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CRNCC NEWSLETTER

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CRNCC Updates

this issue

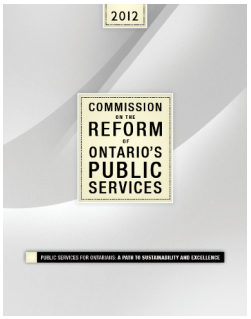
CRNCC Updates

HSPRN / CRNCC Integrated Care Symposium

CRNCC/ OCSA Tweetshop Highlights

Sexuality and Attendant Care

Upcoming Events



Like the acute care sector, the community care sector is expected to measure "quality of care" to enhance accountability, transparency and create better value for money, especially in fiscally challenging times and in light of the recently released ***Drummond Report***. As a vital player in the health system, community agencies must coordinate to create meaningful standardized quality indicators across its sector. How is the community sector doing to date? Are there best practice examples locally, nationally and internationally?

To help answer these questions, the Ontario Community Support Association highlighted ***The Quality Imperative: Getting to Excellent*** in its symposium last October 2011, featuring Dr. Ben Chan, President and Chief Executive Officer, Health Quality Ontario and A. Paul Williams as key speakers. In addition, Janet Lum's presentation drew examples from Australia and the Netherlands while Carolyn Steele Gray (PhD candidate affiliated with the CRNCC) discussed what quality of care looks in Ontario under Community Care Access Centre contracts and Local Health Integration Network Multiservice Agreements. Go to the ***CRNCC Knowledge Bank*** for links to the presentations and reports.

On December 6th 2011, the CRNCC partnered with the Health System Performance Research Network (HSPRN) to sponsor ***Integrating Care for Older Persons with Complex Needs: Lessons for Ontario.*** The CRNCC and OCSA organized a follow-up workshop ***From On Lok to Ontario*** on December 7th 2011 featuring Grace Li who guided participants in identifying the key design dimensions as well as challenges and opportunities involved in adapting the PACE/ On Lok model locally. See details and links to the presentations on page 4 and 5.

All the best from the CRNCC Co-Chairs,

Janet Lum ***A. Paul Williams***

CRNCC/HSPRN Event Highlights

Integrating Care for Older Persons with Complex Needs: Lessons for Ontario

Tuesday December 6, 2011

Decision makers in Ontario and across the industrialized world now face the dual challenges of sustaining already stretched health care systems, while meeting the needs of aging populations with multiple chronic needs. The international evidence suggests that integrating care for older persons with complex needs can enhance well-being and independence while achieving more appropriate and cost-effective care. However, this evidence also emphasizes that there are design fundamentals which increase the likelihood of success. What are these fundamentals? How can they inform health policy strategies in Ontario? This two-day symposium featured academic and practice leaders from Canada and internationally. See and hear what they have to say.

Please click on the name of the speakers for their presentations in PDF format (where available) For the event webcast, please visit the HSPRN website at http://www.hsprn.ca/activities/conf_StAndrews.html

Saäd Rafi (DM, Ministry of Health and Long-Term Care) set the context for the tone of the symposium. With growing fiscal challenges, DM Rafi encouraged us to be bold - to think outside the health care box. The stars are now aligned to re-imagine how better to spend our health dollars to benefit individuals and to sustain our health care system.

Walter Wodchis
(Health System Performance Research Network)

Grace Li
(On Lok, USA)

Isabelle Vedel
(SOLIDAGE, McGill University)

Steve Counsell
(Indiana University Centre for Aging)

Don Ford
(Central East CCAC)

Mark Hundert
(Hay Group Health Care Consulting)

CRNCC Event Highlights

From ON LOK to Ontario
Transferrable Lessons in Supporting Older Persons with Complex Needs

Can We Transfer the Successes of On Lok to Ontario?

On December 7, 2011, the CRNCC in partnership with OCSA co-sponsored a half-day workshop to present key learnings, shared insights and practical innovations behind the ON LOK model of care for older people from diverse backgrounds.

Grace Li, Chief Operating Officer of ON LOK Lifeways, San Francisco:

- shared her experience in setting up and operating an integrated care program for older people from diverse backgrounds using the PACE model;
- talked about how ON LOK addresses ongoing challenges;
- outlined what performance indicators the organization uses to demonstrate success at the individual and system level.

After the presentation, we opened the floor for an interactive "tweetshop" where participants debated the opportunities and challenges for establishing a similar model in their locale.

Participants debated:

Key Design Dimensions

- Who do you target? Why?
- Basket of services?
- How do you identify clients?
- Integration: How do you coordinate?

Challenges and Opportunities

- Policy: funding
- Organization: management commitment, decision-support
- Client: assessment, care planning and delivery, monitoring

Participant Comments

"Great to think outside the box and to reexamine the existing model of care."

"...learning about the On Lok model and 'tweeting' forces us to think big!"

"Grace Li's presentation was great...very informative"

"The workshop is a wonderful opportunity to learn and share knowledge"

From On Lok to Ontario

Highlight of Your tweet Responses

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Who?

There was a vigorous debate about “who” to target.

- Target **frail, high risk older people** (80+) with three or more chronic physical and/or cognitive conditions, and/or medically complex needs, and/or multiple comorbidities.
- We should base eligibility on level of need not age: eligibility for home care is at the low end; eligibility for LTC is at high end. Anyone who is currently eligible for long-term care in Ontario should be eligible.
- We need diversity and flexibility within the target population.
- We should aim for a **mix of clients with low, medium and high level needs** to:
    - put advance care planning in place early before crises happen.
    - prevent deterioration for those with mid range MAPLe scores.
    - encourage those with relatively lower level needs to participate. Often this population does not identify with “frail older people” and will shun programs and services until a crisis occurs, at which point, no care plan is in place.

For a local model of identifying at risk seniors, see Niagara Gatekeepers in the **Winter 2011 CRNCC Newsletter**

Basket of Services?

Most groups agreed that **services should be flexible and client centred.**

- Be based on client’s self-identified needs.
- Be flexible and go beyond traditionally offered services so as to facilitate the client’s capacity to remain independent (e.g., spiritual supports).
- Extend to caregivers.
- Be linguistically, culturally and religiously appropriate.
- Allow for a social worker or system navigator to create a care plan with integrated services.

How do you identify clients?

Most agreed that there should be **multiple ways** to indentify people at risk.

- Self, outreach by community service agencies, primary care providers, community health centres, Community Care Access Centres, pharmacists, family health teams, any health and social care provider, neighbours in the community, civic engagement, hospitals.
- We should follow Denmark’s example and automatically assess everyone at age 75 who isn't receiving home care gets for prevention reasons.
- Electronic health records could ensure that people do not fall through the cracks if a professional doesn't make a referral or if there is no family doctor.
- Telehealth commercials by Ministry of Health.

From ON LOK to Ontario

Transferrable Lessons in Supporting Older Persons with Complex Needs

Highlight of Your tweet Responses

How do you coordinate?

Participants varied considerably in **how coordination should occur**.

- Why reinvent the wheel? **Community Care Access Centres** should coordinate.
- Coordination should happen closest to the client; **Community Service Providers** should take the lead in coordinating care in collaboration with community health centres and/or primary care physicians.
- Care can be supported by a community-based health coordinator. You don't have to be a regulated health professional to coordinate care but need to be aware of what existing services can be leveraged in your community.
- Care coordinators should be working with physicians at the point of care.
- Not everyone has a doctor!

Funding?

- In the On Lok model, money follows people.
- If you're eligible for LTC, then the amount of funds allocated for those people could be used for an On Lok program.
- The amount for LTC minus 5% (or so) + Primary Care.
- Push money downstream from hospitals to the community organizations that sign up to leverage existing resources.
- Funding should go to agency who does care coordination for clients, and builds up the basket of services through partnership/purchase services.
- Cost effectiveness: You hire the Primary Care Physicians, Nurse Practitioners and a team of other providers. They become your staff with the same values, mission and criteria to work to!

Did You Know?

Here are 3 models of performance measurement for home and community care from Canada and around the world:

Performance Measurement Project: South West Community Support Services

Australia Community Care Common Standards Guide

The Netherlands—Quality Framework Responsible Care: Nursing Care and Home Care

From On Lok to Ontario

Highlight of Your tweet Responses

Organization?

- Organizations with the infrastructure and a history demonstrating they can work to this model (groups named many agencies that would be willing to pilot an On LOK project).
- Organizations that think outside the box, are innovative, people oriented, work to evidence based practice.
- The lead agency could be determined by the community in each LHIN to pilot projects for On Lok North model. Then evaluate successes; make necessary changes and then replicate across Ontario.
- Participating organizations would form a “hub” or umbrella organization.
- Governance-Central community hubs-Growing Family health teams/ Community health centers-in coordination with CCAC.
- Need strong administration/project/program management to "hold" the service/interdisciplinary team. One agency structure would be less confusing for clients but need flexibility for integrated partners.

Client Assessment, Care Planning, Delivery and Monitoring?

- Care plan comes from the interdisciplinary team.
- Use existing assessment tools: assessment tools RAI CHA, OCAN, InterRAI, RAI MDS, etc.
- Need to use common assessment tool and shared clinical record/case note mgmt system among partners.
- There has to be a primary case manager/organization to have accountability for the client 24/7.
- Organizations that sign up to collaborate around care should be responsible for the delivery of services.
- We need electronic health records to facilitate assessment, care plans and monitoring.
- We need well established outcome measures: enhanced quality of life/ well-being indicators (social engagement etc), reduced inappropriate ED visits, length of stay in program, reduced acute care and LTC use, increased peace of mind.
- Training, not credentials, determines the quality of assessments. In CCACs all the case managers are nurses or other regulated health professionals and cost approx. $80,000 per year. In the CSS the supervisors are the assessors and their average wage is about $50,000. Each assessor can do about 450 assessments a year. 2 CCAC case managers can do 900 assessments for $160,000. 3 CSS supervisors can do 1350 assessments for about $150,000 = cost savings!

If we missed your tweet, or if you want to add your voice, please send an email to **crncc@ryerson.ca**

You can also follow us on Twitter **@CRNCC**

Profiling:

The Sexuality Access Project

Supporting Sexuality for People with Disabilities Who Use Attendant Services and Attendant Providers

With support from Springtide Resources and funding from the Ontario Trillium Foundation, Cory Silverberg and Fran Odette conducted a path-breaking study about the delicate and often unspoken topic of sexual health and sexual support within client-attendant work relationships. Currently no framework exists for providing or requesting support for sexual activities or expression for people with disabilities with the result that clients and frontline providers may experience fear, frustration, apprehension, abuse, harassment. The Sexuality and Access Project is the first study to ask over 400 respondents, including 310 attendant service users and 154 attendants, to anonymously share their experiences of how they discussed, negotiated and expressed sexuality within the context of their work relationships.

Here are some highlights of the report.

Attendants and Attendant Service users made clear that although they wanted to start professional and respectful conversations about sexuality, a silence about sexuality and attendant services exists at all levels.

Respondents who use attendant services feared “losing services and/or housing or … retaliation in other forms.” People providing attendant services feared “losing employment and expressed reluctance to provide support without clear guidelines, for fear of retaliation from co-workers and/or employers.”

82% of attendants reported that they had never received training or instruction around issues of sexuality or sexual support.

Both service users and attendants readily agreed that guidelines, training sessions and policies to reduce sexual exploitation, sexual abuse and sexual victimization were necessary. They added that guidelines, training sessions and policies need also include positive aspects of sexual health. Specifically, respondents suggested: implementing education and training for staff around sexuality and religious, cultural and moral issues; clarifying staff rights and client rights around sexual support; developing guidelines and policies for staff around sexual support; providing information and seminars for relatives; incorporating sexual support in hiring and orientation processes; and, designating a resource person in each agency.

The authors suggest that integrating the materials contained in *The Canadian Guidelines for Sexual Health and Education* in agency policies and training would be a good place to begin.

Additional Information

Sexuality and Access Project

Health Canada—Canada’s Seniors

World Health Organization Sexual Health Working Definitions

Sexuality and Aging In Focus

Long-Term Care Homes Act

Fran Odette (top) and Cory Silverberg (bottom)

On the Radar

March 2012

20-23 | 2012 Rainbow Health Ontario Conference
Presented by: Rainbow Health Ontario
Location: Ottawa Marriott, Ottawa, ON

April 2012

1-3 | Together We Care: Long Term Care & Retirement Communities Convention and Trade Show
Presented by: Ontario Long Term Care Association
Location: Metro Toronto Convention Centre, Toronto, ON

18-19 | Ontario Gerontology Association 31st Annual Conference
Presented by: Ontario Gerontology Association
Location: Doubletree by Hilton—Toronto Airport, Toronto, ON

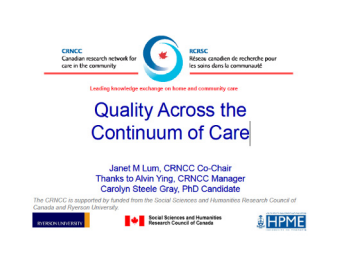
29-May 1 | 2012 Annual Hospice Palliative Care Ontario Conference
Presented by: Hospice Palliative Care Ontario
Location: Sheraton Parkway Toronto North Hotel & Convention Centre, Richmond Hill, ON

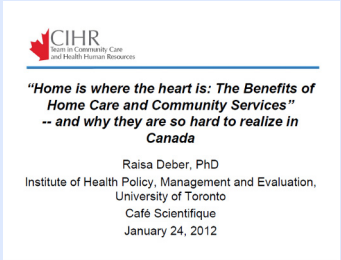
May 2012

7-9 | Great Places to Live and Work: OANHSS Annual Meeting & Convention
Presented by: Ontario Association of Non-Profit Housing and Services for Seniors
Location: Westin Harbour Castle, Toronto, ON

*We encourage you to check www.crncc.ca/events often as our calendar is continually updated

New Reports & Presentations





Janet Lum
Quality Across the Continuum of Care

Institute for Clinical Evaluative Sciences
Health System Use by Frail Ontario Seniors

Raisa Deber
Home is Where the Heart is: The Benefits of Home Care and Community Services—and Why They are So Hard to Realize in Canada

From left to right: Janet Lum, Lori Holloway, Carolyn Steele-Gray, Sujata Ganguli

CRNCC is committed to creating an open and accessible environment that offers current and relevant information. We welcome comments, questions, and concerns.

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