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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 - for our Hospital Partners

Toronto Central Community Care Access Centre

Fall 2010

One Client's Story: Virtual Ward

The Situation:

Ms. Martin is a 58-year old homeless woman with schizophrenia and alcohol/ drug dependency. She was admitted to hospital for COPD complications, was stabilized and discharged to a shelter under the care of the Virtual Ward (VW). The VW Care Coordinator visited the client in the community the next day and along with the nurse, identified a significant decline in her oxygen saturation.

The Plan:

The VW arranged for Ms. Martin to be seen in a clinic the same day, where it was determined she required home oxygen. However, her current shelter environment was unable to manage oxygen. The Hospital Care Coordinator organized admission to a community infirmary within three days to support oxygen therapy. The VW team was able to support the client in the shelter for three days in the community before the planned infirmary admission.

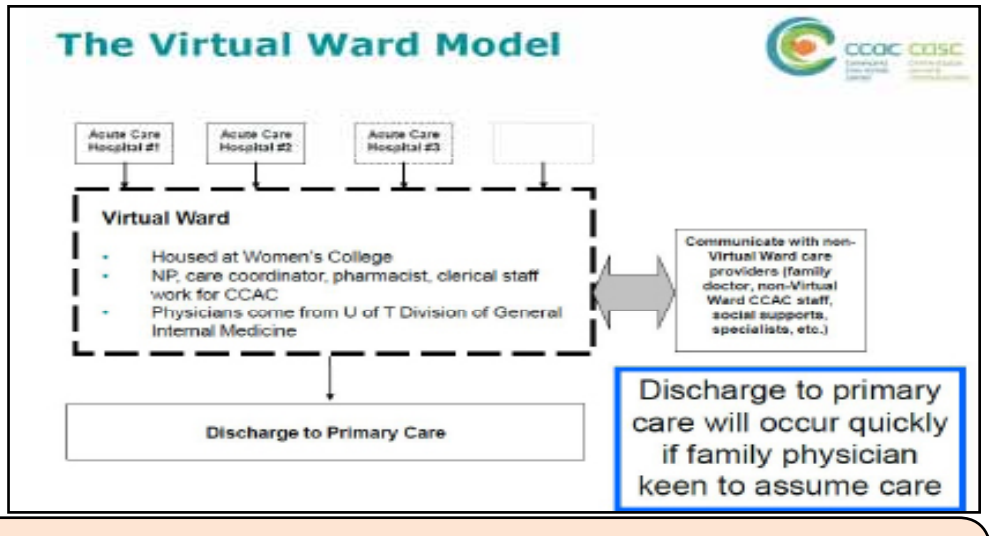
(Client story continued on page 3)

Virtual Ward

The Virtual Ward program is one example of how health system partners are coming together in a different way to enhance the experience of clients and caregivers. The Virtual Ward is an inter-organizational collaboration with Toronto Central CCAC, St. Michael's Hospital, Women's College Hospital and University Health Network. The inter-professional team follows St. Michael's Hospital discharged clients who are at high risk of readmission to hospital. The goal is to provide a more supportive and safe transition of clients with complex care needs home from hospital. Hospital Physicians follow these clients in the community and work closely with the Care Coordinator who provides intensive case management. The Virtual Ward monitors and supports the patient with a team that brings together expertise from acute, community and primary care sectors. The goals of the Virtual Ward Team are to:

- Work together to be effective and efficient
- Ensure the patient's needs are met
- Give the patient a positive experience
- Provide patient with a single point of contact

We are pleased to share with you that over the eight months since we launched the Virtual Ward, more than 135 patients have been admitted to the Virtual Ward – a milestone in getting people home and keeping people home!



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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2010 - investing in quality and improving the client experience

Home First Strategy

The Ontario Government recently made a significant funding announcement for the Aging at Home Strategy to support more seniors to age at home or in the community. The Minister of Health showcased Toronto Central CCAC's Home First Strategy during the announcement which was made from a client's home.

Our Home First Strategy has made a significant impact in supporting more seniors with their care needs in the community and when staying at home is no longer possible, helping with the transition to long-term care.

We're working with acute and rehab hospitals and have recently added Providence Health Care to the Home First family, 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.

Click on the following link to see more about the Toronto Central CCAC Home First philosophy: *Home First video.*

The Home First strategy is part of our overall population-based model of care. We are excited about moving this model into the hospitals as well in the near future. Again, it will allow us to:

- support frail seniors with complex needs and their caregivers to remain at home and in the community.
- focus more on the needs of our clients and provide more support, such as intensive case management, integrated team-based care and
- spend more time with our clients and other community partners

Organizationally, it gives us a greater ability to target and organize resources and activities where they have the most value and create a better client experience.

Improving the Client Experience with Smoother Transitions Across the GTA

Each year, thousands of clients who leave hospitals in the give GTA LHINs go home to other catchment areas. Most transitions are smooth and seamless; at other times, clients have frustrating experiences.

In recognizing the need to work together as "one system, one client", the senior leadership teams of the GTA CCACs – Toronto Central, Central, Central East, Central West and Mississauga Halton – have committed to working collaboratively to ensure every client who transitions between our CCACs has a positive experience.

To that end, we have adopted a quality improvement approach focusing on practical and sustainable interventions that have a positive impact on our clients, caregivers, hospitals and frontline staff. A working group has been established to address short and long-term opportunities.

CHRIS - Provincial Case Management Moving Forward

We will be moving to this provincial case management system, the Client Health Record Information System (CHRIS), in November 2011. Our goal is to optimize the staff and client experience through streamlined business processes internally, and integrating systems externally with other CCACs and Service Providers. CHRIS is the next evolution of our Care Coordination Portal work and we are working collaboratively to ensure we capture the best of both systems.

Although we are some time away from the launch of this new system, we are well into the planning stages. It is a large undertaking which requires training, planning and focussed efforts by many. We will keep you posted.

2010 - investing in quality and improving the client experience

In the News

Community Report 2009-10

We are pleased to bring you this first edition of the Toronto Central CCAC Community Report. In this report we highlight several of our quality improvement strategies, including:

- our new model of care, organized around the needs of specific client groups;
- improvements in our Customer Care Centre to respond to clients who call us;
- our Home First approach designed to support people to come home from hospital

CATCH - Coordinated Access to Care for the Homeless

CATCH (Coordinated Access to Care for the Homeless) is a new Urban Health initiative which helps homeless people who have unmet complex health care needs to access health resources in the community. The program is a partnership between Inner City Health Associates, Toronto North Support Services and Toronto Central CCAC Care Connectors. They work with family physicians, psychiatrists and a CATCH Coordinator to support access to medical care. Nursing, personal support and other resources are also available. This program helps meet the needs of a very hard to serve group of clients.

Accreditation: Quest for Quality in 2010

As you may know, we partnered with Accreditation Canada to help guide us through the accreditation program and to help achieve our Strategic Directions of delivering excellent service, health system leadership, learning and innovation, and community citizenship.

During the onsite survey, which took place November 29-December 2, the surveyors asked questions to assess the organization's processes for clients obtaining services and our administrative processes as well as accompany staff on home visits. We're looking forward to the survey results and will keep you posted.

Resource Matching and Referral

Resource Matching and Referral (RM&R) is an electronic referral system that matches clients to the earliest available services and care setting that best meets their individual needs. Acute care and rehab hospitals, long-term care homes and Toronto Central CCAC are partners in this system and now more than fifty health service providers are able to refer clients electronically.

Toronto Central Hospitals are using RM&R to make referrals to Complex Continuing Care, In- Patient Rehab, CCAC In-Home Services and Long Term-Care Placement Services (Long Stay and Convalescent Care). RM&R works to improve the client experience by:

- improving the processes - the client's information follows the client to their care destinations
- Matching clients to the most appropriate resources at the time of referral, and
- Reducing the amount of time clients wait until they are referred to the most appropriate care setting

RM&R is now being used in the Community to forward LTCH applications from the community to the homes of the client's choice. This improves communication between LTCH's, Client and CCAC and will help in getting client information to the homes of the client's choice in a timely manner.

RM&R also supports our goal of getting people home and keeping people home, by freeing up hospital beds and staff to better serve those requiring hospital care.

Client story continued from page 1

Outcome: An acute care admission was averted. The shelter staff stated without the support from the Virtual Ward they would have sent her back to hospital. The VW team worked with Ms. M to arrange for more appropriate housing. She moved to a community residential hospice and passed away in a supported care setting two months later.