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

Making Connections

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Inside this issue

Ontario
Toronto Central Local Health Integration Network

CEO Message

Welcome to the fall edition of the *Toronto Central CCAC Making Connections*. Fall is a time of renewal and Toronto Central CCAC is excited to renew our focus on communicating with our stakeholders with this newly designed newsletter. Toronto Central CCAC has a lot of great news to share with you about how we are partnering to deliver on our three strategic aims:

- Transforming the experience of our clients and caregivers
- Keeping people home, getting people home
- Investing in our capacity to improve quality

We are committed to transforming the experience of our clients and caregivers. We know that striving to see care through their eyes and understanding what's most important to them is helping us transform their care experience and outcomes. We know that we can't do this alone. It's all about partnering to care to do things differently because together we can do so much more. In this issue we want to tell you about exciting partnerships that are focused on transforming our clients' and caregivers' experience and getting people home. Thanks to the support of our health system partners, we have a number of quality improvement initiatives in place which are making a big difference in the quality of life and health outcomes for our clients. Two new initiatives that speak to the remarkable things that can happen when many like minds unite towards a common goal are the Integrated Client Care Model for Seniors and the Virtual Ward.

The theme of this edition is enhancing care to support more complex care needs. In this issue you will see how we have expanded our team of medical advisors to help advance integration of primary care to keep people home and achieve better health outcomes for clients with complex care needs. You will see examples of how we are increasing integration with partner organizations to foster stronger relationships that will support clients who are most at risk.

Over the fall season we look forward to working with our health system partners and our community to make sure our health system works better for our clients and caregivers.

Stacey Daub, Chief Executive Officer

Partnering With Primary Care to Keep People Home

The most important health care provider in most people's lives is their family doctor or other primary care provider. For our clients who have complex health conditions, partnering to care with primary care is essential to the health and experience of our clients. Over the last number of years, three Toronto Central CCAC medical advisors, Dr. Ivy Oandasan, Dr. Jamie Meuser and Dr. Phil Ellison, have worked with us to better understand primary care and to forge much needed relationships and partnerships with primary care with the goal of collaboratively improving care to our community. In 2008, the government invested in the CCAC to provide the Health Care Connect Program, designed to help unattached patients get connected with primary care. Since that time, we have connected over 2400 patients to a family doctor in Toronto. Most recently through specific quality improvement initiatives like the Virtual Ward and the Integrated Care for Complex Seniors initiatives, we are partnering and integrating our services with primary care in new ways to support our most vulnerable populations together. This movement to better integrate primary and community care will benefit our clients, our community and the health system.

Bridging care and partnerships across primary care, specialty care and community care is also essential to the work of the CCAC and the evolution of our health care system. In July 2011, we appointed Drs. Irfan Dhalla and Samir Sinha as Medical Advisors to the Toronto Central CCAC. Drs. Dhalla and Sinha are system level physician leaders focused on advancing care for complex populations. Their work with us is focused on advancing evidence based care and research for complex populations and connecting systems of care for our community.

Dr. Irfan Dhalla practices general internal medicine at St. Michael's Hospital where his work is focused on adults with complex care needs. Dr. Dhalla was the driving force behind the idea of the Virtual Ward Model (*see page 5*)

Dr. Phil Ellison is a staff physician in the Department of Family and Community Medicine at the University Health Network. He is currently leading the physician engagement for the Integrated Client Care Model for Seniors (*see Page 3*)

Dr. Jamie Meuser is a Palliative Care Physician at the Temmy Latner Centre for Palliative Care and Director of Professional Development in the Department of Family and Community Medicine at the University of Toronto.

Dr. Samir Sinha is the Director of Geriatrics at Mount Sinai and the University Health Network Hospitals. Dr. Sinha is a passionate advocate for the needs of older persons. He was involved in the development of Mount Sinai Hospital's forward thinking Acute Care for Elders (ACE) Strategy that is already demonstrating better patient and system outcomes for frail older adults.

The Integrated Client Care Model for Seniors

Alternate level of care (ALC) refers to people who are in acute care hospitals waiting for the right place of care, even though they no longer require the level of care a hospital offers.

Most seniors expect that their function and health will change as they get older. However, all too often seniors with complex care needs end up being admitted to emergency departments or hospitals simply because they don't have the necessary supports at home and across the health care system to maintain healthy independent lives.

"Elders who are hospitalized frequently decline very quickly, so the better prepared we are to support them across the health care system, the better their health outcomes and quality of life," says Dr. Samir Sinha, Toronto Central CCAC Medical Advisor, Director, Geriatrics and Integrated Client Care Model Site Lead, Mt. Sinai Hospital.

Toronto Central CCAC is supporting the implementation of a Toronto Central LHIN system level partnership designed to enhance integration across all health sectors to provide better supports and health outcomes for seniors. This model ensures a significant paradigm shift in the roles and accountabilities of providers and sectors; a reduction in duplication and gaps; and a shared accountability of all sectors to provide seamless and responsive care.

The range of partners and the level of system engagement that has taken place to ensure an integrated framework have been unprecedented in our LHIN. With shared accountability for bridging relationships and care processes across the system there is collective commitment to work with interdisciplinary and inter-organizational teams to fundamentally shift the way care is provided to support this population.

The basic premise of this model is the belief that despite their complex circumstances most people, if managed appropriately, can remain in the community with adequate supports.

In its simplest form, the model brings together a team of care providers that has planned for and is ready to rapidly respond to the client and caregiver's needs regardless of where they access the health care system.

At the heart of this model are the Primary Care Physicians and Toronto Central CCAC Care Coordinators who are actively engaged and connected to the client and their caregiver throughout their care journey.

Having adopted a shared model of integrated care that spans across primary care, CCAC, acute, complex continuing care, rehabilitation, emergency medical services and community service providers is already demonstrating increased client, caregiver and provider satisfaction and a reduced dependence on acute care.

When Dr. Tia Pham, primary care physician with the South East Toronto Family Health Team, was asked if the Integrated Client Care model is making a difference in her ability to care for her clients with complex needs she expressed, "Primary care is the first point of contact a person has with the health system. To support our patients who require more care, there needs to be a very strong partnership between primary and home care. This model is allowing us the level of partnership and integration across the system so that we can wrap care around clients and be responsive to their needs. I believe it is having a tremendous impact on our ability to successfully care for our patients and their caregivers."

(Continued on page 4)

The Integrated Client Care Model for Seniors

(Continued from page 3)

Dr. Phil Ellison, the lead for primary care engagement on this initiative and a medical advisor to the Toronto Central CCAC sees this model as the key system driver in connecting the critical players and parts of the health system and aligning and leveraging our resources to do what is required to support clients and their caregivers. Dr. Ellison has taken a leadership role in ensuring a strong and successful engagement strategy with the primary care physicians and ensuring their central and critical role in the model.

When the partners in acute care were asked if the model is making a difference their response was a resounding YES as it supports consistent communication, alleviates potential confusion of messaging from different care providers, allows for smoother care transitions and accurate and timely patient information exchange to enhance care.

Participating hospital sites include St. Joseph's Health Centre, St. Michael's Hospital, Mt. Sinai Hospital and Toronto East General Hospital. Plans are well underway for expansion so that all of the Toronto Central LHIN acute care sites are actively involved and more clients and caregivers are enrolled.

Over the past year, our joint efforts to improve the quality of life for vulnerable seniors have resulted in:

- **25%** decrease in clients waiting for long-term care homes in the community because of the CCAC's enhanced support for clients with higher care needs
- **10%** fewer emergency department visits by clients over 80 years-old within the first 30 days of admission to Toronto Central CCAC from an acute care hospital
- A **50%** reduction in the number of clients waiting for long-term care in acute care hospitals and freeing up hospital beds for people who require acute care

This quality improvement initiative is just one example of how we are developing and strengthening partnerships across the Toronto Central LHIN to enhance support to our client populations with complex care needs. We are taking a similar approach with children that have complex care needs and with clients receiving palliative care.

Research estimates that 1% of the population accounts for as much as 30% of total costs and a recent Ontario review found that only 0.3% of patients account for approximately 10% of all hospital discharges and 40% of bed days. Also, complex and vulnerable patients represent as many as 70% of ALC days in the Toronto Central LHIN – *Toronto Central LHIN Value and Affordability Task Force.*

Virtual Ward

Supporting Transitions Home

Toronto Central CCAC transitions about 8,000 clients a month from hospital to home. Almost 50% of those clients go home to other parts of the province. While most transitions work well, 20% of those discharged home are at risk of readmission to hospital within three months. Virtual Ward is an innovative model of care designed to strengthen the bridge between hospitals and home for vulnerable clients at risk of readmission to hospital. It's also focused on building stronger relationships across organizations to improve the client experience and health outcomes.

"Everyone on the team can tell you stories about patients who would likely have fallen through the cracks and ended up back in hospital," says Dr. Irfan Dhalla, General Internist and founder of the Virtual Ward.

The Virtual Ward, based on a UK model, takes the best elements of a hospital ward to the community, 24/7 access, a single point of access and an interdisciplinary team which includes: CCAC care coordinators, physicians, a nurse and a pharmacist to create a ward without walls. What's more, the team gathers daily to hold rounds, just like a hospital, to review each client's care plan, coordinate regular visits with family doctors and identify potential problems to avert hospital readmissions.

"What is truly remarkable about this model of care is the level of collaboration between different organizations and different professionals across the system," says Stacey Daub, CEO, Toronto Central CCAC.

Virtual Ward is research collaboration between Toronto Central CCAC, St. Michael's Hospital and Women's College with funding from the Toronto Central LHIN and the Ministry of Health and Long-Term Care. The goal is to test a scalable model of care that can be implemented anywhere in the province. It is currently in operation at St. Michael's Hospital, Toronto General Hospital, Toronto Western Hospital, Sunnybrook Health Science Centre and Women's College Hospital.

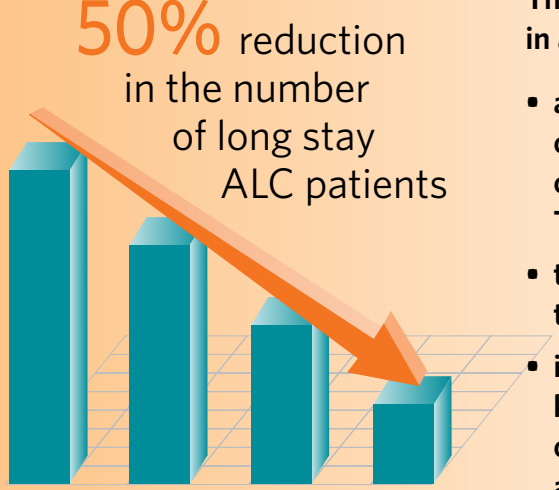
The collaborative efforts between Toronto Central CCAC and hospitals in the Toronto Central LHIN have been the catalyst for two additional projects that are advancing integration of our sectors.

Getting People to the Right Place of Care

Alternate level of care (ALC) refers to people who are in acute care hospitals waiting for the right place of care, even though they no longer require the level of care a hospital offers.

Just one year ago, the number of patients waiting in hospital who could be better served in other care settings was 148. Their length of stay ranged from 40 days to ten years. Today that number is 55.

The Toronto Central LHIN and CCAC introduced a project to address this issue. A team of professionals has been finding ways to help patients find the right care destinations in the community.



The project was highly successful in achieving:

- **a 50% reduction in the number of long stay Alternate Level of Care (ALC) patients in the Toronto Central LHIN**
- **the transition of 70 patients to the right care destination**
- **improved cross-sector knowledge and understanding of the long stay ALC issue and patient care options**

Carlos' Story

Twenty-four year-old Carlos is one of many clients that a Toronto Central CCAC Care Coordinator has been able to support through this improvement project. In July 2005 at the age of eighteen, Carlos suffered a traumatic injury. For six weeks he clung to life after suffering the loss of parts of both legs and some of his fingers. Carlos was moved to a rehabilitation hospital in 2006 and once his rehab was complete, he no longer required hospital care and was waiting for long-term care - the only destination his care team thought appropriate for him. Carlos said he wanted to be in the community, close to his family, so we worked to make this happen. His situation was one of 148 that were reviewed by a team assembled by the Toronto Central LHIN looking at clients waiting in hospitals for other care settings. The team of health professionals, from across the continuum of care, exhausted all opportunities to help clients find the right place of care. For Carlos, the team wanted to find him a supportive place of care in his community that would support his youth and growing independence.

Tracey Raymore, a Toronto Central CCAC Care Coordinator worked with Carlos for 2 months to transition him to the right place of care – a group home close to his family - that allowed him to be independent with some support. After spending 5 years in hospital, Carlos is thriving in his community, is close to his family and friends and is planning to go back to school.

"I am so happy to be back in my community, close to my family and friends. I am looking forward to going back to school like all my friends, " says Carlos.

Community Collaborations for Clients

There are many doors to care in the community and we need to work together as a system to simplify access and make sure no door is the wrong door. Over the last several years, the CCAC and Community Support Sector (CSS) have been working to make accessing care in our community easier for clients and caregivers. In 2008, the Toronto Central CCAC launched the Community Care Resources website www.toronto.communitycareresources.ca designed to provide access to a wide range of care and support services in Toronto. Receiving 625,000 hits annually, this website is widely used by clients, caregivers and providers to find care in Toronto and across Ontario. The Toronto Central CCAC also operates a large 7 day per week information and referral centre, providing personalized support to individuals looking for help in our community.

In 2008 the CSS sector started working together to develop the Community Navigation and Access Program (CNAP). The Community Navigation and Access Project (CNAP) involves a network of 34 community support service agencies in the Toronto area who are collaborating to improve access and coordination of CSS services for seniors. The CNAP Network aims to ensure that 'every door leads to service' so that seniors can reach the care they need. CNAP is supported by the Toronto Central LHIN through the Ontario Aging At Home Strategy. While the CCAC has been connecting clients to care through CNAP since its inception, Toronto Central CCAC has recently started making referrals to CNAP using an electronic referral system known as Resource Matching and Referral. The key to the partnership on information and referral is to make sure no matter how a client connects with an agency or sector; there is a commitment to ensuring they get to the right help safely and supportively.

In addition to making access simpler for our community, the CSS and CCAC have been working on integrating our programming and approaches to care. The following are just some of the partnership activities we have been working on to improve how we care for our clients together:

- An enhanced Adult Day Program with Woodgreen Community Services which integrates CCAC and CSS care for very high risk frail seniors at the community centre
- A partnership with St. Christopher's House enables seniors to receive rehabilitation services through the CCAC at St. Christopher House. Getting seniors out of their home has allowed seniors to access additional support
- A collaborative approach to care to ensure that we are providing integrated care for the many high risk clients we have in common.

"After my car accident my mobility was severely impaired and I was no longer able to function independently. I had no idea where to go for the help I needed. The stress around trying to figure this out was completely lifted when the CCAC Care Coordinator connected me to CNAP. The network linked me to St. Christopher House to provide meals through Meals on Wheels and helped arrange for my transportation to get around the city," says Tom, CCAC Client.

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In any given year Toronto Central CCAC supports different client populations:

Children – 5,000 children to get the right support in schools; **400** children who have complex medical needs and **1,000** children with short term support needs.

End of Life – 1,600 clients to die at home with dignity.

Urban Health – 1,200 clients who are homeless, poorly housed, have mental health or cognitive impairment issues to access services and be supported to live in the community.

Frail Seniors – 6,400 seniors and caregivers are provided intensive seniors-focused care support so that they can remain at home with dignity.

Adults – 1,200 adults and their caregivers to manage long-term conditions.

Helping Seniors be Independent – 12,000 seniors are connected to care and supported to remain independent in the community.

Short-Term Support – 13,000 clients who have short-term medical and rehabilitation needs.

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