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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

Summer 2011

Did you know?

- Toronto Central CCAC transitions 7,000 people from Toronto Central LHIN hospitals every month to CCACs across Ontario
  - approximately 80% of those referrals are referred outside of the Toronto Central LHIN
- Toronto Central CCAC has 110 staff in 26 hospital sites, including emergency departments
- Over the past year, there has been a 50% drop in the number of ALC patients in hospitals waiting for long-term care
- At the same time, the number of Emergency Department visits by CCAC clients over 80 years old is also going down, showing they are safely being cared for at home

CEO Message

Welcome to the Summer issue of *In the Know*. I've been CEO of Toronto Central CCAC since December 2010. Over the last six months I have had the great pleasure of meeting with many of the hospital leadership and have been excited and energized about the tremendous progress we have made together on improving patient flow and reducing the number of Alternate Level of Care (ALC) patients waiting for long-term care (LTC).

Over the coming months I am committed to improving our ability to meet the needs of our diverse client populations and plan to focus our attention on our major aims:

- transforming the experience for our clients and caregivers
- keeping people home, getting people home
- investing in our capacity to improve quality

There are many ways we are working with you to achieve these goals and in this issue of *In the Know*, we highlight some of the activities and initiatives we are working on to prevent unnecessary hospital visits and support positive client transition experiences:

- Alternate Level of Care - Long Stay Project – creating solutions for clients who have been in hospital for extended periods of time
- Integrated client care models – supporting those clients with complex care needs who are most at risk
- An update on the Resource Matching and Referral system

Alternate Level of Care - Long Stay Project

The Alternate Level of Care (ALC) Long-Stay Project is designed to review the care needs of people who have been in hospital for extended periods of time – anywhere from 40 days to 15 years. This is a specialized population requiring specialized care.

Exceptional collaboration and partnerships form the foundation of this emerging program. The CCAC, hospitals, service providers, and community agencies all work together to create solutions for those clients who have had multiple failed attempts to transition to other settings.

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2011- building a culture of quality at every level

The program has a large education component and the process often begins by spending time educating the clients, their families and the hospital staff, on the options and resources available in the community.

At the start of the project in Fall 2010, 148 clients from across the LHIN participated in an extensive review to see if they could be cared for in other settings. It was determined that almost half could be moved and so far 35 clients have been transitioned to care destinations that are more appropriate for them. This number includes the "freeing up" of three much needed ICU beds. There are also 31 clients who have been determined to not be ALC who have been removed from the ALC list. At the end of May only 74 of the original 148 clients remained ALC in hospital.

Currently there is a small team working to create connections with service providers, community agencies and other extended partners, such as supportive boarding homes and group care settings. The team members understand the medical complexity of the long-stay ALC clients and the implications of moving these clients to alternate care destinations.

Benefits:

- The client experience is improved by offering other, more appropriate care destination options and engaging support in the community
- Hospital beds become available for those in need of that type of care
- Best practices for care management and coordination are utilized on a daily basis

Feedback from clients and/or their caregivers post-transition has been positive:

- "She is the happiest I've ever seen her in all my years of knowing her."
- "I like living here better than at the hospital."

On the Road to Quality Transitions

Last Fall, the GTA CCACs adopted a quality improvement approach to improve client transitions across GTA-LHIN boundaries and to make sure every client that transitions between our CCACs has a positive experience. We mapped all our transition processes to identify those steps that add value to clients and hospital partners, and to remove those steps that don't. The working group continues to meet and address long and short term opportunities.

New Integrated Client Care Models

We continue to evaluate and evolve our models of care to improve our ability to meet the needs of our diverse client populations. Our new Integrated Client Care models support clients who are most at risk: children and seniors with complex needs, people with palliative needs to die at home with dignity.

Since March 2011, our CCAC has been implementing a model of care for seniors with complex needs for the Toronto Central LHIN. The goal is to support clients and their caregivers through all the touchpoints of their care journey and help them to avoid unnecessary hospitalizations so they are able to stay at home safely and comfortably.

This integrated client care pilot project started in March 2011 and will run until March 2012 at which time a formal evaluation will be conducted. The four pilot sites for the project are: Mt. Sinai Hospital, St. Joseph's Health Centre, St. Michael's Hospital and Toronto East General Hospital. Learnings from this project will be used to continue to inform the further development of services and supports for our frail seniors population.

The cornerstone of the model is a case management model which involves the family, a CCAC Care Coordinator, a nurse and pharmacist. The team

members are all involved in the home visits and meet every two weeks to discuss the clients' care needs. One of its benefits is that hospital key workers are able to see how the client is living in their home, the challenges and daily tasks and how this differs from the hospital environment.

The primary goal is to improve the overall experience of clients and their caregivers and help them to remain at home longer. Additionally hospitals and the health care system benefit as readmissions and alternate level of care days are reduced.

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 (LTCH) 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 LTCHs, clients and the 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.

Community Navigation and Access

One of Toronto Central CCAC's key roles is to refer people to the services and programs available to them in the community and CNAP (Community Navigation and Access Program) provides our staff with a seamless way to connect seniors with the information they need in the community. And this service is available for everyone to use, not just health professionals.

The CNAP is a network of over 30 not-for-profit community support service agencies in the Toronto area who are collaborating to improve access and coordination of services for seniors, such as Meals on Wheels, adult day programs, shopping, transportation, etc. The toll free number provides a single access point to the agencies and services in this partnership: 1-877-540-6565.