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Toronto Central CCAC / CASC
Community Care Access Centre
Centre d'accès aux soins communautaires du Centre-Toronto

In the Know for our Hospital Partners

Caring and Empathy Excellence Human Dignity
Social Responsibility Leadership

Toronto Central Community Care Access Centre
Outstanding care — every person, every day

In the Know - Hospital Partners

Feedback from our Partners*

I would like to take this opportunity to express my sincere appreciation for the excellent service our team and families from the NICU and Level 2 Nursery have recently received from the CCAC. Prior to my leaving on maternity leave, several issues were identified with service. However, upon my recent return I have had the opportunity to work with the CCAC for several neonatal discharges and have received excellent service.

The following are the improvements in CCAC services I have witnessed:

1. Referral assessments completed in a timely manner (not delaying discharge)
2. Excellent communication to team and families
3. Knowledge about neonatal population and services available
4. Reliable and punctual
5. Enthusiastic

(*Clinical Care Manager, Mount Sinai Hospital)

CEO Message

I've had the most tremendous good fortune to have spent 25 years in the community health field working with some highly inspiring and incredibly dedicated people devoted to ensuring the best of care to our clients in their homes and communities. It is with very mixed feelings that I now tell you of my intention to step down as Chief Executive Officer of the Toronto Central CCAC.

For many years, Toronto Central CCAC has been at the forefront of community health and with the support of our Boards, the government and our health care partners, we have realized amazing achievements and significantly improved the lives of our clients and their families. Along the way, we have transformed the health care landscape and our successes stand as exemplars for the rest of Ontario. Our team is widely acknowledged as a leader and I know it is through our collective efforts that we are reaching ever new levels of quality, innovation and excellence.

Our strengthened partnerships with the hospitals over the last several years have resulted in better service and better care for our clients. I applaud the work our organizations have done to ensure clients get the right care, at the right time, in the right place. I encourage you to continue to push the envelope and develop programs and processes that optimize the client experience.

I have thoroughly enjoyed every moment of the time spent at Toronto Central CCAC. I have accomplished what I set out to do and realized what I envisioned on my first day as CEO. Know that wherever I am and whatever I do, I will continue to watch the story of a better client experience unfold with a keen interest and admiration to those who spend each day improving the lives of our clients.

I have advised our Board of Directors and they will be implementing both interim measures and an established process to appoint a new CEO to lead the CCAC through the next phase of its ongoing journey.

Camille Orridge, CEO
Toronto Central CCAC
June 30, 2010

This publication is produced by the Toronto Central Community Care Access Centre to inform health partners, service providers and the community. Contact us at 250 Dundas Street West, Suite 305, Toronto, ON M5T 2Z5, 416-506-9888; www.toronto.ccac-ont.ca; toronto_ccac@toronto.ccac-ont.ca.

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Ontario
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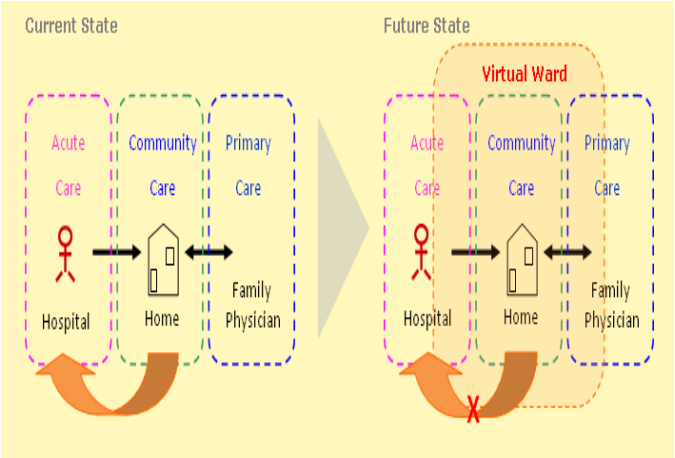
2010 - investing in quality and improving client experience



Virtual Ward - Integrated Team Support

The Toronto Central CCAC is participating in a project called the Virtual Ward. Launched in March, the project is an innovative partnership between the Toronto Central CCAC, St. Michael's Hospital and Women's College Hospital. The partners work together to create an integrated team to support clients discharged from hospital who are at high risk for re-admission. The goal is to provide a more supportive and safe transition of clients with complex care needs home from hospital.

The virtual ward team includes:

- Attending Physician from the hospital
- Hospital Nurse Practitioner
- CCAC Care Coordinator
- CCAC Pharmacist, and
- CCAC Nurse Practitioner

This team meets daily to discuss the care management of clients on the virtual ward. Once the client has safely transitioned home and no longer needs ongoing follow-up, they are discharged from the virtual ward. Many clients continue with CCAC services.

Outcomes:

Reduction in hospital re-admissions

Reduces cost to the health care system

Benefits for everyone:

- Coordinated care and communications
- Daily rounds to discuss patients
- Multidisciplinary team (including a physician)
- Shared information
- Single point of contact with 24/7 physician availability

Home First

Home First, a partnership between Toronto Central CCAC and hospitals and community agencies, is designed to identify and support seniors with high care needs who can wait at home rather than in the hospital to determine their long-term care options. This program is resulting in ALC patients getting home faster and safely and, in many cases, remaining home instead of going to long-term care.

Home First is showing some remarkable results:

- 70 fewer seniors waiting in hospital for long-term care every month, making more beds available for acute care
- 30% reduction in applications from hospital to long-term care
- Significant reduction in crisis placements from hospital with six to 25 seniors avoiding crisis placements every quarter

The Home First Strategy in the Toronto Central LHIN initially began in seven acute care hospitals and has now been expanded to include rehab, convalescent and other facilities – giving patients more options for their care after their hospital care and increasing the availability of acute care beds for people who really need this level of care.

Long-Term Care: New Regulations

The Ministry of Health and Long-Term Care issued new regulations to accompany the Long-Term Care Homes Act, 2007. These came into effect on July 1, 2010.

The three main components of the Act address:

- Residents' rights and care;
- Placement and admissions process; and
- Defining clear roles, responsibilities and authority for the hospital and community sectors

Toronto Central CCAC is working closely with our hospital and LTC partners to plan for the successful implementation of the regulations across the Toronto Central LHIN.

Please note: the new Long-Term Care Homes rates came into effect on July 1, 2010 - all old rate sheets should be discarded.

2010 - investing in quality and improving client experience

Getting People Home - ED Notification

When our clients present in the Emergency Department (ED) the CCAC is doing everything we can to assist them to return home quickly and safely. One of the main reasons for the success of this program was the decision to maintain a dedicated Emergency Department Care Coordinator.

This establishes the CCAC as an integral part of the ED care team, working closely with all staff, including Social Workers and GEM Nurses to assist with efficient transfers of seniors back home and decrease crisis long-term care placements through the Home First and Waiting at Home strategies.

Hospital Care Coordinators are now situated in the seven acute care hospital sites across the Toronto Central LHIN. Work processes have been designed to improve communication and collaboration between hospital and community. ED Notification is an automatic referral to the CCAC through an electronic system.

The trigger: Existing CCAC client >80 years of age – this allows the ED Coordinator to focus on priority clients and better manage their caseloads. They then inform the Community Care Coordinators when their client presents in the ED and when they are discharged or admitted to hospital.

Outcomes - Fewer Visits:

1. Fewer not seen visits for admitted clients as hospital holds are completed in a more timely manner.
2. Notification to Community Care Coordinator that a client presented in the ED ensures timely follow up to prevent a future visit.

FAST Centres*: Providing Urban Health Treatment Options

Robert is one of the clients to benefit from the option of *FAST* Centre care in the community. He first visited the Emergency Department for treatment of a severe wound on his hand. The wait time there was approximately four hours.

Rather than return to the Emergency Department, Robert was referred by CCAC staff to the CCAC *FAST* Centre for his next wound care treatment. Hospital Care Coordinators determine eligibility and suitability of this form of treatment.

Care Options

Clients requiring IV and/or wound care treatment can receive immediate treatment at the *FAST* Centre versus returning to the Emergency Department for scheduled treatment. Results: faster discharge from hospital; no repeat visits to ED for treatment; reducing ED wait times.

Robert called to express his gratitude with the services he has received at the *FAST* Centre, "I am grateful I could receive the care at the *FAST* Centre versus going back to the emergency department."

This treatment option is particularly desirable for many of our urban health clients, as they often do not have specific home addresses or may not be available to wait at home for visiting nursing care.

This is a win-win situation: the client experience is improved as they are able to receive care in a safe, clean environment and as a quality initiative, the health system benefits through cost effectiveness and resource reallocation of scarce community resources. Our *FAST* Centres provide treatment for an average of 1800 clients each month.

(*FAST = Fast Access to Supportive Treatment)

G20 Summit - Thanks

The week of the G20 Summit in Toronto is one to remember. It is also one for which we wish to express our sincere appreciation and thanks to our staff, service providers and hospital partners. Everyone pulled together to ensure people across the city had access to the health care they needed.