2016/2017 annual report

OUTSTANDING CARE – EVERY PERSON, EVERY DAY
Our dedicated professional staff and management are guided by our vision and mission, and we strive to live our values as we deliver care each and every day.

**Our Vision**
Outstanding care – every person, every day.

**Our Mission**
To deliver a seamless experience through the health system for people in our diverse communities, providing equitable access, individualized care coordination and quality health care.

**Values**
We live the values of our compass each day in order to develop shared understanding, build trusting relationships and co-create ways to achieve outcomes.
2016/17 WAS A YEAR of reflection for our organization as we celebrated our organization’s many achievements in recognition of our 10th Anniversary. 2016/17 was also a year of preparation for the implementation of the Patients First Act that, among other changes to the health care system, will result in the merger of the South West CCAC and the South West LHIN early in 2017/18.

The outcome of this self-reflection and preparation, is a sense of pride in all that we have accomplished in the past 10 years and in knowing that we have built a solid foundation on which to base future home and community care improvements.

We are patient centred. Each day we live the principles of Client-Driven Care and the values of our Compass. To make sure we are achieving our vision of Outstanding Care – every person, every day – we check in with patients through Patient Satisfaction Surveys, a robust Patient Engagement Strategy and the support of Patient Advisors throughout our organization.

We are system partners. The business of meeting patients’ needs is complex, led by excellent and skilled staff in collaboration with our health system partners. Initiatives such as Connecting Care to Home, Telehomecare, Health Links, Health Care Connects and partnerships with Primary Care, Community Support Service Organizations among others, have proven to be tremendously valuable in the delivery of home and community care.

We are innovators. Over the past 10 years, there has been a dramatic shift in the patients CCACs support and also in the level of care that can now be provided in the home. High needs patients (Complex/Chronic/hospital) now account for 94% of purchased services spending as of December 2016. Our team has developed innovative solutions (from business processes, to technology to care delivery models) that have enabled the CCAC to achieve balanced budgets without the use of waitlists for in-home patients.

On behalf of the South West CCAC Board of Directors and employees, we are proud to share our Annual Report for 2016/17.
Celebrating 10 Years of Innovative Client Driven Care

In 2007, seven organizations came together to become the South West CCAC. On January 1, 2017 our organization celebrated 10 years of outstanding care, every person, every day.

At the heart of the South West CCAC is Client Driven Care (CDC). We believe in partnering with patients, partners and each other to optimize health and cocreate solutions.

Watch: 10th Anniversary Faces of Care Video

Our South West CCAC Journey

OUR COMMITMENT TO PATIENTS and the public is apparent in our daily accomplishments and in our significant contributions to the health care system. As we celebrate 10 years together, we have much to be proud of!

- Client Driven Care
- Heroes in the Home
- LHIN Quality Awards
- OACCAC Sector Innovation Awards
- Accreditation - Exemplary standing
- Patient Satisfaction Rates
- Expanded Hours (8 - 8, 7 days a week)
- Subject Matter Expert Teams
- Balanced Budgets
- Home First and more complex patients
- Primary Care Connections
- Flex Clinics
- FLO Collaborative
- Telehomecare
- Access to Care
- Population Based Approach
- Partnerships for Health
- South West Self Management
- Connecting Care to Home (CC2H)
- Coordinated Access
- Mental Health and Addiction Nurses (MHAN)
- Advanced Home Care Team (Nurse Practitioners, Rapid Response Nurses)
- Patient Engagement and Patient Advisors
- Palliative Outreach Teams
- Information and Referral
- Mobile Workforce
- Facility Moves and Improvements
- CHRS
- eHomecare: eShift, eClinic
- eNotification, eReferral, eScreener
- Ontario Telemedicine Network (OTN)
- South West Intake Tool (SWIT)
- Electronic Data Sharing with Partners
- Connecting South West Ontario (cSWO)
- ETMS 2.0 development and deployment
- Halogen Software Implementation (performance evaluation process)
- Parklane Software Implementation (disability and accommodation tracking)
- VOIP Telephones
- Dashboards
- Outcome Based Resource Allocation Tool (OBRA)
- Workload Tool for Direct Nursing Programs
- Population Based Reporting
- Report Depot
- Data Repository
- Business Intelligence
- E-forms
- Electronic Signatures
- Quality Improvement Leadership Teams (QILTs)
- Quality Plan, Performance Management Framework, Quality Improvement Plans
- Research Projects with York University, Western University, Wilfrid Laurier University, Queens University
- Canadian Institutes of Health Research grant
We are Patient Centred

Client Driven Care
Through our culture of Client-Driven Care (CDC) and a commitment to continuous quality improvement, we seek to achieve our mission: “To deliver a seamless experience through the health system for people in our diverse communities, providing equitable access, individualized care coordination and quality health care.”

CDC is an evidenced based philosophy of care that puts the patient at the centre of care, and working in partnership with the patient, their family and all partners in care through the equitable sharing of knowledge, status and authority. The South West CCAC and its patients have benefited from 20 years of research led by Dr. Carol McWilliam from Western University that has proven this approach to care improves patient outcomes and uses fewer health system resources.

Client Driven Care Awards
Each year, the South West CCAC staff have an opportunity to recognize peers and colleagues for their dedication to living our principles of Client-Driven Care with the Client-Driven Care Awards of Distinction. In 2016/17, we received 43 nominations.

Client-Driven Care (CDC) is the cornerstone of community practice at the South West CCAC. CDC is about building on strengths, partnerships, teamwork, mutual respect and shared goals in everyday practice. Here are some excerpts from the recipients in each of the five categories:

Patient Care Category - Beth Beddington works positively with partners in coordinating care with patients. She communicates effectively, always with the patient at the centre, in a respectful, trustful manner. She supports patients by listening to understand, and then working collaboratively for their goals.

What Client-Centred Care means to Lisa’s family

“Put your paper and pen down and talk to me and get to know me and get to know my situation and my child and my family and what’s important to us and then take your notes. And somebody who is, again, acknowledging like, you know, you're the expert on Chase. I might know how to help you with system stuff and care coordination but let’s work together. Let me hear what you need.”

What is a Patient Advisor?
A Patient Advisor is a patient or caregiver who has had recent experience (generally within 2 years) as a patient or caregiver with the South West CCAC and is partnering with the South West CCAC to help create, implement, and evaluate policies, programs and practices which affect patient care and services.

Patient Engagement Strategy
In 2016/17, we continued to advance our patient engagement strategy through the recruitment of Patient Care Advisors and the continued use of patient experience interviews.

Patient Care Advisors have provided invaluable insight and guidance as we work to continuously improve health equity in the South West with Indigenous, homeless, LGBTQ and other vulnerable populations. We interviewed 12 patients who accessed care through the Connecting Care to Home (CC2), Telehomecare and Home First care models to ensure that these care models are helping them to achieve their goals and to identify quality improvement opportunities.

Individual Category - Chris Kostakos is well known for providing excellent, professional customer service in his role as an IT Technician. He recently stepped out of his IT role to help translate for a patient, helping him make the decision to move to long-term care, in doing so, he reduced the patient’s apprehension.

Leadership Category – Sherri McRobert’s seamless approach and ability to be innovative in providing a new approach to access for care has changed the lives of patients and allowed her team to be great at what they do; best-delivering patient centered, holistic, client driven care.

Citizenship Category - As a volunteer with Girl Guides of Canada, Kathy Stark is playing a key role as a cheerleader and mentor for girls as they develop skills and confidence that will last a lifetime. Kathy estimates that she has had an impact on about 400 children over the years.

Team Category - Each individual on the Telehomecare team brings strengths that are leveraged by the team as a whole, contributing to their continued success: whether it be ensuring patients receive equipment and supporting them in using equipment; providing coaching, education and support to patients; preparing reports and tracking data or making connections with our internal and external partners to promote the program and increase adoption.
Telehomecare

Telehomecare supports people with Chronic Obstructive Pulmonary Disease (COPD) or Chronic Heart Failure (CHF) through health coaching and remote monitoring in the comfort of their own homes. With easy-to-use equipment, patients measure their own vital signs and answer simple questions about how they’re feeling. Specially-trained Telehomecare Nurses monitor results and contact the patients and alert the primary care provider if needed. Once a week, the patient and their Telehomecare Nurse talk on the telephone about their health. During these coaching sessions, patients learn to recognize early symptoms that they can manage with the information and support provided by their Telehomecare Nurse.

Telehomecare patients say they feel safe and secure and enjoy life more. They go to the Hospital Emergency Department about 50% less often. There is no cost for patients for this program. The South West CCAC Telehomecare program has been one of the most successful Telehomecare implementations in the province.

Upon admission to hospital, patients with moderate intensity COPD or CHF needs are enrolled in the CC2H care pathway and are discharged from hospital with enhanced home care supports in place. The CCAC provides these patients with a robust care plan, using the eHomecare model of care to connect a multi-disciplinary team inclusive of a Directing Registered Nurse (DRN) and an in-home Health Care Technician.

As a result of CC2H patients experience:
- better health outcomes and quality of life
- greater confidence in managing their COPD/CHF symptoms
- shorter and less frequent hospital admissions

We are System Partners

Telehomecare Interview: Lance & Dr. Gill

Lance & Dr. Gill

WHEN LANCE WAS diagnosed with Chronic Heart Failure (CHF), his world was turned upside down. Afraid that any moment could be his last, he took a leave of absence from his job, quit sports and stopped making travel plans. Lance’s family, friends and fellow employees worried about him.

Dr. Paul Gill, Lance’s family doctor provided Lance with information about his condition but like many patients, Lance made appointments (or went to the Hospital Emergency Department) when his symptoms were already at a crisis point. There were not many resources in his community to help him learn how to manage his symptoms. When Dr. Gill learned about Telehomecare he thought of Lance right away.

Lance’s Telehomecare Nurse, Jessica worked with Lance during weekly coaching sessions (and as-needed discussions) to help him understand the connection between his CHF symptoms, habits and health. Lance has learned how to manage his CHF, he is able to recognize symptoms like swollen ankles or dizzy spells and Lance is confident in his ability to make the right decisions for his health.

Today, Lance is more like himself, he is back to work, playing sports again and has planned a vacation with his wife next year to celebrate their anniversary!

Dr. Gill’s experience with Telehomecare has also been positive. He appreciated having a health system partner that could spend the time to help monitor Lance’s daily vital signs and provide him with the education he needed. Since Jessica updated Dr. Gill on a regular basis, he was able to provide more preventative care for Lance.

Today, Lance is more like himself, he is back to work, playing sports again and has planned a vacation with his wife next year to celebrate their anniversary!

Watch: Introducing CC2H

Partnerships with Primary Care

The Partnering for Quality initiative has supported hundreds of physicians with hundreds of coaching sessions on quality improvement, chronic disease and ehealth and more than 50 learning sessions.

Care Connectors continued matching orphan patients with family physicians, an excellent example of our expanded role as system navigator. As of January, 2017, 47,003 orphan patients have been matched, which is the third highest number of orphan patients matched in the province.

South West CCAC Care Coordinators have made on-site connections with all primary care offices across the South West.
For the 5th consecutive year, the South West CCAC was recognized at the South West LHIN Quality Symposium with an award for a large scale quality improvement project.

Using the Assisted Living Services for High Risk Seniors Policy and the CCAC Act and Regulations as guidelines, co-leads from a variety of specialty areas were seconded, at first to understand the current state of assisted living and adult day programs and then, to develop an implementation plan to realign services to meet client needs.

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Research
The South West CCAC is currently involved in six research studies with York University, Wilfred Laurier University, Queen’s University and Western University.

Our “flagship” research commitment is to eShift. We continue to share our experiences to support spread of the eShift model. We are regularly involved in international meetings to support start up, including in the UK, France, Michigan and Vancouver, as well as other parts of Ontario. The final report of our 3 year Evaluation Research partnership with Western demonstrated the model’s significantly positive impact on patients, caregivers, the health care team and the system.

The eShift model of nursing care was introduced to meet the needs of home care clients who wish to die at home with their families. Using specially designed software, the Directing Registered Nurse (DRN) and Healthcare Technician communicate in real-time regarding patient care; the Technician uses a smartphone (e.g., iPhone) modified with the eShift application (software) and the DRN accesses the eShift software on a desktop and / or laptop computer. The DRNs view of the eShift dashboard allows them access to multiple patient files. Documentation and communication about patient observations and care activities occur in the eShift portal linking the DRN and Technician.

Both the quantitative data and the qualitative data demonstrate that eShift has a positive impact on the health care system, health care professionals, caregivers and most importantly patients.

- 1 RN can support an average 6 patients (eShift)
- eShift has reduced the proportion of patients readmitted to hospital in the last 30 days of life from 50% to 1.9% (3 fiscal years)
- eShift has improved quality of end-of-life patients: 32.6% more patients died at home
- eShift reduced caregiver burden: 92.3% of caregivers indicated they did not experience caregiver burnout

Falls Prevention Program
The Grey Bruce initiative of education, awareness and comprehensive assessments continue (meeting or exceeding targets), and we also support the South West Falls Collaborative to implement across the region.

South West Self-Management Strategy
As lead for the development of a South West self-management strategy, the team works to support people living with chronic conditions, their caregivers and health care providers with self-management. The team supported Stanford training for people living with chronic conditions, diabetes and pain, as well as peer and master training.
Total Referrals

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- **6.1%**
- **32.6%**
- **1.2%**
- **2.5%**
- **1.0%**

Patients Served

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- **2.2%**
- **2.6%**
- **7.4%**
- **5.6%**
- **0.4%**
- **3.8%**

Home and School Visits to Patients

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- **9.5%**
- **10.9%**
- **10.3%**
- **11%**
- **6%**
- **2.5%**

Spending on Patient Care

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- **4.8%**
- **8.2%**
- **9.7%**
- **6.1%**
- **0.9%**

CCAC by the numbers

Statistics and financial data for the 2016/17 fiscal year estimated at March 1, 2017

DRAFT

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