in the know
at Toronto Central CCAC

1 H1N1 Preparedness: Prior to the WHO advancing to Pandemic Level 6, the staff and service providers of Toronto Central CCAC were ready! Over the past year, we have ordered, stockpiled, trained, mask fit-tested staff and generally prepared for the eventuality of a pandemic. The goal of our plan is to be ready to support the health care system by helping people stay out of hospitals and receive the care they need in their homes and communities. We will also support hospitals as they transition H1N1 clients back to the community.

2 Resource Matching and Referral: The Resource Matching and Referral Program (RM&R) is a new way for health care providers to send client referrals to each other. Beginning in September, hospitals will be able to refer directly to the community, enhancing communication and collaboration between health care providers during the referral process, improving the efficiency of referral processes and matching clients to the most appropriate resources at the time of referral. RM&R helps to free up hospital beds and staff to better serve those requiring hospital care.

3 Home Care Research Open Forum – Leading the Way: Toronto Central CCAC hosted its first research forum in mid-April. Over 60 researchers listened as keynote speaker Dr. John Hirdes spoke about current and future research in home care. Designed to help the CCAC finalize our first research strategy and identify new research partnerships, the event provided an excellent forum for discussion. The final report is now available on our website at www.toronto.ccac-ont.ca.

Transforming the Way We Work in Hospitals: Working with Hospitals to Reduce Patient Flow

We're doing more than ever this year to improve client flow from hospitals and help reduce hospital emergency department wait times and alternate level of care (ALC) patient days. Here are the key features:

- Getting the CCAC involved earlier in a patient's hospital stay, so that we can reduce and even prevent patients from being designated as needing ALC.
- Piloting a "Home First" project at two hospitals (Sunnybrook and Toronto Western) to rapidly return patients back home for care and, where we can, reduce the need for long-term care.
- Extending our "Waiting at Home" program to help return ALC patients home while they wait for long-term care.
- Introducing a dedicated CCAC Emergency Department (ED) team to better work with ED staff to transition patients home from EDs, identify patients at risk for repeat ED visits, link patients to community support programs, and avoid unnecessary hospital admissions.
- Re-focusing our ED Notification system on those patients who would most benefit from CCAC and community service help.
- Changing how we assess and determine eligibility for long-term care.

Major Aims for 2009/10

At Toronto Central CCAC, we are transforming our model of care and implementing a population-focused model to better help our clients find their way to the right place of care. Guided by our 2008-2011 Strategic Plan, we created four major aims to support the strategic direction of Excellent Service. One in particular addresses the need to support work being done with the hospitals:

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inbox

This publication is produced to inform health partners, service providers and the community.

Toronto Central CCAC Community Care Access Centre

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

Ontario

- **Getting people home and keeping them home:** The purpose is to keep people independent in their homes and communities thereby helping to free-up emergency hospital beds for those in need.
- Transforming the experience for our clients and caregivers
- Building our quality and safety capacity across the organization
- Enhancing access and equity to community services

In addition to our already established programs serving clients with post-acute care, rehabilitation, mental health, palliative and acquired brain injury support needs, we will be introducing new programs designed specifically for frail seniors, and adults with disabilities.

Connecting People to Care

Launched by the Ministry of Health and Long-Term Care, *Health Care Connect*, is devoted to helping Ontarians without a family doctor access health care in their community. At the core of the program are "Care Connectors", located at CCACs across the province whose role is to help people without a family doctor access primary health care in their community. This new role reflects the government's commitment to strengthen and enhance the role CCACs play in the health care system and to ensure Ontarians have access to the right care when they need it.

Health Care Connect is also now available online to allow round the clock access to registration for your clients, yourself or someone else, http://www.health.gov.on.ca/en/ms/healthcareconnect/public/register.aspx.

Change Ideas that Work: Lessons from the Flo Collaborative

The Flo Collaborative forum provided a rare opportunity for health care organizations within the Toronto Central LHIN to share experiences and learn from leading experts in quality improvement and system transformation. In Spring 2009, the Toronto Central LHIN and Toronto Central CCAC partnered to capture and share the knowledge and resources developed.

The objective of this successful half-day forum, *"Change Ideas that Work: Lessons Learned from the Flo Collaborative,"* was to promote knowledge exchange among providers from across the health care continuum and take a first step toward building awareness and capacity for transformation across the system. More than 130 health care providers attended the event, representing all sectors of the community including long-term care, home care, complex continuing care, community support services, acute hospitals and rehabilitation services.

While the Flo Collaborative focused on reducing Emergency Department and Alternative Level of Care pressures, key learnings from the program are relevant and timely for all health care organizations.

Teams were provided with a common "handbook" of 6 core attributes of good transition planning:

1. Organize patient care around an estimated date of discharge
2. Screen patents for risk factors that may delay transition
3. Organize regular and frequent communication with inter-disciplinary teams
4. Develop visual triggers for staff, patients and families that clearly articulate discharge status
5. Develop joint transition/admission protocols, standardize processes, and eliminate duplication of roles
6. Partnerships to facilitate creative strategies for improving transitions

Each of these attributes included a series of "change ideas" that could be adapted, tested and implemented by the partnerships.

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Ontario