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Community Care Access Centre
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Centre d'accès aux soins communautaires du Sud-Ouest

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Connecting with Care through
PARTNERSHIP

Home First Philosophy Blooms in South West

All 14 LHINs have committed to making this philosophy a top priority

On March 26, the 14 LHINs and CCACs came together to discuss Home First, a philosophy of integrated care that focuses on keeping clients, especially high needs seniors, safe in their homes as long as possible. Central to the approach is the idea that after an acute episode, clients should go from hospital to home before deciding about next steps. The idea is not new, but now all 14 LHINs have committed to making this philosophy a top priority, using common language, tools and outcome measures.

CCACs will play a pivotal role in implementing the Home First philosophy, and the South West CCAC already has a head start.

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The philosophy of Home First begins with the recognition that hospital is not the best place for elderly people to spend extended periods of time. "A lot of research has shown that there are serious risks when people stay in institutionalized care after the acute episode has ended," says Jennifer Fazakarley, Home First lead with the South West CCAC. "They're at higher risk of contracting infectious diseases, and of experiencing social isolation and physical decline."

Hospital is also not the ideal place to make tough decisions about the future, especially about the move to long-term care.

Of course, long hospital stays are not good for the health system, either. Ontario has more than its share of ALC patients, and that means road blocks for people needing emergency care and elective surgery.

The South West CCAC is already working on the issue. The innovative Safe at Home and Wait at Home programs resulted in more than 160,000 hospital days avoided in the 10/11 fiscal year. CCAC assessment processes ensure that only the most vulnerable seniors are admitted to long-term care, and CCAC case managers are already committed to completing LTC applications from home when possible. The CCAC's integrated discharge planning model and two current initiatives – the high-risk seniors project in London and the long-term ALC review (for patients who have been ALC for more than 40 day) – are also focused on Home First goals.

Fazakarley says the next step is for CCAC case managers to do more active case finding, identifying clients who are at risk of being ALC within 48 hours of their admission to hospital. "We need to get in there very quickly, before people are labelled as ALC or LTC, and help them get back to their homes. Then if they do require LTC, we must support them in the community while they make the transition."

Home First means a system-wide culture change, Fazakarley says. "The LHIN, the CCAC, hospitals, long-term care, community support services, mental health, and primary care all have to work together to wrap care around the client, to prevent hospital admission, get people home, and keep them there." The CCAC is now aligning resources to better support high risk seniors and adults with complex needs by creating Intensive Case Management positions in the hospitals and in the community.

Home First could mean an increase in hospital bed capacity, a reduction in ALC days, and even a reduction in demand for LTC beds. Above all, it could mean easier transitions and a better quality of life for frail seniors. Says Fazakarley: "What's happened in other areas is that people who went home to wait for LTC sometimes ended up being able to stay at home, once the right services were wrapped around them."

IN THIS ISSUE

Provincial report celebrates CCAC focus on quality

A Message from Sandra Coleman CEO, South West CCAC

The South West's innovative eShift program is front and centre in the first ever Ontario-wide CCAC Quality Report.

The program reflects our partnership approach to improving care. Through eShift, PSWs caring for medically fragile children overnight are connected with a registered nurse via smart phones, in case medical issues arise. eShift ensures that more children are able to stay at home safely.

There are many other stories in the report that reflect the commitment of Ontario's CCACs to continuous improvement, and the critical role that our care providers and other system partners play in the improvement process.

Among other interesting information in the report:

- Every day more than 6,700 people work for CCACs across Ontario.
- All CCACs have annual quality improvement plans, formal client complaint processes, Board Quality Committees, and common client, service provider, and employee satisfaction surveys.
- Every Ontario emergency room has a dedicated CCAC case manager and all hospitals have a case manager working on in-patient wards.
- CCACs receive just 4.5% of the total amount of public funds spent on health care.

Of course, facts and figures don't tell the whole story. One client was quoted as saying, "If we didn't have CCAC services, we wouldn't be able to live at home. Before your help came here, we just existed: now we're living." Another wrote, "Your staff are angels in disguise and true assets to your organization..."

Perhaps the most important part of the Report is the section that outlines opportunities for improvement. Some key areas are:

- Paying more attention to the client experience
- Customizing care
- Creating integrated care teams
- Helping clients live at home as long as possible
- Using technology to improve care

At the South West CCAC, we track our own quality indicators and are very pleased with our progress, and 94% of our clients rate the quality of their care as good/excellent. We also recognize that we can only continue to improve care with the full support and participation of our partners. Thank you for the important role you have played in improvement projects to date. We look forward to working with you to make care better in the future.

To find out more, view the report at www.sw.ccac-ont.ca

Quality and Process Improvement (QPI) initiative under way

The South West LHIN and the South West CCAC recently launched the Quality and Process Improvement (QPI) initiative to develop and support health care quality improvement projects throughout the region.

Lana Dunlop, Quality and Process Improvement Program Lead and three coaches will provide support to targeted improvement projects. "My role," says Dunlop, "is to support health service providers in the South West to develop a sustainable culture of continuous quality improvement, which will ultimately improve the patient experience across the continuum."

A QPI website, Quest for Quality, is currently under development. It will support alumni of FLO and Partnerships for Health, and will also provide resources for people just starting out on the quality improvement road. Quest for Quality and the QPI initiative was formally launched at the LHIN's Quality Symposium on April 28th.

Dunlop says the QPI initiative has the potential to make a big difference in health care across the South West. "I expect to see more system integration, more integration of best practices, more streamlined and standardized processes, and ultimately better outcomes for patients and clients," she says. "Perhaps the most important outcome would be a culture change throughout the system."

Living well with Chronic Disease

Peer leaders implement a new program to help clients manage their own chronic diseases

Karen Cook has been working as a dietitian at Tillsonburg District Hospital for more than 30 years. Recently, she took on a new challenge as a peer leader with the Living a Healthy Life with Chronic Conditions program, part of the South West CCAC's focus on self-management.

"I often see people with chronic disease who are struggling," says Cook, who currently coordinates the hospital's Diabetes Education Centre. "We don't really have the time to teach our patients self-management. When I first heard about this program, I thought, 'yes, this is the future!'"

Self-management refers to the tasks that a person must be able to do to live well with one or more chronic conditions. "We know that people spend only five to ten percent of their time with a health care provider," says Sally Boyle, Self-Management Program Lead. "We want them to be able to do well the rest of the time."

"I've changed my approach to focus on the one thing clients can do before the next appointment."

The Living a Healthy Life with Chronic Conditions workshop is a major part of the program. An evidence-based workshop series developed and tested at Stanford University, it consists of six two-and-a-half hour sessions, available FREE to people with any chronic condition and their caregivers.

The sessions are conducted by trained peer leaders. Some are health professionals like Cook, and others are members of the community who themselves live with or care for someone with a chronic condition. Topics include dealing with difficult emotions, healthy eating, communicating with your health care providers, getting active, and more. In addition, participants learn valuable skills in goal setting, problem solving and communication.

"There was an amazing dynamic at the six sessions," says Cook, who led a course last fall. "Everyone in the room was facing the same issues. They learned techniques for living with chronic disease and they formed wonderful friendships."

An important aspect of the program is setting weekly goals and developing action plans to achieve them. "People found that once they wrote a goal down and committed to it, they actually did it," says Cook.

More Living a Healthy Life sessions are planned in the next few months. There will also be another peer leader training session in early spring. Boyle's team is working hard to plan and promote the sessions.

In addition to the consumer workshop, the program will offer information on supporting self-management for health service providers. Says Boyle: "The fact is, patients can attend the Living a Healthy Life program but they still need support from their providers to make it work." In addition a website is being developed that will support participants, peer leaders and health service providers to learn more about self-management.

Cook says she has benefited from the experience of being a peer leader. "It has helped me work with my own clients to set goals," she says. "I've changed my approach to focus on the one thing clients can do before the next appointment. That way, when they come back they feel they've succeeded, not failed."

A Conversation with: Catherine Statton Regional Administrator, South West Diabetes Regional Coordination Centre (RCC)

Q. What is the RCC and what are its goals?

A. The South West RCC is one of 14 established by the Ontario government as part of its diabetes strategy. We are the only one hosted by a CCAC – a reflection of our track record of building effective partnerships. The goal of the RCCs is to provide regional leadership to integrate and coordinate diabetes programs and services.

Q. What is your role within the RCC?

A. I'm the regional administrator. Our team also includes a physician lead, Dr. Gordon Schacter, an analyst, Jamy Brodt, a consulting endocrinologist, Dr. Charlotte McDonald, an outreach manager, Rachel LaBonte, and an executive assistant, Corey Wilson.

Q. What has the RCC been doing since it was established last summer?

A. Our main focus in the first year has been to do an inventory of diabetes services across the region. We are also working to engage our stakeholders so that we can obtain input and more easily make system changes. And finally, we've been developing regional and provincial performance metrics.

Q. What are the future plans?

A. There are a number of priorities on our radar. Engaging primary care practices will be a major focus in the year ahead. We also want to start looking at how we can make system improvements to ensure equitable access to care, and find efficiencies that will have an impact.

Q. Why is the work of the RCC important?

A. Today more than 9% of people in our region have diabetes. With an aging population and more people living longer with diabetes, the numbers will only increase. Diabetes is a challenging disease to manage. Although diabetes care has been well funded for many years, those investments haven't made a huge impact on outcomes. To make a real difference we must have a clear vision for how we want things to change and be sure we've got all stakeholders engaged.

Partnerships for Health delivers stellar results

Partnerships for Health (PFH), a three-year initiative to improve diabetes care at the primary care level, wrapped up at the end of March. "PFH is leading edge work and the results need to be shared," says Stewart Harris, Principal Investigator of the external evaluation team. "There were improvements in 10 of the 11 diabetes indicators selected by the project team, and improved team functioning. There is still a lot of data to be analysed, but so far, these are great results and findings."

Among the results:

- Improvement in the percentage of patients achieving blood lipid and blood pressure best practice guidelines
- Improvement in the testing and documentation of HbA1c, ACR, eye exams, foot exams, depression screening, and the prescription of ACE/ARB
- Improvement in efforts at early prevention and disease management, including a reduction in the percentage of smokers
- Improvement in team functioning, and in patient and staff satisfaction
- Increase in referrals for services from CCAC and community support services
- Reduced hospitalizations

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