



2010 – 2011

CCAC Quality Report

ENHANCING THE CLIENT EXPERIENCE

As a result of Home First and other home and community initiatives, **21% more patients waiting in hospitals** for Alternate Level of Care (ALC) **returned home** between April 2009 and June 2011.¹

¹ Compiled from Access to Care Reports, Cancer Care Ontario, April 2009–June 2011.

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Part One

CCAC Leadership Message

Ontarians care deeply about our health care system, but at times the system can seem complex and confusing. Community Care Access Centres (CCACs) help people find the services they need, where and when they need them.

Ontario's 14 CCACs employ experienced health care professionals to assess each client's needs, develop personalized care plans and coordinate community-based services. This coordination of care enables our clients to live safely at home, attend school, move into Long-Term Care (LTC) or when the time comes, die where they choose with dignity. In serving a diverse population of more than 600,000 Ontarians, we aim to ensure each person has equitable access, experiences smooth transitions through our health care system and consistently receives outstanding quality of care.

This commitment to quality and accountability is embedded in our vision of providing outstanding care to every person, every day. Quality is an ongoing evolution, which we are committed to measuring and improving. With the support of the Ministry of Health and Long-Term Care, provided through Ontario's Local Health Integration Networks (LHINs), we are working with our health care partners to improve quality through changes and initiatives that address the province's health care priorities.

As leaders of Ontario's CCACs, we are pleased to provide you with our 2010–2011 Quality Report, which we developed to:

- Explain how we are working with our clients and caregivers and using their stories and experiences to improve our care.

- Share our collective performance results, including successes and opportunities, as driven by our goal of continuous quality improvement.
- Demonstrate the value and impact of our care coordination approach in helping clients navigate through the health care system.
- Show how Ontario's CCACs address health care priorities and support a sustainable system.

Our CCACs successfully work together to apply our care coordination expertise and quality care commitment to help optimize Ontario's health care system and enhance the client experience.² Within this report, we have applied a solution-focused approach to demonstrate how we are using these strengths to impact four of Ontario's health care priorities: keeping more people safe at home; increasing access to health care services; smoothing transitions between health care services; and sustaining quality care. This report also outlines our steps to address the improvement opportunities cited in our inaugural 2009–2010 Quality Report.

We continue to look for ways to improve performance and adopt innovative solutions to overcome challenges, as Ontario's home and community care sector evolves. With this in mind, we have also highlighted opportunities for improvement and our interim progress.

This report documents the performance of our sector with the best evidence currently available. We are enhancing our data collection and increasing our outcome-based metrics. To this end, we are collaborating with LHINs and other partners to create province-wide commitments that define quality within home care service delivery and set

² The terms most often used in this report to refer to the role and function of CCAC staff are *Case Manager* and *Care Coordination*, respectively. These terms may

be replaced by similar terms, including *Care Coordinator*, *Case Management*, *System Navigator*, *System Navigation*, *Patient Navigator* and *Patient Navigation*.



CCAC Vision Outstanding care—every person, every day.

CCAC Mission To deliver a seamless experience through the health system for people in our diverse communities, providing equitable access, individualized care coordination and quality health care.

benchmarks. These commitments will help us more closely monitor progress toward improving the quality and consistency of care throughout the province.

On behalf of our CCACs, we thank you for your support and encouragement as we work together to advance positive changes for all Ontarians.

As the Chief Executive Officers of Ontario's

14 CCACs, we present this quality report and with it, affirmation of our ongoing commitment to drive continuous quality improvement across Ontario's health care system.

We welcome your feedback on this report, our performance results and the ongoing evolution of the home and community care sector.

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A Glimpse of Home Care in 2010/11



24% (approximately 10,000) more high need clients were supported by CCACs each month on average, than the previous year.³



91% (aggregated average) of approximately 13,000 clients surveyed by an independent research firm said they were satisfied with their CCAC experience.⁴



98.7% of all long-stay CCAC clients had their medications reviewed by a primary care provider or other qualified health professional.⁵



40,000+ clients without a family physician or nurse practitioner to oversee their medical care and provide referrals to specialized services, were matched with one by a CCAC nurse, serving as a Care Connector.



21% more Alternate Level of Care (ALC) patients returned home after discharge from hospital between April, 2009 and June, 2011. (And 22% fewer patients moved from hospital to Long-Term Care homes in the same time period.)

³ CCAC records of high need clients, as defined by *Method for Assigning Priority Levels (MAPLe)* scores—an algorithm derived from the RAI-HC. It provides information about the client's risk of adverse health outcomes.

⁴ Based on the *Client and Caregiver Experience Evaluation (CCEE)* and responses provided on a scale of 1 to 10, where 0 is very dissatisfied, 5 is neutral and 10 is very satisfied.

⁵ Long-stay CCAC clients are defined as those who received CCAC services for more than 90 days.

Innovation Highlights

1. Population-Based Client Care Model

Half of all CCACs (7 out of 14) are now organizing how they deliver services according to the needs of different client populations. This means CCACs can now better match the right type and level of care coordination to each client.

EARLY RESULTS:

High need clients (those living with multiple complex health conditions) have said they “feel more supported, particularly during transitions to different health care services, and less socially isolated,” among other benefits.

2. Client Health Related Information System

CCACs completed the deployment of the Client Health Related Information System (CHRIS)—a province-wide solution that gives CCACs access to a common electronic record for every client they serve and connects Case Managers to help them deliver better care.

RESULTS:

CHRIS improves each CCAC's ability to efficiently respond to client needs by enabling Case Managers to retrieve, review and document detailed information about a client's care and health services delivered.

3. Integrated Client Care Project

CCACs are pioneering the Integrated Client Care Project (ICCP)—a multi-year initiative that targets and organizes resources around specific populations to drive more integrated care, improve the client and caregiver experience and deliver value through outcome-based payments.

EARLY RESULTS:

All 4 wound care implementation sites showed more than the 30% targeted decrease in the wound size within 4 weeks (on average). With outcome-based payments, the nursing agency was paid a portion of the agreed fee upon referral and the balance at specific intervals, as wound reduction targets were met. If targets were not met, payments were delayed—versus the traditional system that charged for nursing visits, despite the outcome.⁶

⁶ There is room for discussion when the service provider delivers best practices but the ICCP target is missed due to extenuating circumstances.

Executive Summary

In 2010/11, more than 600,000 clients across Ontario received help from Community Care Access Centres (CCACs) to live safely at home, attend school, move into Long-Term Care (LTC) or at the end of their lives, to die with dignity. This Quality Report demonstrates how CCACs' care coordination is helping Ontarians access the services they need, and provides updates on our efforts to continuously improve quality of care and address the improvement opportunities cited in last year's inaugural report.

The Client and Caregiver Experience Evaluation survey was developed in response to the opportunity to measure our clients' experiences with CCAC services. This survey collects feedback from at least 13,000 CCAC clients each year on how well we are meeting their expectations and delivering on our quality commitment.

Another improvement opportunity set for 2010/11 was to deliver better care by customizing care coordination to meet each client's needs. Our most significant step in this direction is our Client Care Model, which matches the right level of CCAC care coordination, resources and services to groups of clients or "client populations," according to their needs.

With this new model and other initiatives, our 14 CCACs are applying their strengths to advance four of Ontario's health care priorities in the following ways:

1. WORKING TO KEEP MORE PEOPLE SAFE AT HOME WITH QUALITY CARE

Two key components of our risk management and safety support for our clients are aimed at: helping people take their medications safely and reducing the likelihood of falls at home and in the community.

Last year, a primary care provider or qualified health professional reviewed the medications taken by 98.7 per cent of CCAC clients, who received services for more than 90 days. Proper medication safety can help prevent unnecessary visits to hospital Emergency Departments and improve health outcomes for our clients.^{7,8}

The number of Ontarians who are 85 or older is increasing significantly. As people age, they are more at risk for serious injuries due to falls. Our CCACs are responding with more falls prevention strategies, which encompass education, therapy and referrals to community-based programs and specialized services. In supporting more frail seniors at home, we are seeing an increase in the number of falls reported by our clients, but it is lower than we might expect. We will continue to expand our home safety activities to reduce the risks for all clients, especially frail seniors.

⁷ Multi-Sector Service Accountability Agreement (M-SAA) Indicators, 2010/11.

⁸ A primary care provider can be a family physician or nurse practitioner who oversees a person's health care and refers them to specialized services, as required.



More than 4,500 Case Managers cared for more than 600,000 CCAC clients across Ontario in 2010/11.

2. INCREASING CLIENTS' ACCESS TO HEALTH CARE SERVICES

In 2010/11, CCACs' *Home First* approach and other initiatives gave more of our clients improved access to community-based health care, which helped them live at home for as long as possible. The province-wide *Home First* approach is about CCACs and hospitals working together to explore every opportunity for clients to go "home first," before considering LTC homes or other options. Home First makes it possible for more people than ever before to return home after a hospital stay, where they can continue their recovery or safely wait for a LTC bed or alternative arrangements.

Home First and other initiatives have also helped ease Emergency Department wait times and enabled 21 per cent more Alternate Level of Care (ALC) patients to return home after they were discharged from hospital between April, 2009 and June, 2011.⁹

This corresponds with a 22 per cent decrease in the number of ALC patients who moved from hospital to LTC homes in the same time period. This helped us dedicate six per cent more LTC beds to our highest need (complex care) clients in 2010/11.

For some of our clients, a major barrier to care is finding a primary care provider (family physician or nurse practitioner) to oversee their medical care and make referrals to specialized services, when required. Through Ontario's Health Care Connect program, CCAC nurses have helped clients overcome this barrier since 2008 by serving as Care Connectors to match clients in need with a primary care provider.

Our CCACs are building on the positive results of Home First and other initiatives to improve access to health care further.

⁹ Alternate Level of Care (ALC) patients are people who no longer require a hospital's services and can be more effectively cared for elsewhere.



CCACs serve clients of all ages—from helping children to attend school to enabling seniors to live safely at home, move into Long-Term Care or die where they choose with dignity.

3. HELPING PEOPLE NAVIGATE THROUGH THE HEALTH CARE SYSTEM

CCACs help clients as they move between different health care providers, services and settings to address their changing health care needs.

To better help clients who need high levels of support from across the health care system, we are designing and implementing Ontario's Integrated Client Care Project (ICCP). The ICCP organizes our teams around specific populations so that we can create a better client and caregiver experience and also realize other benefits. This multi-year initiative is organizing care around four specific client populations: wound care and palliative clients in 2010/11, with plans to expand to frail seniors and medically complex children in subsequent years.

We are also applying several other province-wide initiatives to help clients smoothly and safely transition across health care services, including:

- Improving transitions from hospital to home by collaborating with hospitals to care for Ontario's most vulnerable populations through various initiatives, such as the Virtual Ward.
- Expanding CCACs' care coordination role to manage access for different health services across Ontario, such as adult day programs, supportive housing, assisted living, complex care and rehabilitation beds.
- Exploring and testing alternative reimbursement models, based on paying for better outcomes and better care for our clients.

4. SUSTAINING QUALITY CARE TODAY AND FOR TOMORROW'S GENERATIONS

Home and community-based health care must evolve to keep pace with our aging population and the changing needs of our health care system.

During 2010/11, different CCACs embraced more efficient ways to deliver quality care for the long-term:

- Exploring new technologies to help people better manage their care at home, such as the *Ontario Telemedicine Strategy* pilot.
- Providing better care for medically fragile children and palliative clients with eShift, a CCAC-developed innovation that provides nursing support to more clients.
- Using teams of providers to deliver care more efficiently to clients who live close together.
- Creating a single electronic client record for use by all CCACs through our Client Health Related Information System (CHRIS).
- Empowering clients with *Chronic Disease Self-management Programs*, which enable them to better manage their chronic diseases.

As the population served by CCACs continues to have higher levels of need, we are shifting resources to provide service where the need is greatest and working with other health care partners to ensure clients receive the right care, from the most appropriate service provider, when and where they need it.

Enhancing the Client Experience with Quality Care

Ontarians' need for health care services is growing and this extends well beyond emergency services and other care provided in hospitals. Today, more than ever, Ontarians are receiving care in their homes and communities that was previously delivered in the hospital and there is an array of services to support them.

At the heart of this system are Ontario's Community Care Access Centres (CCACs), which knit the province's health care services together. More than 4,500 Case Managers in our 14 CCACs apply their care coordination expertise to deliver quality of care province-wide. In 2010/11, CCACs provided quality care to more than 600,000 clients.

Measuring Our Clients' Experience

In the *2009/10 Quality Report*, our CCACs highlighted several opportunities to improve the quality of care they provide and identified how we planned to address these opportunities. One of these opportunities was to find a way to measure our clients' experiences and compare them across CCACs to determine what we are doing well, where we can improve and to learn from each other.¹⁰

CLIENT AND CAREGIVER EXPERIENCE EVALUATION

To this end, our CCACs collaborated to develop a survey called the Client and Caregiver Experience

Evaluation (CCEE), which is conducted by an independent research firm. Designed to collect feedback from our clients on how well we are meeting their expectations and delivering on our quality commitment, the CCEE was pioneered by half of Ontario's CCACs in 2009.¹¹

By 2011, this client survey was adopted by all 14 CCACs using a random sample of at least 1,000 respondents per CCAC. The survey measures our clients' satisfaction at various times when they are receiving CCAC services. Questions cover their experience with starting CCAC services, trust and relationships with CCAC staff and service providers, such as personal support workers, nurses and therapists. Using results from each CCAC, we can compare client experiences across the province.

SURVEY HIGHLIGHTS

According to this survey, an aggregated average of 91 per cent of the respondents were satisfied with their CCAC experience (as shown in the Client Satisfaction with Overall CCAC Care Experience graph on the next page).

This indicator is the combined average satisfaction rate for 13 CCACs, based on the overall experience of clients and caregivers, including experiences with CCAC Case Managers (*or Care Coordinators*) and service providers (as shown in Satisfaction Ratings by CCAC graph on next page).^{12, 13}

These results are promising and the feedback from our clients, their caregivers and families is helping us identify areas for improving the quality of our care.

¹⁰ 2009 – 2010 CCAC Quality Improvement Report, Quality Improvement Opportunity #1, p. 34

¹¹ Early CCEE adopters were selected based on the timing of their contract renewals.

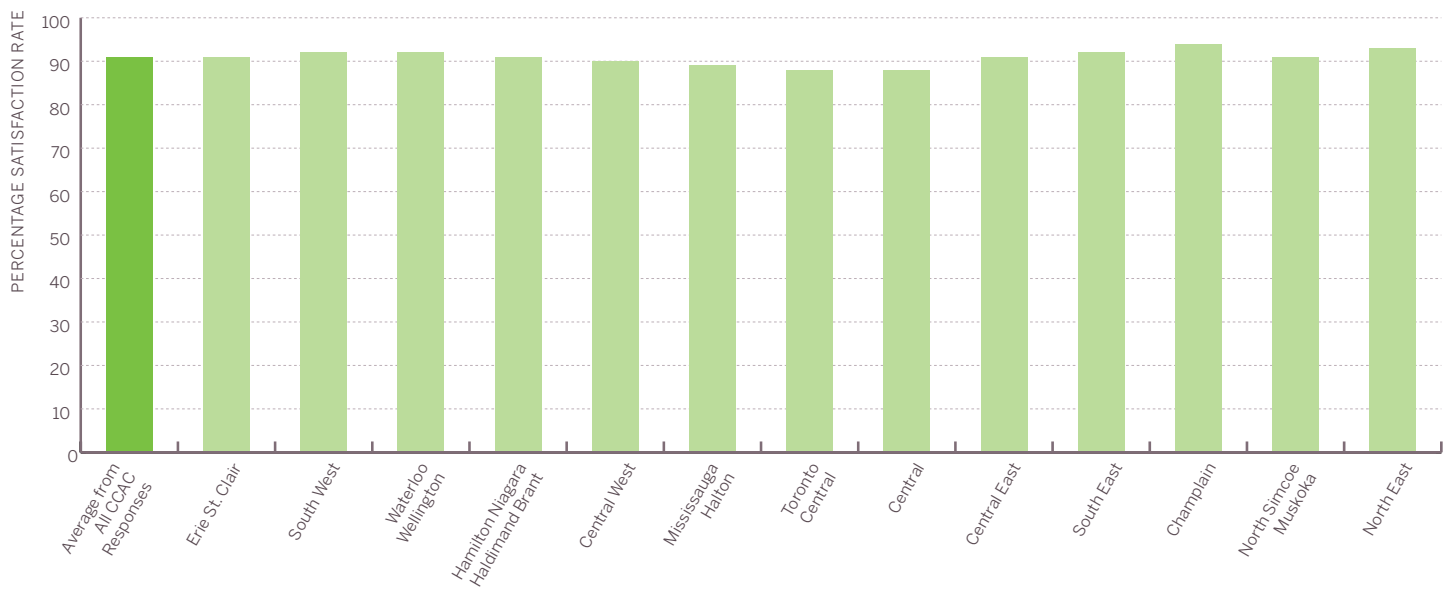
¹² Results exclude North West CCAC, which conducted the CCEE survey in a later time period.

¹³ CCEE survey results, based on responses provided on a scale of 1 to 10, where 0 is very dissatisfied, 5 is neutral and 10 is very satisfied.

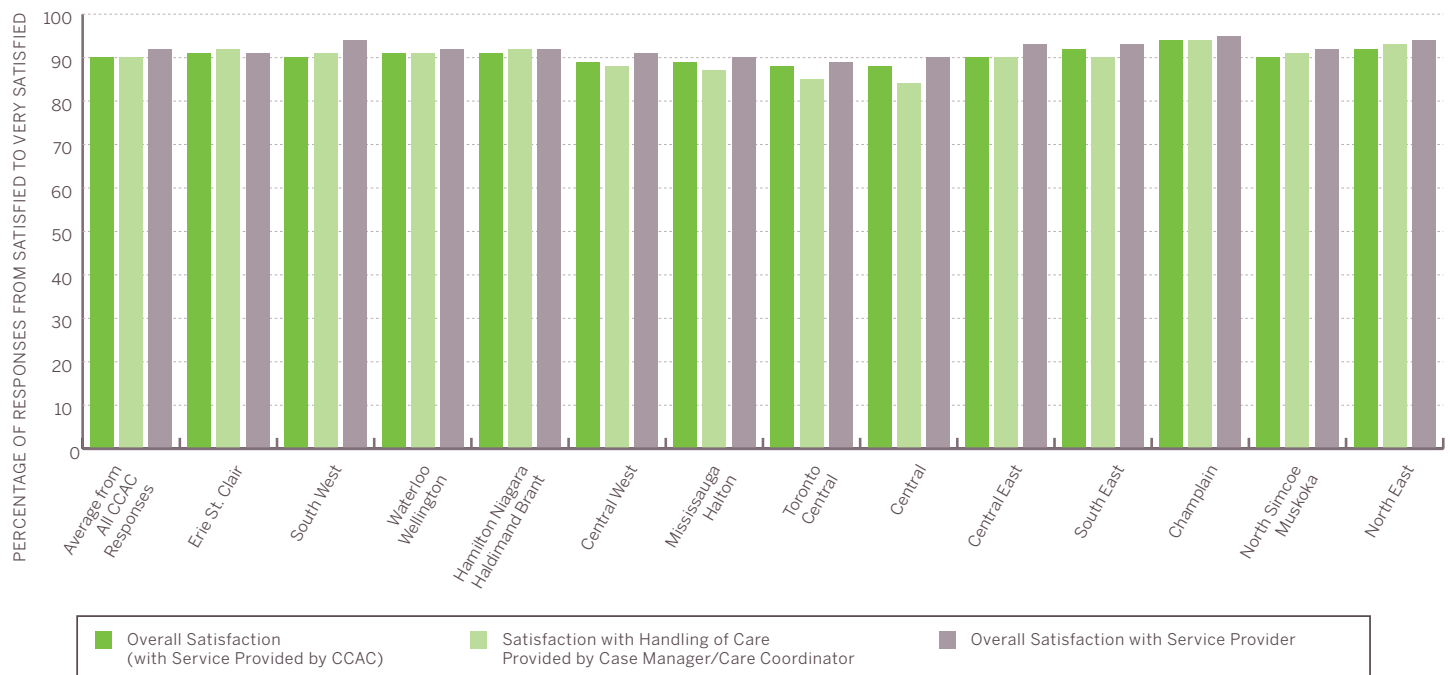


CCAC Case Managers are regulated health care professionals who collaborate with service providers and work in hospitals, emergency departments and as part of community health and family teams.

Client Satisfaction with Overall CCAC Care Experience



Satisfaction Ratings by CCAC



Delivering Quality Care to Our Clients

Our CCAC Case Managers are experts in health assessment, care planning and outcome evaluation and have extensive knowledge of local health care and community services.

As regulated health care professionals, our Case Managers are assigned to hospitals, emergency departments and work as part of community health and family health teams. They help Ontarians find and access home care and community services and move between different types of services, such as going from hospital to care at home or in a local clinic.

OUR CASE MANAGERS WORK WITH OTHER HEALTH CARE PROFESSIONALS AND COMMUNITY SERVICE AGENCIES TO HELP PEOPLE:

- Spend less time in hospital and more time recovering at home
- Make fewer unnecessary visits to emergency rooms
- Find a local family physician or nurse practitioner to oversee their care
- Who have short-term rehabilitation needs, return to work or go to school
- Continue to live in their own homes and communities, as they age or cope with long-term health problems
- Move to a Long-Term Care (LTC) home or other alternate care destination
- Who are facing a life-threatening illness, to be supported and cared for at home or their preferred location

Case Managers start by talking with clients and caregivers to learn about their health care needs. They then develop personalized care plans for them, which may include: adaptive equipment, clinical services, such as nursing, therapy and personal support, and referrals to community support organizations that can help with a range of different community services, such as meal preparation and transportation. Our staff also work with clients on an ongoing basis and make adjustments to services, as their needs change.

Care coordination is particularly important for clients coping with multiple illnesses or chronic conditions, to help them find, understand and access the different services available to them.

Customizing Care Coordination to Meet Each Client's Needs

Recognizing that the health and social support needs of our clients vary widely, another improvement opportunity we identified in 2009/10 was to deliver better care by customizing care coordination to meet each client's needs.¹⁴

As a key quality improvement initiative, our CCACs have developed a new model of care designed around the care needs of different populations of clients. This standardized, population-based Client Care Model matches the right level of CCAC care coordination, resources and services to groups of clients or "client populations," according to their needs. It also includes standard care pathways that are based on research evidence and designed to reduce variations in care.

¹⁴ 2009 – 2010 CCAC Quality Improvement Report, Quality Improvement Opportunity #2, p. 35.



CCACs partner with families, health professionals and schools to help children who survived a catastrophic injury at birth or otherwise suffer from serious ailments requiring around-the-clock care.

As of 2011, 7 of our 14 CCACs are using this model of care delivery, with the remaining CCACs in the process of adopting it and incorporating key learnings, as it evolves.

TO DATE, WE HAVE FOUND MANY PRELIMINARY RESULTS WITH THIS NEW MODEL OF CARE, SUCH AS:

- Our clients and caregivers feel more supported, especially when transitioning between different health care services.
- Our high need clients (with multiple conditions) experience reduced social isolation.
- Our CCACs are better able to target their resources where they are needed the most.

During this last year, we also completed the deployment of the Client Health Related Information System (CHRIS)—a province-wide solution that gives our CCACs access to a common electronic record for every client we serve. CHRIS helps us to realize significant improvements and efficiencies in the quality and safety of the care we provide.

The relationship between the client, their caregiver and the individual provider is a key component of integrated care.

The vast majority of The Change Foundation's survey respondents (99%) reported that they were able to establish a good working relationship with their last client. (Based on The Change Foundation's Ontario-wide survey of personal support workers, Case Managers and other regulated health professionals.)¹⁵

Helping Children with Medically Complex Issues

Evan's Story

Born with a life-threatening chromosome disorder called Edwards Syndrome, seven-year-old Evan was not expected to live past one month. Due to a ventricular septum defect in his heart, Evan developed pulmonary hypertension and regularly takes medication for it.

From the time he was an infant, the CCAC has coordinated Evan's care. His CCAC Case Manager has worked closely with him and his family to understand his needs, help them navigate through the health care system, and connect him to a wide range of community resources.

At home, Evan has a nurse with him overnight to administer his feeding tube and provide respite support for his mother. At school, Evan receives occupational therapy to improve his balance and develop fine motor skills, like holding a pencil. His physiotherapist helps him with his movement and exercises. Today, Evan can stand on his own by holding onto objects and he continues to make progress.

¹⁵ *Integration of Care: The Perspectives of Home and Community Providers*, The Change Foundation, June, 2011, pg. 11.

“I wanted to be able to stay in my home but after experiencing a fall, I didn’t know if that would be possible. The CCAC helped by linking me with services in the community I didn’t even know existed, such as transportation to get me to appointments, the CNIB and someone to teach me more about my diabetes. I knew I would have to use these services to stay at home and I was very grateful for the help figuring things out.”

– CCAC client

Care coordination delivers health benefits to those with multiple needs, while improving their experience of the care system and driving down overall health care (and societal) costs.¹⁶

The next part of this report visually depicts the varied dimensions of care coordination and the latter part highlights some important ways that CCACs are driving better quality care in keeping pace with Ontario's health care priorities.

¹⁶ Care Coordination Model: Better Care at Lower Cost for People with Multiple Health and Social Needs. IHI Innovation Series white paper. C. Craig, D. Eby and J. Whittington. Cambridge, Massachusetts: Institute for Healthcare Improvement, May, 2011, p. 2.

CCAC Case Managers at Work

“Clients are at the Heart of Everything We Do”

Client-Centred Care in Collaboration with Other Health Care Professionals

Main Image: Working closely with other professionals at the Family Health Team, Jane, a Community Case Manager (left), collaborates with Dr. Mullen, a primary care physician (right), and Mary, her client (centre), to coordinate the best care for her specific needs. **Bottom left:** Jane meets with Dr. Copps to discuss new patients. **Bottom centre:** Allison, the receptionist who oversees the Family Health Team, helps Jane coordinate her upcoming visits to clients' homes. **Bottom right:** In the process of planning care, Jane reviews a client's medical record with Jeanette, one of the clinic's nurses.



Giving Clients the Support to Live Safely in their Own Homes

Main Image: Catherine (Jean) wants to continue living independently at home. To support this choice, Andrea, a Community Case Manager, regularly provides recommendations to help Jean safely manage her activities of daily living. **Bottom left:** Andrea arrives for her weekly visit to see how Jean is doing and ensure that her needs are being effectively met. **Bottom centre:** Andrea updates Jean's health care information and the next steps they have agreed on for her care plan. **Bottom right:** Andrea and Jean discuss obstacles in the home and falls prevention ideas.



“Every time I interact with our CCAC Case Manager regarding any matter, I feel as if I have spoken to a person who really CARES. Please accept my congratulations on having such a person on your team and, if you can, please let her know how much we appreciate her efforts in making my parents’ life a little better.”
– CCAC client’s family member

Enabling Clients to Spend Less Time in Hospital and More Time Recovering at Home

Main Image: Shirlee, a Hospital Case Manager (left), meets with Dr. Rawof, a physician in the Rapid Assessment Unit of a hospital emergency department. **Bottom left:** Shirlee reviews patient files so that she can develop care plans with each client before they are discharged from hospital. **Bottom centre:** Sera, a nurse practitioner in the in-patient unit of this large hospital, gives Shirlee a client update. **Bottom right:** Shirlee checks details so she can best support patients to go home, as soon as they are ready.



Supporting Clients with Enhanced Care Needs and their Caregivers

Main Image: Stephanie, a Community Case Manager (left), has a family meeting with Norman, her client (centre), and Ann, his wife and caregiver (right). They discuss the enhanced care Norman needs to manage a neurological condition that affects his swallowing and activities of daily living. **Bottom left:** Stephanie holds a dietary supplement and discusses Norman’s nutritional regime, as outlined by the dietician. **Bottom centre:** Norman shows Stephanie how he manoeuvres his walker to move around the main floor of his home. **Bottom right:** Stephanie and Norman have a one-on-one conversation about his health care needs and concerns.



“It’s nice to have an agency like CCAC to provide you with extensive information, offer various services and direct you to the appropriate, available resources.”

– Mother of a CCAC client, who is a child with medically complex issues

Supporting Children at School or Care in the Community Where People Need it Most

Main Image: Mary Jane, a Pediatric Case Manager (centre), collaborates with educators, service providers and families to give children like Matthew the support they need to attend school and reach their potential. Matthew particularly enjoys honing his computer skills with help from Kirsten, his Educational Assistant (left), and Heather, his mom (right), nearby. **Bottom left:** Wendy, a registered nurse, and Mary Jane, help Matthew get ready for lunch, which he receives via a feeding tube. **Bottom centre:** Mary Jane reviews Matthew’s care plan with Nilusha, a dietician. **Bottom right:** Mom stops by for a visit with Matthew and Mary Jane.



Helping Clients Safely Return Home after Surgery

Main Image: Ieta, a Hospital Case Manager, facilitates Ronald’s discharge from hospital after cardiac surgery and coordinates home care and other community care services to help him recover. **Bottom left:** Ieta gets ready to visit Ronald on his last day in hospital, so she can help him prepare for the journey home and return to his life and his community. **Bottom centre:** Ronald reviews his care plan with Ieta. **Bottom right:** Helping smooth Ronald’s transition back to his home, Ieta connects with care providers and community agencies to ensure the support he needs is in place upon his return home.



Part Two—Addressing Ontario's Health Care Priorities

1. Working to Keep More People Safe at Home with Quality Care

One in every three senior citizens is likely to fall at least once per year.¹⁷ In fact, falls, as well as medication-related issues are among the leading reasons why Ontario's seniors with complex health care needs are admitted to hospital.

Ontario's CCACs recognize that when given a choice, most seniors will choose to live as long as possible in their own home, even if this means living with increased risks, such as those posed by stairs, slippery floors or medications. As part of our commitment to deliver quality care, we help clients and their families identify and understand their health risks, recommend ways to improve home safety and support their decisions about how and where to live. To do this, we see our clients regularly, assess their needs and safety on an ongoing basis and help them figure out better ways to manage their activities of daily living.

Two key components of our risk management and safety support for our clients are aimed at helping people take their medications safely and reducing the likelihood of them falling at home or in their community.

CCACs are Helping More People Use Medication Safely

Almost two-thirds of Canadians—who are 65 years and older—take five or more medications each year; for one-third, this increases to 10 or more by age 85.¹⁸ As a senior takes more medications, their risk of experiencing dangerous drug interactions, health issues from side effects and potential accidental overdoses, rises.

For clients at a higher risk for medication-related issues, a CCAC Case Manager will arrange for a physician, pharmacist or other qualified health

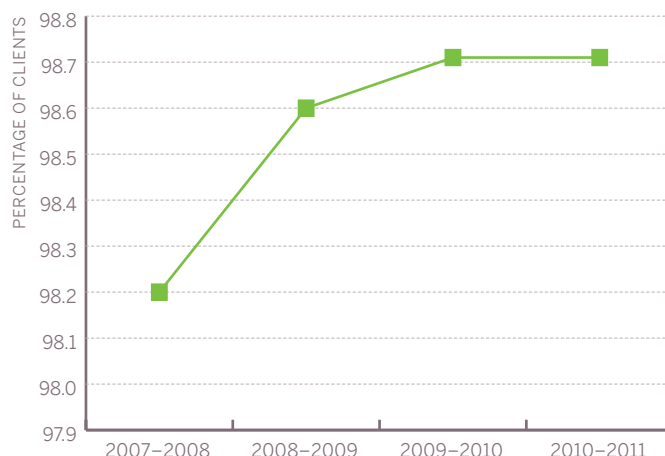
professional to review their medications. A medication review by a qualified health professional can help people understand how and when to take their medications, manage multiple medications and watch out for side effects, such as dizziness, confusion or other health issues. Practicing proper medication safety can help prevent unnecessary visits to hospital Emergency Departments and improve health outcomes for each of our clients.

In 2008, one CCAC initiated a program called *Medication Management Support Services* (MMSS). Other CCACs across the province are learning from this experience and have started to enhance their own medication safety programs.

VALUE FOR OUR CLIENTS

Last year, CCACs reported that an average of 98.7 per cent of CCAC clients, who received services for more than 90 days, were referred to a primary care provider or other qualified health professional for a medication review (as depicted in the following graph).^{19, 20}

Prevalence of CCAC Clients Referred for a Medication Review



¹⁷ World Health Organization (WHO), 2007.

¹⁸ Drug Use Among Seniors on Public Drug Programs in Canada, 2002 to 2008, CIHI, 2010. (Based on data from six provinces.)

¹⁹ Multi-Sector Service Accountability Agreement (M-SAA) Indicators, 2010/11.

²⁰ A primary care provider can be a family physician or nurse practitioner who oversees a person's health care and refers them to specialized services, as required.

These review rates are higher than those presented in a recent Canadian study that showed that fewer than half (or 48 per cent) of seniors with chronic health conditions (that is those requiring medical care to address a long-term illness or condition), had their medications reviewed by a physician.^{21, 22}

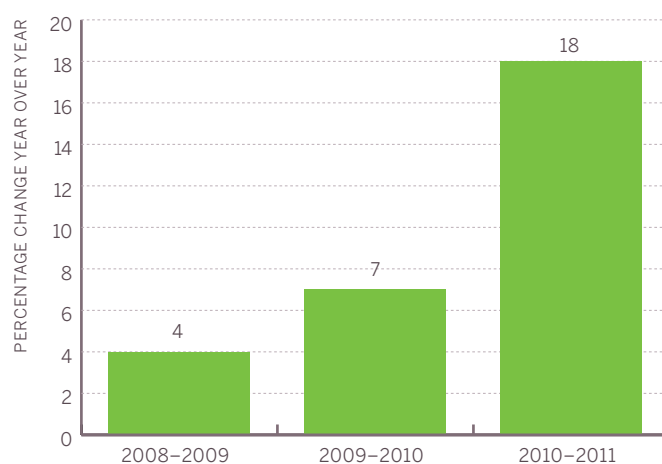
Helping People Avoid Falls at Home and in the Community

Falls have a tendency to happen more often at home and are the most common cause of major injuries that require hospital stays for Ontario's seniors.²³ According to the Canadian Institute for Health Information (CIHI), more than 70,000 seniors across Canada were admitted to hospital for falls from 2008–2009 and half of these falls occurred in the home.²⁴

Our CCACs are responding by implementing more falls prevention strategies, which encompass education, therapy and referrals to community-based programs and specialized services. These efforts include:

- Educating clients and caregivers about risk factors.
- Helping clients access walkers and other types of adaptive equipment.
- Providing occupational therapy and physiotherapy services in the home to recommend safety improvements and teach clients strengthening exercises.
- Linking clients to community-based programs.
- Referring clients to falls prevention clinics and specialized geriatric services, as required.

CCACs Are Serving More Higher Need Clients



These initiatives coincide with a more than 10 per cent rise in the number of Ontario adults aged 85 and older between 2009 and 2011, and with this, a higher need for home care support. These clients are also more vulnerable to falls, as it's estimated one in two seniors over the age of 80 will fall at least once a year.²⁵

VALUE FOR OUR CLIENTS

As our CCACs are now seeing a higher number of frail or higher need seniors with complex health needs, we are also seeing a rise in the number of reported falls but less than we might expect.

In 2011/12, our CCACs will evolve their falls strategies even further by working with their respective Local Health Integration Network (LHIN) and Public Health Units to consistently implement Ontario's *Integrated Falls Prevention Program*.

We will also set targets to potentially decrease the number and impact of falls by clients aged 65 and older and provide more assessments and closer monitoring.

²¹ A *chronic care* client requires medical care to address a non-communicable illness or condition, lasting three months or more and often with a slow progression, such as heart disease, lung disease or diabetes.

²² *Seniors and the Health Care System: What is the Impact of Multiple Chronic Conditions?* Canadian Institute for Health Information (CIHI), January, 2011, p. 2.

²³ *Ontario Trauma Registry 2009 Report: Major Injury in Ontario*, F. Yang, A. M. McKeag and C.M. Fortin, CIHI, 2009.

²⁴ *Series on Seniors: Seniors and Falls*, Information Sheet, CIHI, 2010.

²⁵ Public Health Agency of Canada, 2011.

Addressing Readmission Rates and Emergency Department Visits

With CCACs' efforts to improve care coordination support, create customized care plans and improve home safety, we are gradually starting to see fewer visits to the Emergency Department by seniors aged 80 and older with less urgent and non-urgent needs.²⁶ Eight per cent of these clients made avoidable visits to the Emergency Department in 2010/11; 12 per cent of all clients, who had been discharged from hospital, went to the Emergency Department for a least a short visit within 30 days after returning home. Continuing our efforts to reduce hospital readmission rates is a key quality improvement opportunity for our CCACs.

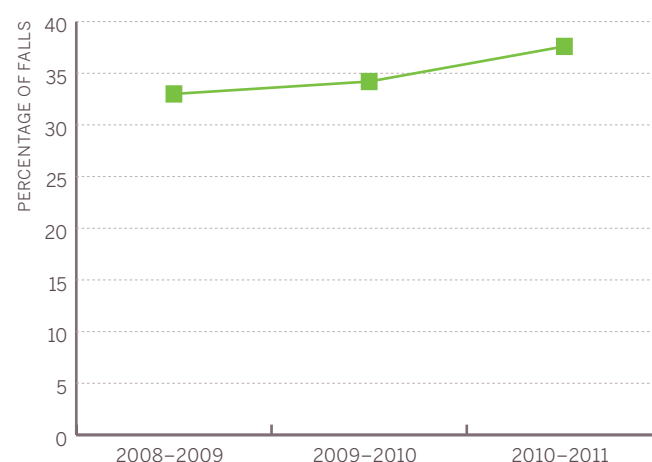
CCACS HAVE PLANS TO IMPROVE SAFETY IN 2011/12

Using our data to better track and understand client risks related to falls and medication safety, our 2011/12 improvement initiatives are focused on expanding our safety initiatives to:

- Improve our capability to respond more rapidly with nursing services to help our very high need clients (or *complex care* clients with multiple chronic conditions) transition from hospital to home and increase the rate of medication reviews within 24 hours of hospital discharge.^{27, 28}
- Set targets to reduce Emergency Department visits by our clients, due to a medication issue, such as a dangerous drug interaction or accidental overdose.
- Reduce our clients' readmission rates within 30 days of being discharged from hospital, as per local reduction targets set by each CCAC and its LHIN.
- Set targets to reduce the number and impact of falls by our clients aged 65 years and older.

²⁶ These clients are defined as *Less Urgent* and *Non-Urgent* by the *Canadian Triage and Acuity Scale* (CTAS), a common assessment tool used by Emergency Departments and paramedics to define patient needs for timely care and to evaluate their acuity level, resource needs and performance against certain operating

Percentage of High Need Clients Reporting a Fall



Readmission Rates to the Emergency Department



objectives. CTAS level 4, are patients with *Less Urgent* conditions related to their potential for deterioration or complications, who should be seen by a physician within one hour. CTAS level 5, are patients with *Non-Urgent* conditions that could be part of a chronic problem and should be seen within two hours.

²⁷ *Rapid response nursing solutions*: Help seniors and children with complex care needs transition from acute care hospital beds to their home by providing in-home nursing visits, within 24 hours of discharge, seven days a week.

²⁸ *Complex Care*: Clients who have completed the acute phase of care and are medically stable but require daily skilled assessments from an inter-professional team to manage multiple complex chronic conditions.

2. Increasing Clients' Access to Health Care Services

Today, four out of five seniors live with one or more chronic or long-term condition and age-related health illness. Between 2009 and 2012, the number of adults aged 85 and older is projected to increase by 15.6 per cent across the province.²⁹

As the average age of Ontarians rises, so does the number of active CCAC clients with more complex illnesses or conditions, who require the greatest amount of support and care. In 2009/10, we identified the following quality improvement opportunity: To support even more of our clients who want to live at home for as long as possible.³⁰

In 2010/11, we addressed this opportunity through initiatives that gave our clients improved access to community-based care. Our CCACs have also helped reduce the number of hospital beds occupied by Alternate Level of Care (ALC) clients—that is people who no longer require a hospital's services and can be more effectively cared for elsewhere.

Home First: More Clients Going Home

All our CCACs now use a *Home First* approach, which gives more people than ever before the option to return home after a hospital stay.

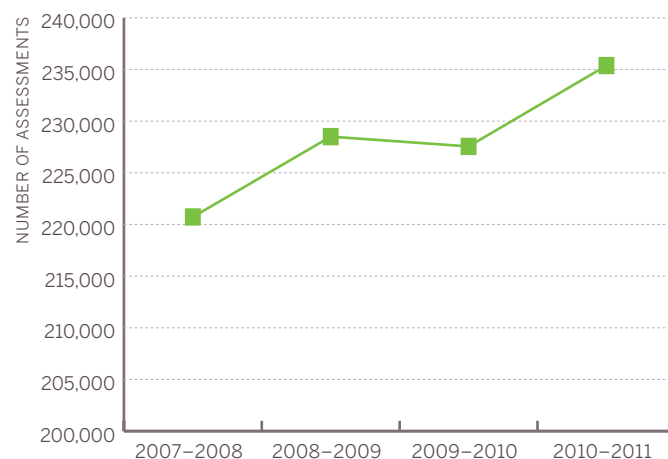
This approach to care reminds us that every time a client goes into hospital, they usually prefer to recover at home. It means providing enhanced home care services and linking to community support services that make it possible for patients, often frail seniors, to leave the hospital and safely wait for a LTC bed or continue their recovery at home. With this approach, hospitals and CCACs work quickly with clients while they are still in hospital, to plan for the care they will need to go home.

We work with our service providers to deliver on care plans that call for a range of support services, from in-home personal support to specialized care, including chemotherapy home infusion and home dialysis. There are now more options than ever for our clients to receive health care in the comfort of their own homes.

There are times when a client returns home and finds that home care services are not sufficient and that they need the higher level of care and support offered by a LTC home. If this happens, a CCAC Case Manager will support them through the application process.

To help support Home First, as well as other initiatives, our Case Managers are completing an increasingly higher volume of RAI-HC assessments for our long-stay clients (needing chronic or complex care).³¹ In 2010/11 alone, they completed approximately 7,800 more assessments for long-stay clients than the previous year, as shown in the following graph. These increased assessments help us more accurately evaluate our clients' changing needs.

Number of Health Care Assessments Completed by Case Managers



²⁹ 2006 Census, Aging, Statistics Canada, 2007.

³⁰ 2009 – 2010 CCAC Quality Improvement Report, Quality Improvement Opportunity #4, p. 37.

³¹ Resident Assessment Instrument for Home Care (RAI-HC) is a standardized, multi-dimensional assessment system for determining client needs, which includes quality indicators, client assessment protocols, outcome measurement scales and a case mix system.



The province-wide Home First approach is about CCACs and hospitals working together to explore every opportunity for clients to go “home first,” before considering Long-Term Care homes or other options.

In discussing better care for the elderly, Dr. Ben Chan, Chief Executive Officer, Health Quality Ontario, suggests: “We want to know who’s got the best process out there for any particular area and then, once we have that, try to find ways in which we can rapidly spread that across the system.”

Since being introduced at one CCAC in 2008, Home First has been adopted province-wide and is delivering impressive results—from honouring our clients’ wishes to return home to easing Emergency Department wait times, alleviating the demand for LTC beds in most regions and helping to reduce the number of people in hospital beds, who don’t need to be there.

VALUE FOR OUR CLIENTS

With Home First and other initiatives, fewer seniors are now waiting in hospital beds to move to a LTC home. This also helps ensure that LTC beds and hospital beds are available for those who need them most.

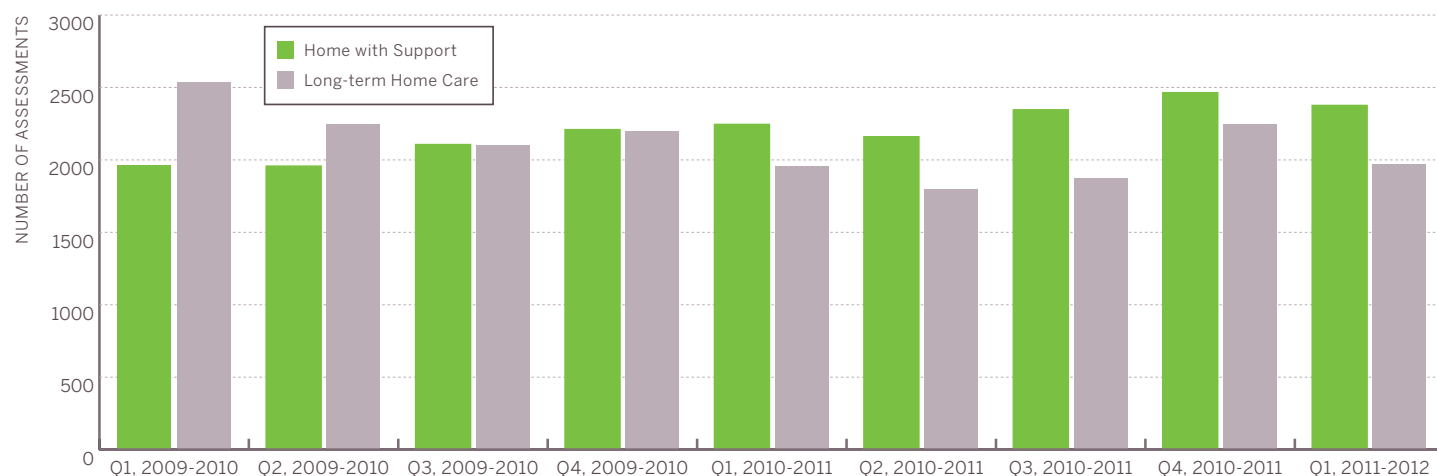
As our CCACs become an increasingly important

point of contact and support for aging Ontarians, we are effectively linking more clients to the most appropriate care for their specific needs. Investments from LHINs have also helped increase the availability of suitable, community-based support services that enable our clients to live safely at home.

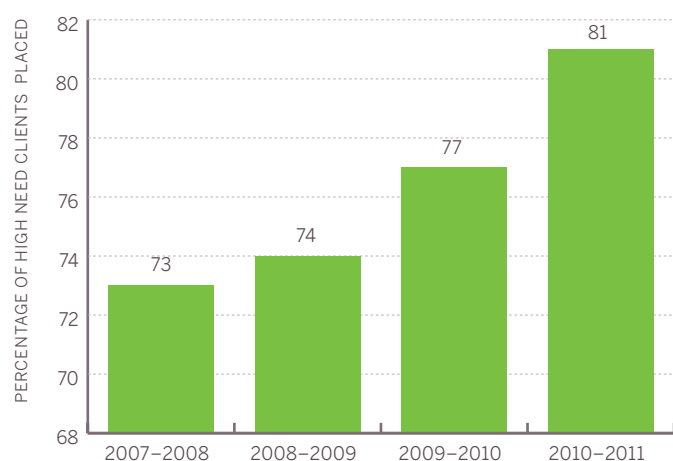
As a result of Home First and other home and community initiatives, there was a 21 per cent increase in the number of ALC patients who returned home after they were discharged from hospital between April 2009 and June 2011, as shown in the following graph. This corresponds with a 22 per cent decrease in the number of ALC patients, who moved from hospital to LTC homes in the same time period.

This shift has also decreased the overall demand for LTC beds and allowed us to dedicate available beds to our highest need (complex care) clients. Specifically, 81 per cent of all the clients we placed in LTC homes last year were individuals with very high needs – four per cent more than in 2009/10.

Helping More Ontarians to go Home with Support



More Long-Term Care Beds are Supporting Higher Need Clients



CCACs are Care Connectors: Helping Clients Find Primary Care Providers

For some clients, a major barrier to care is finding a family physician or other primary care provider, ideally within their community, to oversee their medical care and when required, refer them to specialized services.

In 2009, the Ontario Ministry of Health and Long-Term Care (MOHLTC) launched a program called *Health Care Connect*. This program was designed to help 500,000 Ontarians without a primary care provider to find one, as well as reduce emergency room congestion and help those with chronic diseases to better manage their conditions.³²

Working with our provincial partners, CCAC nurses serve as Care Connectors to identify local primary care providers, such as physicians or nurse practitioners, who are accepting patients, and match them with clients. Within the first two years of Health Care Connect, we helped more than 49,000 Ontarians find a primary care provider and in 2010/11 alone, we did the same for more than 40,000 people.³³

Addressing Wait Times for Hospital and Community Referrals

Typically clients with the greatest need, as determined by a RAI-HC assessment, are referred to CCAC services from hospital. Before these clients are discharged, a CCAC Case Manager working in the hospital assesses their needs and develops an initial care plan for them. This process helps ensure essential service providers and other home supports are arranged before a client returns home. Half of these clients receive their first service visit within one day of being discharged from hospital, while the remaining clients have their service start within four to five days of discharge.

In the past three years, our sources for CCAC referrals have shifted. We now receive the majority (an average of 60 per cent) of client referrals from hospitals and an average of 43 per cent from the community—four per cent less than in 2008/09.

The average time our clients referred from community sources waited to begin receiving non-case management services, such as nursing, physiotherapy, occupational therapy and personal support, decreased by slightly more than a day in 2010/11.

This reduced duration of days from referral to the date of first service for 90 per cent (or the 90th per centile) of community referrals is depicted in the following graph, which shows community, as well as hospital referrals to non-case management services.

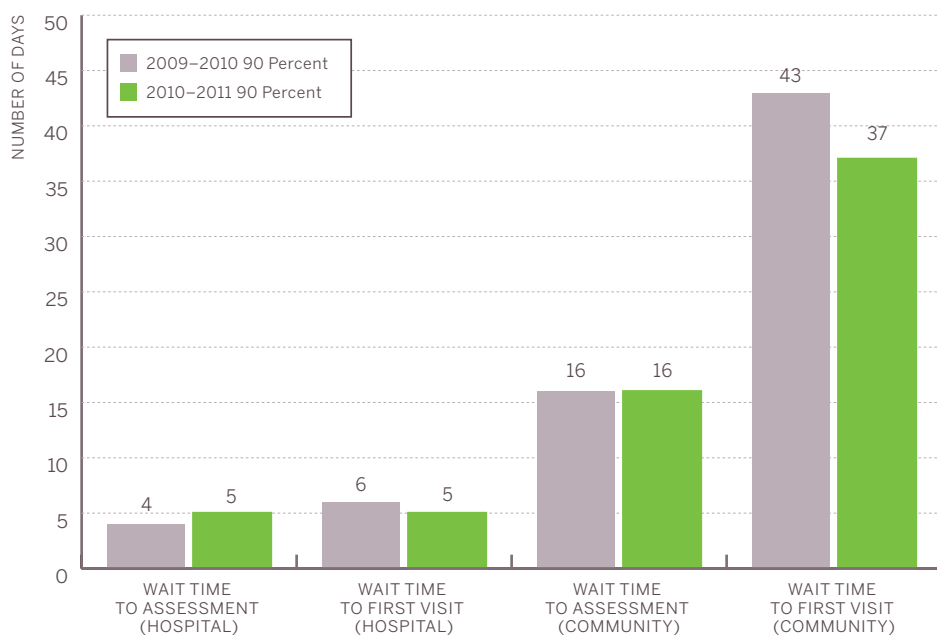
Wait times for 50 per cent (or the 50th per centile) of community and hospital referrals stayed the same as the previous year. For half (or the 50th per centile) of our clients referred from hospital, services start within one day after they are discharged.

³² *New Agreement with Doctors Improves Access to Care*, Ontario.ca/health news, October 18, 2008.

³³ *McGuinty Government Delivering Results in 2010*, Ontario.ca/health news, December 31, 2010.

In comparison, clients who live in the community and are referred for CCAC services usually have less urgent needs. In 2010/11, 50 per cent of these clients received their first service within six days after they were assessed.

90th Per centile Wait Times to Assessment and First Visit



CCACS HAVE PLANS TO IMPROVE SERVICE ACCESS IN 2011/12

Building on the positive results of Home First and other initiatives to improve access, we will set targets and aim to:

- Reduce the time to first service for community-referred, complex care clients.
- Increase the number of end-of-life or palliative care clients who are supported so that they can die at home, if that is their preferred place to receive care.

Meeting People's Health Care Needs at Home

Mr. Brown's Story

Mr. Brown is 80 years old and he had been in and out of hospital numerous times prior to being placed in a Long-Term Care (LTC) home. From LTC, he required hospitalization once again. Throughout this time, Mr. Brown remained adamant that he wished to return home.

Through CCAC Home First, he was able to modify his house and equipment was installed to ensure it was accessible to suit his needs. Mr. Brown was provided with physiotherapy to build up his strength and endurance, nursing care to help heal his wound, and personal support services to assist him with his personal care needs. His CCAC Case Manager has regular contact with him to ensure that all of his needs are being met. Through the services CCAC put in place for Mr. Brown, he is now managing well and is able to remain at home.

In 2010/11 CCACs provided more than 20 million hours of personal support services to clients like Mr. Brown to enable them to live in their homes for as long as possible.

3. Helping People Navigate through the Health Care System

As our clients' health care needs change, they will need the help of a range of providers, such as physicians, nurses, personal support workers and therapists, in various health care settings, including hospitals, clinics and at home.

Across the health care system, our clients interact with many providers, re-tell their stories, make life-changing decisions and transfer their medical information through many hands. The experience can be overwhelming, confusing and stressful.

Connecting People to Community Health and Social Support Services

Our CCACs help clients face these challenges and support them as they move between different health care services, including community health and social services, rehabilitation and various types of residential care. This includes clients with complex needs, who may use different providers, sometimes concurrently, as well as those who have diverse language, educational and cultural backgrounds.

A Case Manager serves as each client's single point of access to connect them to the most appropriate health and community care services for their individual needs. As such, all our CCACs are accessible to Ontarians 12-hours a day, seven days a week, through a provincial toll-free telephone number (310-CCAC) and a live attendant is available to respond to information requests and queries. After hours support is available as well. Many CCACs also meet their diverse community's specific needs by providing information in preferred languages, if

required, such as Arabic, Bengali, Chinese dialects (including Cantonese and Mandarin), Finnish, Hindi, Italian, Ojibwa, Portuguese, Punjabi, Russian, Spanish, Tagalog (Filipino), Tamil and Urdu, as well as English and French.

Working with People Being Discharged from Hospital

Our Case Managers work closely with hospital staff to ensure our clients return home with the needed care in place or move to a different health care setting to receive the services and care they need.

We also have staff assigned to work in each hospital, including in Emergency Departments. For hospitals with more than 20,000 Emergency Department visits each year, a Hospital Case Manager is dedicated to that department for at least eight hours a day, five days a week. Our CCACs are also working to establish stronger partnerships with primary care providers and foster more collaboration to improve chronic disease prevention and management.

Supporting Clients Better through Integrated Care Teams

A recent report tells us that one per cent of the Ontario population uses almost half (49 per cent) of its health care resources.³⁴ This one per cent of our clients includes those individuals with the most complex, chronic health conditions. To better help these clients who need high levels of support from across the health care system, our CCACs are designing a program that provides care and support and is integrated across multiple health care providers: Ontario's Integrated Client Care Project (ICCP).

³⁴ *Ideas and Opportunities for Bending the Health Care Cost Curve: Advice for the Government of Ontario*, OACCAC, Ontario Federation of Community Mental Health and Addiction Programs (OFCMHAP) and the Ontario Hospital Association (OHA), April 2010, p. 5.



The Integrated Client Care Project (ICCP) supports our clients with integrated care teams to improve health outcomes. It focuses on organizing care around the following client populations: Wound Care, Palliative Care, Frail Seniors and Medically Complex Children.

The ICCP is addressing a 2009/10 quality improvement opportunity of supporting our clients with integrated care teams to improve health outcomes.³⁵ Launched in 2009/10, this multi-year initiative uses best practices to enhance transitions, improve health outcomes and advance provincial priorities for the health care system.

Increased integration directs us toward a focused, in-depth understanding of our clients, their caregivers and overall needs. It helps us target and organize our resources around specific populations so that we can create a better client and caregiver experience for them, while ensuring the best value for Ontario's health care dollars. In addition, the ICCP improves our ability to assess clients in a consistent manner, work more effectively with partners and measure client outcomes and experiences.

"LHINs and CCACs should continue to work towards ensuring the CCACs are the single point of access for transitioning patients to the most appropriate care settings, including 'Assess and Restore' programs."

– Dr. David Walker, Provincial ALC Lead

THE ICCP FOCUSES ON ORGANIZING CARE AROUND FOUR SPECIFIC CLIENT POPULATIONS:

1. **Wound Care** – Participating clients with diabetic foot ulcers and venous leg ulcers
2. **Palliative Care** – Participating home care clients who receive an end-of-life diagnosis or who are expected to die within 12 months, as well as those who have been identified as having unmet end-of-life needs that require support
3. **Frail Seniors** – Participating high need senior clients who are at home and require chronic or complex care
4. **Medically Complex Children** – Participating children with medically complex issues that usually require technological devices and whose families require teaching and support to care for them at home and in other settings

With progress in the wound care client population well underway, some CCACs, LHINs and other service providers began exploring this approach to care for palliative clients in late 2011. And plans are underway for applying the ICCP to the other cited client populations in the future. Furthermore, we are looking at

³⁵ 2009 – 2010 CCAC Quality Improvement Report, Quality Improvement Opportunity #3, p. 36.



The ability of individuals to enter the health system at any given point, and then navigate the continuum of care smoothly and efficiently, is one of the hallmarks of a high-performing, patient-focused health system.³⁶

how the ICCP supports the Excellent Care for All Act to promote better quality health care and improve the value of the health care services we provide.

CCACS ARE ALSO APPLYING SEVERAL INITIATIVES THROUGHOUT ONTARIO TO HELP OUR CLIENTS SMOOTHLY TRANSITION ACROSS HEALTH CARE SERVICES, INCLUDING:

- **Wrapping care around each client's individual needs**
Our CCACs are collaborating with hospitals to care for Ontario's most vulnerable populations. One CCAC applied this shared care model to form a team made up of CCAC and hospital staff, including family physicians and specialists. CCAC staff coordinates care for these clients, who have been discharged from hospital but have a high risk of being readmitted, and the team serves as a "virtual ward" to follow their progress. Several CCACs also use this model to care for end-of-life (palliative) clients.
- **Helping people get to the right place of care: expanding CCACs' care coordination role**
Our CCACs and their LHINs have been working together to fulfil the 2009/10 improvement opportunity to help people get the right care, in the right place across the system, by connecting them to the most appropriate health care services.³⁷ As a result, some CCACs are now managing access for different health services across the province, including adult day programs, supportive housing, assisted living, complex care and rehabilitation beds. Dr. David Walker's report: *Caring for Our Aging Population and Addressing Alternate Level of Care*, released on June 30, 2011, supports the expanded CCAC role as a single point of access for key services and a connector to the most appropriate care.

- **Bringing value to clients and the health care system**

The way CCACs currently pay service providers does not reward the use of best practices or achieving the best possible outcomes for our clients. Our CCACs are exploring and testing several alternative reimbursement models based on paying for better outcomes and better care for our clients.

Through the ICCP, we are exploring outcome-based payments, which will move us from a system that pays for an activity, such as the number of nursing visits a client receives, to one that pays for results, such as how quickly the client's wound heals. This alternative client-based costing model sets our clients' payments to health care providers according to the value they receive. Specifically, payments are aligned with pre-defined client outcomes that the health care provider must achieve. This model is being gradually tested by CCACs in 2011/12.

VALUE FOR OUR CLIENTS

The first two stages of the ICCP are well underway and we are beginning to see results:

- **Wound Care Group** – Of the four early implementation sites that served more than 1,000 clients, all exceeded the target wound reduction goal of 30 per cent within four weeks (on average) and reductions for venous leg ulcers ranged from 38 to 80 per cent. Furthermore, 72 per cent of clients reported a better ability to manage their own care using the program provided, following the integrated client care assessment.
- **Palliative Care Group** – This phase launched in late 2011 and is being implemented and evaluated at six CCAC sites.

³⁶ *Four Pillars: Recommendations for Achieving a High Performing Health System*, OHA and OACCAC, page 18.

³⁷ *2009 – 2010 CCAC Quality Improvement Report, Quality Improvement Opportunity #5*, page 37.

Beyond the numbers, our clients' experiences and feedback speaks to the impact of our transition initiatives and how they are helping clients move smoothly between health care services.

CCACS HAVE PLANS TO HELP CLIENTS BETTER NAVIGATE THE SYSTEM:

We will leverage the following opportunities to further improve transitions in the coming year by:

- Building on our work with LHINs to identify more opportunities to reduce unnecessary Emergency Department visits and hospital readmissions and improve the experiences of people who transition between different health services.
- Integrating assessments and information systems across our CCACs and different health care services, so that different providers will be able to consistently retrieve each client's health information.
- Improving public access and connection to information about community health and social services in local communities across Ontario by building on two CCACs' experience with thehealthline.ca.
- Increasing and smoothing transitions of our very high need (complex care) clients moving from hospital to home, by providing support for them to safely live in their community.
- Continuing to strengthen CCAC relationships with primary care providers and family health teams.
- Enhancing the CCAC system navigator role to help our clients get the right care they need, at the right time and in the right place.
- Implementing solutions to track and monitor our clients (and other Ontarians), who are referred from CCACs to community support service organizations, to assess if and how well their needs are met.

Coordinating Care for People to Convalesce and Heal

Mrs. Thompson's Story

Mrs. Thompson was 72 years old and living alone in her home when she underwent quadruple bypass surgery and required some post-operative care. Although she has three children, only one lives in her area and he was unable to give her full-time care.

Mrs. Thompson's CCAC Case Manager recommended and arranged for her to convalesce in a rest and retirement home for four weeks after surgery to regain her strength. Once Mrs. Thompson returned home, her Case Manager collaborated with her son and additional community support services to create a full care plan and tailored it to her needs. An occupational therapist visited Mrs. Thompson to ensure her home was practical for her healing. She also had a nurse visit to help with her medications and wound care and a meal delivery service provided her with proper daily nutrition.

Through careful navigation between health care services and by connecting Mrs. Thompson with appropriate health system supports—from hospital, to convalescence residence, to home—a CCAC Case Manager was integral in helping her recover.

4. Sustaining Quality Care Today and for Tomorrow's Generations

As Ontario's population grows older and lives longer, its health care needs will become more complex and the need for care in the home and in our communities will increasingly be a critical component of a modern health care system.

Caring for More High Need Clients in the Community

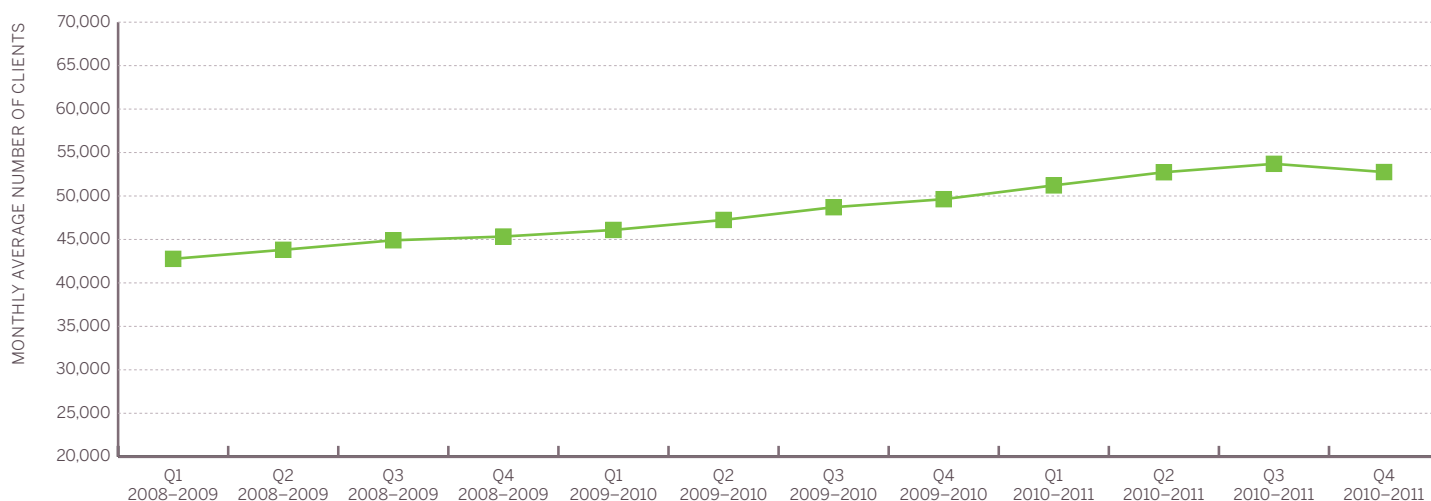
Today, we have more high need clients in the community than ever before. In the past three years, the monthly average number of high need clients supported by CCACs (defined as those with high scores in MAPLe—a common decision-support tool) has increased by approximately 10,000 or almost 24 per cent.³⁸

The role of home and community-based health care must evolve to keep pace with aging Ontarians and our provincial health care system. We are looking for new ways to deliver quality care to more people, as cost-effectively as possible.

DURING 2010/11, CCACS EMBRACED VARIOUS WAYS TO IMPROVE QUALITY CARE FOR THE LONG-TERM:

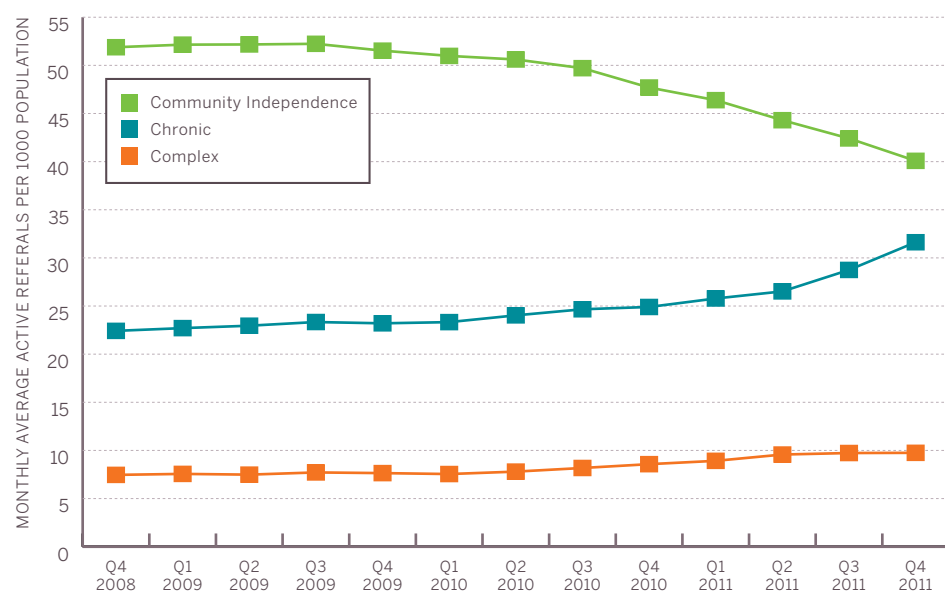
- **Exploring new technologies to help people better manage their care at home** – In partnership with the *Ontario Telemedicine Network* and family health teams, several CCACs participated in the Ontario Telemedicine Strategy pilot, which was funded by the MOHLTC and Canada Health Infoway. It tested remote monitoring technology to help clients with congestive heart failure and chronic obstructive pulmonary disease manage their own care at home more efficiently, and in doing so, reduce Emergency Department visits, hospitalizations and LTC admissions.
- **Providing better care for medically fragile children with eShift solution** – This CCAC-developed innovation supports more children at home by connecting an enhanced-skill personal support worker in the home with a pediatric registered nurse via a web-enabled

High Need Clients in the Community with CCAC Support



³⁸ Method for Assigning Priority Levels (MAPLe) is an algorithm derived from the RAI-HC. It provides information about the client's risk of adverse health outcomes.

The Population of Clients Served by CCACs is Changing



iPhone. CCAC service providers use the device to share information securely through a web portal. Instead of working one-on-one with clients, eShift enables each pediatric registered nurse to monitor, mentor and manage care for clients at up to four locations simultaneously.

- **Providing care more efficiently to clients who live close together** – An example of this is a cluster care approach, in which a team of service providers are assigned to deliver personal support care to all the clients in an apartment building, retirement home or neighbourhood. This model offers clients more scheduling flexibility and makes more efficient use of staff time.
- **Creating a single electronic client record for use by all CCACs** – Investing in an electronic health record for CCACs to enable health system integration and support better client care was cited as an improvement opportunity in the 2009/10 Quality Report and implemented by the end of November 2011.³⁹ Our Client Health Related Information System (CHRIS) provides a single clinical support system, which Case Managers across the province can access to retrieve, review and document detailed information about a

Applying a New Program for Timely and Effective Healing

Mrs. Retz's Story

One CCAC developed an advanced wound care program based on clinical research and best practices for optimal wound healing, using advanced wound care products and protocols. Elfriede Retz (Oma) and Wendy, her daughter and primary caregiver, experienced this new program firsthand. After Oma received surgery in hospital, Wendy helped transition her home and set up home care services to treat her surgical wound and bed sores.

"When Oma came home from the hospital she was in incredible pain. The nurse placed the proper pad on her back and used a special barrier cream, making it easier for Oma to move around. She also worked on the wound, packing in such a way that allowed Oma to lie on her side in bed, optimizing comfort," said Wendy.

The CCAC conducted a negative pressure wound therapy assessment to determine if Oma was an appropriate candidate for this program. A nurse visited her every three days until the treatment was completed. Her daughter saw how wound therapy helped cut healing time in half and the number of nursing visits decreased, as the need for dressing changes eased. Through this advanced wound care program, clients like Oma are receiving care based on best practices for safe, timely and effective healing.

³⁹ 2009 – 2010 CCAC Quality Improvement Report, Quality Improvement Opportunity #6, p. 38.

A recent analysis sponsored by the Ontario Community Provider Associations Committee (CPAC) and The Change Foundation estimated that home and community care contributes to \$150 million in annual savings and value to the health care system.⁴⁰

Only five per cent of Ontarians account for 84 per cent of the province's hospital and home care expenditures.⁴¹ Chronic disease accounts for an estimated 55 per cent of direct and indirect health care costs. As our population ages, the burden of chronic disease management on our health care system will increase.

client's care and health services delivered. CHRIS connects Case Managers across the home and community care sector and supports sustainable quality by providing a common platform to track, transfer and measure integrated electronic data about our clients and their care, which can be used to drive improvements.

- **Empowering clients with chronic disease by providing prevention strategies** – Several CCACs have begun facilitating the delivery and support of *Chronic Disease Self-management Programs*, which enable clients to help prevent and manage their chronic diseases. The model informs and empowers individuals to actively manage their condition through the skills learned in action plans and other sessions, such as dealing with pain, fatigue, difficult emotions, nutrition and exercise. Some CCACs are also teaching health care providers about self-management and how they can adjust their practice to help clients better manage their disease and in doing so, achieve their best state of health and wellness.

CCACs are Spending More on High Need Clients



VALUE FOR OUR CLIENTS

Our client population is changing, as shown in the above graph. And as the number of high need clients (chronic and complex) rises and lower need clients (those living independently in the community) declines, we've tailored our services accordingly.

This means supporting increasingly more clients with chronic, complex and end-of-life services between 2007/08 and 2010/11 and referring more clients with less intense support needs to community support agencies.

As the population of clients served by our CCACs continues to have higher levels of need, we are shifting resources to those client populations where the need is greatest.

The number of our clients who require hip and knee replacement has also increased from more than 14,500 in 2008/09, to almost 17,000 in 2010/11 and we provided in-home rehabilitation services to support them. This shortens our clients' length of stay in hospital and decreases costs to the system.

⁴⁰ *Valuing Home and Community Care*, Boston Consulting Group, 2010.

⁴¹ *Ideas and Opportunities for Bending the Health Care Cost Curve: Advice for the Government of Ontario*. OACCAC, OFCMHAP and OHA, April, 2010, p. 5.

By increasing our capacity to support clients at home and in their community, we are also helping to alleviate pressure on hospitals and LTC homes and enabling improved system planning.

Ontario's rapidly aging population dictates the need for continued investment to adapt and optimize our system to sustain delivery of quality care to all clients, particularly those with increasingly high needs or chronic and complex health care issues.

CCACS HAVE PLANS TO IMPROVE SUSTAINABILITY AND VALUE IN 2011/12:

With ongoing support, we will work to achieve improvement opportunities in 2011/12 that:

- Increase the use of telehome care services that can provide remote care to our clients.
- Increase the number of our high need (complex) clients being safely cared for in their homes.
- Support Ontario's move to a patient-based funding model, which is designed to better match funding to client needs.
- Shift the way rehabilitation needs for our hip and knee replacement clients are met by embracing the recommendations in the Walker report: *Caring for Our Aging Population and Addressing Alternate Level of Care*.
- Work more closely with our community support services and other community partners to ensure those clients who need a small amount of care can access it through various sources.

Number of Clients Receiving Personal Support Care and Average Personal Support Hours per Client



To keep pace with the demand to support more high need clients, who require more service, CCACs provided more than 575,000 additional personal support hours (necessitating an increase of \$36 million or six per cent) in 2010/11 than the previous year. This means that on average, high need clients received 19 per cent more personal support hours in 2010/11 than in 2008/09. These increases help more high need clients to live independently at home.

Our Commitment: Delivering High Quality Care to Ontarians

We believe home and community care is the foundation of a high functioning and sustainable health care system. Much research also supports the premise that home and community care is a cost-effective alternative to care in hospitals and LTC for many people.⁴²

Building on the positive results of Home First and other quality improvement initiatives, we will continue to enhance our clients' home and community care experience and proactively adapt to maintain high quality care that meets the new and ever-evolving challenges of Ontario's rapidly aging population.

Our clients should expect to receive, as an integral part of their health care, support and comfort from compassionate, skilled people who provide a high quality provision of care, who honour client choice and who respect an individual's need for dignity. CCACs, in collaboration with our partners, work very hard every day to meet our clients' expectations; however, there is still room for improvement. We welcome feedback on our performance. We listen to our clients and want to learn from their experiences.

Moving forward, our quality improvement efforts will continue to focus on strengthening and expanding our care coordination expertise, setting new targets and achieving better health outcomes. These include keeping Ontarians safer at home, improving their access to needed services, exploring different options with them, helping them navigate through the health care system, and obtaining higher quality care for today and tomorrow.

Care should be shifted closer to the patient such as through home-based care, particularly as health issues shift more towards chronic matters rather than acute ones.⁴³

– Don Drummond

⁴² Final Report of the National Evaluation of the Cost-Effectiveness of Home Care, Marcus Hollander and Nina Chapell, Health Transition Fund Canada, 2002.

⁴³ Therapy or Surgery? – A Prescription for Canada's Health System, Don Drummond, C.D. Howe Institute, Benefactors Lecture, 2011.

CCACs have a responsive team of staff who will answer your questions and help you access the care you need. CCAC services are fully funded by Ontario's Local Health Integration Networks (LHINs) and serve people of all ages.

English 310.CCAC (2222)

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