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

Connecting with Care through Partnership

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The CCAC as System Navigator

A Message from CEO Sandra Coleman

As you all know, earlier this year Deb Matthews, Minister of Health and Long-Term Care, issued a powerful call for change through her *Action Plan for Health Care*. Two weeks later, the Drummond Report echoed many of the same themes. Ontario's CCACs have embraced the promise of change, issuing *Accelerating Ontario's Action Plan for Health Care*, a white paper that describes how CCACs are already supporting the goals of the Plan and will continue to push them forward in future.

Accelerating has three major themes:

- Integrating family health care through a robust care coordination model partnering with CCACs
- Focusing on the complex needs of an aging population through intensive CCAC case management
- Driving quality and accountability through patient-based funding models

In this newsletter, we'd like to tell you what the South West CCAC is doing in each of these areas. You'll read about our work in support of primary care and hear from Dr. Rob Annis, Primary Care Lead for the South West LHIN, about the potential for further partnership. You'll also hear about our approach to intensive case management, which is helping many elderly clients get home from hospital and stay there.

The South West CCAC is strongly committed to the third theme, quality and accountability. In addition to the provincial CCAC quality report, we track our performance through a framework that measures specific outcomes against four strategic goals. Both the Performance Management Framework and our annual report to the community are available online at www.sw.ccac-ont.ca.

The foundation enabling the three themes outlined in Accelerating is the idea that CCACs serve as effective and efficient "system navigators" for our clients. In this critical role, we help clients move smoothly through a complex and often confusing health system, receiving the care they need, when and where they need it.

CCACs are ideally suited for this system navigation role for several reasons:

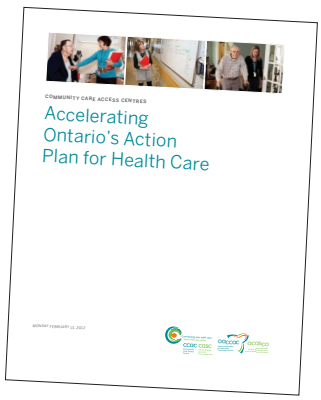
- Our case managers work across geographies and institutional boundaries.
- They provide full medical, social and functional assessments.
- They work collaboratively with partners in every part of the system, from primary care physicians and hospitals to long-term care homes and community support agencies.
- They have a highly effective tool in our state-of-the-art Electronic Medical Record, known as CHRIS.
- They have a reliable and robust source of health system information in thehealthline.ca.

Our commitment to supporting family health care, focusing on the complex needs of the elderly, driving quality and accountability, and serving as effective system navigators is reflected in the performance results listed on page two. In addition to providing exceptional care for our clients, South West CCAC's special initiatives have saved the health system more than $70 million in the 11/12 fiscal year alone.

We have work to do

Looking ahead, we will continue to support the goals of the *Action Plan*. Home First will expand in 2012-2013, as will our engagement with primary care. We will be rolling out our innovative population-based model of care, which will ensure that scarce resources are used to support the clients who need them most. We will continue to change and improve what and how we work to do more with our resources. We can't rest until every client receives the navigation support they need to receive the right care in the right place.

We will continue to enhance our role as system navigators to improve client care. We can only be successful in that role with the support of our system partners. >



> In the years ahead, we will work with our partners to reduce the pressure on hospitals and long-term care homes by supporting more clients to stay or return home safely. We will work with primary care practices across the South West to help their patients navigate the health system. We will work with community support agencies to ensure clients get the best care and support possible in their own communities.

We look forward to working with you to achieve the vision of the *Action Plan*. Together let's make healthy change!

Marking Five Years of Excellence

January 1, 2012 was the fifth anniversary of the South West CCAC, which was created through the merger of 7 CCACs in 2007. Here are a few of the comments we heard on that occasion from leaders in the health system.

"The difference the South West CCAC has made in the last five years is visible everywhere."
Jeff Low, Board Chair, South West LHIN

"Community care is important because people want to stay in their own homes. One word to describe the CCAC? System navigator!"
Michael Barrett, CEO, South West LHIN

"People are living a better quality of life in their own homes, thanks to the work of the South West CCAC. I want you to know that the impact of your CCAC is felt not just in the South West, but across this province."
Deb Matthews, Minister of Health and Long-Term Care

By The Numbers

During 2011-2012, the South West CCAC improved care and saved costs.

52,000	Number of clients served.
92%	Overall client satisfaction (target 90%).
100,654	Number of long-term care and hospital days avoided supporting Home First (Intensive Hospital to Home, Wait@Home and Safe@Home programs).
655	Number of clients served by High-Risk Seniors program who would otherwise have gone to long-term care (LTC).
608	Number of consultations by Nurse Practitioners with LTC residents to prevent unnecessary ED and hospital visits (with more than 535 avoiding hospital).
128	Number of clients supported to die at home through eShift, or 91.5%, saving 6,219 hospital days.
55,000	Calls for system navigation and referrals to community agencies.
2,322	Number of clients placed into long-term care.
15,210	Total number of orphan patients matched with family doctors (approximate).
325	Number of clients and caregivers who have attended a Living a Healthy Life with Chronic Conditions workshop.
98%	Clients receiving live answer when calling the South West CCAC.
$420,400	Cost savings due to use of CCAC FlexClinics.
$2.1 million	Cost savings due to evidence-based wound care improvements.
8%	CCAC administrative expense.
200	Partnership tables and collaborative projects the CCAC team participates in.

Partnering with Primary Care

"I see it as being transformational. It will help us keep people at home a whole lot longer, and provide the right care at the right time at the right cost. I'm really excited to be part of it."

Case Manager Connie Vandersleen is talking about the strengthening partnerships between the South West CCAC and primary care practices across the region. She works closely with a three-site Family Health Team in the Stratford area, connecting to discuss mutual clients both formally, through case conferences, and informally by drop-in, phone or e-mail. Several times a year, she delivers a list of common clients and reviews them with the doctors.

"I feel much more connected to our clients if I've had a conversation with their physicians," says Vandersleen. "I feel that I'm bringing so much more to the individual, and in return, I can take more back to the physicians." Among other things, she shares information about the clients' home life, social environment and socio-economic status. "Often that can be really important in planning care for the most challenging patients."

Clients feel better knowing that everyone is working together, Vandersleen says. "Having the case manager and the doctor talking the same language and knowing what each other is doing really enhances the care journey for clients," she says.

Partnership between primary care and the CCAC also has benefits for the system, says Nancy Dool-Kontio, Senior Director Strategic Planning and Integration. "Often primary care physicians tell case managers they don't even know when a patient has been admitted to hospital or is receiving services at home," she says. "Without that knowledge there's a danger of starting to discuss long-term care prematurely, when the client could be accessing community or home supports and staying at home longer."

Partnerships for Health (PFH), the quality improvement initiative that formally ended in March 2011, focused attention on the CCAC-primary care partnership, with case managers assigned to each of the 74 primary care practices involved. The outcomes (see sidebar) were remarkable. Case managers have continued to work with the 74 practices as part of the Partnering for Quality Care in Chronic Disease program.

Dool-Kontio says the partnership approach will eventually spread to all 700 primary practices in the region, although it may take some time. "We clearly need to work more effectively with primary care physicians," she says.

The Physician's Perspective

Dr. Rob Annis is Regional Primary Care Lead for the South West LHIN and co-Chair of the South West Primary Care Network. In these roles he is working with his colleagues to foster and support quality improvement and improved access to primary care across the region. Annis participated in the Partnerships for Health (PFH) initiative, and experienced the impact of having a case manager working as part of his team. "The CCAC was a key player in PFH and clearly has a role to play in other quality initiatives," he says. "Case managers can act as facilitators and connectors, especially when it comes to the transition from hospital to community." Annis says building face-to-face relationships with case managers is critical for primary care physicians.

Dr. Joshua Shadd, a palliative care specialist and professor at Western's Schulich School of Medicine and Dentistry, agrees. "There's a very important symbiotic relationship between the CCAC and primary care," he says. "They need one another, and benefit from one another." Shadd says there is some overlap between the work of the two sectors, and that makes good communication critical. "It's important that we understand who does what and what's happening where. Informal interactions really help with that."

"Primary care has a pivotal role within the health system, and so does the CCAC. We are connected through our common clients, and there's an onus on all of us to provide the best level of care we can as a team."

Proving the power of partnership

Among the outcomes of the PFH initiative:

- Appropriate referrals to CCAC increased by 26%
- 100% of partners said there was enhanced communication between partners
- 100% of physicians said having a case manager as part of the care team enhanced patient care
- 80% said it facilitates timely referrals
- 93% said it enhances their knowledge of community resources
- Visits to ED and hospitalization went down by 5% per year

Intensive Case Management: Supporting those who need it most

Recently Donna Ladouceur, Senior Director of Client Services, had a visit from a neighbour. He dropped by to tell her about his positive experience with intensive case management while care was being planned for his wife. He told Ladouceur that the case manager followed them from start to finish, laying out all the options, and making herself available to answer any questions.

It was music to Ladouceur's ears. "He echoed exactly what I had hoped our clients and families would experience with intensive case management," she says. "When case managers are able to spend time with complex clients and their families and understand what supports are available in the community, long-term care doesn't have to be the only option."

CCAC Intensive Case Managers (left to right): Diane Dodge, Heather McCullum and Peggy Callaghan.

The concept is simple. The most complex clients get intensive case management, often from designated case managers, while the least complex can often be connected to the care they need with a telephone call. Intensive case management can involve community case managers attending case conferences in the hospital before discharge, meeting clients when they get home, visiting them at home two to three times per week, and speaking to them daily by phone. Gradually the level of case management is reduced as the client settles in. "It's the most significant change we've made in our approach to case management in 20 years," Ladouceur says. "We had a model that pulled case managers in many directions: this one lets them focus on a specific population of clients."

Intensive case management is a key enabler in the Home First initiative. With Home First, intensive case managers in London and St. Thomas hospitals work with hospital care teams to discharge complex clients so that they can decide their next move from home. Community intensive case managers are the "catcher's mitts" who support these clients when they get home. The CCAC provides extra services to help clients get settled at home through the Intensive Hospital to Home program, including in many cases 24/7 personal support for a short time. The Home First approach will be rolled out across the South West over the next several years.

Heather McCallum is a community-based intensive case manager. "I have the time to sit with my clients and families, understand their goals, help them with self-management skills, and connect them better with other community partners," she says. "Because these are complex clients, I know that every day is going to be different, and that I have to be very flexible. But it gives me huge job satisfaction because I can really focus on their needs."

With intensive case management, many clients can get home who would otherwise have to wait in hospital for long-term care placement. That, in turn, frees up beds needed for acutely ill patients. In some cases, clients improve in their familiar surroundings and are able to stay home, rather than going to long-term care.

McCallum says it's wonderful to see what a difference intensive case management can make. She remembers one frail client arriving home a few days before Christmas, to his wife's great delight. "They had always had a nap together in the afternoon," says McCallum. "When we got him onto the bed that day, she snuggled up to him and a little tear came into her eye. I thought, 'That's why we do this program.'"

Home First Results

Thanks to intensive case management, Home First is having a real impact on clients and the system.

- The number of patients per month designated ALC-LTC at London Health Sciences Centre has dropped from a high of 48 in June to a low of 12 in February.
- By March 10, a total of 46 complex patients had gone home through Home First.
- Of those, 40% received 24/7 personal support when first discharged (an indication of their complexity).
- Only 2 had been re-admitted to hospital, both due to unexpected medical crises.

South West CCAC office contact Information:

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

www.thehealthline.ca

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