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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

Making Way for Change in Home and Community Care

Important work lies ahead for CCACs and health partners to transform the current system into a stronger, more stable and integrated home and community sector that puts patients' needs first.

Last year, 700,000 people received home and community care through the province's 14 Community Care Access Centres (CCACs). The South West CCAC supported 60,000 of those people.

CCACs take very seriously, the responsibility for delivering the highest-quality care to patients and achieving value for government investment.

Recently, the 14 CCACs and the Ontario Association of Community Care Access Centres, (OACCAC) released a White Paper: *Making Way for Change: Transforming Home and Community Care for Ontarians.*

The White Paper documents the barriers arising from the current legislative, policy and funding framework, the result of a patchwork of changes over the last 20 years.

To better meet the diverse and evolving needs of Ontario patients and caregivers, our White Paper recommends changes to create a more flexible and streamlined system of home and community care supported by up-to-date laws, and with regional funding better allocated and aligned to local patient care needs.

The recommendations in Making Way for Change call for action in four areas:

- Create flexible, adaptable home care service models that recognize and respond to the unique needs of patients
- Stabilize sector funding to ensure more equitable, evidence-based and predictable funding decisions that support better patient care
- Strengthen province-wide and regional health system capacity planning and ensure that future home and community care needs are built into long-term planning
- Introduce a modern, patient-centred legislative framework for home and community care

While the White Paper is focused on profound system-wide, transformation, we continue to implement regional initiatives such as Health Links and Home First to improve patient care. Updates on these initiatives are included in this bulletin.

The Deputy Minister of Health and Long - Term Care, Dr. Robert Bell, also recently announced there will be a call for expressions of interest for 10 to 15 " Acute Home Care" pilots in which hospitals and CCACs will integrate more fully to support some patients post discharge, including direct links to hospital specialists and physicians with more intensive home care for 30 days, before transitioning to regular CCAC home care supports.

An example of how patients might benefit from this model of care:

- a patient would be discharged home from hospital shortly after major surgery
- an Integrated Home Care Plan would be organized to support the patient in their home, with the added expertise of their hospital care team, as appropriate to the patient's individual needs
- in the event of a complication, (ie: wound care) the home care nurse could immediately use their iPad to video conference the appropriate physician or specialist
- the physician/specialist would be able to see the issue and work with the health care professional and the patient in real time to develop solutions

In this Issue

It is an exciting opportunity for partners to work together to provide more care for more people in the community by using our collective expertise combined with advances in technology that would have been impossible just five years ago. No decisions have been made yet as to what organizations will be participating in these pilots, but we will keep our partners informed.

As we move forward with these initiatives, among many others, we look forward to working with you, engaging in essential conversations so that we can all achieve better care for people and the greatest use of our collective resources.

Contact the South West CCAC at
1-800-811-5146
www.healthcareathome.ca/southwest

A Message from Sandra Coleman, CEO South West CCAC

As stewards of valuable health care resources, we cannot afford to duplicate services among partners.

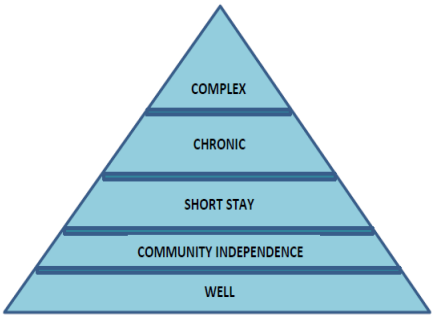
With tremendous growth forecasted for the population we serve over the next 20 years, health system partners need to work together, more closely than ever before to make sure people get the care they need.

At the South West CCAC, we are already seeing validation of these forecasts. Growth has continued to increase by 10% or more per year over the last four years. In the last year alone, requests for CCAC in home services increased by 33%.

Today, patients living in their homes and communities have more complex health issues than ever before – more than 85% of our patient care budget is spent on supporting people with complex needs in the community. Just five years ago, these people would have likely moved to long-term care or remained in hospital.

Care coordination is critical, as every possible resource, every community service, and support from family/ friends, needs to be considered to support patients.

Using a multi-year strategy, we have invested significant time and resources to shift our patient care model to support the balancing of resources among patients with the greatest needs.

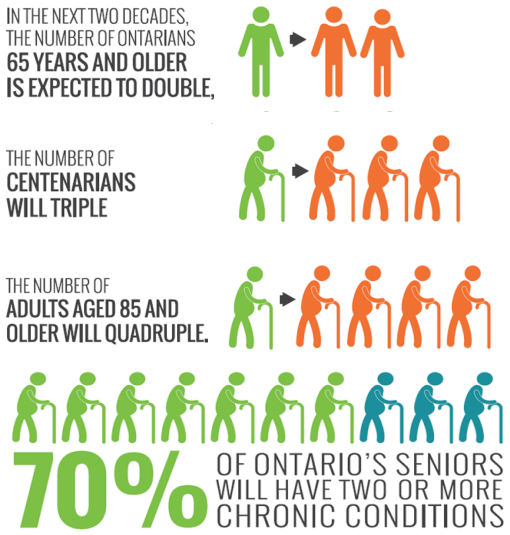


Client Care Model – A population-based approach to segmentation of client services for Ontario CCACs

Patients with less complex needs will continue to need support from community organizations, (ie: Meals on Wheels, Adult Day Programs and Exercise Classes) to help them live their lives with the best possible health and well-being.

Looking forward, we are planning to support more modest growth this year in order to balance our budget by the end of this fiscal year on March 31, 2015. We forecast being able to support all patients with Complex and Chronic needs, as well as those being discharged from hospital.

Remaining in the community with supports has resulted in better health and quality of life for patients, as well as a more efficient use of health care dollars.



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

Snapshots of Heroes at the Owen Sound (above) and London (above, right) events.

Heroes in the Home is an annual recognition program sponsored by the South West Community Care Access Centre (CCAC), in partnership with the southwesthealthline.ca. Each year, CCAC patients and others involved in home and community care have the chance to nominate a special caregiver – whether a family member, friend, volunteer, or a health care professional - to receive special caregiver recognition for going above and beyond the call of duty.

Hundreds of people have attended the South West CCAC's ceremonies held in Owen Sound and London, while the Stratford event will take place on November 12.

The nominations are heart-warming and inspiring. A few quotes from the nominations include:

* *Nickie always sets Bud's mind at ease*
* *Lori puts the "care" in caregiver*
* *Diane provides encouragement and a great listening ear*
* *Kelly arrives each day with a smile on her face and kindness in her heart*

Developed in the South West, the Heroes in the Home program has been recognized as an innovative leading practice by Accreditation Canada and seven other CCACs across Ontario are hosting Heroes events.

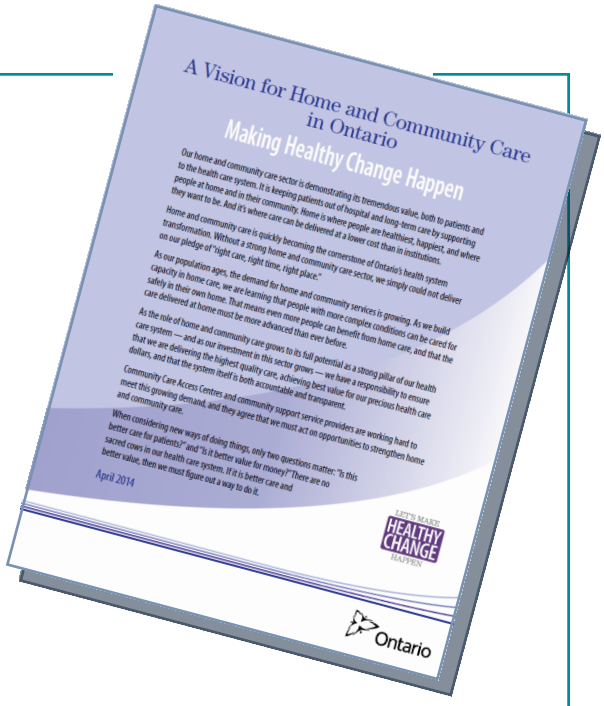
Expert Panel on Home and Community Care

In April 2014, the former Minister of Health and Long-Term Care, (MOHLTC) Deb Matthews shared her vision for Home and Community Care and announced the creation of a Blue Ribbon Panel. The following people were appointed to the expert panel; Gail Donner, (Chair), Cathy Fooks, Joe McReynolds, Dr. Samir Sinha, Dr. Kevin Smith, and Donna Thomson. Click here to read their bios.

As a result of the provincial election, this initiative was put on hold. Current Minister, Dr. Eric Hoskins, recently reconvened the panel who have been delegated to develop recommendations for the home and community care sector by examining:

- Opportunities to make service delivery more consistent across Ontario to promote equal access to services and quality home and community care in all communities.
- Opportunities to make provincial funding for services and investments in home and community care consistent across the Province to improve transparency and maximize funds available for patient care.
- Opportunities for innovation and new approaches to care to improve patient experience, quality, choice and value for money.

The Panel will provide its recommendations to the Minister by the end of January 2015.



HEALTH LINKS UPDATE

Florence's Huron Perth Health Links Experience

Florence, (above-right) was referred to the Huron Perth Health Links after a series of health issues.

After a few falls in her two-story home, Florence (age 88 years) moved to a new apartment in April 2014. Shortly after her move she developed pneumonia followed by laryngitis, that resulted in a lengthy illness, (she is also being monitored for other chronic health conditions).

The Clinton Family Health Team asked Florence and her family to participate in a Health Links coordinated care conference.

Attendees also included a CCAC Care Coordinator, Florence's Family Physician and Nurse Practitioner, as well as a representative from ONE CARE Home & Community Support Services.

During the care conference, everyone had a clear understanding of Florence's medical status and needs as well as the supports available in the community, and from family and friends.

Most importantly, Florence was able to identify what she wanted and valued; being self-reliant was key.

Working together, the team was able to organize care and services such as:

- ✓ Medication schedule
- ✓ Exercise routine (eventually classes)
- ✓ Occupational therapy assessment and recommendations
- ✓ Equipment purchases
- ✓ Community support services

These, among other elements of her care plan have contributed to Florence's physical and well being.

In Ontario, five per cent of patients account for more than two-thirds of health care costs.

Typically, these patients have multiple, complex conditions, the most common of which include one or more of the following:

- Chronic diseases like COPD or diabetes
- Advanced age
- Bone fractures
- Mental illness
- End of life issues and complications
- Children with complex needs

For these patients, multiple ailments lead to multiple interventions in the health-care system. 75 per cent of seniors with complex needs who are discharged from hospital receive care from six or more physicians and 30 per cent get their drugs from three or more pharmacies. The result is sub-optimal care that costs the health care system more.

The current approach is expensive and unsustainable.

The Health Links model was created to improve the coordination of care by bringing local providers together and ensuring that people are at the centre of their own care.

Health Links will help close the gaps that often occur when a patient moves from one provider to another. Coordinating care is an important step in improving the services available to patients with complex needs which will result in better care and significant health system savings.

CCAC Care Coordinators provide unique support to patients of all ages and stages in all parts of the health care system.

- ☑ Regulated health professionals, Care Coordinators have the expertise and resources to organize care conferences and arrange Integrated Care Plans.
- ☑ Every Care Coordinator is a single point of access for patients to home and community care services with the ability to support transition to long-term care or other care destinations when appropriate.
- ☑ More than 630 Primary Care physicians have been connected with onsite Care Coordinators who work together to support common patients and develop care plans.
- ☑ Care Coordinators have relationships with multiple service provider agencies to quickly get patients a wide-range of health care services, from wound care to respiratory therapy to meal services and adult day programs.
- ☑ Access to the CCAC Intensive Home Care Team which is comprised of more than 40 Registered Nurses and Nurse Practitioners who provide rapid response nursing care to high risk patients, patients with chronic conditions and palliative patients.
- ☑ Established electronic resources have been developed by the CCAC, that enable the sharing of information, quickly and safely, with multiple health care providers.

Home First has been rolled out in all hospitals across the South West.

"The way I looked at it, if I had a chance to come home and be with my family, I'd take it and enjoy whatever time I had." - Faye

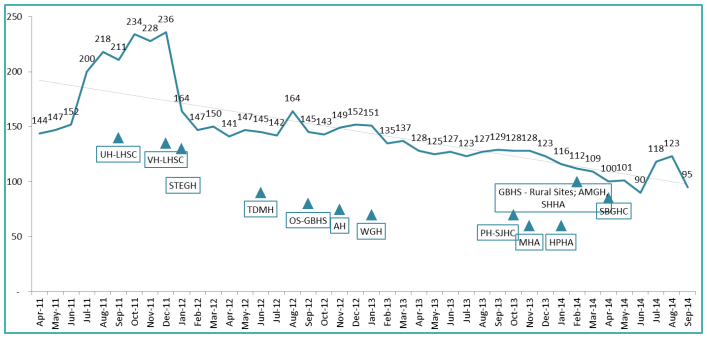
What is Home First?
When complex elderly patients enter hospital, every effort is made to support them to return home on discharge.

Currently, more than 800 people are supported in their homes each month, rather than being designated Alternate Level of Care (ALC) and waiting in hospital for long-term care or another service.

What does Home First mean for patients?
For patients and their families, Home First made a big difference in quality of life. Patients are able to make choices and decide their next steps in comfort and privacy of home.

In many cases (about two thirds) patients recovered enough to stay at home on regular CCAC services – a remarkable achievement, given that before Home First, they all would have been placed in long-term care. For some, it also meant having the choice to die at home.

How has Home First impacted hospitals?
Home First has contributed to declining Alternate Level of Care for long-term care designations in hospitals since it was first launched at LHSC in September 2011.



Patients waiting in hospital for long-term care

Does the Home First approach result in value for money?
Yes. The South West LHIN recently conducted a Value For Money assessment in Elgin County. It was determined that without Home First, patients waiting in Alternate Level of Care (ALC) status in hospital for discharge to long-term care or other service levels, would have stayed in hospital for approximately 10,243 ALC days.

Supporting these patients in the community with home care plans resulted in a cost avoidance of an estimated $8.8 million between January 2012 and March 2014.

The South West CCAC has updated the economic impact analysis to include all of the South West for 2012/13 and 2013/14 and has calculated the total two-year cost avoidance resulting from care in home instead of hospital to be $30.4M.

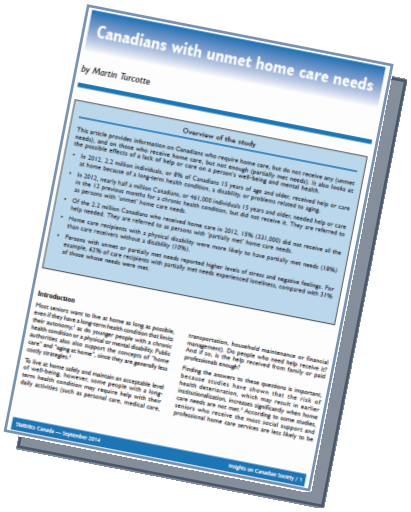
Stats Canada Report

You may have read about the Stats Canada report released in September; Canadians with unmet home care needs.

The report is described as providing: *"...information on Canadians who require home care, but do not receive any (unmet needs), and on those who receive home care, but not enough (partially met needs). It also looks at the possible effects of a lack of help or care on a person's well-being and mental health."*

Reports like this help the public to keep talking about what is important to them as they age and/or experience health related challenges.

For those of us who work in Home and Community Care, it helps us to better understand the people we care for and the challenges they face. It also helps us to increase awareness about the value of our work, and how we can contribute to system-wide solutions. You can read the report by clicking here.



Patient Care Resources

FlexClinics

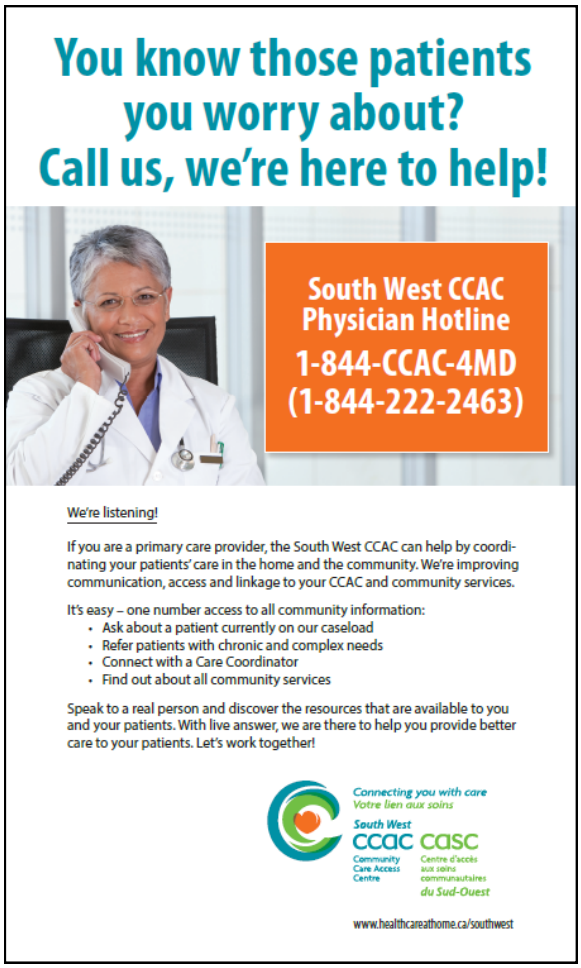
FlexClinics are clinics staffed by Registered Nurses set up in a variety of community settings across the South West, based on the needs of patients in each area. When case managers assess patients for community care they will determine whether they are appropriate for a Flex Clinic. Most patients who are ambulatory and not immuno-suppressed or medically fragile will be referred to a FlexClinic for nursing care. Advantages are:

- Patients can schedule their own appointments to fit their schedules
- They do not have to wait at home for the nurse to arrive
- Getting to appointments encourages patients to be active, an important part of the healing process
- Getting out can also help patients feel more like themselves again.

FlexClinics also ensure that the CCAC is able to offer timely, high quality nursing care when and where patients need it. FlexClinics are located within easy traveling distance for any patient.

Care Coordinators have shared accountability with provider agencies for optimizing Flex Clinic Utilization. Optimizing Clinic Utilization is also important so that resources are freed up for patients that are medically complex thus necessitating in home care.

FlexClinics are an important component of the South West CCAC's provision of community based nursing care. Please keep this in mind when discussing follow-up care with your patients.



Primary Care Hotline

Recently, the South West CCAC launched a dedicated phone line specifically for physicians, making it easier than ever for our community physicians and primary care providers to contact us.

The direct line enables the South West CCAC to build important relationships with important physician partners and to further improve their understanding of the CCAC.

Physicians and primary care providers who want to discuss common patients, 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.** and they will be immediately connected to a Care Coordinator.

You know those patients you worry about? Call us, we're here to help!

We're listening!

If you are a primary care provider, the South West CCAC can help by coordinating your patients' care in the home and the community. We're improving communication, access and linkage to your CCAC and community services.

It's easy – one number access to all community information:

- Ask about a patient currently on our caseload
- Refer patients with chronic and complex needs
- Connect with a Care Coordinator
- Find out about all community services

Speak to a real person and discover the resources that are available to you and your patients. With live answer, we are there to help you provide better care to your patients. Let's work together!

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