Premier Visits Home First Couple

On May 24 Ontario Premier Kathleen Wynne visited Peggy and Norman Patterson at their London home to hear at first-hand about their experience with the Home First approach. This may be the first time a Premier has visited a CCAC or made a home visit.

Peggy had a stroke two years ago and is legally blind. Norman has Parkinson’s disease. Last year he went to hospital for knee replacement surgery and had a bad drug reaction. Thanks to the work of the CCAC and its hospital and community partners, Norman was able to return home with 24-hour care for several weeks. He’s now able to take walks in the neighbourhood, and attends an Adult Day Program two days a week.

Clearly moved by their story, the Premier said it highlighted the importance of her government’s ongoing investments in home and community care. “In addition to the quality of life that is so much enhanced for people like

For more on Home First, see page 3. To see a video of the visit go to youtu.be/nDdbght6CkM.

Celebrating Partnership and Vision

The CCAC and its partners gathered on May 6 to hear from Dr. Samir Sinha and explore new and better ways to partner

The CCAC’s annual learning symposium brought together CCAC employees, care provider staff and representatives from community support service agencies to explore new and better ways to work together to improve care. The event also included an interview with Dr. Samir Sinha, the geriatrician who has shaped Ontario’s new Seniors Strategy.

CEO Sandra Coleman started the day by welcoming participants at sites in London, Seaforth and Owen Sound. Coleman pointed out that the privilege of extra funding for community care comes with a responsibility to “do more, better and differently.” She added: “We will discover that the more effectively we can work together, the more time we will have for the people we serve together, and the better we will be able to provide that service.” Deb Matthews, Minister of Health and Long-Term Care, sent video greetings to the event. Michael Barrett, CEO of the South West Local Health Integration Network, touched on the theme of the day, saying, “No single organization can achieve meaningful change in the health care system alone. The importance of partnership cannot be overstated.”

Here are some excerpts from Coleman’s conversation with Dr. Sinha.

“Right now 14.6% of our population are older Ontarians, and they account for more than half of our health and social service spending. The number of older Ontarians continued on page 3
A Message from
CEO Sandra Coleman

Return on Partnership

This is a time of great challenge and great opportunity in home and community care. Our patient populations are growing and we are all caring for sicker people with more complex care needs. At the same time, there is growing recognition that a move from institutional to home and community care is what Ontarians want and what the system needs to be sustainable.

In the community sector, there are many different partners, each providing a piece of the care puzzle. It is only when all the pieces come together that patients experience safe, high quality and compassionate care. The South West CCAC has a unique role to play in putting the pieces together, but we simply can’t do it alone. We count on our partners – the LHIN, hospitals, long-term care homes, contracted care providers, community support service agencies and others – to work shoulder to shoulder with us.

Earlier this year, we at the CCAC held a day-long workshop for all staff at which we renewed our commitment to the principles of Client-Driven Care (CDC). CDC reminds us to work with our partners as we work with our patients – by building strong relationships, developing shared understanding, and co-creating solutions.

In May we brought our partners together for our annual learning symposium (see page one). Then in June we celebrated the fruits of partnership. The CCAC and its partners received two South West LHIN Quality Awards, recognizing the extraordinary success of the Home First approach and a project to streamline processes in the emergency department at St. Thomas Elgin General Hospital.

As funding in our sector increases, we know that we will be expected to do more, differently and better. The South West CCAC and its partners have proven that we can do that. During the past year, we received 4.8% more funding than the year before, but increased spending on patient care by 8.5% and increased home visits by 10.7%. Our admin costs were just 3.6%. That kind of Return on Investment is exactly what our health system needs. And we know that partnership is the only way to achieve it. In the year ahead, we look forward to deepening our relationships with our partners and innovating better care together.

WHAT’S THE BUZZ

Coleman leads OACCAC

On June 19 Sandra Coleman was unanimously elected Chair of the Board of the Ontario Association of Community Care Access Centres (OACCAC) for a one-year term. The OACCAC is a not-for-profit organization established to represent the common interests of Ontario’s 14 CCACs. “I welcome this opportunity to continue contributing to the OACCAC and the CCAC sector at this very important time,” says Coleman. “This is an exciting time for home care in Ontario. I look forward to working with a stellar group of Directors and staff to champion home care, the patient experience, Client-Driven Care and the tremendous value for money we bring to the system.” One of Coleman’s first official duties was to introduce Minister Deb Matthews at the OACCAC conference in June. Matthews commented that Coleman had been “instrumental and inspirational when it comes to my understanding of the home and community sector.”

Physiotherapy Expansion

The Ministry of Health and Long-Term Care is moving ahead with plans to expand the delivery of physiotherapy services in Ontario. Under the plan, CCACs will receive $33 million in new base funding to expand the provision of in-home physiotherapy services to 60,000 new seniors and other patients. Starting August 1, CCAC will be the single point of access for all publicly funded in-home physiotherapy services. In addition:

- Long-term care homes will receive $58.5 million to provide one-on-one physiotherapy, and $10 million to provide exercise and activation classes.
- $10 million will be made available to provide exercise and falls prevention classes through Elderly Persons Centres and other community organizations.
- $44.5 million will be used to expand access to community-based physiotherapy clinics.
- Physiotherapists will now be included in the interdisciplinary care teams in Family Health Teams, Community Health Centres, and Nurse Practitioner-led clinics.

Beamish Taylor Leads Performance Management and Accountability

Lois Beamish Taylor has joined the senior leadership team at the South West CCAC in the role recently vacated by Gord Milak. Beamish Taylor is a highly experienced health care executive, most recently Senior Director - Quality, Risk and Integration at Closing the Gap Healthcare Group. Her experience also includes stints with the Elgin CCAC, VON, and London Health Sciences Centre. Watch our next issue for a feature interview with Beamish Taylor.
Home First Approach Proves Effective and Efficient

“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.” — Home First client

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 go home on discharge. During 2012 as many as 800 people a month were supported at home rather than in hospital, thanks to the Home First approach. These were people who would otherwise have waited in hospital until a space became available in a long-term care home.

For patients and their families, Home First makes a big difference in quality of life. They can make choices and decide their next steps in comfort and privacy. They can regain strength, surrounded by family and familiar objects. RAI (evidence-based assessment) scores of Home First patients went down from an average of 16.1 in hospital to 14.9 in their first community re-assessment, indicating a significant functional improvement. In many cases, patients recovered enough to stay at home on regular CCAC services. For some, it meant having the choice to die at home.

The impact on the health system was also positive. The number of people waiting in hospital for long-term care decreased from 135 in January 2012 to 73 in May 2013. The acuity level of people moving into long-term care increased, as did the acuity level of people being supported in the community.

A recent analysis by the CCAC revealed that the Home First approach is also cost-effective. Among the most complex 371 Home First patients, we found that the average per diem cost for patients was $412 in the first 22 days, and $50 thereafter. This compares to hospital per diems of $450 to $900, and long-term care per diems of $108. The average annual cost per patient was approximately $35,000 on Home First. The average annual cost per patients if they had stayed in hospital until they could be placed in long-term care would have been approximately $84,000. The net economic savings to the system was approximately $11 million.

Of the remaining Home First clients:
- 1,980 of the 2,200 were still at home after a month.
- More than 1,100 were still at home at the end of two months.
- The average cost per person was less than $55 per diem.

Peggy Patterson, whose husband Norman returned home from hospital on an intensive care plan, is an enthusiastic supporter of the Home First approach. “It took a village to get Norman home,” she says. “It’s a partnership and it works very well. It just shows what a village can do!”

CCAC CEO Sandra Coleman agrees. “The success of Home First illustrates the power of partnership. When we all work together across the care spectrum, our patients are the winners.”

Home First was one of two initiatives involving the South West CCAC that received Quality Awards at the annual South West LHIN Quality Symposium.

Celebrating Partnership continued from page 1

will double from 1.9 million to 3.8 million over the next 20 years. If we don’t get it right for them, then our system won’t be sustainable for all of us in the future.”

“Collaboration is the absolute key. Being innovative and taking risks is important too. We’re all going to make mistakes, we’re all going to step on toes, but if we work in the spirit of partnership, there is the opportunity to grow together.”

“In my practice I have a community care coordinator that I can connect with electronically. When you have a ‘buddy’ you can be more creative about care. We have to form these relationships and connections because it’s what our patients expect of us.”

Dr. Sinha and CEO Sandra Coleman

“To summarize Health Links in a word, it’s collaboration. It’s about understanding that it takes a village to care for a frail older Ontarian. It’s about communities coming together to wrap support around people with a lot of health issues. At the end of the day, we are stronger when we work together.”

Watch for the South West CCAC 2012-2013 Annual Report to the Community, available online in July.
South West CCAC Leads Major eHealth Project

“It’s in the best interests of patients for providers to communicate effectively with each other. Patients assume that we share information with one another, but in reality sharing across transition points or multiple providers is a big challenge. We at the South West CCAC want to work with partners across the system to solve that challenge.”

That’s Nancy Dool-Kontio, Senior Director, Strategic Planning and Integration, talking about the CCAC’s role as the Connect Southwestern Ontario (cSWO) delivery partner for the South West LHIN.

cSWO is one of three groups (the other two are cNEO and cGTA) that comprise a province-wide eHealth initiative to leverage existing technologies to connect health care providers. cSWO will work to implement two main technologies. Clinical Connect enables health care providers across the spectrum to view patients’ electronic health records. HRM, when fully developed, will enable hospitals to share clinical information with a variety of physician Electronic Medical Records. In addition cSWO will work with technologies such as eNotification, eShift and SouthWestHealthline.ca, and support the IT needs of burgeoning Health Links. The South West team will meet regularly with delivery partners from the other three LHINs that are part of cSWO, to share information, ideas and best practices.

The goal of cSWO, says Dool-Kontio, is to improve the use of technology and ultimately, the quality of patient care. “This is about using proven technologies that are already in use,” she says. “It’s about working with providers to understand how they want to use the technologies in their daily practice.”

Craig Hennessy, eHealth Lead for the CCAC and lead for cSWO South West delivery partner, agrees, adding, “With the Baby Boomers moving through the system and finite resources to care for them, it’s clear that we have to build on our existing eHealth assets to meet the needs of consumers, clinicians and health care organizations, and improve communication and coordination across the care spectrum.”

Introducing the Intensive Home Care Team

Jack, 87, had been in the hospital for three weeks. His family wanted him home, but were worried about how they would manage his care, especially in the early days. To their relief, Jasmine, a CCAC nurse, visited Jack on his first day home. She helped the family members understand his condition and taught them how to care for him. She went through his meds, noticing a discrepancy that she was able to clear up with a call to his pharmacist. She also reminded them that Jack would need to see his family doctor the following week, and his specialist in a month’s time. By the time she left, everyone was feeling more relaxed and confident. Although Jack encountered some challenges during his recovery, he didn’t need to go back to the hospital.

“Jasmine” is a CCAC Rapid Response Nurse (RRN), part of the South West CCAC’s new Intensive Home Care Team. The team includes more than 40 Registered Nurses and Nurse Practitioners. RRNs provide in-home care to high-risk patients within 24 hours of hospital discharge.

Other team members are:
• Community Nurse Practitioners, who care for patients with more than one serious chronic condition, doing assessments, ordering tests and treatments, and connecting with family docs and specialists
• Hospice Palliative Care Nurse Practitioners, who have specialized expertise in caring for patients in the final days of life
• Geriatric Resource Nurses, who have specialized expertise in promoting the holistic health of the elderly
• Mental Health and Addictions Nurses, who work with school boards and others to support children and youth with mental health and addictions issues

To make a referral to the Intensive Home Care Team, speak to a care coordinator or call 1 800-811-5146.