



Connecting you with care
Votre lien aux soins

South West
ccac **casc**
Community
Care Access
Centre
Centre d'accès
aux soins
communautaires
du Sud-Ouest

Volume 5 Issue 2 November 2011

Connecting with Care through **PARTNERSHIP**

Home First Under Way

The approach is helping more clients remain in their homes

Maria, 86, has mild dementia. She was recently hospitalized with pneumonia and ended up staying in hospital for close to a month. By the end of her stay, she was very confused and couldn't recognize the nephew-in-law whose home she shares. Thanks to an intensive care plan from the CCAC, Maria was able to get home to her granny flat in her niece's house. To keep her safe, the CCAC provided 24/7 care. Maria seemed better the moment she got home, greeting her nephew-in-law and the family dogs by name and smiling broadly for the first time in many weeks. After a month of the intensive plan, her service was reduced to the usual CCAC levels.

Maria's story is based on several success stories already happening through *Home First*, with clients being supported to return home with extra services. Each one would otherwise have been designated Alternate Level of Care (ALC)/Long-Term Care (LTC).

As we reported in April's newsletter, *Home First* is a new way of providing client care. The central idea is that when a person enters hospital, the hospital and Community Care Access Centre (CCAC) staff members, family members and others work together to get him or her home upon discharge, if at all possible. "It's all about ensuring that the right person receives the right care in the right place," says Jennifer Fazakerley, CCAC lead for *Home First*. "It's part of an overall strategy in the South West LHIN to improve access to care." Fazakerley says *Home First* builds on existing CCAC programs available throughout all of the South West such as Wait@Home and Safe@Home. The Safe@Home program for example, involves 11 Nurse Practitioners working in every county supporting acutely ill clients to stay in their own homes and avoid hospitalization. All these programs reduce the pressure on hospital and long-term care beds, and help people stay at home for as long as possible. Now, even more intensive service plans are available, starting in London, spreading soon to St. Thomas Elgin General Hospital and other hospitals across the South West.

Fazakerley is working closely with her hospital partners, Natalie Berkiw, Project Leader at University Hospital, and Sherri Lawson, Director, London Health Sciences Centre,

to implement changes to discharge processes to help more clients like Maria get home. At the heart of the initiative are two teams of intensive case managers, one each for the hospital and the community. The case managers work closely with clients and families to determine what support they need at home and ensure that it's available. "There are lots of advantages to this approach," says hospital intensive case manager Gail Molloy. "There are people waiting for hospital beds, so this frees up a bed. And for the client, it means getting back to familiar settings, routines and people, and less likelihood of coming down with a bug."

"We're already starting to see a decrease in the number of ALC/LTC designations made in hospital..."

Hospital case manager Cindy Beckett agrees, adding, "When clients know they can go home and will have extra supports, they are inspired and motivated to take part in their own recovery. They are empowered at a time when they may not feel they have much power over their lives."

The lessons learned so far? "For me, this work has really heightened my awareness of the need to engage the CCAC earlier," says Lawson. "I've come to recognize the value case managers bring to the discharge planning process." Adds Berkiw, "It's important to engage all the stakeholders, and especially the frontline staff and providers, early on. They live and breathe this work, so who better to redesign it? And when they are involved, they own the changes."

Is it working? Signs are positive, says Fazakerley. "We're already starting to see a decrease in the number of ALC/LTC designations made in hospital and other indicators that suggest the beginning of a cultural shift and change in practice."

IN THIS ISSUE

Bringing Value Home + Relieving the Pressure on Hospitals
+ Expanding Access to thehealthline.ca + Smoothing the
Transition to Long-Term Care + Celebrating PSWs



Bringing Value Home

A Message from Sandra Coleman CEO, South West CCAC

Earlier this year the Ontario Association of CCACs (OACCAC) published a report entitled *Bringing Value Home*.

Value, as defined in the report, is the ratio of positive health outcomes to cost of care. Research has shown that home and community care is a cost-effective alternative to care in hospitals and long-term care for many people. A recent analysis sponsored by the Change Foundation estimated that home and community care contributes \$150 million in annual savings to the health system, despite representing less than 4.5% of total health care spending.

We also know that health outcomes are better at home, and clients and families feel more satisfied. At the South West CCAC, 90% of our clients rate their satisfaction with CCAC services as good or excellent.

When home and community care is working, it reduces the burden on acute hospitals and long-term care homes, enabling them to focus on the care they provide best. Last year, for example, more than 200,000 patient hospital days were saved through two innovative CCAC programs, Safe@Home and Wait@Home, that support high-risk clients at home. Now we're moving into a new era of collaboration with our hospital partners through the *Home First* initiative.

Are we making a difference? Yes! Last year alone:

- Through the High-Risk Seniors pilot project, 50 clients who would otherwise have gone to LTC remained at home.
- The Long-Term ALC Review project resulted in 42% reduction in ALCs
- Partnerships for Health resulted in a 5% reduction of CCAC clients with diabetes going to hospital

Expanding Access to thehealthline.ca

You've come to count on thehealthline.ca to help you find information, and to get information out about your organization. The website, launched a decade ago, is user-friendly, accurate, and up-to-date. It includes more than 5,000 agencies across the South West, services and programs, along with innovative extras like news, careers, events and a health library.

Now the rest of Ontario will benefit from the same great features. A two-year project is under way to develop a province-wide database and enable other CCACs to provide access to their local service information with same online tools used by visitors to thehealthline.ca in the South West and Champlain LHINs. Ultimately, the provincial solution will host some 50,000-service profile records, and welcome millions of users each year.

- FlexClinics saved \$370,000.00
- More than 40 clients were supported to die at home through e-Shift, an innovative use of information technology to connect PSWs caring for palliative clients with a Registered Nurse
- Wound care improvements saved more than \$2.6 million

Programs like these reduce the pressure on hospital and long-term care beds (the cost side of the equation) and help people stay at home for as long as possible (the positive outcome side).

Of course, we can only achieve true value in health care through collaboration and partnership. That's why we at the CCAC value our partners across the health system, and look for every opportunity to work closely with you. Together we are building a sustainable health system that provides outstanding care, every person, every day.

Download the *Bringing Value Home* report at www.ccac-ont.ca/uploads/201108_bringingvaluehome/In_House_Digital_Publishing/index.html

A Milestone in Care Connecting

Family doctors and nurse practitioners help their patients stay well, treat and support them through long-term illnesses, and refer them to specialists for more complex health challenges.

Research shows that primary care produces better health outcomes, lower costs and greater equity in health. The South West CCAC plays a key role in ensuring that people in the South West benefit from primary care.

In 2009 there were an estimated 500,000 "orphan patients" – people without access to primary care – in Ontario. That year, the Ontario government established Health Care Connect to help people who didn't have a family doctor find one. By mid-November, the South West's team of hardworking Care Connectors had connected more than 10,000 orphan patients to primary care. "I know how difficult this has been, and appreciate your determination, patience and passion for your cause," said CEO Sandra Coleman when the milestone was reached. "Many clients' health care experience is better as a result of your efforts."

To access Health Care Connect, visit www.health.gov.on.ca/en/ms/healthcareconnect/public/ or call 1-800-445-1822.



Care Connectors (l to r): Anna Ackland, Janice Ross-Greenside and Andrea Fisher. Absent: Sherri McRobert

Smoothing the Transition to Long-Term Care

Through a community engagement project, videos, and now *Home First*, the South West CCAC and its partners are doing everything they can to make the move easier.

"Staff and systems at the new long-term care home were new to mom, and mom lost a lot of ground. But she has gained it back. I didn't realize the impact of the decision."
— CCAC Client

It is a challenging, even traumatic, experience for clients and families. The move to long-term care means significant change and loss. CCAC case managers help people make the transition as comfortably as possible. They work in partnership with family members and staff members at long-term care homes to support clients throughout the process.

"The transition isn't just a physical move: it's a major life decision."

Earlier this year, Nancy Dool-Kontio, Senior Director Strategic Planning and Integration, and Shirley Koch, Regional Manager, Strategic Planning and Integration, studied the experiences of clients and families making the move to long-term care. They used a combination of in-person and telephone interviews, and journals kept by people moving through the process.

Among their findings:

- Clients and families value the support and information they get from CCAC case managers. One family member noted that, "We had all the information needed, it was well explained, we were well supported, and communication with mom and the family was good. The case manager could answer our questions and did so truthfully." Several people said they would like to have more time with case managers, both in the community and in the hospital.
- Touring long-term care homes was often not possible, because of the urgency of the situation or weather challenges. Most caregivers said that pictures or videos of long-term care homes would be helpful. The CCAC has subsequently completed three-minute videos profiling each of the 74 homes in the South West. They are available online or as a free DVD distributed by case managers.

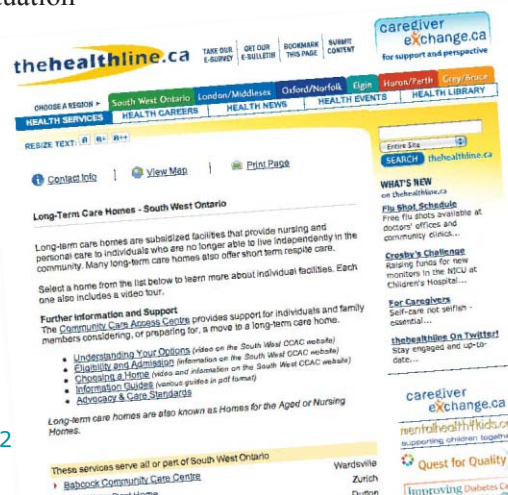
- Caregivers expressed a range of emotions around the post-admission adjustment period. One man noted, "It's hard to drop a parent off in a long-term care home because it takes a person a while to adjust, and it takes staff time to get to know the resident." Several comments reflected on the excellent care provided by the homes. One woman commented, "Now that my husband is in long-term care, he's doing really well."

"One of the things we were often reminded of during the project was the huge emotional impact of making this type of decision," says Dool-Kontio.

"The transition isn't just a physical move: it's a major life decision."

To support clients and families, the CCAC has developed a series of videos that provide general information about the long-term care transition experience. Narrated by Mary Lynn Priestap, a CCAC expert on long-term care, the videos deliver practical advice, simply and succinctly. "Keep in mind that this isn't an easy process for anyone," says Priestap at one point. "It can be emotionally and physically exhausting for you and your family. Remember, your case manager is always available to support you and answer your questions."

Home First also addresses some of the issues raised through the study. The *Home First* approach ensures that whenever possible, clients go home from hospital before making a major decision such as moving to long-term care. That means families have more time to plan, and can be more directly involved in the process. "Moving to long-term care will never be easy," says Koch. "We're doing everything we can to make it smoother, and to support clients and families through the process."



CELEBRATING HEROES

The annual Heroes in the Home events were held across the South West in October and November



Every year as the leaves change color and the air becomes crisper, the CCAC holds its Heroes in the Home events. This year, more than 400 caregivers and professional care providers were honoured at events held in London, Stratford and Owen Sound. Among them were many wonderful Personal Support Workers (PSWs) from the CCAC's care provider agencies. PSWs are on the front lines of virtually every CCAC care team, and often, the team members that clients see most often. In many cases, they become valued members of the family. Here's what some nominators said about their PSWs.

"Derrick is so compassionate, punctual and has a good sense of humour. We enjoy talking of world events, baseball games and our families. A very dedicated caregiver. His smile is worth a million words."

"Sherri is reliable, professional, knowledgeable, and very observant, especially when it comes to any changes in our condition. You cannot help but feel better when Sherri leaves because of her positive attitude."

"Dave is the most thoughtful and caring fellow I have met in many years. He and Dick bonded right from the start and are very close. Dave not only gives physical support but emotional support as well."

"I know I can count on John during this difficult period. His kind treatment is outstanding. His tone in conversation is uplifting and gentle, and he anticipates my husband's everyday needs. If I had to rate him, I would give him an A+++."

"Kim is much, much more than a PSW – she is a bright light in our lives. She is dedicated, cheerful, compassionate, thoughtful, generous and sincere. She has made my wife's unbearable burden more bearable."

Our thanks to every PSW who goes above and beyond providing care for CCAC clients. Your work makes a world of difference.

HEROES IN THE HOME

View the video of the Stratford event at http://youtu.be/n_oGFO3bW48.

South West CCAC office contact Information:

London	519 473 2222	Walkerton	519 881 1181
Strathroy	519 245 3233	Stratford	519 273 2222
Owen Sound	519 371 2112	Woodstock	519 539 1284
St. Thomas	519 631 9907	www.sw.ccac-ont.ca	
Seaforth	519 527 0000	www.thehealthline.ca	



This product is made from 100% recycled fiber.

RETURN UNDELIVERABLE ITEMS TO
South West CCAC
London (Head Office)
356 Oxford Street West
London ON N6H 1T3



Connecting you with care
Votre lien aux soins

South West
CCAC CASC

Community
Care Access
Centre

Centre d'accès
aux soins
communautaires
du Sud-Ouest