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

Connecting with Care through Partnership

Volume 6 Issue 2 Fall 2012

Getting Home First

A dedicated team and motivated client in Tillsonburg achieve remarkable results

"I was a bit worried when I first met Faye, but it all went smashingly well. Faye's story truly gives new meaning to the word 'team.'"

That's Care Coordinator Nancy Thornton, talking about the first client to be discharged from Tillsonburg General Hospital under the Home First banner.

Home First is an approach to hospital discharge based on the philosophy that when a person enters hospital, everyone should work together to get him or her home before making any major decisions about the future. The CCAC provides high intensity case management and in-home services for up to four weeks, so that clients can settle in, recuperate and decide about their next steps. At London Health Sciences Centre, where the Home First approach has been in place since June, ALC days have been reduced by half.

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Thornton worked with Faye, an 85-year-old woman who had been hospitalized for three months following a serious fall. Before the fall, she had lived in a granny flat with her little dog. She shared the house with her daughter, Robin, who has Parkinson's disease. It looked as if Faye's next move would be to long-term care. But Home First offered an alternative.

Faye left the hospital in a wheelchair with one arm in a sling. Weakened from her long stay, she was unable to sit up on her own and it took two people to help her stand up. At first, she received 24-hour personal support, as well as nursing, physical therapy, occupational therapy and intensive care coordination. Melissa Oates, an occupational therapist with Pace Home Care, was one member of Faye's team. "You don't see many clients as motivated as she was," Oates says. "She was great to work with because she would tell me her goals and we would problem-solve together with the personal support worker." Oates was amazed by the progress Faye made during the two months she worked with her.

Gradually, Faye's condition improved and she was able to do more for herself. By the end of four weeks, Thornton was able to transition her to the regular CCAC service. Says Faye: "I'm happy I was able to come home and be with my family. I can look out the window here and see all the clouds going by. I'm content."

Communication Key to Successful Home First Partnership

When the CCAC launches an innovative new approach to community care, it takes many strong and committed care provider partners to make it happen. We profile one of our partners here.

In preparing to launch Home First, CCAC contracted with St. Elizabeth Health Care to handle the new volume of nursing and personal support in London and Middlesex. The organization was also contracted to provide care as the program spread to St. Thomas Elgin, Tillsonburg and Woodstock hospitals. "We have a long history working with St. Elizabeth," says Gord Milak, the CCAC's Senior Director Performance Management & Accountability. "It's a relationship built on the principles of Client-Driven Care."

Eileen Cunningham is a Regional Director with St. Elizabeth Health Care. "We have forged a very close relationship with the CCAC to make Home First happen," she says. St. Elizabeth staff and especially the lead for the program, Jean Bennett, work very closely with the CCAC's Intensive Case Managers, often connecting once or twice a day to plan care and solve problems.

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A Message from CEO Sandra Coleman

Supporting Innovation

As you are probably aware, there are those who are questioning the value of Ontario's 14 CCACs. We at the South West CCAC welcome open and frank debate about the future of health care in Ontario. We recognize that change is necessary and inevitable. We know that all parts of the health system must become more effective and efficient, and we are committed to innovation and improvement in care delivery.

In our submission to Dr. Samir Sinha, who is developing Ontario's Seniors Strategy, Ontario's CCACs demonstrated their commitment to positive change by recommending:

- Provision of up to 24/7 home care for limited periods of time to help seniors get home from hospital
- Enhanced access to health care information and referral, so that seniors and caregivers can manage their own care
- More flexible service models to address individual needs
- Enhanced local capacity and access to community support services, to ensure that everyone has access to transportation, home support, meals, assisted living and other services in their communities
- Specialized care in long-term care homes for complex clients with special needs

At the same time, we emphasized the importance of the ongoing role of care coordination, especially for the most complex seniors, in supporting people to stay safely at home and avoid hospital. Care coordination is a clinical therapeutic intervention that ensures people connect with the care they need, when and where they need it. CCAC care coordinators bring years of training, clinical expertise, experience, and great compassion to their jobs.

CCACs are not stand-alone organizations. One of our unique characteristics is that we act as hubs in complex regional networks, linking acute, specialty and primary care, community support agencies, long-term care homes and many other components of the health system. It is only by collaborating with our system partners that we are able to improve lives, make transitions smoother, support independence, ensure safety, reduce duplication and system costs, and continue to innovate and improve. Thank you for your critical role in this network.

continued from page 1 Cunningham says the involvement of clients, families, the CCAC, other system partners and staff from her organization in care planning helps ensure the success of Home First. "These are complex clients who require many different strategies to keep them safe at home. The sooner we are aware of what their individual needs are, the more successful the transition."

As a result of the new volume created by Home First, St. Elizabeth has hired more than 150 new Personal Support Workers (PSWs). Cunningham says that given the complexity of the Home First clients, she looks for experienced PSWs and provides additional education at monthly staff meetings. She is proud that her organization has met the requirement for 100% acceptance of Home First clients.

Another key to success, she says, is that her PSWs are provided with smart phones. "The CCAC care coordinators can access them at any point and the PSWs can send messages directly to the care coordinators and supervisors. Communication happens in real time."

For his part, Milak says St. Elizabeth has been "very responsive and very innovative" in meeting the needs of Home First clients. "The success of this approach is very much about communicating, developing a shared understanding, and co-creating solutions with the whole care team."

WHAT'S THE BUZZ

Accreditation Preparations

Like many other health care organizations, the South West CCAC has embraced the value of third-party accreditation based on national standards. We have spent the past year working through the process with Accreditation Canada and will be hosting our site survey team during the week of October 21. "Ultimately accreditation is not a test," says Nupee Hardeep Sadra, CCAC Accreditation Lead. "It's a validation of what we do every day and how we're providing high quality Client-Driven Care for our clients."

Nurses Hired by CCAC

The South West CCAC has hired 12 Mental Health and Addiction Nurses to work in local school boards, providing comprehensive assessment and system navigation, and support for students making the transition from hospital back to school. The CCAC has also hired 13 Rapid Response Nurses, who will work with clients recently discharged from hospital. Recruitment is now under way for five Palliative Care Nurse Practitioners.

eShift Recognized, Expands

The CCAC's innovative eShift program enables specially trained PSWs to provide overnight care for complex clients by linking them by smart phone to a registered nurse. In August the program was selected as an Accreditation Canada Leading Practice. eShift is currently available in London and Middlesex, Elgin, Grey and Bruce counties. It will expand throughout the South West in the months ahead, thanks to funding from the South West LHIN.

Enhancing Health Literacy

Health professionals have a responsibility to ensure that clients understand health information

The statistics are startling: 60% of adult Canadians and 88% of Canadian seniors have low health literacy skills. That means they aren't able to manage their health between appointments because they don't understand the instructions they've been given.

"Health literacy" refers to the ability of clients to access information, understand it, and use it to manage their health. "It's not just about reading and writing," says Sally Boyle, Program Lead for the South West Self-Management Program. "Even university-educated people can have trouble understanding and remembering what they're being told in the midst of a health crisis."

Health care providers should never assume that clients understand what they're told, Boyle says. She herself was a diabetes educator for many years. "In many situations I thought I'd done a good job of educating clients and there was lots of nodding, but then they went home and didn't follow through – not because they didn't want to but because they didn't understand and were afraid to ask."

The principle of "Universal Precautions" used in hospitals for infection control can also be applied to patient communication, she says. "We should expect that at every encounter there is a risk of miscommunication, and we should treat everyone the same, creating a shame-free environment where people feel free to ask for clarification."

Boyle says there are special guidelines to make written communication such as brochures and leaflets easier to read and understand. When it comes to verbal communication, she recommends the "teach back" technique. Once a provider has given instructions to a client about, for example, taking a medication, she should ask him to tell her in his own words how the medication is to be taken. Then if there are any misunderstandings, she can clear them up right away.

Boyle will be offering a series of free Health Literacy Workshops across the South West in October and November. *For more information: www.swselfmanagement.ca/trainingsessions.*

Partnership Fuels FlexClinic Development

Four years ago, the CCAC decided to pilot a new approach to community care: FlexClinics. FlexClinics are small nursing clinics located in communities where there is a critical mass of ambulatory clients. Instead of building dedicated but costly clinic facilities, the CCAC uses existing space on a part time basis to minimize any capital costs. Care Partners was selected as the partner agency in the successful pilot. Today there are more than 30 FlexClinics across the South West, and ten of them are operated by Care Partners.

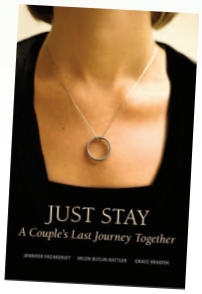
Beth Byrnes, Regional Manager with Care Partners, says the project was a success from the beginning. "We know from conducting client satisfaction surveys that clients love the fact that they can book an appointment, rather than waiting at home all morning or afternoon for the nurse to arrive," she says. "This approach definitely increases capacity, too. The time saved by not driving from home to home enables our nurses to see more clients. In fact, a nurse can see three clients in clinic in the time it would take her to make one home visit."

A critical part of the FlexClinic concept is transitioning clients who have been receiving home-based care to clinics once they are well enough. Byrnes says team work has helped smooth a sometimes challenging transition. "We discussed it as a group with the CCAC and all the providers and worked together on the key messages," she says. "Right from the time of referral, the clinics are discussed as an option, and we all send the same message, using common language."

Between mid-July and mid-August 2012, more than 120 CCAC clients made the transition from home visits to clinic care. Overall, Gord Milak, the CCAC's Senior Director Performance Management & Accountability, says that FlexClinics help the CCAC provide more care with the same resources, while empowering clients to return to their normal lives as quickly as possible. "FlexClinics have become an important part of restoring clients' independence and getting them back into their communities," he says. "Great providers like Care Partners are critical to this success."

Walking the Final Journey as a Team

CCAC Care Coordinator authors book based on personal experience



Regional manager Jennifer Fazakerley is a quietly efficient, always cheerful staff member who has earned the deep respect of her CCAC colleagues. She is also a woman who has experienced one of the most devastating blows life can deliver – the loss of her beloved husband Rob at the age of 46. Now she is co-author of a new book, **Just Stay… A Couple's Last Journey Together**. The book documents the journey she shared with her husband from the time he was diagnosed with metastatic pancreatic cancer in August 2009 until he died at home in September 2010. In this excerpt, Fazakerley talks about the team that supported and guided her.

"Reflecting back on our journey, I realize that the impact of the team we assembled was more than that of its individual parts. I believe the level of communication between us all, with Rob and me at the hub of this very complicated wheel, was quite unusual… And who was our team? Rob and I, the palliative care physician, the oncologist, the nurse practitioner, and the spiritual care specialist. At different times, we had also a visiting nurse, a surgeon, chemotherapy nurses, dietitians, endocrinologists, and a case manager. Grace, Helen, and Dr. Fryer were the 'core,' because they all offered me a relationship, not simply a service.

I believe we have to have a health care system of individuals who are willing to be intuitive. The concept of "after care" is almost nonexistent in the system but was an essential component of my surviving bereavement.

I also feel that another key to our team's success was the level of intentional communication between all the members… A communication link was essential to inform medical players about minute-by-minute changes that can and often do happen with cancer. Grace very often orchestrated this communication. She would schedule some of her bi-weekly visits for the day prior to our monthly oncologist visits so she could assess Rob thoroughly and e-mail a summary of his current state to the cancer clinic. She was a master of intentional communication and system navigation. She would connect the players who needed connecting, in their own language, and then stay in contact, to keep the focus on Rob and his care…

There was also a community that held us up and became an essential part of our team as well: family members, friends, neighbors, even strangers. Rob's and my intentional communication through the Rob Update e-mails served to connect us with so many people who held us up through their web of support."

To purchase *Just Stay*, visit www.juststay.ca

A Friend recounts final days

Recently the CCAC received a letter from a caregiver whose 89-year-old friend had died at home with support from the CCAC and its partners. In this excerpt, the caregiver describes the team effort that supported his friend in his final days.

"The nurse from CCAC came on Friday and she agreed that Mac was palliative and needed 24-hour care. The team that developed the care plan involved Mac, the CCAC and myself, and had to be put into effect immediately if Mac were in fact going to remain in his own home… Mac was very lucid and involved with decisions for his care. He was relying on the expertise of the staff from CCAC and my knowledge for resources from the community. The next two weeks were filled with daily visits from the Care Partner nurses and periodic visits from the doctor. A team meeting for reassessment was done each week… The care providers were always very eager to help in any way they could, from filling in for short shifts to providing little extras to make Mac's journey a little easier for him. Everyone worked as a very caring team. Care providers communicated through completing daily flow sheets after each shift to ensure the care plan would be carried through… As his friend and power of attorney, this journey with Mac was draining, both physically and emotionally, but knowing I helped to fulfill his last wish made it all worthwhile."

To learn more about palliative care resources, visit www.swpalliativecare.ca.

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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