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Community Care Access Centre
Centre d'accès aux soins communautaires du Sud-Ouest

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HEALTH LINKS BULLETIN

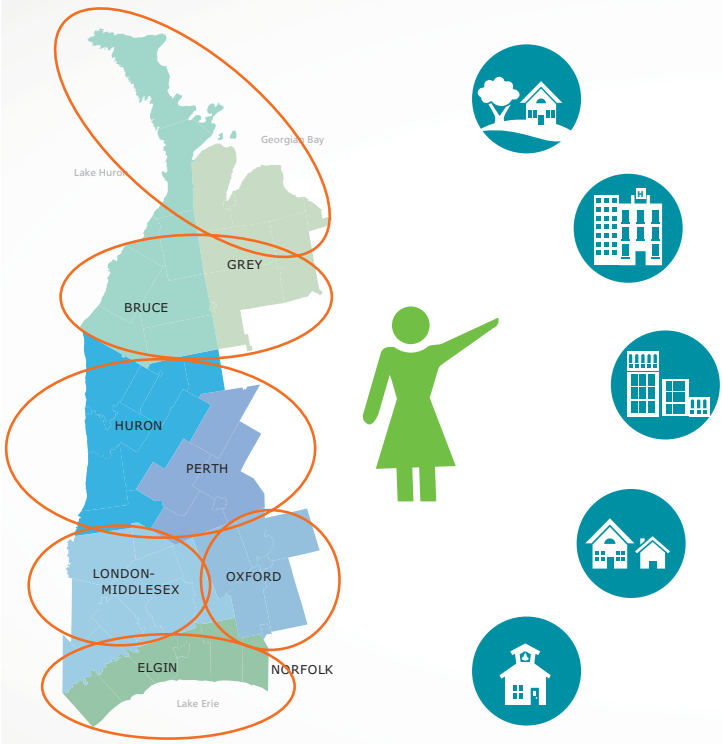
Working Together to Provide Complex Patients with Better Care

Addressing the needs of the health-care system's highest users

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 typically include one or more of the following:

- Chronic diseases like congestive heart failure, Chronic Obstructive Pulmonary Disorder or diabetes
- Advanced age
- Bone breaks, including hips
- 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. The care they receive is often provided by a number of different professionals, which may lead to gaps in care. Health-care providers agree the current approach is expensive and unsustainable.



Health Links Collaboratives in the South West

How the CCAC can help

The South West CCAC is excited to be working with many system partners as Health Links form in each community to provide better care for patients through more sharing, innovating and collaborating. The CCAC gets people the home and community care they need to stay well, heal at home and stay safely in their homes longer. When home is no longer an option, we help people make the transition to other living accommodations.

Our Care Coordinators provide unique support to patients of all ages and stages in all parts of the health-care system. As regulated health professionals, Care Coordinators work directly with patients in hospitals, doctors' offices, communities, schools and in patients' homes. They are familiar with, and connected to, every community in the South West and every part of the health-care system.

CCAC Connections to Primary Care

The South West CCAC has made a concerted effort to connect Care Coordinators to each primary care practitioner in the region. These on-site Care Coordinators act as a single point of contact to the CCAC for home and community services for patients. The Care Coordinators help explain referral processes, serve as a resource to discuss common patients and help determine how best to provide help and support. They are also experts at developing collaborative patient care plans involving not just the CCAC's contracted providers, but also any other community or health system supports.

"Care Coordinators bring critical experience to the table," said Dr. Cathy Faulds, a physician with the London Family Health Team who works with a CCAC Care Coordinator. "When devising care plans for patients, Care Coordinators are thinking about occupational therapy and physical therapy; about wound care; about transportation needs and meals. They think about these things and then have the connections to make them happen."

"He fell (Tom) and suffered a hip fracture that required surgery," said Dr. Faulds. "But thanks to the planning work done between our team and the CCAC Care Coordinator, he was able to be discharged home from hospital."

One of Dr. Faulds' patients, Tom, is 85 years old. He has transitional cell carcinoma of the bladder, congenital heart failure, ischemic heart disease, A Fibrillation, and is also at significant risk of falls. He is no longer driving and walks using a cane. And yet, Tom is still able to live in his own home with his wife of 48 years.

"He fell and suffered a hip fracture that required surgery," said Dr. Faulds. "But thanks to the planning work done between our team and the CCAC Care Coordinator, he was able to be discharged home from hospital."

Being regularly onsite at the Family Health Team enabled the CCAC Care Coordinator to immediately meet with the patient and develop a care plan that involved regular visits from a personal support worker, combined with house calls from a physician on Faulds' team.

"This man had three ER visits for 'spells' prior to his fall and ultimate fracture," said Faulds. "It was the coordination between our team and the Care Coordinator that enabled him to be discharged home with his spouse, rather than to long-term care."

Care Coordinators and Health Links

Dr. Cathy Faulds

The benefits Care Coordinators bring to primary care are equally applicable to Health Links, and as such, the CCAC has aligned one of our Care Coordinators with each of the Health Links in the region. It is a move Dr. Cathy Faulds, who also sits at the table of the London Health Links, supports.

"It has been hugely educational for us as family physicians to better understand the resources that exist," she said. "Community supports, specialized program details – the Care Coordinators are the keeper of that knowledge and provide us with up-to-date details on available resources, and on patients' progress. Their knowledge is well suited to the Health Links initiative."

Health Links are required to complete a care plan for every patient, and provide access to a primary care provider. Care Coordinators' existing on-site relationships with more than 425 community primary care practices, links with all other primary care practices, and experience with collaborative patient care planning and system navigation to link in all health supports in each community, will prove to be a valuable asset in this work.

To arrange for a CCAC Care Coordinator to be connected to your practice, or to learn more about their involvement in Health Links, please contact Jennifer Fazakerley at 519-539-0901, ext. 5073 or jennifer.fazakerley@sw.ccac-ont.ca

South West CCAC service offering to Health links

The South West CCAC can be an important partner in the Health Links initiative. Given its role as the single point of access to home and community care, its onsite connections to more than 425 primary care practices, and its specialized technology for innovative information sharing, the South West CCAC is uniquely positioned to work with each of the Health Links in the South West to help address the needs of the health system's highest users.

We also have relationships with multiple service provider organizations in the region and can quickly get patients a range of health-care services including physical and occupational therapy, nursing, wound care and respiratory therapy, as well as numerous community supports including transportation, meal services and adult day programs.

CCAC Intensive Home Care Team

This team 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. The team is a valuable partner to primary care providers in providing care to complex patients via specialized roles, including Rapid Response Nurses, Geriatric Resource Nurses, Community-based Nurse Practitioners and Hospice Palliative Care Nurse Practitioners.

Rapid Response Nurses:
- provide high-risk patients with in-home care within 24 hours of hospital discharge
- conduct comprehensive head-to-toe patient assessments
- work with primary care doctors to treat patient ailments in-home
- conduct medication reviews
- provide patient and family education
- ensure appropriate follow-up appointments are scheduled

Geriatric Resource Nurses:
- care for frail, elderly patients with complex conditions
- are experts in promoting the holistic health of the elderly
- provide geriatric assessments through the use of comprehensive assessment tools
- work with primary care physicians and other health-care professionals

Community-based Nurse Practitioners:
- care for complex patients with more than one serious chronic condition
- conduct patient assessments
- provide clinical oversight within their scope of practice to complex patients with limited access to primary care
- work with hospitals, primary care practitioners family doctors and specialists to provide patient care in the community

Hospice Palliative Care Nurse Practitioners
- offer specialized palliative care and end-of-life care services in the community
- provide early diagnosis of hospice palliative care needs
- help improve pain and symptom management through medication and other interventions
- help patients with access and referrals to specialist services

Home First

Home First is an approach to care based on the idea that when a patient enters the hospital, every effort is made to help him or her return home on discharge. The Home First approach to care has been enabling patients to return home from hospital since it was first implemented in September 2011. Since that time, Home First has saved the health-care system more than $10 million as it continued to spread across the South West, with overwhelming results.

- 800 people with complex needs are able to stay in their own homes each month thanks to Home First supports
- the number of people waiting in hospital for long-term care placement (ALC-LTC) has been cut in half
- 31 per cent less patients are waiting in hospital for care elsewhere

Hospital physicians, the CCAC and community partners continue working together to spread Home First to all hospitals in the South West by March 31, 2014.

On-site Care Coordinators

The South West CCAC has made a concerted effort to connect Care Coordinators to every primary care practitioner in the region, and currently has relationships with more than 425 community primary care practices.

On-site Care Coordinators:
- act as a single point of contact to the CCAC for patients in need of home and community care and services
- help explain referral processes
- discuss common patients with primary care practitioners
- collaboratively develop patient care plans

Falls Prevention and Intervention program

The Grey Bruce Falls Prevention and Intervention program is a collaborative program to reduce falls by focusing on preventative care and intervention. The South West CCAC identifies seniors at risk of falls and those who would benefit from intervention. We assess and connect these seniors with community-based programs that increase and maintain functional abilities, including self-management programs, exercise programs and for those at greatest need, in-home therapies. Under this program:

- falls risk screening was instituted for anyone admitted to an Emergency Department over the age of 75
- 6,870 people were screened in six EDs in six months
- 365 individuals were referred on to the CCAC
- Multidisciplinary assessments for seniors by PTs, OTs and RNs were also instituted
- Forty-seven per cent of seniors assessed in 2012-13 reported fewer falls in the last 90 days, and 22 per cent reported fewer ED visits

We are now working with our partners to spread this approach across the South West.

eHealth enablers

The South West CCAC thrives on technology and innovation, and utilizes a multitude of electronic resources on a day-to-day basis to enable us to share information quickly and safely, across multiple transition points and multiple health-care providers. Our electronic resources include:

- **eScreener** – hospital-based electronic screening tool that identifies patients with multiple needs at risk of a complex discharge. It generates eReferral to the CCAC for assessment and service planning.
- **eReferral** – enables electronic referral from Hospital to CCAC for assessment and service referral, and from CCAC to community support services, long-term care, and post-acute hospital services
- **eNotification** – enables electronic notification to alert hospitals when a CCAC patient presents in the Emergency Department or is being admitted to hospital
- **eMedication reconciliation** – provides a list of medications to primary care Electronic Medical Records and to the CCAC upon patient discharge from hospital
- **Client Health and Related Information System (CHRIS)** – the CCAC's Electronic Medical Record platform for the secure exchange of electronic information with its partners

South West Self-Management program

Offered by the South West CCAC in partnership with the South West LHIN, the program focuses on support and empowerment for patients living with chronic diseases like diabetes, COPD and Alzheimer's. It offers free workshops to:

- train patients and caregivers with the skills, tools and confidence to better manage their conditions
- train health service providers on how best to integrate self-management principles into their clinical programs

The goal of the program is to have a coordinated approach to support patients, caregivers and health-care providers with self-management.

For more information, contact Sally Boyle, Program Lead at sally.boyle@sw.ccac-ont.ca

Partnering for Quality

The Partnering for Quality program works with primary care practices in the South West, using a quality improvement approach, to help them better utilize their electronic medical record systems, connect patients to community care and supports, and ultimately to improve patient care and health outcomes for people living with chronic conditions. The team works with primary care practitioners in a variety of settings, including:

- Family Health Teams
- Family Health Groups
- Family Health Organizations
- Community Health Centres
- Nurse Practitioner-led clinics
- Solo practice physicians

For more information, contact Rachel LaBonté, Program Lead at 519-641-5401 or rachel.labonte@sw.ccac-ont.ca

CCAC by the Numbers

> Each year, the South West CCAC cares for more than **60,000 patients** – or one in 17 people living in the South West.
> The South West CCAC provides more than **2.5 million in-home visits** each year.
> **94%** of CCAC clients are satisfied or **very satisfied** with their care.
> The South West CCAC received the **highest possible rating** from **Accreditation** Canada in October 2012.
> The South West CCAC **spends less than 3.6% of its budget** on administration.

How to contact us

Call 1-800-811-5146.

Visit our website at www.healthcareathome.ca/southwest.

Drop into one of our offices across the South West.

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SouthWesthealthline.ca