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

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Connecting with Care through
PARTNERSHIP

Partnering to Make a Difference

Cheshire and CCAC work together to help high-risk seniors stay at home

An 82-year-old man with COPD has been living in a seniors 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 explores how supports in the home enable these high-risk seniors to stay safely in their own homes and communities.

Megan Nichols, Regional Manager of Client Services, 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."

Cheshire Homes of London is also involved in the project. Cheshire has been providing 24-hour support to adults with disabilities in their own homes for two decades. The clients are connected to Cheshire care providers by pagers. "We're a well established non-profit organization and we have the infrastructure in place," explains Judi Fisher, Cheshire's Executive Director. "That means we're in a good position to operationalize the pilot quickly."

During the project, which will run until March 31, 2011, CCAC case managers will identify seniors who are at high risk of re-admission from among patients at the emergency department or the medicine in-patient unit at University Hospital. Those who score 16 or more on the new RAI Contact Assessment tool may be referred to Cheshire for "supports for daily living." Supports for daily living provides enhanced in-home services including 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 a bowel accident or other unscheduled need.

Left to right: Karen Chatfield and Diane Dodge, South West CCAC Case Managers

Two case managers, Karen Chatfield and Diane Dodge, have been hired to support the project by providing intensive case management (ICM). ICM includes rapid and regular in-home assessments, intensive system navigation, and even accompanying clients to doctor's appointments. Through the CCAC's Safe@Home service, a Nurse Practitioner is also available to meet with clients in the hospital before discharge and do follow-up visits within 48 hours of discharge, ensuring a safer transition from hospital to home.

The pilot project will be fully evaluated, tracking indicators such as re-admission rates, visits to emerg, withdrawal of applications to long-term care, caregiver burnout, ALCs and length of stay. The CCAC is collaborating with researchers from the University of Toronto to complete the evaluation.

Fisher says the potential is enormous. "If we can do this successfully, we would be able to offer people a real alternative to long-term care. Clients feel much safer knowing that if something happens, there's somebody available 24 hours a day to help them. As a result they're less likely to head straight to the emergency department."

She adds, "I'm 63, and I'd really like this option to be available to me when I'm my mother's age!"

IN THIS ISSUE Making Quality Happen + Celebrating Partnerships for Health + Heroes in the Home 2010 + Innovative Solutions + Electronic Referrals + thehealthline.ca Expands

Making Quality Happen

A Message from Sandra Coleman CEO, South West CCAC

THERE'S A LOT OF TALK ABOUT QUALITY in health care today, especially in the context of the Ontario government's *Excellent Care for All Act*. The Act was passed early this year and currently applies to hospitals, but will soon be rolled out to other health care organizations, including CCACs. At the South West CCAC, we welcome the Act's focus on the oversight and reporting of quality: we have always been focused on quality care and continuous improvement.

Aristotle said that, "quality is not an act: it is a habit." In other words, quality is not a recipe with a set of specific behaviours, but rather a way of being with our clients, families and one another. From my perspective, quality is about positive relationships, care experiences, and health outcomes. It's about care that wraps around clients and supports them to manage their own health.

Quality also ensures that our health system will be sustainable in the future. In a recent speech Minister Deb Matthews noted, "Poor quality care is very expensive care. If we don't get it right the first time, not only does the patient suffer, but the system suffers too."

So far, the South West CCAC is doing well on the quality front. In our last client survey, 93% of clients reported their satisfaction with our services as good or excellent, the highest percentage of any CCAC in the province. On the Ontario Health Quality Council report, the South West CCAC out-performed the provincial average in 19 of 22 indicators. Our Care Connectors program has matched more than 5,200 orphan patients with family physicians. Our innovative Safe@Home and Wait@Home programs resulted in more than 85,000 hospital patient days avoided last year alone.

Of course, we are always striving for improvement. As you read on page one, the CCAC is working with our partners to find innovative ways to support high-risk seniors at home. We are also working to ensure best practices in wound care. Through participation in the Partnerships for Health initiative (page 3), we are helping to improve clinical outcomes and reduce hospitalization for people with diabetes.

Continuous improvement is indeed a habit at the South West CCAC. But one thing won't change: our commitment to Client-Driven Care. Our philosophy of respect, collaboration and building relationships remains at the heart of our enterprise. You, our partners in care, are critical to our success in living these principles. We look forward to working closely with you as we move into a new era of high quality community care.

Heroes in the Home: *Quality and Qualities*

"She has lifted me up. She is an angel, just an angel. She does everything for me, looks after me. She is a caring person, a loving person, a very human person."

That's cancer patient Barbara Bernat, talking about her nurse Kathy Daugharty to a reporter from the *London Free Press*. Daugharty was one of more than 450 people recognized as part of the South West CCAC's annual recognition program, Heroes in the Home.

Any caregiver can be nominated through the program – a family member, friend, community volunteer, support worker, case manager, nurse, therapist or other health care professional. All nominees are celebrated at events across the region. This year Heroes events were held in Mitchell, Woodstock, Owen Sound and London between October 14 and November 4.

The program has proved so successful that CCACs in Champlain, Haldimand-Norfolk-Hamilton-Brantford, and Mississauga-Halton have adopted the concept.

"Heroes in the Home events are truly remarkable," says CEO Sandra Coleman. "The stories you hear are deeply touching and inspirational. In doing this program, we celebrate the quality of care our Heroes provide, which is second to none. We also celebrate their qualities – kindness, compassion, partnership, perseverance and good humour. And we celebrate what they teach us about quality care throughout the health system, based on mutual respect and collaboration."

Celebrating Partnerships for Health

The PFH Outcomes Congress heralded a new era in collaboration

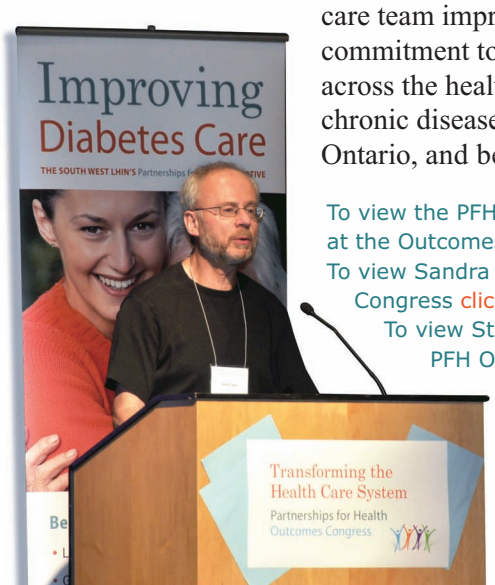
Three years ago, a research initiative quietly got under way in the South West. Last month, participants gathered at the Outcomes Congress, reporting excellent results on virtually every dimension. The key to this success? Effective partnership. It's no accident that the initiative is called Partnerships for Health.

Partnerships for Health launched early in 2008 with the goal of improving care for people with diabetes by advancing primary and community care partnerships, empowering patients, and enabling improved information management. The initiative got under way with three primary care teams from Brockton, Clinton and Strathroy. The second wave got under way in January 2009, with nine additional teams. Today 73 primary care practices across the South West LHIN are engaged with Partnerships for Health.

Each practice built an interdisciplinary team, including physicians, nurse practitioners, nurses, diabetes educators, health educators, CCAC case managers, mental health workers, home care and community service providers, pharmacists, ophthalmologists and others. The teams worked collaboratively to make and measure process and clinical care improvements. They met together on a regular basis to share information and experiences. Teams were supported to make better use of their electronic medical records, and to use data to track their progress.

At the Congress, teams proudly reported that:

- Patients received more regular screening tests, and more comprehensive, proactive care
- Clinical outcomes improved
- Patients felt more satisfied and supported, and more confident about managing their own conditions
- Patients were connected to more in-home and community resources
- Patients attended ER and hospital less often
- Communication and collaboration improved among health professionals providing primary and community care to people with diabetes



(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.

Keynote speaker Steven Lewis congratulated the teams on their success, and went on to lay out a vision for primary care reform based on similar principles. "The ultimate solution," he said, "is to make primary health care so comprehensive that you don't ever have to think about handing off to someplace else. It should be a much more unified and integrated system." He also argued that health care professionals must be prepared to advocate for positive changes in the health system. "A fully formed health worker is an active citizen who influences the system she works in."

Minister of Health and Long-Term Care Deb Matthews was at the event and thanked the teams for their hard work. "I think it's wonderful that health providers are coming together to better integrate our health care system to improve the patient experience and quality of patient care for people living with diabetes," she said.

Partnerships for Health was funded by the Government of Ontario, and sponsored by the South West LHIN and the South West CCAC. "This has been a transformative experience for everyone involved," said Sandra Coleman, CEO of the South West CCAC. "Our case managers had an opportunity to work closely with primary care teams to coordinate care. As a result, now 100% of the physicians report satisfaction with communication with the CCAC and that having the CCAC case manager as part of the care team improves patient care. This reinforces our commitment to working in partnership with providers across the health spectrum, and will change the way chronic disease management is done across South West Ontario, and beyond."

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 or www.partnershipsforhealth.ca.

Key note speaker, Steven Lewis

eHealth News

Electronic referral system launched

CCAC case managers in Grey-Bruce can now use the CCAC's database, CHRIS, to make electronic referrals to community support agencies. When completing information for a client who could benefit from, for example, meal delivery or an adult day program, they can simply click a button to send the referral electronically to the appropriate agency. The client doesn't have to repeat information that the CCAC has already shared with the community agency.

"Historically we've found that when we just hand out phone numbers, follow-through doesn't necessarily happen," says Darlene Bogie, Regional Manager for Quality. "The new process is helping to facilitate the referral in a more timely fashion."

The Grey-Bruce experience will be used to implement a similar system across the region.

Innovative solution to providing overnight care

eShift is a new initiative that helps provide overnight home care for children with complex medical needs. The innovative solution connects a personal support worker in the home with a registered nurse by way of a web-enabled iPhone. eShift enables one nurse to monitor, mentor and manage care at up to four locations simultaneously, rather than just one nurse with one client.

"Essentially we're giving a remote nurse eyes, ears and hands on location," says Gordon Milak, Senior Director of Performance Management and Accountability with the CCAC. "This system has all the efficiencies of a hospital while allowing children and parents to be where they're most comfortable."

thehealthline.ca expansion under way

Thehealthline.ca has always been an important source of accurate, up-to-date health services information for consumers and professionals. Now, through a project funded by the South West LHIN, it is being expanded to make it even more useful.

Thehealthline.ca will soon include separate records for each program or service in the region. For example, information about Clinton Public Hospital is currently contained in one record. As of April 2011, it will be broken out into at least 24 records, one for the main organization and 23 for the organization's 23 main services. The number of records will grow to 5,000 during 2011 and 10,000 by 2012.

Other new features include:

- Exclusive views giving providers access to additional information about the listed services
- Easier sharing of data
- Support for enhanced administrative reporting, search and display
- Postal code search that allows users to search by location and topic
- Enhanced service profiles with additional information, news, events and jobs provided by the listing agencies

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Seaforth	519 527 0000	www.thehealthline.ca	

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