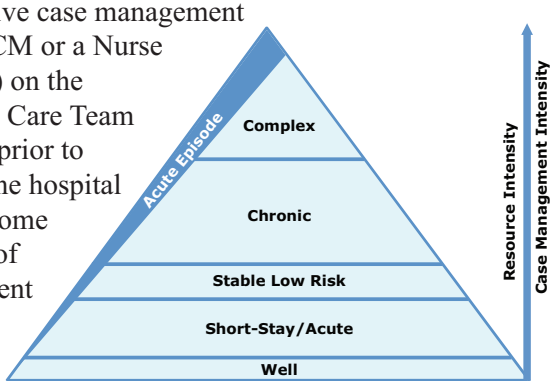
"This is an opportunity to test our new population-based approach and see if it helps to keep this population healthier and safer in their own homes."

Megan Nichols, Regional Client Services Manager, says the project originates from the South West LHIN's Integrated Health Services Plan. "Part of the plan is looking at strategies to build a more integrated system of health care for seniors," she points out. "This project is one piece of the puzzle."

During the pilot, which will run until March 31, 2011, 100 people 75 years or older will be identified from among patients at the emergency department at London Health Sciences Centre or the medicine in-patient unit at University Hospital. Those who score 16 or greater on the new RAI Contact Assessment tool may be referred to Cheshire Homes of London for "supports for daily living."

Supports for daily living include scheduled needs such as getting out of bed, bathing and getting dressed. The service also ensures that an attendant is available 24 hours a day to answer a client's pager call when they have fallen or have some other unscheduled need.

Two case managers, Karen Chatfield and Diane Dodge, have been hired temporarily to support the project by providing intensive case management (ICM). Either ICM or a Nurse Practitioner (NP) on the Advanced Home Care Team will visit clients prior to discharge from the hospital and then in the home within 48 hours of discharge. Frequent follow-up visits will be made to assess need and connect clients with appropriate resources. The clients will be encouraged to develop a "shared care plan" detailing their responsibilities once they are discharged. Says Nichols, "This is an opportunity to test our new population-based approach and see if it helps to keep this population healthier and safer in their own homes."



The high-risk seniors project will be rigorously evaluated. Indicators such as re-admission rates, visits to emergency, withdrawal of long-term care applications, caregiver burnout, and length of stay will be tracked. The "supports for daily living" portion of the project has a cap of 30 clients, but other clients who are eligible for the service will be followed to compare results.

Ultimately, says Nichols, if the project is successful, the benefits will show up during re-assessment. "Case managers go out on a regular basis to do the RAI," she says. "If we have the right supports in place, we should see the scores on that assessment go down, indicating that clients and caregivers are functioning better in their own homes."

A Message from
Sandra Coleman, CEO
South West CCAC

Never an Accident

There's lots of talk about quality in health care today. We all want good health care for our families and ourselves. We know that with limited resources and an aging population, our health system can only be sustained if we learn to work more efficiently and effectively.

John Ruskin said, "Quality is never an accident: it is always the result of intelligent effort." There are many signs of intelligent effort around us. The Ontario government introduced the *Excellent Care for All Act*, designed to improve the quality of the patient experience in Ontario. Currently applied only to hospitals, the *Act* will be rolled out to CCACs and other health care organizations in time. The *Act* calls for quality committees, client and staff satisfaction surveys, declarations of values, and processes to address patient experience issues.

We at the South West CCAC already have most of these strategies in place! In fact, we have been making "intelligent efforts" to improve quality right from the start. For example, we played a key role in Partnerships for Health (see page 3), a project to improve diabetes care by creating interdisciplinary teams with dedicated case managers with each physician practice, doing small tests of change, empowering patients, and supporting the use of information systems. At the recent Outcomes Congress, teams from across the South West reported on exceptional success in keeping patients healthier and helping them feel empowered.

The high-risk seniors project that you read about on page one of this newsletter is another example of our commitment to quality. There are several other projects under way this fall that will yield important information about how to deliver care better.

Does this imply that we haven't been doing our best in the past? Absolutely not. Quality improvement is about applying new understanding based on rigorous research to our practices.

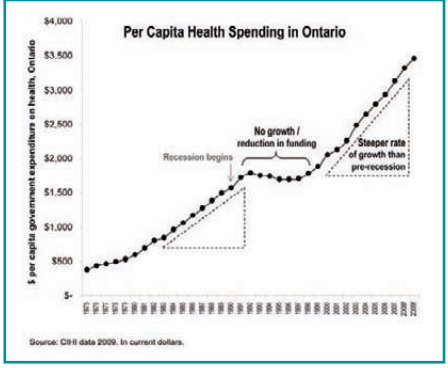
Each one of you takes great pride in providing quality care to your clients and caregivers — it's "never an accident" that our client satisfaction ratings are among the highest in the province! I know you will embrace new opportunities to improve quality.

WHAT'S THE BUZZ?

Excellent Care for All Act

The *Excellent Care for All Act* is designed to put patients first by improving the quality and value of the patient experience through the application of evidence-based health care. To learn more about this innovative legislation, visit www.health.gov.on.ca/en/legislation/excellent_care/.

Cuts and containment can result in higher costs in the future



Room for Improvement

A recent "Chartbook" from the Institute for Clinical Evaluative Sciences noted the following:

- The number of people aged 85 and older grew by 36% between 2002 and 2008
- The rate of emergency room visits for fall-related injuries was unchanged over time
- The number of ALC seniors almost doubled between 2005 and 2008
- Overall wait times for long-term care placement have increased substantially, with a median wait time of 103 days in the last quarter of 2008-2009
- There are big differences across Ontario in how quickly clients receive in-home assessment

To view the "Chartbook" go to www.ices.on.ca.

Safe at Home

The Ontario Association of Community Care is part of a research team recently awarded $1 million to study safety risks related to home care. Lisa Droppo, the OACCAC's Chief Analytics, is one of 24 members on the multi-disciplinary research team. "OACCAC and its member CCACs are excited to be part of this illustrious, cross-Canadian group of researchers," Ms. Droppo says. "We will learn more about adverse events in home care, and develop knowledge and skills that will advance our ability to learn from and make improvements in client safety."

Quality Improvement at Work

The South West CCAC plays a critical role in the success of Partnerships for Health

Recently members of the South West CCAC team joined a very special celebration: the Outcomes Congress of the Partnerships for Health initiative. "We certainly have something to celebrate," says Nancy Dool-Kontio, Senior Director, Strategic Planning and Integration. "The CCAC's involvement in this initiative helped to increase understanding of our role and improve communication with our partners across the care spectrum. That in turn led to better care coordination and better clinical outcomes for clients."

The Partnerships for Health (PFH) initiative began in early 2008. It was designed to improve care and outcomes for people with diabetes by making improvements in four key areas:

- Improving clinical outcomes
- Empowering clients and supporting self management
- Developing effective partnerships
- Enabling improved communication and information management

The first wave of Partnerships for Health consisted of three physician teams from the Brockton, Clinton and Strathroy Family Health Teams. The second wave got under way in January 2009, with an additional nine teams. Currently there are 73 primary care practices involved across the South West.

Each practice built an inter-disciplinary team, including physicians, nurse practitioners, nurses, diabetes educators, health educators, CCAC case managers, mental health team specialists, pharmacists, ophthalmologists and others. The teams worked collaboratively to make and measure care improvements.

The teams developed improvements guided by Ontario's Chronic Disease Prevention and Management Framework. They then tested them using the IHI quality improvement model, which involves making small tests of change. Information was shared among the teams through several learning modalities: learning collaboratives, spread collaboratives, web-based learning, knowledge transfer days, and on-site coaching.

(Left to right): Nancy Dool-Kontio, *Senior Director, Strategic Planning and Integration*; Deb Matthews, *Minister of Health and Long-Term Care*; Catherine Statton, *Project Manager, Partnerships for Health, North* and Rachel LaBonté, *Project Manager, Partnerships for Health, South* at the Outcomes Congress, October 7.

- To view the PFH Improving Diabetes Care video presented at the Outcomes Congress click here.
- To view Sandra Coleman's presentation at the PFH Outcomes Congress click here.
- To view Steven Lewis' presentation at the PFH Outcomes Congress click here.

or view the videos at www.youtube.com/user/swccac.

Among key findings from PFH:

- 100% of partners say there has been enhanced communication between partners
- 100% of physicians say having a case manager as part of the care team enhances patient care
- 89% of physicians say having a case manager on the team facilitates timely referrals
- 82% of CCAC staff involved in PFH say communication to and from the CCAC and primary care has improved
- Referrals to CCAC for our in home services from the primary care sites involved in PFH increased from 39 in 2008 to 307 in 2009
- Increased referrals by CCAC to community supports
- Clinical outcomes such as A1C, LDL and blood pressure improved
- Patients reported that they felt more satisfied and supported, and more confident about managing their own conditions
- There was a 5% annual decrease in the numbers of CCAC clients with diabetes attending ER or being admitted to hospital

Dool-Kontio says the initiative has uncovered a rich vein of learnings that will be shared in the months to come. "It's exciting to be involved in a project that confirms everything we believe about the value of partnership," she says. "Now we have to keep moving forward, building relationships with primary care practices, supporting our clients to be active members of the care team, sharing information and growing together."

Celebrating HEROES IN THE HOME

Caring Together for our C

Oxford and Norfolk Counties **October 20**

Grey and Bruce Counties **October 26**

Perth and Huron Counties **October 14**

FEATURED STAFF MEMBER

Val McCrae

Role: Supportive Care Resource Team CM

Years of CCAC service: 15

Passions: "A member of the Owen Sound Golf and Country Club since a young girl, I enjoy golfing whenever I can. If I could golf every day of the week, that would be awesome. Along with golf, I enjoy spending time with family and friends, scrapbooking and cross country skiing. My part-time jobs (not really jobs) include being a jeweller with Fifth Avenue Jewellery and Beauty Consultant with Mary Kay Cosmetics.

I am on the Board of Big Sisters and enjoyed being a 'Big Sister' very much. I also volunteer for Victim Services.

My husband and I have 2 sons, the eldest will graduate in June 2011 from the Canadian Memorial Chiropractic College in Toronto and the youngest is a Nuclear Operator at Bruce Power."

Fundraising

Woodstock Access CM Kate Wright (right) and her sister Kristen Sommers (left) participated in the Weekend to End Women's Cancers on Sept 11-12. The 4,633 participants walked 60 km through the streets of Toronto and raised $10.8 million for the Princess Margaret Hospital Foundation.

Did you know ... ... that Canada's first national park was created 125 years ago? Some time, take a few minutes to go to www.celebrateparks.ca to see which one. While at the site, check out the video clip submitted by Rachel Henderson (daughter of Kathryn Henderson, IT in Stratford) on why the Bruce Peninsula National Park is her favourite Canadian Park. Rachel submitted her video to the Celebrate Parks Video Contest and hopes to be selected the winner. Good luck Rachel.

Someone's junk is another's treasure

The Woodstock site social committee raised $185 at an indoor yard sale held Sept 30 and Oct 1, 2010 for our Angel Tree Fund. Also, on Sept 30, while colleagues shopped for treasures, they enjoyed the Alzheimer's Coffee Break, which raised $87 for the cause.

Meet Mr. and Mrs. Cornelis Dank

On August 13, 2010 Roelie Veldhuizen (Administrative Assistant in Woodstock) and Cornelis Dank were joined in marriage during a beautiful ceremony at the Netherlands Reformed Congregation in Norwich. We wish them many years

Welcome New Staff

Huron: Patricia Little, *Casual CM*

Perth: Angela Muir-Hughes, *Casual CM*; Michele Wismer, *Administrative Assistant*

London: Michelle Scime-Summers, *Client Services Manager*; Laura Macel, Paul Rivest, Andrea Sweiger, Cailin Vince, Linda McFarlan and Marg Kooy, *Casual CMs*; Martin Bauwens, *Data Analyst* and Hilary Di Crescenzo, *Financial Analyst*