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

Volume 7 Issue 3
December 2013

WORKING TOGETHER TO IMPROVE CARE

A bulletin for partners of the South West CCAC

HOSPITALS

RETURNING TO THE COMFORT OF HOME

Home First philosophy continues spreading to hospitals across the South West

In the last five years, 95 year-old Olga Brauer has had both legs amputated below the knee, broken her hip in a fall and, most recently in late July, broken her femur.

Each of these injuries has required extensive rehab at London's Parkwood Hospital, and after enduring so many challenges, the London resident has decided moving into a long-term care home is the right decision for her.

> "I'm very happy to be home, and it's all thanks to the CCAC...

Thanks to the Home First philosophy, which was recently implemented at Parkwood Hospital, Brauer was discharged from Parkwood at the end of October and provided the proper supports to stay in the comfort of her own home until a spot in long-term care becomes available.

"I'm very happy to be home, and it's all thanks to the CCAC and its partners," she said. "I'm so grateful for what they've done for me."

The concept is simple. Identify patients in hospitals who are waiting to transfer to other care settings, and get them the care they need to be able to make that wait from the safety and comfort of their own homes. The Home First approach to care has been enabling patients in the South West to do just that since it was first implemented at London Health Sciences Centre in September 2011.

Since that time, Home First has spread to other hospitals across the South West in St. Thomas, Woodstock, Ingersoll, Tillsonburg and Owen Sound, with overwhelming results. In 2012, Home First enabled nearly 800 people a month to be supported at home, rather than in hospital. In addition, the number of people waiting in hospital for long-term care on any day decreased from 137 in January 2012 to 87 by October of 2013, and Home First has saved the health system more than $10 million.

Since being implemented at Parkwood in September, Home First has enabled 15 patients to return home. In Brauer's case, she was discharged home with regular occupational therapy and 12 hours a day of personal support care for the first month. Her care then changed as her health stabilized, requiring three hours of personal support each day, with continued occupational therapy, for as long as it takes her to make the transition to long-term care.

More than two thirds of all Home First patients are able to remain in their homes and out of long-term care. Others, like Olga, decide long-term care is still the best option. Home First enables people to make these types of decisions and wait for spots in long-term care from the familiar environments of their own homes. "I'm happy to have decided on long-term care, it will take a lot of my worries away," said Brauer. "But I'm also very happy to be waiting from home. I'm terribly grateful to be here, I really am."

The Home First philosophy was also recently implemented at the Middlesex Hospital Alliance Strathroy site, and plans are in place to implement it at the Huron Perth Health Alliance in December. Hospital physicians, the CCAC and community partners are all working together to spread Home First to all hospitals in the South West by March 31, 2014.

Olga Brauer is waiting comfortably at home for a spot in long-term care, thanks to Home First.

A Message from CEO Sandra Coleman

WORKING TOGETHER TO ACHIEVE CHANGE

At the South West CCAC, we ask **two important questions** each and every time we work with people:

1. What's the most important thing you'd like us to do together today?
2. Have we, together, addressed your concerns and goals today?

We ask these questions to ensure we remain focused on providing quality, Client-Driven Care. And there is one word, one common theme, which not only exists in these two questions, but in every single facet of the South West CCAC and in everything that we do. That word, concept and driving principle is "together."

As we strive for outstanding care, for every person, every day, we are all the more successful because of the trusting relationships we have built together with our partners across the entire health-care system.

Right now, together with hospitals and community partners, we are spreading the Home First philosophy across the entire South West. Together with community support service agencies, we are ensuring people who need adult day programs are accessing those important services in a fair and equitable manner. Together with school boards, we are helping children with mental health issues stay in school. We're working together with long-term care homes to achieve smoother transitions from hospital for the elderly, and with primary care practices to develop a better model of care for patients with chronic illness. We're also working closely with the Ministry of Health and LTC and the South West Local Health Integration Network (LHIN), who generously provide the financial support for our efforts.

The health system is changing. It is evolving to a model where more care than ever before is being provided at home and in the community. At the South West CCAC we get people home and community care, but the importance of strategic partnerships in any system transformation cannot be emphasized enough. No one has the luxury of thinking only of their own organization anymore. The CCAC's heart beats in every corner of the South West, and we work together with our partners to develop trust, meaning and a shared understanding in order to provide the best possible care for people, and to achieve real change.

I am extremely proud and grateful that we as an organization have the opportunity to do this work together with you, our valued partners.

HEALTH UNITS

A SOLID FOOT HOLD

Falls are a leading cause of injury among seniors. They are responsible for more than 90 per cent of hip fractures and half of all injury-related hospitalizations. Falls also cost the health-care system hundreds of millions of extra dollars each year.

The South West Falls Collaborative is a new partnership co-chaired by the South West CCAC and the Grey Bruce Health Unit. It's aiming to keep seniors in the region on their feet by increasing partnerships in the health-care system and establishing a consistent approach to falls prevention across the South West.

"The objective is to learn what successful falls prevention work is already underway in the region, and build a comprehensive falls program that incorporates those strategies," said Nancy Dool-Kontio, CCAC co-chair for the South West Falls Collaborative. The new South West model will incorporate many elements from the highly successful Grey Bruce Falls Prevention and Intervention program, which combines awareness and advocacy with skill building and policy development.

Under this program, falls risk screening was instituted for anyone admitted to an Emergency Department over the age of 75. In six months, 6,870 people were screened in six EDs with 365 individuals referred on to the CCAC. Falls prevention information was provided to a further 1,180 lower-risk individuals.

Multidisciplinary assessments for seniors by PTs, OTs and RNs were also instituted. Forty-seven per cent of seniors assessed in 2012-13 reported fewer falls in the last 90 days, and 22 per cent reported fewer ED visits.

Grey Bruce Falls also began partnerships with EMS to identify people at risk and refer them to the CCAC, resulting in 65 referrals last year, and trained more than 350 PSWs and other care providers to deliver home exercise programs to seniors. With a mind to the future, they worked with Georgian College to implement falls prevention criteria in the school's PSW curriculum.

"It's these types of successes that will inform the South West-wide falls prevention strategy and ultimately benefit patients across the entire region," said Dool-Kontio.

More Successful Grey Bruce Falls Initiatives

- Providing fall risk assessments and follow-up treatment to CCAC patients
- Training primary care and community partners to screen for risk of falls
- Enrolling more seniors in home/community exercise programs
- Empowering seniors to manage their own care via self-management tools
- Screening admitted hospital patients with Morse Fall Risk Assessment Tool
- Using "fall leaf" symbol at hospital inpatients' bedside to ID patients at risk

PARTNERING FOR QUALITY HELPS PEOPLE WITH CHRONIC CONDITIONS

Seventy-six per cent of primary care practices in the South West have an Electronic Medical Record (EMR). These EMRs house a vast array of patient information and data, but analyzing this content isn't always easy.

Partnering for Quality (PFQ) is working with primary care in the South West – Family Health Teams, Family Health Organizations, Community Health Centers, Nurse Practitioner-led clinics and solo practice physicians – to help them better utilize their EMR systems and ultimately improve patient care.

"You need to be putting quality data in to get quality data out," said Rachel LaBonté, PFQ Program Lead at the South West CCAC. "Our team helps practitioners maximize their EMR use from start to finish. Once you can pull quality reports, once you know your population, you can put strategies in place to do things differently and improve patient care on a much wider scale."

That is the goal of PFQ. To improve care for patients, specifically those with chronic conditions, by working with primary care to help them develop the skills and techniques in quality improvement.

The PFQ team consists of an eHealth coach, who works with primary care on things like standardizing data and entering it consistently into EMRs, and a data analyst, who assists primary care teams with understanding their data to develop a wider picture of their patient population.

PFQ also provides support to leverage partnerships in the community. "If, for example, the primary care teams have complex, chronic diabetes patients, we want to know they are working with local support groups, and if they're not, we want to connect them," said LaBonté.

The Quality Improvement coach, another key PFQ role, helps teams learn QI methodologies and how to implement QI tools, and also works to ensure the patient experience is improved.

"Primary care teams may reach the point where they have better data, have made changes and implemented a population-based approach, but if the patient experience isn't positive, then all is for naught," said LaBonté.

The Quality Improvement coach helps teams measure the patient experience by helping implement surveys, tools and techniques to capture feedback at a number of key care points and, based on the results, co-create any necessary changes.

Ultimately, PFQ is seeking to instill these skills and techniques into every primary care practice in the South West to improve patient care across the entire region. Currently there are over 250 physicians and 350 stakeholders accessing the services of the PFQ team. PFQ is a LHIN-funded program. The services the team provides are tailored based on the needs of individual practices.

If you are interested in discussing how the PFQ can support you, please contact Rachel LaBonté, PFQ Program Lead at **rachel.labonte@sw.ccac-ont.ca** or 519-641-5401.

Supporting Primary Care

The CCAC works in partnership with primary care to help support their patients in a variety of ways.

Intensive Home Care Team

The Intensive Home Care Team is comprised of more than 40 Registered Nurses (RNs) and Nurse Practitioners (NPs) in specialized roles. It is a valuable partner to primary care in the provision of care to complex patients. To connect with the team, please contact Melody Boyd at melody.boyd@sw.ccac-ont.ca or 519-377-1074.

Help patients to help themselves

The South West Self-Management Program offers the Living a Healthy Life workshop series free of charge across the South West. The workshops are designed for people living with chronic conditions, and those caring for them. For more information, refer your patients to www.swselfmanagement.ca.

Care Coordinators on Site

We are committed to connecting 100 per cent of our primary care partners with one of our Care Coordinators. To have a Care Coordinator connected with your practice, contact Jennifer Fazakerley at jennifer.fazakerley@sw.ccac-ont.ca or 519-539-0901, extension 5073.

Health Care Connect

Health Care Connect identifies doctors or nurse practitioners who are accepting patients and links them with people who are in need of a family health care provider in their community. If you know someone in need of a family health care provider please refer them to www.ontario.ca/healthcareconnect or have them call 1-800-445-1822.

JOINT-COMMUNICATION HELPS MORE PEOPLE

In health care, so much depends on clear communications. As such, South West CCAC Care Coordinators are working together with people with complex needs who are about to transition to long-term care, their families and key stakeholders (from long-term care and hospitals) to have pointed conversations that ensure everyone is on the same page before a transition to long-term care takes place.

These care conferences are improving the process of transitioning people from the community or hospital into long-term care, and are ensuring a better overall experience. The collective group discusses any unique or special needs the person may have, and works to identify any potential issues.

"We find in some instances the information on paper doesn't go deep enough," said Anita Cole, Regional Client Services Manager at the South West CCAC. "There may be special equipment needs, special nutritional needs, or specific family dynamics that are easily identified during care conferences, but that might otherwise be overlooked."

On average, in the South West, between 225 and 250 people transition to long-term care homes each month. There are currently 1,534 people waiting to be admitted to long-term care, and the average wait time is 118 days. Care conferences are helping to address these numbers by identifying any potential problems at the outset, in order to ensure the transition to long-term care is as seamless and easy as possible for the person.

"Care conferences provide the opportunity to build relationships, have discussions and reach a shared understanding of each other's situation," said Cole. "In the past, without this joint communication, it was more difficult to meet the person's needs. Each care environment is so different, we really had no opportunity to all sit together to identify these differences or any potential gaps."

Care conferences began this fall as part of the South West CCAC's continued focus on Client-Driven Care.

"There are incredible stories from long-term care homes about people settling in quickly and becoming part of that community," said Cole. "When someone goes into long-term care, their world gets bigger with a whole new network they didn't have before. We love playing a role in helping that happen."

For more information on long-term care homes and wait times, please visit us at www.sw.ccac-ont.ca.

A complete list of long-term care homes, virtual tours, guides and videos about the placement process are available at www.southwesthealthline.ca.

SouthWesthealthline.ca

LONG-TERM CARE (LTC) STATISTICS

118	average wait time (in days)
78	number of LTC homes in the South West
7,383	number of LTC home spaces in the South West
225 - 250	people transfer to LTC homes each month in the South West

EQUITABLE ACCESS TO CARE

The South West CCAC is working in collaboration with Adult Day Programs (ADPs) to implement a new referral model called Coordinated Access, that ensures access to these programs takes place across the South West in a fair and consistent manner.

Through Coordinated Access, people wishing to attend an ADP will connect with the CCAC. Using standard eligibility criteria developed in conjunction with ADPs, the CCAC determines the appropriateness of each person for ADP services, and refers those who are eligible to their ADP of choice.

ADPs determine the suitability of each person by considering requirements such as the individual's need for an electric wheelchair or for the administration of medications, along with factors such as available physical space and staffing levels at the ADP.

"This is a wonderfully collaborative model that ensures the people attending these programs are right for the service, and that they will do well there," said Shirley Koch, CCAC co-lead for the Assisted Living, Supportive Housing ADP program.

New this fall, referrals are being sent to ADPs from the CCAC electronically, via e-referral on the CCAC's CHRIS system. This means referrals are sent efficiently and securely, and will allow for tracking and analysis of statistics and data over time.

Before Coordinated Access, each ADP had its own eligibility criteria, which often varied from program to program. Consistent eligibility criteria are now used for all ADPs, and the CCAC and ADPs work together to manage wait lists using agreed-upon principles for prioritization.

The approach is of great benefit to people, said Michele Pegg, co-lead for the Assisted Living, Supportive Housing ADP program.

"If someone has been waiting in the community but is managing fine at home, and someone else is in hospital and needs an ADP to get home, the CCAC and ADP would look at the list together and would prioritize the hospitalized patient," she said. "The collaborative model ensures each available space is offered in a fair and equitable manner."

Coordinated Access is continuing to roll out in support of Client-Driven Care across the South West. Already in use in Oxford, Grey and Bruce counties, it is currently being implemented in London/Middlesex, Elgin, Huron and Perth counties. Full implementation is expected by March 31, 2014.

Adult Day Programs in the South West

have worked with the southwesthealthline.ca to enhance their online service profiles.

Standard information including:
- hours of operation
- specialized services
- nutrition and medication assistance

is now available for each program. Visit **www.southwesthealthline.ca** and search "adult day programs" or navigate to **Your Health** > **Seniors** > **Adult Day Programs**.

SouthWesthealthline.ca

CCAC by the Numbers

Each year, the South West CCAC **cares for more than 60,000 patients** – or one in 17 people living in the South West.

The South West CCAC provides more than **2.5 million in-home visits each year**.

94% of CCAC clients are satisfied or very satisfied with their care.

The South West CCAC received the **highest possible rating from Accreditation Canada** in October 2012.

91% of South West CCAC clients receive a visit within five days of getting home from hospital and **99% of very high need clients receive their first nursing visit within 24 hours**.

The South West CCAC spends **less than 3.6% of its budget on administration.**

MENTAL HEALTH AND ADDICTION NURSES AT WORK IN SCHOOLS

THE STATISTICS ARE STARTLING.

- Nearly **ONE IN FIVE ONTARIO CHILDREN** under the age of 19 experiences a mental, emotional or behavioural disorder.
- **SEVENTY PER CENT** of mental health problems have their onset during childhood or adolescence.

The Mental Health and Addiction Nurses (MHAN) now working in schools across the South West help ensure that children with mental health issues get the help they need, as quickly and effectively as possible.

The MHAN program is a partnership between the Ministries of Health and Long-Term Care, Children and Youth, and Education, implemented by Ontario's Community Care Access Centres. In the South West, nurses began working in schools in December 2012, and the program is now in place in every school across the region.

Glenda Dhinsa, Manager of the team, says the MHAN program works in close partnership with school boards. "It's very much a collaboration," she said. "Boards determine the criteria for referral and student populations they want our nurses to work with." Each Board also has a Mental Health Lead who works closely with the nurses.

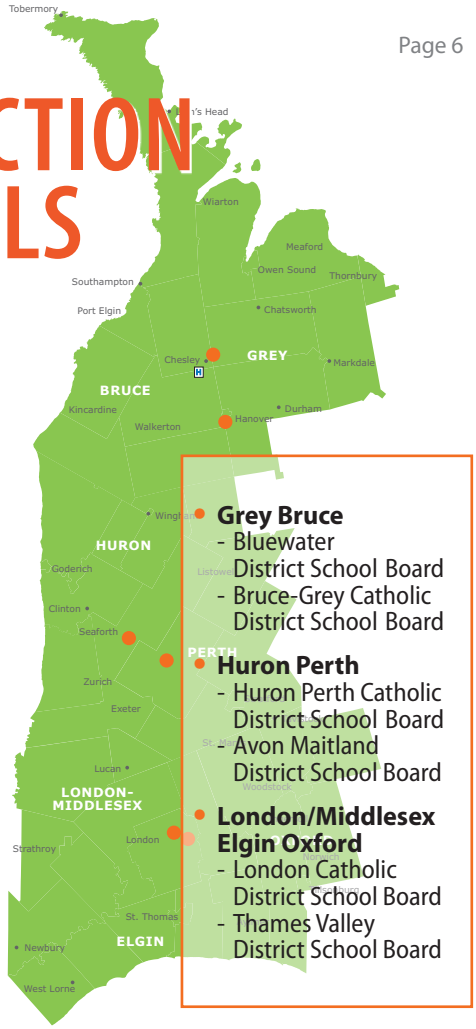
The issues faced by children referred to the program are diverse, ranging from anxiety, emotional disturbance, suicidal ideation and depression, to family dynamics and abuse, mood disorders and addiction. The nurses are trained to approach each situation holistically, said Dhinsa. "They are able to address physical, psycho-social and mental health issues. They know about medications and side effects, and they're trained in therapeutic interventions such as cognitive behavioural therapy, grief counselling, suicide prevention and crisis intervention."

Recently, a nurse helped a student with an anxiety disorder by having the student record his thoughts for a period of time. The nurse then challenged the negative thought patterns, helping the student to achieve improved feelings of well-being and, ultimately, better success at school.

Nurses also help educate students and educators about mental health promotion and resiliency building skills, and meet regularly to work in partnership with school staffs and with mental health providers in the surrounding community. In Huron and Perth counties, for example, the nurses and their community partners get together for a joint annual education day.

Initial response to the program has been very positive, said Dhinsa. "We hear from our school partners that many students are more stable and are practicing effective coping strategies. Perhaps most important, the work of our team makes it possible for them to stay in school."

For more information on the Mental Health and Addiction Nurses, please contact Glenda Dhinsa, Manager, Nurse Practitioners and Mental Health and Addiction Nurses at glenda.dhinsa@sw.ccac-ont.ca or 519-474-5679.



HOW TO CONTACT US

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