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

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Spring 2015

WORKING TOGETHER TO IMPROVE CARE

A bulletin for partners of the South West CCAC

Outstanding Care - Every Person, Every Day

Jack and Jean live in Stratford Ontario. Jack is 76 years old and has dementia, diabetes and renal failure. Jean, age 67 has arthritis, diabetes, depression, frailty and also has difficulties with her hearing and vision.

Their care plan has historically included several home and community support services (CSS) to help them maintain their independence.

Jack and Jean receive significant support from their only child Sherrie, who works full time and attends post secondary education.

Recently, both Jack and Jean experienced changing health that required hospitalization and Sherrie found herself overwhelmed by the demands of caring for her parents and navigating the health system on their behalf.

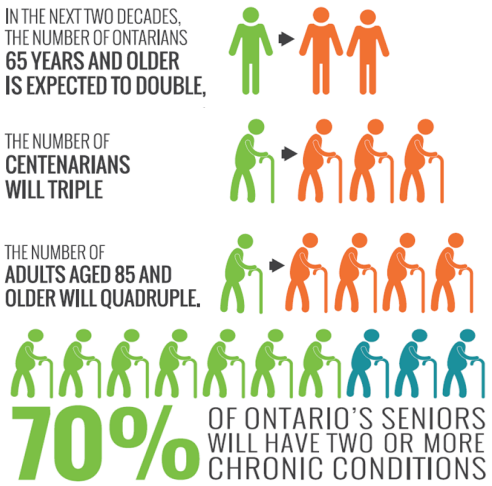
The CCAC Care Coordinator worked with the family and OneCare Home and Community Support Services and other partners to put a comprehensive plan in place which has kept both Jack and Jean at home ever since without any further trips to the hospital.

On March 6th, the CCAC and One Care were honoured to host the Deputy Minister of Health and Long-Term Care (MOHLTC), Dr. Robert Bell, with members of his senior team on a home visit with Jack and Jean, along with Mike Barrett and others from the MOHLTC and the South West LHIN.

During the home visit, the value of care coordination, system navigation and home and community care support was very clear. Jack, Jean and Sherrie were also able to clearly articulate the challenges they face on a daily basis.

While in the South West, the Deputy Health Minister and his team also learned more about the great health system partnerships in place here.

In following up with us after his visit, Dr. Bell and his companions shared the sentiment in an email, *"...that was a powerful example of the complex patients you are supporting in the community, and their appreciation for being able to stay in their homes."*

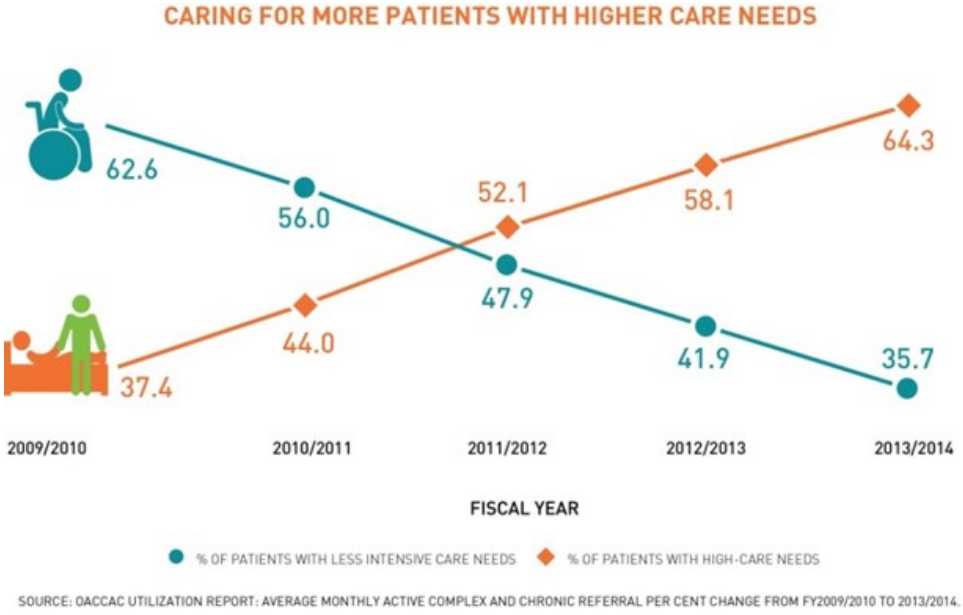


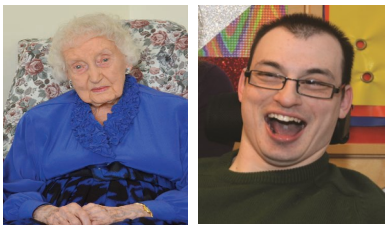
South West CCAC by the Numbers

- 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
- 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 95% get their first PSW visit within 5 days

In this Issue

A Message from Sandra Coleman, CEO South West CCAC





Apparent in the delivery of the Roadmap and the recent provincial budget, the modernization of home and community care is one of the government's top priorities.

Throughout the home and community care sector, everyone of us is successfully caring for people with more complex health issues than ever before. Just five years ago people who would have had to move to long term care are now able to remain in their homes and communities.

This is causing a ripple through the entire health care system; fewer unplanned trips to Emergency Departments, shorter hospital stays for patients and increased complexity of those moving to long-term care are just a few of the impacts we are seeing. All of which is contributing to improved quality of health and life for Ontarians and a more efficient use of our health care resources.

Furthermore, public expectations for our health care system are changing; Ontarians strongly desire to have additional control and choice over which services they receive and how those services are delivered.

With our home and community care sector partners, CCACs look forward to the public better understanding the tremendous value that we bring to the health care system.

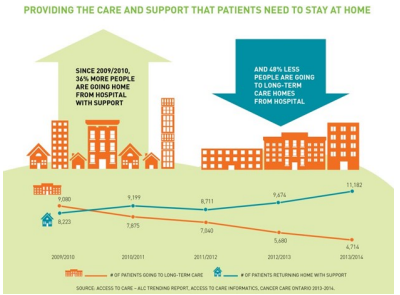
Moving forward, there will be significant opportunities to improve the way in which we deliver care in the future and we, as a sector, will need to be relentless in our focus on improving care for patients. I believe that our sector is ready.

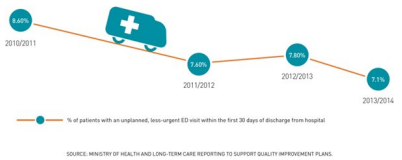
Among the 14 CCACs in the province, we anticipate the following will be among the key areas of focus for development and expansion:

- eHomecare, telehome care and palliative care
- greater standardization in care and practices across the 14 CCACs that can be described to the public, and
- integrated care/funding opportunities with hospital partners and others

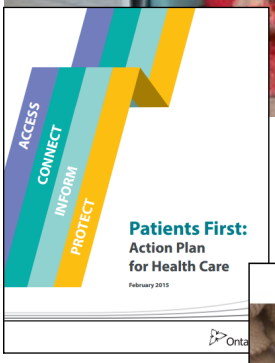
As we rise with our health system partners to meet these opportunities and challenges, I am confident that together we can support more patients with better care enabling more days at home.

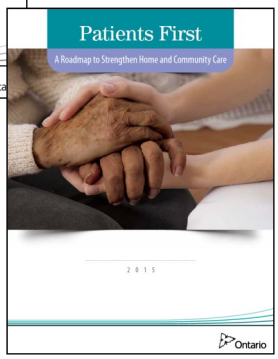
- Sandra





Patients First: Action Plan for Health Care to Improve the Health Care Experience





Click on the images to read these reports.

Ontario has introduced the next phase of transformation to the province's health care system to improve results for patients and support the needs of an aging population.

The plan - Patients First: Ontario's Action Plan for Health Care - outlines how the province will increase access to better and more coordinated care, and ensure the health care system is sustainable for generations to come.

This action plan focuses on four ambitious but achievable goals:

1. **Access**: Providing patients with faster access to the right care.
2. **Connect**: Connecting people with the services they need to receive better coordinated and more integrated care in the community, closer to home.
3. **Inform**: Providing people with the education, information and transparency they need to make the right decisions about their health.
4. **Protect***:* Protecting our universal public health care system for generations to come, ensuring that decisions are based on value and quality.

More recently, on May 13, 2015, Health Minister Eric Hoskins released the government's roadmap as "the first phase of our plan to remake the home and community care sector" over the next three years.

The roadmap includes the following goals for strengthening home and community care:

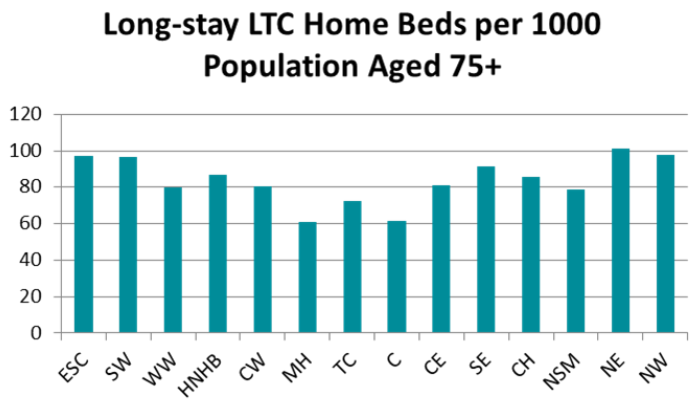
- Put clients and caregivers first
- Improve the client and caregiver experiences
- Drive greater quality, consistency and transparency
- Plan for and expand capacity
- Modernize delivery

The plan includes 10 steps toward "achieving higher quality, more consistent and better integrated home and community care," and clear timelines to achieve these goals.

At the South West CCAC we welcome the direction that the government has laid out and have many initiatives currently underway that align with this roadmap.

The Roadmap: Ten Steps to Strengthen Home and Community Care

1. Develop a statement of home and community care values to guide transformation of home and community care.
   - Read the South West CCAC Declaration of Patient Values here.
2. Create a levels of care framework to ensure services and assessments are consistent across the province.
3. Increase funding for home and community care by five per cent each year ($750 million over three years).
4. Move forward with bundled care, in which a group of providers will be given a single payment to cover all the care needs of an individual patient.
   - Learn more about the London Middlesex Partnership for COPD and CHF Short Stay Patients on page three.
5. Offer self-directed care, giving clients and their caregivers funds to hire their own provider or purchase services.
6. Expand caregiver supports to ensure caregivers have better resources to care for their loved ones and themselves.
7. Enhanced support for personal support workers by continuing to move forward on increasing the PSW hourly base wage, and create more permanent employment opportunities.
8. More nursing services by increasing the maximum number of nursing visits a patient care receive, allowing CCACs to exceed nursing service maximums (subject to regulation changes).
9. Provide greater choice for palliative and end-of-life care by expanding access and equity, establishing clear oversight and accountability and enhancing public education.
   - Learn more about the South West Hospice Palliative Care Network
10. Develop a capacity plan that includes targets for local communities and standards for access to home and community care. This is very important given the wide range of capacity on issues like long-term care.



Ontario's Provincial Budget; Home and Community Care is a Significant Focus

"To further enhance capacity and drive system transformation, the government will continue to increase funding in the sector by about five per cent per year, investing more than $750 million over the next three years."

Ontario Minister of Finance Charles Sousa presented the 2015 Ontario Budget on April 23. The 2015 Budget outlines a four-part plan to "ensure the province is the best place to live, from childhood to retirement, and where everyone has the opportunity to realize their full potential".

The budget continues to build on the Patients First: Action Plan for Health Care to Improve the Health Care Experience.

Funding will support people of all ages who require care in their home, at school or in the community. This includes:

- Investing $75 million to support more visits at home for people who need nursing services and more hours of care for those who have complex care needs and require in-home personal support services like dressing, bathing and help taking medication;
- Moving forward with the recommendations of the report prepared by the Home and Community Care Expert Group, "Bringing Care Home," by testing innovative approaches to bundle funding specific to a patient's needs as they transition out of hospital and back into their homes and communities;
- Investing more than $40 million over four years, including about 10,000 more rehabilitation therapy visits, to enhance coordinated services for frail, complex-needs seniors who have recently lost strength or mobility due to an injury or long hospital stay. Services will help seniors regain strength and remain independent longer, reduce their need for admission to hospital or a long-term care home, and support families and caregivers; and
- Creating 69 Community Health Links across the province by bringing local health care providers together to work with complex-needs patients and their families by coordinating the delivery of care. By wrapping care around the patient, the team of providers can avoid duplicated or unnecessary services, avoid gaps in their care or prevent trips to the hospital.

London Middlesex Partnership for COPD and CHF Short Stay Patients

In response to the provincial government's call for Integrated Funding Model proposals, LHSC and the South West CCAC have developed a proposal that is under consideration for approval.

Initially, the project would focus on LHSC patients who are experiencing moderate Chronic Obstructive Pulminary Disease (COPD) and Chronic Heart Failure (CHF) who are being discharged home in London Middlesex. Hospital and community care teams would work together with COPD and CHF specific resources from the moment a patient arrives in hospital and for up to 60 days post discharge, at which time he/she would be transitioned to a care plan that would support their ongoing needs.

The outcomes would include:

- better health and wellness for patients and their caregivers
- decreased readmission to hospital
- shorter hospital length of stay
- hospital avoidance

The Patient Experience - When a patient arrives at hospital, they will receive appropriate treatment and immediately be connected to a Hospital Patient Navigator. The Patient Navigator will assess the patient and those patients with moderate needs will be connected with a CCAC Clinical Care Coordinator. This is a new role combining the roles of a hospital Care Coordinator, a Rapid Response Nurse and a community Complex Care Coordinator.

Prior to hospital discharge, the Clinical Care Coordinator will organize a care conference which will include the patient, his/her family, primary care, the service provider team, the Patient Navigator and others where appropriate to develop a Coordinated Care Plan.

After being discharged from hospital, the Clinical Care Coordinator will conduct the initial home visit and work with the care team to monitor the patient's needs and progress. Once discharged from hospital, there are a number of resources in place to support the patient:

- A single dedicated service provider employing all in-home visiting staff to ensure a single integrated care team, paid on a bundled basis by outcome, rather than fee for service
- An evidence based care pathway, with hospital discharge after a shorter LOS (5 days instead of 8-11 days), initially supported with up to 24/7 shift care, then with less intensive daily visiting care, moving to self management and independence supported by telehomecare
- One number for patients to call for all patient concerns and enquiries
- Community Clinics specific to COPD and CHF at St Joseph's Health Care

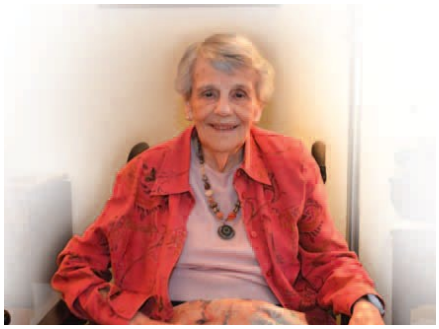
eHomecare Technology is a fundamental component of the new approach that will enable more comprehensive care and close monitoring of a patient's health. The entire care team will have access to real time data and have the ability to immediately intervene to avoid a crisis.

- Electronic Medical Record (EMR)
- Two-way communication with primary care providers and support services
- Real-time communication between the patient and their care team (i.e.: Skype, OTN)

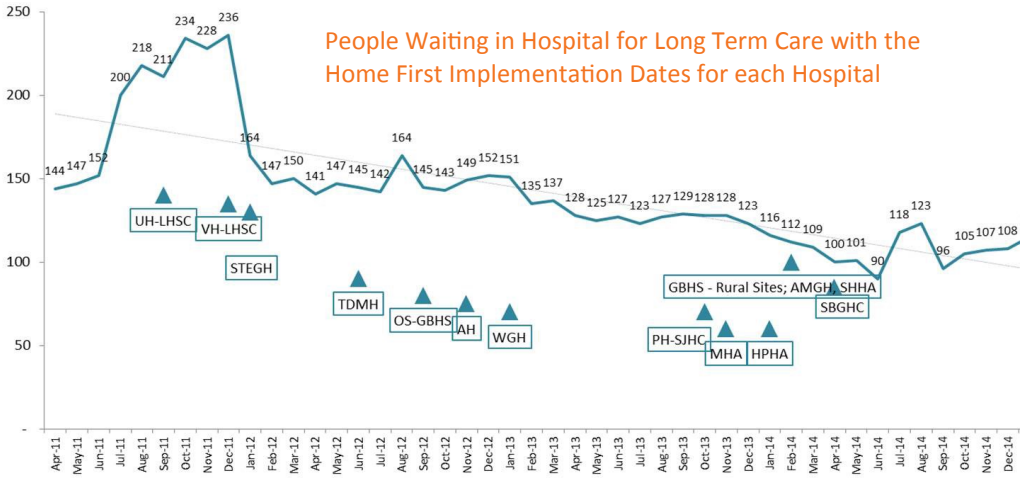
For example, a worker in the home may identify an issue that requires direction from a specialist such as a Cardiologist. The Cardiologist will have the ability to log on to the patient's Electronic Medical Record, immediately Video Conference with the patient and the worker in the home, at which time they will be able to direct the most appropriate course of action.

Care conferences will be organized on an as-needed basis and prior to the conclusion of the 60 day time period to continue, modify or discontinue services. At this time, the patient would be transitioned to the most appropriate care plan for their needs.

Home First Continues Improve the Lives of Patients and Positively Impacts the Health Care System



"I'm happy to have decided on long-term care, it will take a lot of my worries away," said Olga Brauer, (age 95) "But I'm also very happy to waiting from home."



Home First is an approach to providing care based on a simple but powerful idea: *When a patient enters the hospital, every effort should be made to ensure adequate resources are in place to support the patient to return home on discharge.*

Home First implementation in the South West began in September 2011 at London Health Sciences Centre, University Hospital campus and was then rolled out at all South West hospitals by March 2014.

Recently, we completed a 2012—2014 Home First Impact Analysis that detailed evidence proving that Home First has made a tremendous difference on the health-care system.

By the numbers:

- The net economic savings to the system because the 463 patients in 2013/14 returned home was approximately $20 million.
- The South West has the second lowest Alternate Level of Care (ALC) rate in the province.
- In 2013/14 an additional 3,468 other complex patients benefited from the Home First approach during the 365-day period, receiving robust care plans to ensure that they were able to go home from hospital.

What's Next for Home First?

In 2015/16 the South West CCAC will be expanding the time frame for Home First robust service plans from 30 days to up to 60 days. Additionally, the Home First approach will now include people who have experienced:

- Strokes
- Chronic obstructive pulmonary disease (COPD)
- Chronic Heart Failure (CHF)

- Medication Disorganized? (Meds not clearly labeled, Ad lib containers, old meds mixed with current medications.
- Has the patient made any 911 calls in the past 30 days?

Upon receiving the referral a CCAC team member will follow up with these people to organize additional support services as appropriate.

Community Paramedicine Throughout the South West

"Community paramedicine" encompasses a variety of programs and a variety of enhanced roles for paramedics. Community paramedicine can also include public education, access to community fibrillation, referrals to programs and expanded scope for paramedics (for example flu shot clinics, or provision of IVs in LTCHs for antibiotics), wellness programs, blood pressure checks, etc.

A formal study of this program in Toronto found that when paramedics responding to emergency calls referred patients to community services, there was a 50 per cent decrease in the number of repeated 911 calls and a 65 per cent decrease in the number of emergency department transports.

Expanding community paramedicine in Ontario was a key recommendation contained in Dr. Samir Sinha's report, Living Longer, Living Well.

Paramedic Referral is now operational with the 7 EMS services throughout the South West.

In the South West, paramedics employed by our partner organizations have received the additional knowledge, training and tools to identify patients for electronic referral to the South West CCAC.

Paramedics use an assessment tool called PERILS that predicts harmful outcomes like death, hospitalization, or a return to the ED after an initial encounter with an EMS paramedic. The tool itself assigns one point to an affirmative answer to any of the three following questions:

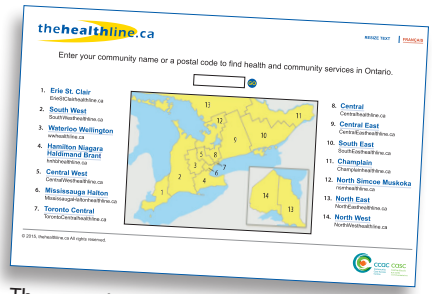
- Are there any problems observed in the home that would prevent this client from being safely discharged home from the ED, or contribute to recurrent EMS/ ED use?

Home and Community Care Resources

SouthWesthealthline.ca

SouthWesthealthline.ca is a great resource for information about local health and community services to help your clients and patients stay healthy, get well and live independently.

- Home and Community Care
- Health Care Professionals
- French Language Services and Resources Fr
- End-of-Life Care Supports
- News and Events
- Health Care Facilities
- Stroke Resources
- Clinics and Classes
- Support Groups
- Social Supports
- Careers



There are 14 regional sites. Find services across Ontario at thehealthline.ca.

Promote local events, clinics, classes and support groups on southwesthealthline.ca

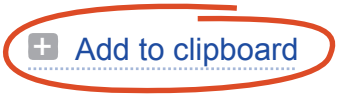
SouthWesthealthline.ca lists thousands of upcoming events, classes and clinics and it's easy to find the right one by using the new filters to search by event topic, type, location and keyword.

- Exercise and Physical Activity
- Wellness and Prevention
- Seniors
- Social Action
- Caregiving
- Support Groups
- Professional Development

Posting your event is easy!

- Go to the Submit Event page and complete the form
- Enter recurring events just once using the date calendar
- Click submit!

It's easy to help others by sharing information using the *NEW* Clipboard



1. Research services
2. Add them to the clipboard
3. Include comments (optional)
4. Email or print for a caregiver, family member or friend

Help and support for caregivers

Don't forget to tell families and caregivers that they can connect with caregiving news, service information, tips and other supports at CaregiverExchange.ca.

If you need help or have a question about using southwesthealthline.ca, email editor@thehealthline.ca.