Driving Transformation By Seeing The System Through The Eyes of Patients and Their Families

Connecting you with care
Votre lien aux soins
CCAC Community Care Access
CASC Centre d'accès aux soins

Our Aim: Supporting populations with complex needs with better care at home in their communities, utilizing existing resources… **Our Approach:** Creating One Team

Phase 1: 2007-2010

Moving to a population based model

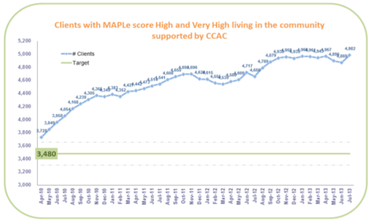
Set the Foundation for Integration

What we did:

- Challenged existing structures to provide skilled expertise and support for patients and caregivers
- Went from a generic-focus to a population-focused model of care
- Reorganized all business functions around the populations

What we achieved:

- Improved client and caregiver experience
- Reduced pressure on acute care settings with ALC-LTC reduced by 50%
- Fewer unnecessary ED visits and reduced demand for LTC admissions and crisis placement
- 25% of patients withdrew their LTC applications
- The CCAC is supporting more and more complex patients:



Lessons learned:

- Real transformation is about making a culture shift
- Improving the client and caregiver experience was our priority
- Organizational transformation touched every part of the business
- Essential to have staff engaged at all levels
- Stability in operations while implementing change is imperative

Phase 2: 2010-2012

Driving the highest possible integration for complex populations

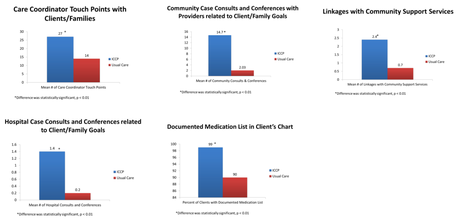
An Incubator to Test System Change and Achieve System Readiness for Integration

What we did:

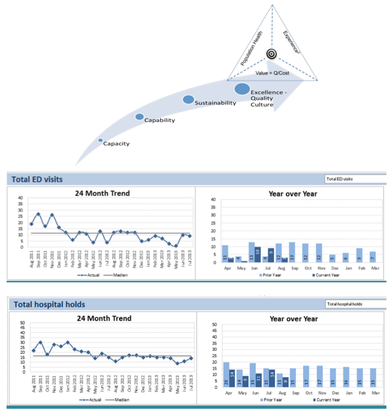
- Population focused integration – brought every sector together and asked ourselves '*where are we failing people and their families?*'
  - Activation/Socialization
  - Navigation/Coordination
  - Medication Management
  - Smooth Transitions
  - Independent Living
  - Medical Support and Self Care
  - Rapid Response
- Defined our target population: Older adults with complex needs (complexity: medically, socially, functionally and cognitively), including home-bound, high-risk, frail older adults:
  - 2 or more Ambulatory Care Sensitive Conditions (congestive heart failure, hypertension, diabetes type 2, chronic obstructive pulmonary disease, asthma, angina, epilepsy)
  - Admission to acute care within the last year
  - RAI assessment/score
  - ≥ 65 years
  - TC LHIN resident
- Why focus on the top 1-5%? This strategy is twofold - address the most complex *and* prevent others from becoming complex
  - a place to start as an incubator to drive the tightest integration, test and learn many new initiatives, and chose one with greatest value and opportunity for scalability and sustainability
  - embed learnings and standards of practice across all populations

Driven by IHI framework – early learning:

- Qualitative Information Sources:
  - Client and Caregiver Experience
  - Provider Experience
  - Sector Leadership Interviews
  - Focus Groups
- Quantitative Information Sources:
  - Outcome Measures from Retrospective Cohort Analysis



- ICCP Care Coordinator Time Study
  - Creating virtual integrated teams: Care Coordinators are the connectors of the team and they spend a great deal of time bringing the team together to wrap care around the client and their family
- Trending of ED Visits and Hospital Holds for ICCP Older Adults



Key Innovations

CCAC working Hand-in Hand with Primary Care	► Weekly Case Conferencing and close communication with CCAC around Complex Patients' Care ► Embed in Primary Care: virtual case conferencing, joint home visits
Care Coordination Across the Continuum of Care	► Client/Caregiver "Quarterback" to develop the interdisciplinary, inter-organizational care teams ► System Navigation and Coordination ► Shared assessments, care plans, joint home visits, regular rounds with the care team, client and family
Acute Care Partnership and Protocols	► Identification and flagging of high risk patients ► Transitions supported via Virtual Ward
Pharmacy Engagement	► Moving to a single pharmacy for each patient
Caregiver Support	► Training for Care Coordinators to support caregivers and address caregiver burden ► Creation of caregiver plan for each individual case
Partnership with Emergency Medical Service (EMS)	► Flagging and enhanced communication around ICCP patients ► Emergency Department Transfer Package ► Hospital Repatriation system

Lessons Learned

- Point of care integration (interdisciplinary, inter-organizational care teams) – bringing the care team/delivering care to client/family where they are
- **Our most critical lesson learned is the need for primary care and community care to work in hand-in-hand to support those with complex needs**

Client and Caregiver Experience	Roles and Relationships	Information Sharing and Flow
► Clients and caregivers see the value of a system-wide "**quaterback**" whos assembles the care team to focus on client and caregiver goals	► Strong, meaningful relationships **between integrated care team members** are critical to success	► Each member of the integrated care team requires **access to key information** ► **Information empowers clients and caregivers** to feel secure and supported

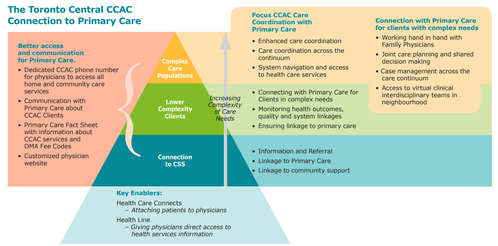
Phase 3: 2012-Onwards

Leveraging Primary Care

Cornerstone for Integration

What we're doing:

- Improving Access to CCAC/Community Based Services and Information for Primary Care Providers
- Connecting a CCAC Care Coordinator to all primary care providers with an emphasis on working closely for the 1-5% of patients
- Supporting non-team based primary care physicians with a CCAC Inter-disciplinary care team in their community and building better clinical support for patients with complex needs
- Advancing integrated care for complex populations (1-5%) by leveraging the existing programs and integration strategies to inform best practices that would be further embedded



How we're doing this…

- Toronto Central LHIN primary care strategy being delivered through Health Links
  - Creating teams of linked health care providers across the province to manage patient needs
  - Focus: Complex Populations
  - Every health link will require involvement from CCACs, Primary Care, and local hospitals
  - 9 Health Links
- The Network Concept will seamlessly bring together primary health care, community based services, acute hospital-based care, and teaching and training opportunities together.
- The first focus will start with Primary Care Providers and the CCAC as a foundation. This is about ensuring primary care is available where patients live their lives

- Principles embedded in a QI Framework:
  - Encourage simple solutions while waiting to develop complex ones
  - Agree to start working together differently immediately
  - Build incrementally over time
  - Drive Change from experience
  - Balance the needs for scientific evidence and outcomes with quality improvement frameworks
  - Empower front line staff: Inspire creativity, remove barriers
  - Invest in the relationships
  - Shared accountability across the team
  - Shared comprehensive assessments
  - Shared planning & decision making
  - Regional Design and Local Customization
  - Demonstrating value on the ground – less talk and more delivery

Joseph's Care before ICCP…

- Is not putting his needs first
- Is represented with inter-related health and social care issues
- Is fragmented with multiple unconnected providers
- Requires home-based care but he has office-based providers
- Is too reliant on EMS and Hospital Visits

Joseph's care with ICCP…

- Does not differentiate between organizations and operates at ONE TEAM
- Is discussed regularly at inter-disciplinary and inter-organizational rounds that have shared decision around on coordinated care plan
- Supports Joseph and his caregiver and have advance care planning in place
- Provides the right care at the right place at the right time
- Integrated care planning based on what is most important to Joseph
- Has a CCAC Care Coordinator who knits the team together
- CCAC Care Coordinator and Primary Care Provider work hand in hand
- Rapid response in the community
- Integration between CCAC, community, primary care and acute care