Connecting you with care
Votre lien aux soins
South West CCAC
Community Care Access Centre
CASC
Centre d'accès aux soins communautaires du Sud-Ouest

Connecting with Care through PARTNERSHIP

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The South West CCAC is working with its partners to walk the talk

Recently the 14 Community Care Access Centres (CCACs) of Ontario came together to develop a new vision and mission that captures the essence of our expanded mandate as system navigators (see Sandra's message overleaf). The new CCAC logo bears the simple but powerful statement, "Connecting You with Care."

At the South West CCAC, there's nothing new about this concept. Since the CCAC was launched in January 2007, we've been working hard to connect our clients with care by working closely with our health care partners.

One of the newest initiatives is called, appropriately enough, Health Care Connect. It's an innovative program designed to help people without a family doctor find one in their community. Marg Vallee is one of two Care Connectors working with the South West CCAC. People looking for a family doctor register through Telehealth Ontario. Vallee and her colleague, Anna Ackland, then work to match patients with a family physician.

Although they only started in early February, Vallee and Ackland have already attached patients to doctors. "There are so many people out there who do not have family physicians," says Vallee. "That's one reason emergency departments get bogged down. This is an opportunity to work in partnership with family physicians to make a real difference for patients and the health system."

Connecting people with care is also the idea behind www.thehealthline.ca. The innovative website, considered an Ontario model, puts South West health and social services information at the fingertips of clients and professionals across the South West. Designed to be easy to use, it offers separate listings for each county in the region, and a variety of other information resources. Three Regional Community Partnership Coordinators (RCPC) work to connect and build relationships with listing organizations. "Health professionals often tell me how valuable thehealthline.ca is for locating local services," says RCPC Teresa Zohorsky. "It's also an easy way for community agencies to build regional awareness, reduce duplication, and promote services, events and activities at no cost."

Partnerships for Health, a pilot project in chronic disease management, is an example of partnering with primary care to connect clients with care. South West CCAC case managers are members of teams now at work developing new approaches to diabetes care at the primary care level. Up to 100 more primary care practices will join over the next several months (see story page 4).

Among other ways the South West CCAC connects clients with care through partnership: the new Transition Unit at Parkwood Hospital, South West CCAC case managers working in hospital emergency departments, integrated hospital discharge planning, Aging at Home projects, and the Flo project (see story page 4).

"At the core, our job is truly about connecting people with care," says CEO Sandra Coleman. "We do it by partnering with other health professionals across the care spectrum. The stronger our partnerships, the better the connections we make for our clients."

Panel discussion members (l to r): Elaine Todres, Moderator; Sandra Coleman, ED, South West CCAC; Ruthe Anne Conyngham, Chair, Canadian Healthcare Association; Tom Closson, President and CEO, Ontario Hospital Association; Kelly Gillis, Senior Director, Planning, Integration and Community Engagement, South West LHIN; Jackie Wells, Director of Community Support Services, VON Middlesex-Elgin and Margaret Mottershead, CEO, Ontario Association of CCACs

Inside: See how Partnerships are *Making a World of Difference* (Page 3)

Brand New

A Message from Sandra Coleman, Executive Director, South West CCAC

Brand is one of those mysterious concepts that marketing gurus like to talk about. You may be surprised to read that the CCACs of Ontario have been involved in an intensive branding exercise over the past six months.

Why? Because we believe that by identifying what we stand for and aspire to, we are more likely to achieve it on a day to day basis. By developing a shared vision, we create a roadmap to lead us into the future. By working together as a provincial group, we move toward more consistent quality care across Ontario.

On a more practical level, the new brand reflects significant changes that have occurred in CCACs over the past several months. In December the Minister of Health and Long-Term Care announced several measures to strengthen CCACs, including an expanded system navigation role. Working with our partners and the LHIN, we will soon be able to be a single point of access for more services. As of April 1, CCACs once again become non-profit community organizations. This means that our board members will be selected locally to reflect the needs and concerns of our communities, rather than appointed by Cabinet through the Order-in-Council process.

The brand development process itself was fascinating. The CCACs explored four key questions with employees, service providers, other health professionals and the public – Who are we? What do we do? How do we do it? What do we aspire to be? It became clear that in complex and sometimes confusing health system, CCACs are the organizations people turn to for help in navigating the system and connecting with the right care.

At the end of the process, we have a new vision and mission for all CCACs. These statements are truly aspirational. They are the direction we are headed, not the place we have arrived.

Vision: Outstanding care – every person, every day.

Mission: To deliver a seamless experience through the health system for people in our diverse communities, providing equitable access, individualized care coordination and quality health care.

These commitments are signposts, encouraging us to embrace the process of continuous improvement and innovation. The South West CCAC started down this road long before the branding exercise, and we are now more focused on the way forward than ever.

But we can't do it alone. To realize our full potential, we must work with you, our health system partners and providers. Together, we can indeed deliver outstanding care to every person, every day.

Staying Safe at Home

The Advanced Home Care Team helps clients stay out of hospital

In January John Strybosch, 85, who suffers from congestive heart failure, took a turn for the worse. His wife, Lena, called the family doctor, Dr. Frank Wong, who saw them immediately. "The doctor hadn't seen John for a bit," says Lena. "He was worried, and got a lot of action going quickly."

Dr. Wong wanted to admit John to the hospital, but a bed wasn't available. The family wanted to avoid hospitalization, so Dr. Wong made a referral to the Advanced Home Care Team (AHCT).

The AHCT is an innovative collaboration between the South West CCAC and its partners in the region. The Team consists of Nurse Practitioners who work closely with family doctors, case managers and other health professionals. Their goal is to provide advanced care at home, so that hospitalization can be avoided.

In John's case, his care team included Sara Renouf, a Nurse Practitioner with the AHCT, South West CCAC case manager Kathy Faulds, a Registered Nurse from St. Elizabeth's, and a personal support worker. With their help he was able to recover comfortably at home. He even had an X-ray with a portable X-ray machine set up in his garage!

In all, more than 500 people were served by the Advanced Home Care Team in the past year, with 86% of them avoiding a hospital stay as a result. That amounts to a saving of more than 25,000 "patient days" in regional hospitals, a big help at a time when hospital beds are a premium.

"I was a bit concerned that John wasn't in the hospital," Lena says. "But they gave us all the help we needed, so we could do it at home. I would definitely recommend this kind of care."

Making a World of Difference

South West CCAC hosts world-class conference on the future of community care

Evelyn Harris-Williams, Chair of the South West CCAC, called it the Board retreat that "grew, and grew and grew some more."

On February 24, the South West CCAC hosted an exciting day of speakers from across Canada and around the world, all focused on the future of community care. The event began as a plan for the annual Board retreat, but ultimately attracted some 400 participants including Board members, South West CCAC staff members, representatives from other CCACs, service providers, hospitals, community support agencies, long-term care homes, primary care providers, students, researchers, LHIN Board and staff members, and others.

Sven-Olof Karlsson, former CEO of the Jönköping County Council in Sweden, was the keynote speaker. Jönköping is recognized as one of the top health care systems in the world. Karlsson told the assembled group that the experience in Jönköping proves that low cost can be combined with high quality in health care. He talked about the critical role of leadership, and shared many of the strategies used to make positive change. He concluded, "My strategy has always been to involve lots of people in change. If everyone works on a small project and we can see a small result from each of these projects, together we get a big change."

You have two jobs: to do your job today and to improve it!
— Sven-Olof Karlsson

Other speakers included Sholom Glouberman, Philosopher in Residence at the Baycrest Centre for Geriatric Care, health policy analyst Marcus Hollander, researcher Margaret MacAdam, and Valerie White, CEO of the Department of Seniors in Nova Scotia. The day concluded with a lively panel discussion, featuring leaders in community care from across Ontario.

Hollander presented an array of powerful research results to prove his contention that "... there is a real value and benefit to home care and home support services." For example, a study conducted for Veterans Affairs Canada found that clients living in long-term care facilities, in the community, and in supportive housing had similar levels of health-related quality of life, but that home care was considerably less costly.

MacAdam also explored research about new models of care for seniors. "The evidence indicates a need for a common entry point, uniform assessment and care planning protocols," she noted. "The Ministry's decision to expand the CCAC's role as "care connectors" for all seniors will help to provide a key feature of successful programs."

White told the group about the *Strategy for Positive Aging* developed in Nova Scotia. The Strategy includes nine goals: celebrating seniors, financial security, health and well-being, maximizing independence, housing options, transportation, respecting diversity, employment and life transitions, and supportive communities. She also introduced the concept of "age-friendly communities," and shared the Nova Scotia experience.

"It was a fabulous day that reinforced everything we're doing at the South West CCAC," says CEO Sandra Coleman. "All our speakers reminded us that we can no longer conduct business as usual. We all must be prepared to question everything and try new approaches. Innovation and partnership is the only way forward."

Presentations and video from the February 24 conference are available at *www.thehealthline.ca,* in the *Health Library* (upper right).

Partnerships for Health Prepares to Grow

In May 2008, we reported on the launch of an exciting new project, Partnerships for Health (PFH), focused on improving care for people with diabetes at the primary care level.

The first and second waves of PFH teams are now well under way, and the results are very positive. One Wave I team developed a new approach to coordinating care for its patients. The team, which includes primary care physicians and allied health professionals, a South West CCAC case manager and a Diabetes Education Centre (DEC) nurse, worked together to review the practice registry of patients with diabetes and identify people who would benefit from case management or needed education and self-management strategies through the DEC. "This represents a real improvement in care coordination across agencies," says Mike Hindmarsh, a member of the PFH leadership team. "Ultimately this kind of integrated care improves patient health and reduces utilization of the health system."

Recruitment has now begun for up to 100 practices to be part of Wave III. "Wave I and II are about learning and design," says Marg McAlister, also a member of the PFH team. "Wave III is about spreading the learning and sharing new approaches to care."

Wave III participants will benefit in many ways, McAlister says. They will have the opportunity to learn quality improvement techniques and hear the latest research on diabetes management. They will also strengthen their practice teams, improve their use of technology, and learn how to empower patients to care for their own health. "We have some exciting new information and ideas to share," she says. "Ultimately, this will help primary practices provide better care for patients with chronic diseases."

To find out how your primary care practice can get involved, visit www.partnershipsforhealth.ca.

Going with the Flo

"We saw great results from the Flo projects..."

Flo is an 85-year-old woman with several chronic conditions. She is frail and getting confused. Right now she's in hospital and it looks as if a long-term care home is the next stop.

Flo is imaginary. She is modeled on Esther, the model patient used by the Jönköping County Council in Sweden to focus health professionals on creating a more integrated and seamless patient experience. Flo's story lies at the heart of the Flo Collaborative, a project of the Centre for Healthcare Quality Improvement to help make transitions from acute care hospitals to other settings faster and easier. The 18-month project involved 29 teams across Ontario.

Two teams were formed in the South West, involving St. Thomas Elgin General Hospital and Grey Bruce Health Services staff members working with South West CCAC case managers and managers. In Grey Bruce strategies included daily bullet rounds and whiteboards to track discharge status in the nursing station and patient rooms. In St. Thomas, the team developed a new nursing assessment form used when patients are admitted to identify potential discharge risks, introduced the use of whiteboards, and developed a tool for faster communication between the hospital and the South West CCAC. Both units saw a decrease in average length of stay of approximately a day and a half, and a decrease in the number of ALC days.

"We saw great results from the Flo projects," says Jennifer Fazakerley, Improvement Advisor to the South West CCAC. "Now we look forward to sharing both the improvements and the process with our partners across the region."

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