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

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WORKING TOGETHER TO IMPROVE CARE

A bulletin for partners of the South West CCAC

CCAC launches physician hotline, supports primary care

The South West CCAC continues to work to support our primary care partners in the region. We have launched a new dedicated phone line specifically for physicians, making it easier than ever for our community physicians and primary care providers to contact us. The line enables the South West CCAC to build on relationships with important physician partners and to further improve their understanding of the CCAC. Physicians and primary care providers who want to discuss a common patient, or who have patients with acute or chronic care needs that are not being met with their current treatments can simply call **1-844-CCAC-4MD (1-844-222-2463)** any time from 8 a.m. to 8 p.m. to immediately talk to a Care Coordinator.

The South West CCAC has made a concerted effort to connect Care Coordinators to each primary care practitioner in the region, and now have **Care Coordinators on site with more than 600 physicians across the South West.** These on-site Care Coordinators act as a single point of contact to the CCAC for patients, and are familiar with, and connected to, every part of the health-care system. Care Coordinators can support physicians by collaboratively planning patient care and providing valuable information on home and community-based services.


Dr. Cathy Faulds

"It has been hugely educational for us as family physicians to better understand the community resources that exist," said Dr. Cathy Faulds, a physician with the London Family Health Team who works with a CCAC Care Coordinator. "Care Coordinators are incredibly knowledgeable about community supports and specialized program details, and provide us with up-to-date details on available resources, and on patients' progress."

The new physician hotline was launched to make it even easier for physicians and Care Coordinators to connect. "It's a fantastic resource to help us communicate more effectively and more efficiently, and will help further improve the care provided to people in the South West," said South West CCAC Client Services Regional Manager, Jennifer Fazakerley. "The hotline is yet another tool to support our goal of continually improving communications with our physician and community partners."

Call the physician hotline today at 1-844-CCAC-4MD (1-844-222-2463) to speak to a Care Coordinator, or to have a Care Coordinator connected to your practice, contact Jennifer Fazakerley at 519-539-0901, ext. 5073 or jennifer.fazakerley@sw.ccac-ont.ca.

South West CCAC by the Numbers

60,000 patients are cared for every year, or **1 in every 17** people in the region

more than **2.5 million in-home visits** are made by the South West CCAC

94% of CCAC patients are **satisfied or very satisfied** with their care

Used **increased funding to raise the care provided** by more than 11% in 2013/2014

less than 4% of our budget is spent **on administration**, with another 4% on IT and facilities, for less than 8% overall

95% of all patients discharged from hospital get their **first nursing visit within 5 days** and 90% get their first PSW visit within 5 days

A Message from CEO Sandra Coleman

The importance of home and community care

It has been a busy spring for Ontario's CCACs and the home and community care sector in general. In addition to our ongoing work with partners to keep more and more people at home, we have also been taking part in an increased amount of public discussion regarding home and community care. There has been local and provincial media coverage, MPP discussion at Queen's Park, and the ongoing Local Health System Integration Act (LHSIA) review, in which the CCACs have been active participants.

Ontario's CCACs have always been eager to discuss how to further improve the quality and value of home and community care. In 2013, the OACCAC and other Ontario health-care organizations undertook research and analysis on current and future issues in the sector and launched a series of papers – available here: www.oaccac.com/Policy/Pages/research-papers-and-reports.aspx - that posed questions like What should we expect from our health system? and How will we come together to meet the needs of patients? Answering these questions and identifying what transformative change we need is an important part of ensuring a stable health-care system for the future. There is great work happening in home and community care right now, but we need to explore where we go from here.

In the South West we have continued with initiatives like spreading Home First to our region's hospitals and working to make in-person connections with our physician partners to provide better care to patients. Home First is now implemented in every hospital in the South West and we have Care Coordinators on site with more than 600 physicians. We have also continued exploring new endeavours like participating in community programs with our EMS partners, and launching our dedicated physician hotline to better connect physicians with the CCAC and improve patient care. We regularly hear from patients and family members about how pleased they are with the care we provide in conjunction with you, our valued partners.

The work we do together provides people with more options and enables them to live the lives they want to live. More seniors are living independently at home; more acute-care patients are recovering from treatment at home – South West ALCs are among the best in the province; and when the time comes, if they so choose, more individuals are now able to die at home.

The home and community care system is evolving. We welcome this evolution and look forward to working with our partners to participate in the informed and productive discussions that come with it. Together, we will ensure the home and community system continues to perform at the highest caliber, and continues to provide the best possible care to every patient, every day.

Ontario's CCACs' commitment to quality

Ontario's CCACs are committed to the continual improvement of all aspects of their business in order to keep adding value to the province's health-care system. The fourth-annual CCAC Quality Report, entitled *How We Care*, tells the story of how the province's 14 CCACs are progressing on their commitments to improving quality of care, patient experience and patient safety in homes and communities across the province.

The 2012-13 fiscal year was tremendously successful and saw Ontario's residents benefit greatly from the province's CCACs. Collectively they:

- supported more than 650,000 Ontarians with home and community care
- helped bring 192,000 patients home from hospital
- cared for more than 300,000 seniors at home
- delivered health services at school to 82,000 children and youth
- provided end-of-life care in the home to 25,000 Ontarians

The How We Care report focuses on the quality of care provided by CCACs and efforts towards improving that care. CCACs continue to strive to provide better care, better access to that care, and better value for people in homes and communities in the province. The Report measures CCAC performance, tracks progress on the targets laid out in the last quality report, and looks to the future – setting new targets for the years ahead.

As Ontario's population continues to age, the current health-care system will continue to evolve to better address the needs of this changing population. Ontario's CCACs are working with partners - hospitals, community support services, primary care, community health centres, service provider organizations and long-term care homes – to help build a health system that works for Ontarians.

To learn more about the South West CCAC's commitment to quality care at **healthcareathome.ca/southwest >> Our Performance >> Quality Improvement.**

Home First spreads to all South West hospitals

More patients than ever before are going to be returning to the comfort of their own homes from hospitals in the South West. As of March 31, the Home First approach to care has been launched in every hospital in the region.

"This is a tremendous achievement that is really going to help patients, hospitals and the health-care system itself," said Access to Care Director, Sue McCutcheon. "We're just thrilled to have reached this milestone with our partners."

Home First is an approach to care based on the idea that when a patient enters the hospital, every effort should be made to help him or her return home upon discharge. It has been enabling patients in the South West to return home from hospital since first being implemented at London Health Sciences Centre in September 2011.

Goderich resident Helena Shoemaker recently returned home under Home First, where she lives comfortably with the help of her daughter Marjorie and a robust service plan.

Since that time, Home First has saved the health-care system more than $10 million a year by reducing the number of people waiting in hospital for a spot in long-term care by more than 50 per cent, and by enabling 800 people with complex needs to stay in their own homes each month.

"We worked in partnership with hospital physicians, community partners and the South West LHIN to implement Home First at each hospital," said McCutcheon. "Each time it was implemented and launched it was done collaboratively by a team of South West CCAC Care Coordinators, hospital staff members, and other team members who worked diligently at each hospital to ensure it was a success."

The Home First implementation team was the recipient of the South West CCAC's 2013 Client-Driven Care award in the team category, and last year's South West LHIN Quality Award.

Nearly 40 per cent of Home First patients are able to remain in their homes and out of long-term care once they leave hospital, while others ultimately 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.

Partnership helps long-term care home welcome 192 new residents

Close to 200 Southern Ontario residents now call London home after having moved into Henley Place, a new long-term care home that recently opened in the city's North end.

Operated by Primacare Living Solutions Inc., a Canadian long-term care provider, Henley Place features 192 beds, split into six different 32-bed wings. The home opened on December 20, 2013, and needed to fill all of its beds on a tight schedule. "They only had 90 days to fill every bed," said South West CCAC Regional Client Services Manager Anita Cole, "so the CCAC got right to work."

The South West CCAC began working with Henley Place in early 2013 to prepare for the home's opening. In order to meet the 90-day deadline, the plan was to fill the home at a rate of four to eight residents per day. "Helping someone find their new home in long-term care can be a complicated thing to do," said Kristie Clark, Director of Clinical Services with Primacare. "At an average of 16 people a week, it was a very quick pace to maintain."

Staff at the South West CCAC conducted assessments to develop a solid understanding of residents' needs, ensured updated clinical information was received from family doctors and long-term care homes, and had conversations with residents and their families to determine move in dates. "In many instances we had a lot of internal movement between long-term care homes, so we also had full teams working rapidly to backfill other long-term care homes," said Cole.

Care Coordinators Lois Gilchrist and Susan Deffett (standing left to right) and Client Services Assistant Tanya Willems (seated) helped residents move to Henley Place.

The process was incredibly successful. With everyone working together, the South West CCAC and Primacare were able to come in well ahead of the Ministry of Health and Long-Term Care mandated 90 days. "It was extremely smooth, and successful," said Cole. "We worked closely with the home and it was through that relationship and partnership that clients transitioned in an efficient, effective manner."

The process was a great example of a successful partnership in terms of the pure dedication to the clients and the process it took to fill the home. "It was really a whole team effort," said Clark.

South West CCAC wins third-consecutive LHIN Quality Award

Left to right: Michael Barrett, CEO, South West LHIN; Margo Hunsberger, RN, Owen Sound Family Health Team (OSFHT); Dr. Don Hunsberger, OSFHT; Debbie Kean, IT Support and Communication, OSFHT and Gillian Kean (RN), OSFHT; Andrea McInerney, PFQ; Mary Lapaine, Board Chair, South West CCAC; Jeff Low, Board Chair, South West LHIN and Sandra Coleman, CEO, South West CCAC

The annual South West LHIN Quality Awards were handed out May 14 in Stratford, and for the third year in a row, the South West CCAC was involved in an award-winning project. The Partnering for Quality (PFQ) Team worked closely with the Owen Sound Family Health Team and the Diabetes Grey Bruce team on their diabetes strategy, and was recognized for their work.

The PFQ team supports primary care and system partners to improve chronic disease prevention and management by helping them get the most out of their electronic medical records (EMR). By optimizing EMR use, system partners can extract more meaningful data to support improvements in patient care.

PFQ supported the Owen Sound FHT and Diabetes Grey Bruce teams in a variety of ways, including an eHealth Coach who helped the team complete comprehensive searches in their EMR, and a Quality Improvement (QI) coach who helped identify and map out value added processes and clarify roles and responsibilities among team members.

"As always, our success is tied directly to our wonderful partners," said PFQ Quality Improvement Coach Andrea McInerney. "It is an honour to share this award with them."

eShift program goes international

It started in the South West in 2009 as a pilot project with one nurse and two patients. Today, just five years later, the eShift model of care is spreading around the globe. Already running across much of Southern Ontario - it was launched in Waterloo Wellington in March and will launch in Erie St Clair and Hamilton Niagara Haldimand Brant later this year - eShift was also launched in the US by Hospice of Michigan in December 2013. Soon, it will be up and running in France and England as well.

"We started with a small team on that first project," said Megan Nichols, Regional Quality Manager at the South West CCAC. "So it is completely surreal that from that tiny project we now have an international model of care."

The eShift program is an innovative nursing model of care that uses specialized technology to connect off-site nurses to specially trained Personal Support Workers (PSWs) in palliative patients' homes. The PSWs carry out activities on behalf of the nurse, which enables a single nurse to care for up to four patients, in four locations, at one time. The model provides an easier way to get nursing resources into rural and remote areas, gives much needed relief to patient caregivers and family members and enables more patients than ever to die in the location of their choice. It was selected as an Accreditation Canada National Leading Practice, acknowledging it as a "sustainable, creative and innovative service" of national significance.

When word of eShift's success in the South West spread, many jurisdictions began to inquire. In early 2013, when Hospice of Michigan expressed interest in learning more about eShift, the South West CCAC met with them to discuss the program. "They loved it," said Nichols. "They went back to Michigan to engage with their own regulatory bodies and colleges to develop an implementation plan, and launched last December."

This past April, the South West CCAC hosted a delegation of physicians and eHealth leads from St. Luke's Hospice in Sheffield England, and from The Health Network in Franche-Compte, France. "They'd seen our presentations and read the information, but they wanted to see eShift in action," said Nichols.

Delegates from France and the U.K. visited London, Ontario to learn about eShift.

"They came and saw eShift provided overnight in a patient's home and then went on to Michigan to see it done in that environment."

The Health Network in France expects to roll out eShift in the fall of 2014 to their palliative patient population, while St. Luke's is considering how to implement eShift into their long-term care settings for end-of-life patients. Both European organizations, and Hospice of Michigan, have expressed an interest in partnering in a joint learning collaborative.

"That is huge," said Nichols. "We now have the opportunity to conduct joint research and to learn from each other's best practices to continue improving patient care. For something to have spread this quickly and this dramatically is hugely exciting."