South West
Community Care Access Centre
CCAC
CASC
Centre d'accès aux soins communautaires
du Sud-Ouest

March 2008

Client-Driven
CARE

KTA FACT SHEET:
Celebrating Collaboration for Client-Driven Care

THE KNOWLEDGE BASE

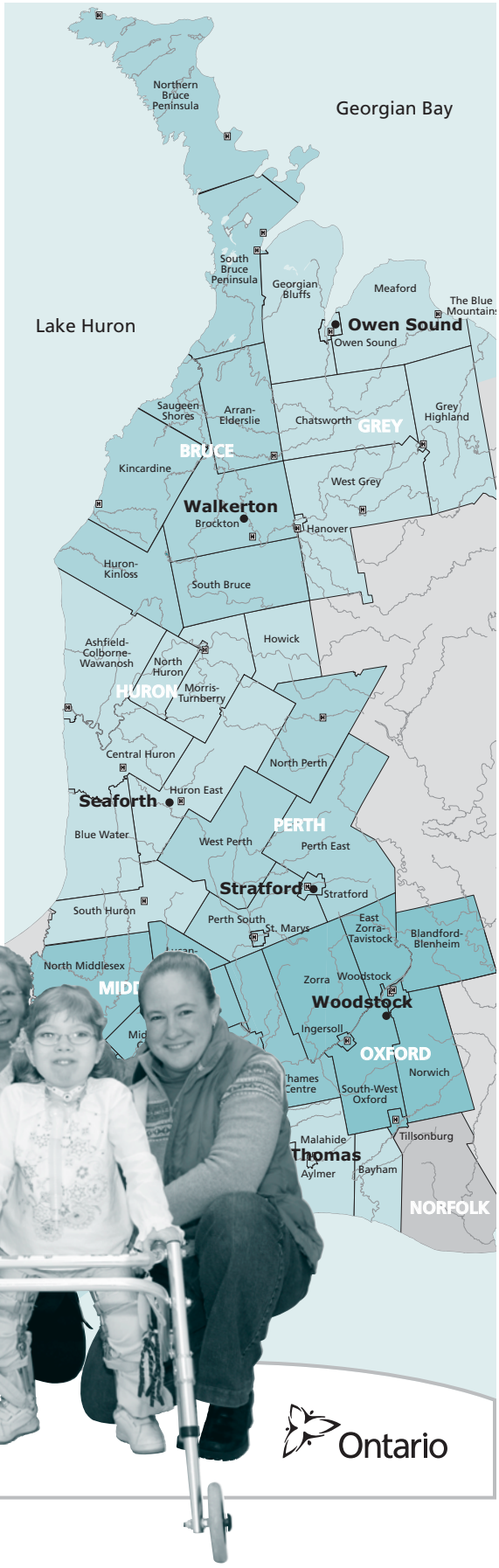
When the South West CCAC came together as a new organization early in 2007, the theme of Client-Driven Care was chosen as a cornerstone of our corporate culture.

Client-Driven Care was developed through many years of collaborative research work with Professor Carol McWilliam of the Faculty of Nursing at the University of Western Ontario. It's an approach to working with clients, their families and other community care team members that involves building human partnering relationships focused on connecting, sharing and creating solutions together. Client-Driven Care improves the quality of care for clients, and the quality of work life for CCAC staff and care providers.

MAKING IT REAL

The South West CCAC is working hard to integrate the principles of Client-Driven Care into everyday practice through information, education and "Knowledge-to-Action" (KTA) projects. As the name suggests, KTA projects are practical strategies based on the client-driven care principles. A small group of people undertook Client-Driven Care KTA projects during 2006. Then in February 2007, 200 South West CCAC staff members and service providers gathered to learn more about Client-Driven Care and develop new KTA projects.

Teams were formed at each South West CCAC site. Each team included frontline and managerial staff from the South West CCAC and provider agencies throughout the region. Many of the team members didn't know each other before the projects started, but all developed productive working relationships. The teams developed and piloted their action strategies from March to November, 2007. Here are some of their outstanding results.



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1. London West – Staff Orientation

The London West team recognized that for Client-Driven Care to be used consistently throughout the South West, it must become an integral part of the training for new staff at the CCAC and its service providers. The team took on the task of designing an orientation program to introduce new members of the care team to the concepts of Client-Driven Care.

The program includes:

- A video on Client-Driven Care
- Guided conversations process guide
- Role plays
- Debriefing, questions and feedback session

The team also developed a package to be sent out prior to the orientation session, sample role plays and guided conversation starters, and a recommendation to incorporate Client-Driven Care training at team meetings for current staff.

2. Strathroy – Improving recruitment and retention

The Strathroy team decided to tackle a key issue for community care – the shortage of community health professionals, especially Personal Support Workers and Community Support Workers (PSWs/CSWs), in rural areas. They developed the concept of "flex care areas" to allow service providers to work in their own neighborhoods and reduce travel times. The team envisions the creation of a new function, the Dispatcher, who would take requests for service from case managers and forward them to the appropriate agency, based on the flex care areas.

The team also calls for:

- Standardized wage rates across agencies
- Improved benefits packages for providers
- Flexible mileage and gas rates for all providers
- Reduced disparity between hospital and community care wages

The team presented their ideas to the Inter-Agency Leadership Partnership (IALP) in November, and invited representatives from four agencies to discuss them in January. All of these suggestions can then be part of the planning by the CCAC for its next RFP.

3. Owen Sound/Walkerton – Standardizing Criteria for Case Conferences

Case conferences are an important way to build relationships with clients and among the team, and to ensure that all team members are working toward the same client goals. The Owen Sound/Walkerton team felt that case conferences were often not called when they were needed.

The team developed a Case Conference Indicators Form with standardized criteria for calling a case conference, such as:

- Goals not achieved within expected time
- Safety risk to client, family and provider
- Frequent visits to Emergency
- Sudden change and deterioration due to physical problems, loss of caregiver or change in living arrangements

The new system encourages care providers to be more proactive about calling case conferences when they see a need.

The team piloted the Indicators Form and found that although providers didn't want to fill out "another piece of paper," they were happy to have guidelines for when a case conference is useful. Team members hope the Form will become part of the policy for case conferences used throughout the South West CCAC.

4. St. Thomas

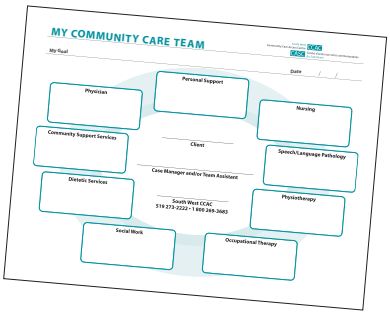
Complementing the work of the Owen Sound/Walkerton team on guidelines for when to have a case conference, the St. Thomas team worked on guidelines for how to have a meaningful conference. The team believes that when well implemented, case conferences can make a positive difference on the front line of care.

The guidelines cover:

- Who should attend a conference
- How to plan and run the conference
- How each member of the team should prepare for the conference
- How to develop an agenda based on ROPES (Respect, Openness, Participation, Experimentation, Sensitivity and Support)

In addition, the team prepared Client Conference Worksheets to help providers and clients or caregivers prepare, and a template to use for summarizing case conference outcomes. The guidelines have been piloted informally in the St. Thomas area and proved helpful. The team hopes to roll out its approach across the South West in coordination with the Owen Sound project.

5. Stratford – My Home Care Team



The Stratford team focused on streamlining communication between the community care team and clients. Team members recognized that clients are often confused about who their team members are and what they do. My Home Care Team is a one-page chart that identifies the provider participants involved in a client's care and provides contact telephone numbers for each one. There is space at the top of the chart for a client-directed goal. The chart can go in the Record-in-the-Home or on the fridge for easy reference. My Home Care Team has been piloted successfully with 25 clients and will be put into use across the South West.

6. Woodstock – Communication between PSWs and case managers, and retention strategies

In Woodstock, two groups went to work on KTA projects. The first group focused on strategies to improve communication between PSWs and case managers. Case managers know that because PSWs are in regular contact with clients, they have valuable information about how they're doing – in fact, the PSW is often the person with the closest relationship with a client. At the same time, case managers have information about clients that is important for the hands-on care providers to know.

The team created two tools:

- Written guidelines for when and how communication should take place between PSWs and case managers
- An Interagency Assignment Form to inform PSWs about clients' functional state and health history

The tools for the direct communication are currently being piloted in three locations in Oxford County.

The second group worked on strategies to help meet the shortage of community care workers in Oxford County. One PSW member of the group tracked her time over a two-week period, noting time spent on phone messages and travel, as well as direct care. The group had several recommends for consideration around retention and job satisfaction and urges further discussion of this critical issue. Prep time will be part of the planning information for the next RFP.

7. London East, Seaforth, Owen Sound/Walkerton – Chart-in-the-Home

These three teams all chose to focus on improving communication between the community care team and the client and family to provide a base for seamless Client-Driven Care. Given the geographic challenges, the three teams worked independently at first, then the team leads came together to amalgamate their ideas for a new Chart-in-the-Home (CITH). The teams see the CITH as a tool for communication among the team, as well as with the client.

Among the features of the new Chart-in-the-Home:

- A user-friendly design that doesn't intimidate clients, and makes it easy for them to understand the care suggestions
- White tabs with clear black print and large type size for easy reading
- A plastic sleeve to put information clients are given by providers

The teams developed a prototype CITH and recommend the development of consistent policies for its use. A roll out plan is now in development for the South West.

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