

Central West
Community Care Access Centre **CCAC**

CASC Centre d'accès aux soins communautaires
du Centre-Ouest



COMMUNITY CARE *Currents*



*A note
from the
Executive
Director*

An important part of the ALC solution

Partnerships are invaluable. They strengthen communication, capitalize on efficiencies and leverage the experiences of others. Most importantly, they improve patients' lives and serve as a pillar of health service integration and transformation.

Since its creation following a major realignment of Community Care Access Centres (CCACs) in January 2007, Central West CCAC has been reaching out to local health system partners to create and act on real collaborative opportunities that will help patients access the health and support services they need in the community. Through formal relationships with hospitals, long-term care homes and service providers to informal efforts with local community agencies, Central West CCAC is playing a significant role in an integrated health system.

We are a firm believer in applying a 'systems-thinking' approach to how we work with others, how we plan services and how we make decisions. In this issue of *Community Care Currents*, we share stories of some of the excellent work underway with our partners to help address alternate level of care (ALC) days in our local health system.

Willing partnerships, open collaboration and a commitment to integration are vitally important tools that organizations, including our own, can use to help solve such system-level issues as ALCs. For it is only the sum of a health system's parts that truly makes integrated and collaborative health care delivery possible.

Marina Ellinson
Executive Director
Central West CCAC

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NORMAL VIEW

PRINT

A collaborative response to ALCs

“Most patients waiting in an ALC bed are not getting the type of care they really need.”

It's a common story – the patient who spends hours or even days in the emergency department waiting to be admitted. But it's often patients who are ready to leave the hospital who face the real wait. Those requiring an alternate level of care (ALC) may spend weeks or months in a hospital bed waiting to be transferred to the appropriate destination.

“Most patients waiting in an ALC bed are not getting the type of care they really need,” says Marina Ellinson, Executive Director, [Central West CCAC](#). “In an ideal world we would eliminate ALCs altogether. So we need to ask ourselves ‘why’ this is happening and work with our partners to ensure patients get the right care, at the right place, at the right time.”

Reducing the number of patient days spent in ALC beds is a major priority for health system partners, government and Local Health Integration Networks (LHINs). Patients who should be receiving care elsewhere such as a long-term care home, rehabilitation centre or even at home are instead cared for in acute care or other settings, occupying beds better suited for those who need them the most.

There are myriad reasons as to why ALCs exist in the system, from the availability of resources in the community such as long-term care beds, to problems accessing home supports, to communication challenges between providers. No matter what the causes may be, Marina believes that CCACs are ideally positioned to play a leadership role.

“We're the integrator between acute care, long-term care and home,” she says. “We too have been looking at how we do things – from intake and assessment to long-term care placement facilitation to how we work with our partners – so that barriers to patient flow are removed or minimized.”

Currently, the CCAC and [William Osler Health Centre \(WOHC\)](#) – this CCAC's largest hospital partner – are working closely to test and implement strategies to improve patient flow and reduce ALC days through the province-wide “Flo Collaborative” and a new Inpatient Flow and Access Committee (see stories inside).

The CCAC has also initiated regular meetings to build stronger linkages with Central West long-term care homes, along with hospitals, community partners and representatives from the [Central West LHIN](#) and [Ministry of Health and Long-Term Care](#). The meetings provide a forum to identify opportunities to improve the quality of care patients receive, to ensure the system is working efficiently and to provide an opportunity for open dialogue, information-sharing and collective problem-solving.

“From a system perspective, a patient waiting in an ALC bed should be a huge red flag that something has slowed, stopped or ground to a halt,” says Marina. “It's a road block in a system that is meant to flow. That's why all of us have to be at the table working together to find the right solutions.”



Making the move: a partnership in action

“A successful strategy was having the CCAC placement case manager talk directly with the lead person at each home when a bed became available.”

When William Osler Health Centre (WOHC) turned to Central West CCAC for help when coordinating last October’s transition to the new Brampton Civic Hospital, the CCAC welcomed the opportunity to not only help the hospital during this critical transition, but also to revitalize the CCAC’s relationship with its largest hospital partner. The result was plenty of planning, creative problem-solving and a renewed partnership.

In order to move as few patients as possible, it was necessary to significantly lower the patient census at Peel Memorial Hospital in the weeks leading up to the move. Reducing the number of alternate level of care (ALC) patients was a particular challenge as most patients in ALC beds wait weeks, even months, for an appropriate bed in a long-term care home or other setting.

The responsibility for reducing the number of ALC patients fell to a joint CCAC-hospital task force. The group quickly engaged community support agencies and long-term care homes in the planning. Carolyn Clubine, Director of the Long-Term Care Division for the [Region of Peel’s Health Department](#) was an important part of these planning discussions.

“The hospital and CCAC were honest that they were expecting the move to be challenging,” she says. “It gave people a real sense of the value of their contribution.”

And contribute they did, according to Dilys Houghton, Senior Director, Client Services for Central West CCAC.

“We asked people to do things they don’t do otherwise,” she says. “For example, long-term care homes typically have five days to review applications. We asked them to review them the same day or within 24 hours. They did that. Some homes with vacant beds increased their staffing and agreed to admit patients faster than normal. Partners demonstrated enormous flexibility throughout the process.”

Finding solutions

Close collaboration was critical to the entire initiative. Each day for three weeks, CCAC and hospital staff held a teleconference to review the status of each patient and look at options. They then worked closely with the long-term care homes to find suitable placements.

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Making the move: a partnership in action (continued)

“We realized early on that there wasn’t going to be one magic solution.”

“A successful strategy was having the CCAC placement case manager talk directly with the lead person at each home when a bed became available,” says Carolyn. “They would discuss the needs of particular patients and prioritize the best candidate for the bed. It was a proactive and case-by-case approach.”

Respect for client choice was a fundamental principle, so the team worked closely with clients and their families. If waiting lists for specific long-term care homes were long, the team offered alternative choices that clients were often happy to accept.

The team also worked closely with long-term care homes to problem-solve particular situations. And when long-term care wasn’t an option, the CCAC turned to its contracted service providers and local community support agencies, such as CANES, who were at the table willing to provide the resources to care for people at home.

“We realized early on that there wasn’t going to be one magic solution,” says Dilys. “We recognized it would be a number of little things that would make a difference. It was about looking at every client closely and problem-solving for that person.”

The results speak for themselves. The hospital successfully reduced its patient census prior to the move – exceeding its original target by 30 per cent.

Applying new learnings

The census reduction effort provided new insights and learnings that Central West CCAC and WOHC are already acting on. Staff members from both organizations continue to hold regular teleconferences to problem-solve placements for ALC patients. The CCAC is also reviewing its long-term care placement processes, an exercise enhanced by its work in the “Flo Collaborative”.

According to Dilys, the strengthened partnership with WOHC is one of the most rewarding outcomes of the process. The CCAC is also committed to further enhancing its working relationship with [Headwaters Health Care](#), the hospital that serves the northern area of the LHIN, as well as all of the 23 long-term care homes in Central West.

“I think the intensity of the effort and the level of cooperation was quite extraordinary,” says Dilys. “Sustaining this positive momentum will be a priority for us and, hopefully, for our partners.”

Reducing ALC days: It's all about flo(w)

“Someone is actively helping patients leave the hospital and get to the most appropriate place for them.”

When it comes to reducing alternate level of care (ALC) days, it's all about flow – moving patients through the health care system to ensure they get the right care, at the right place, at the right time.

This is the idea behind the “Flo Collaborative” – a quality improvement strategy from the [Ontario Health Performance Initiative](#) that involves CCACs, hospitals and other health care providers across the province.

Central West CCAC and William Osler Health Centre (WOHC) are partners in this 18-month initiative. Their joint team is testing ways to improve patient flow from acute care to long-term care and other destinations. A medical floor at WOHC's Etobicoke General Hospital serves as the pilot unit.

Removing barriers to patient flow

The initiative began in late September and is already delivering results. One of the changes involves a new, proactive approach to managing long-term care waiting lists. Three times a week, a hospital discharge planner and CCAC case manager hold a teleconference to review the patients waiting for long-term care placements. The discussion identifies strategies that could help a patient move out of hospital

more quickly – identifying additional long-term care homes that could meet the patient's needs, for example.

Melissa Morey-Hollis, a WOHC occupational therapist and “improvement advisor” for the initiative, says the meetings serve a watchdog function.

“From a patient perspective it means they're not just sitting on waiting lists,” she says. “Someone is actively helping them leave the hospital and get to the most appropriate place for them.”

Until recently, when a long-term care bed became available, the process of offering it to the family was complex. Just how complex became apparent when the team tracked the number of steps involved. Three different hospital and CCAC staff members spoke to the patient and family. The patient chart was accessed six times. And there was a minimum of eight phone calls and 10 “handoffs” between staff members.

Now, thanks to the efforts of the Flo work group, all that has changed. Only one staff member deals with the patient and family using a new streamlined process. As a result, a bed offer can now be completed in one hour instead of 24.

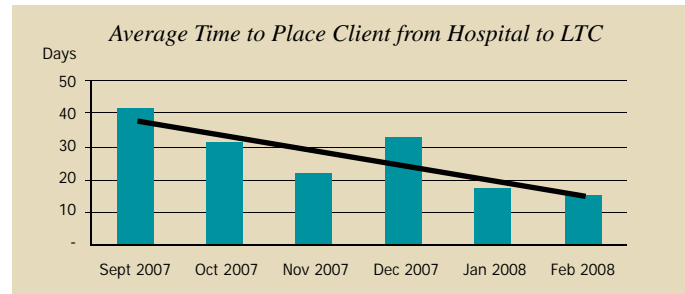
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CCAC hospital case managers join a WOHC discharge planner in a long-term care placement teleconference.

Reducing ALC days: It's all about flo(w) (continued)

“It's to everyone's advantage to work closer together and build those linkages.”



The average time to place WOHC hospital clients into long-term care homes has fallen significantly since the fall 2007 despite a consistently high number of monthly referrals.

Improved discharge planning

Discharge planning plays a critical role in ensuring patients don't spend unnecessary time in hospital. It's one of the areas the Flo team hopes to improve.

“We're trying to achieve more timely discharges,” says Elaine Chemeris, Director of Medicine at WOHC. “The objective is to have an estimated date of discharge from the time a patient is admitted.”

But setting a discharge date is only part of the solution. Meeting it involves the patient, family and entire health care team. The Flo team is experimenting with 20-minute team meetings two to three times a week



Melissa Morey-Hollis (r) of William Osler Health Centre speaks to the joint CCAC-WOHC patient flow committee. Joining in the discussion are committee chair Dr. Asim Masood, WOHC's Deputy Chief of Staff (l), and Dilys Haughton, the CCAC's Senior Director, Client Services.

to review current patients and where they are in the discharge process. By involving CCAC staff in these 'upstream' meetings, all the necessary arrangements can be put in place for a smooth transition.

Openness to new ideas

Dilys notes that participating in the “Flo Collaborative” is leading everyone involved to look carefully at “what it is we do.” And new ideas are welcome.

“In an organization, it sometimes takes a while for things to get through the management process,” she says. “But this Collaborative says, ‘That's a good idea. Let's go for it.’ It really speeds up the change process.”

New ideas and approaches are not limited to the “Flo Collaborative”. The CCAC and WOHC are also partnering on a new Inpatient Flow and Access Committee. Reporting directly to William Osler Supervisor Ken White, the new committee is looking at how to reduce ALCs by improving processes across both organizations. It's just one more sign of a partnership that's working.

“It's to everyone's advantage to work closer together and build those linkages,” says Elaine. “It's not about my silo or your silo. It's about providing the best care for the patient regardless of what organization you work for.”

About Central West CCAC

Board of Directors 2008/09

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Marina Ellinson,
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Dilys Haughton
Senior Director, Client Services

Allan Madden
Senior Director, Corporate
Services and HR/OD

Christine Nuernberger
Senior Director, Strategic
Planning and Integration

Central West Community Care Access Centre (CCAC) is one of 14 CCACs in the province that arranges and coordinates community-based health care services. CCAC's are fully funded by the Ministry of Health and Long-Term Care.

Central West CCAC helps thousands of people each year receive the care and support they need at home, at school or in the community following injury, illness or the complications of age or disability. We arrange for and coordinate the provision of **community-based nursing, rehabilitation and supportive care** to people of all ages – from children to adults to seniors – to help them live as independently as possible. We also facilitate **access to long-term care homes** so that those no longer able to live on their own can stay in their communities longer and receive the support and nursing care they need within a comfortable home-like environment.

Valuable health system partners, CCACs are considered a reliable resource to help people **navigate the healthcare system**, acting as a vital link to the health support and information people need, when they need it.

Quick Facts:

- Central West LHIN population: more than 720,000
- Central West CCAC serves communities from northern Mississauga and northern Etobicoke, to Brampton, Caledon, west Woodbridge, Orangeville, Shelburne and surrounding communities.
- Clients served in 2007/08: approximately 19,000
- Employees (full-time equivalents): 220
- Long-term care homes in Central West area: 23
- Long-term care beds in Central West area: 3,440
- Hospitals in Central West area: William Osler Health Centre (Brampton Civic Hospital, Etobicoke General Hospital) and Headwaters Health Care (two sites: Orangeville and Shelburne)

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the CCAC are fully funded
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and Long-Term Care and are
provided at no charge to those
with a valid Ontario Health
Card. Anyone can refer to the
CCAC: a physician's referral
is not required.

Our Vision

To be recognized across the country as Centres
of Excellence for integrative community services
and health information by 2017.

Our Mission

Our passion is health; our strength is our
people and our partners; and our promise
is compassionate care. On a day-to-day
basis we are:

- an easy-to-use gateway to information
and high quality health services;
- an innovator seeking to optimize people's
health, wellbeing and autonomy;
- an integrator partnering with others to
reduce the barriers to access, respect
diversity and improve the care experience
of people across the health care continuum;
- an employer of choice that believes in
the remarkable capacity of our people to
continuously learn and make a difference;
- an open communicator who promotes
positive relationships; and
- a steward of public resources that is
openly accountable and contributes to
a sustainable health system.

Our Values

Our clients come first

We demonstrate this commitment through active
listening, showing compassion, encouraging
independence, acting as advocates, and facilitating
access to quality care

Respect is critical to all good relationships

It underscores all our interactions with clients,
staff and community partners

Learning environments are empowering

We explore and adopt new ideas to improve
our practice

Diversity is an asset

It creates a richness of experience and
an appreciation of other possibilities

We are accountable

We strive for consistency, fairness, and optimal
outcomes through the wise use of resources
and the measurement of results