



Making Connections

Spring 2012

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CEO Message

January 1, 2012 marked the fifth anniversary of the Toronto Central CCAC. This milestone also marks a new beginning for the CCAC. Over the last few months, Toronto Central has been planning our future and developing a new Strategic Plan for 2012-2016. This issue of *Making Connections* is dedicated to bringing you news about our exciting journey.

As we build our future, we want it to be inspired and informed by the people most impacted by our work. And most of all, we want to create meaningful and transformational change for our clients and the health system. Our plan promotes improvement at three levels:

- Client Experience, Safety and Quality
- Population Health and Education
- System Sustainability and Integration

Over the last few months we opened our hearts and minds to our partners and staff members by inviting them to participate in an online discussion about our future using an exciting web based tool, *Innovation Grapevine*. We also reviewed feedback from our clients and their families about their care experience and quality of their care. Seeing care through their eyes and understanding what's most important to them is ultimately what's going to help us deliver a better care experience and health outcomes. We know there are challenging and difficult times ahead and we are committed to focusing on solutions and advancing the system through partnerships to address these challenges. The government's Action Plan for Health

Care and the recently released "Drummond Report" offer areas for advancement to the health care system. One prominent tenet of the Action Plan is to "ensure families get the best health care where and when they need it" and our own strategic directions are in line as we move forward supporting our clients to live full lives and delivering what is most important to them, while providing better value for health care dollars.

I am excited to share with you our draft strategic directions which have been inspired by our clients and their families, valued partners, staff members and our current health care environment.

Draft Strategic Directions:

- 1: We will relentlessly pursue every option to deliver what is most important to every client
- 2: We will support our clients to live the fullest and healthiest lives possible
- 3: We will unleash the potential of our people
- 4: We will drive the highest possible care integration for our client populations who need it the most

As you turn the pages of this newsletter you will read about some of the work we are doing and partnerships we are forming to lay the foundation for our future.

Over the next few months we will continue to engage you in shaping our final strategy, identify the major activities we need to deliver on it and how we are going to measure the outcomes. I am energized about our future and look forward to bringing you news of our fully formed strategy in the next issue of our newsletter.

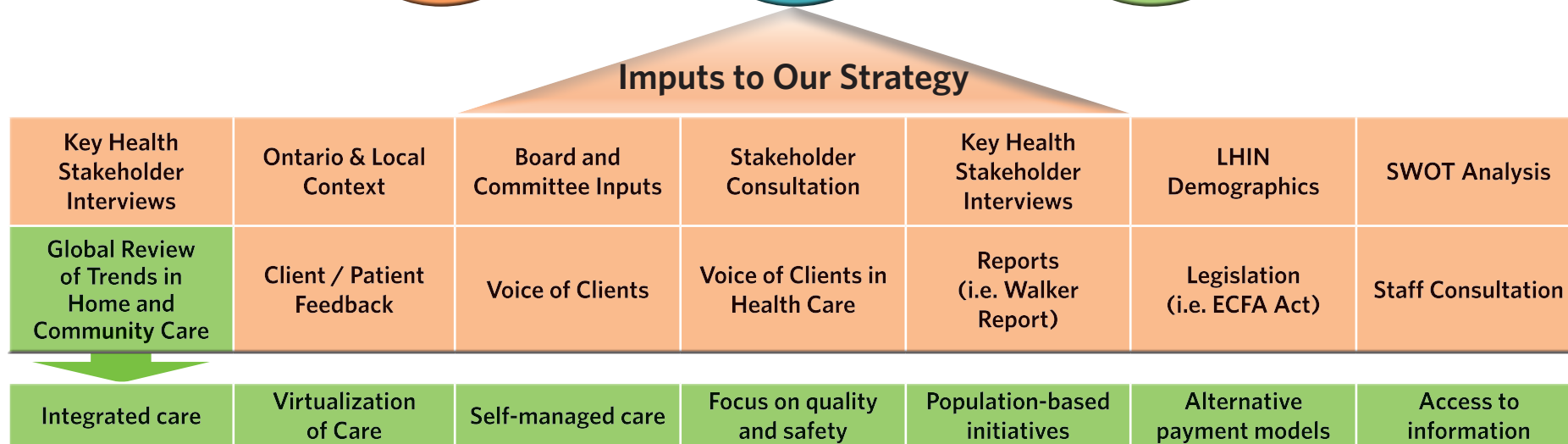
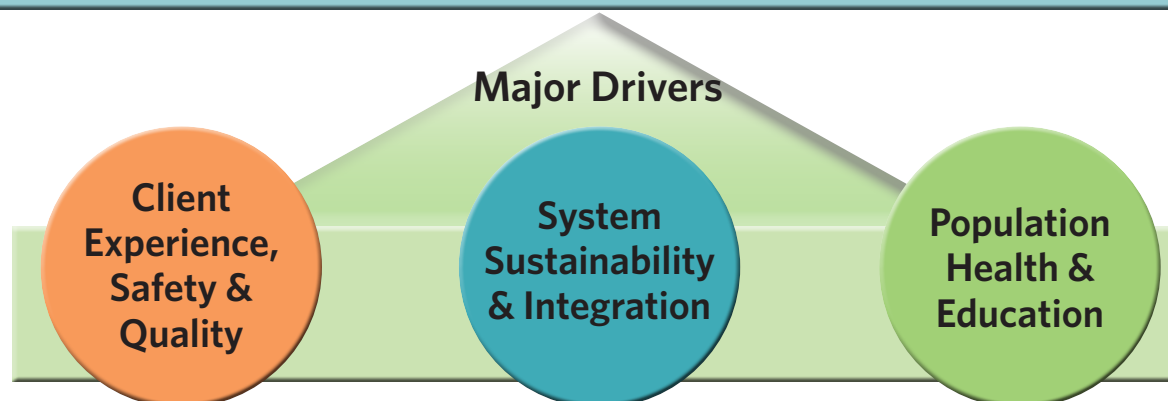
Stacey Daub, Chief Executive Officer



Draft Toronto Central CCAC Strategic Plan 2012/2016

Vision: Outstanding care – every person, every day

Mission: To deliver a seamless experience through the health system for people in our diverse communities, providing equitable access, individualized care coordination and quality health care.



Relentlessly Pursuing Every Option to Deliver What's Most Important to Our Clients

Over the past few years our CCAC's key strategic direction, transforming the client experience, has established a strong foundation for client-focused care. We are taking it to a whole new level with our first strategic direction by **relentlessly pursuing every option to deliver what is most important to every client**.

We have also been seeking feedback from our clients and caregivers through surveys. This year we will be acting on what they have told us is most important to them:

- Care coordination that involves frequent contact with clients
- Courtesy and respect
- Control and choice about their care
- Time and support for caregivers
- Support with understanding and connecting to the services they need

This means we must push boundaries and identify creative solutions to support clients in making choices for themselves. We value the power of partnering to care, so we will pursue every opportunity to engage them to plan, design and evaluate our services.



The primary link that our clients and caregivers have to getting care is through our frontline staff, so we will create opportunities for personal support workers and other service providers to deliver a more flexible and customized care experience. A client experience improvement pilot project is just one example of how we are creating opportunities for frontline workers to do this. A *Changing the Conversation* project was piloted last summer with two of our service provider partners, VHA Home Healthcare and CBI. Personal Support Workers were asked to focus on clients' immediate needs or concerns, such

as making a cup of tea or letting the dog out one last time. Three questions were developed for Personal Support Workers to ask their clients during their scheduled visits:

- 1) *What's the most important thing I can help you with today?*
- 2) *I will be leaving in a few minutes. Is there anything else I can help you with before I go?*
- 3) *Is there anything you would like me to tell the office, the supervisor or the CCAC?*

We are planning to 'change the conversations' we have with clients to really understand what's most important to them every time we talk to them and not just deliver service according to the plan that was developed when the client first came to us.

This evidence-based approach has generated positive feedback from our clients and their families; "they are more caring and concerned about my needs".

*Choice is one of the most important things we can offer our clients,
and the support they want, not just what we think they want.*

Focusing on What's Most Important to the Client

On one particular visit, Anna, a CCAC Care Coordinator asked if there was anything else she could do for the client before she left. That was when Molly opened up about how upset she was about being unable to care for her dogs who are like her children.

Molly wasn't always physically able to let them outside, so she placed newspapers down for them to use, but her health condition sometimes made it difficult to change them as frequently as she would like. The dogs sometimes got bored being indoors and were consequently seeking attention. Molly felt guilty. She also felt embarrassed about the state of her house when she wasn't able to change the newspapers.

Anna offered to arrange for someone in her neighbourhood to help with the dogs, changing the newspapers and letting them outside on occasion. Just knowing this was possible had a very positive effect on Molly, it relieved the distress she felt and also created a less stressful environment for the dogs.

This one question changed the whole relationship. Molly and Anna connected. Most of all, the positive outcomes for Molly were:

- It improved her safety as she often had to get down the stairs to let the dogs out; or bend over to pick up the newspapers despite her balance and support issues.
- It improved her self esteem. She didn't feel so guilty about not being able to provide the dogs with the necessary exercise or let them out.
- It restored her dignity. Her house was cleaner, so she wasn't so self-conscious about the care of the dogs and state of house.



"I never imagined that it would be possible for my care coordinator to get me this kind of help. This has made such a big difference for me. I can now invite my friends over for a coffee because I am not embarrassed about the state of my house," says Molly, CCAC Client.

Supporting Our Clients to Live the Fullest and Healthiest Lives Possible

The Drummond Report on Broader Public Sector Reform highlights that the economic crisis in Ontario, as in many parts of the world, is making the delivery of health care more challenging. What is clear is the rising prevalence of chronic diseases is placing great pressure on our health care resources at a time when almost 50% of our budget is already spent on health care. We are also operating within a health care system that was designed for acute care needs when we have shifted more to chronic care. As well, our system has always been focused on treating people when something goes wrong and not on preventative care.

At Toronto Central CCAC, adults with long term chronic diseases needs make up 40% of our clients and they receive almost 70% of all services provided by our CCAC. If we want to be sustainable we need to fundamentally change the way we deliver care to refocus our future around the needs of our changing populations.

Our second draft strategic direction is focused on addressing this health system challenge in Toronto by **supporting our clients to live the fullest and healthiest**

lives possible. This means we will be shifting our culture of care to one that is focused on giving our clients the power to manage their own care for as long as possible. The foundations of this model are education for our clients and providing them with access to the best possible resources to help them make informed choices in the treatment of their chronic disease.

One example of a different approach to chronic disease management is a new collaborative, client-centred model of diabetes self-management education in the community setting, called *Choices and Changes*. This initiative identifies each client's *preparedness* for change and their *conviction or confidence* to achieve realistic and attainable goals. The ultimate goal is to improve their health outcomes. What's more, it also builds on our first strategic direction because it enables personal support workers to grow and operate beyond their traditional boundaries by empowering them to act as coaches for their clients. Our goal is to help clients manage their health with less reliance on the health care system.



The first phase of the project has been focused on delivering training to personal support workers. This initiative will be evaluated and we intend to apply the learning to other client populations.

Unleashing the Potential of Our People

In November, 2011, Toronto Central CCAC was named one of Greater Toronto's Top Employers for the third year. This recognition reflects the dedication and enthusiasm that our staff members and teams place into making this organization a great place to work. We know that our employees are the most valuable resource we have to deliver on our vision. That's why our third draft strategic direction is focused on ***unleashing the potential of our people***.

The most important contact that we have in fully engaging our clients and caregivers in what's most important to them is through our frontline staff and service providers. We are committed to tapping into their power to make a big difference by releasing their time to care. This means we will do everything we can to create an environment where every employee can reach their full potential – to grow personally and professionally and think outside the box. We have seen the incredible ripple effect this can have on our clients and their families, the community, and even the international arena. We have

some great examples of how this can happen when our staff and teams are inspired to push boundaries and challenge the status quo. The amazing ideas they shared through the *Grapevine*, an online discussion tool, about our future were just one example.

A recent example of this is with two of our staff members, Frank Wagner, Bioethicist, and Kim Ibarra, Program Evaluation Specialist & Ethics Consultant. They have been doing exceptional work challenging us on how we address ethical issues through training and consulting with our staff, service providers, some other CCACs and the Community Ethics Network in the Greater Toronto Area. The international community has taken notice and they have been invited to participate with several major international organizations as part of a working group to develop ethics guidance material to help providers in community-based organizations manage ethical dilemmas in working with households affected by HIV in over 15 locations around the globe.



Kim Ibarra and Frank Wagner.

John Miller, Projects Coordinator for the Coalition on Children Affected by AIDS (CCABA), was enthusiastic about their contributions, "Mr. Wagner's experience in leading the process to develop *Community Ethics Toolkit - Ethical Decision-Making in the Community Health and Support Sector* is so directly relevant to the project that I was astonished to find him at all, let alone here in this very city."

Driving the Highest Possible Care Integration for Our Client Populations Who Need it the Most



As we build our future, we intend to respond to our current health system challenges. We know that clients and their families interact with many different service providers and organizations, and at times the health care system can seem complicated and fragmented. We also know that when clients transition between many different providers they face a number of challenges because of poor transitions between providers that can lead to a poor client experience and health outcomes.

Integrated Care is one of the biggest improvement opportunities that we identified from our global and national environmental scan. It's also a priority for the government in Ontario.

Our fourth strategic direction will focus on ***driving the highest possible care integration for our client populations who need it the most***. To achieve this goal, we know that we will have to challenge how we organize and deliver services to our clients and their families with a primary focus on the client and caregiver experience. We intend to break down barriers with existing partners, and push the boundaries with new partnerships. In the fall issue of *Making Connections*, we highlighted some of the work our CCAC is driving on a Toronto Central LHIN initiative which is beginning to do this. The Integrated Client Care Model for seniors is taking an integrated approach to care for older adults with multiple complex care needs. The approach is designed to bend the cost curve for some of the system's most complex and costly patients – the 1% of the population that

accounts for 43% of hospital and home care costs. We plan to take the learnings from this initiative to help us drive integration for other populations with complex care needs, starting with children and end-of life clients. Our plan is to get a deeper understanding of people who have difficulty accessing our services and working with them to improve access.

We are just beginning to push the boundaries further by building on the momentum gained from the Integrated Client Care Model for seniors by partnering with seven Family Health Teams, and House Calls to develop and evaluate an Integrated Home-Bound Primary Care Model (IHBPC). We are learning more about our home-bound clients who are unable to access services outside of their home due to significant physical, cognitive or functional impairment that makes it difficult to leave the home. The ultimate goal is to connect them with primary care led integrated inter-disciplinary, inter-organizational care teams who can be responsive to their changing needs.

(Continued on page 8)



Driving the Highest Possible Care Integration for Our Client Populations Who Need it the Most

(Continued from page 7)

The Toronto Central LHIN brought together the *Primary Care for Home-Bound, High Risk and Frail Seniors Task Group* in March 2011. This partnership has won the recognition of the *BRIDGES Team* (Building Bridges to Integrate Care): A joint initiative of the Departments of Medicine and Family Medicine funded by the Ministry of Health and Long-Term Care and has been awarded funds to conduct a comprehensive evaluation of the model. *BRIDGES* supports innovation and integration in health service delivery by linking academics, clinicians, hospitals, and CCACs.

The recognition of the *BRIDGES* team to fund the evaluation of the *IHBPC* model demonstrates the collective interest and willingness to move the health system forward

to better support older adults with complex needs and to evaluate the effectiveness of innovative integrated interventions.

We are excited about this partnership. We believe that by reorganizing and maximizing efficiencies of the current resources in the system, and embedding integration in the community where older adults and their caregivers live, these teams will improve care for older adults and their families. We also believe the evidence will show that it's an important community solution for improving quality and addressing health system sustainability.

Research shows that more integrated approaches to care result in better health outcomes and overall cost savings.



The few initiatives that we have highlighted are just the tip of the iceberg.

Every **10%** reduction on the **48** billion expenditure
used by **1%** of the population equals **4800** million in savings



Celebrating Our Successes

Dipti Purbhoo, Senior Director, Client Services, Toronto Central CCAC, received *The Society of Graduates, Department of Health Policy, Management and Evaluation (HPME), University of Toronto 2011 Leadership and Innovation Award*. Dipti has over twelve years

experience in home and community health care. She is a creative and innovative leader who focuses on new methods of service delivery that better the client experience. Dipti recently implemented a new population based model of care that changed more than 50 years of home care history, aligning services and supports to client populations. She has built an excellent reputation as an effective consensus builder with her ability to forge partnerships and strategic alliances among health, community and government sectors.



Health Innovations

Toronto Central CCAC was well represented at the fall Health Innovations Expo. The Minister of Health and Long-Term Care, Deb Matthews, and (former) OHA President & CEO Tom Closson,

targeted one of our exhibits, the *Integrated Client Care Model for Seniors*, a Toronto Central LHIN initiative, for a visit. This model serves older adults with complex medical care needs (to learn more about this initiative, see the article on page 7). Two additional CCAC collaborative initiatives were also showcased: the *Alternative Level of Care Long-Stay Program* and the *Virtual Ward* for seniors care strategy.

Building our Future: Inspired by Our Partners

Thanks to all of our valued partners for providing feedback on our draft strategic directions through surveys and interviews. The survey was sent to a wide range of partners. The following are some examples of the feedback we received:

Draft Strategic Direction #1

We will relentlessly pursue every option to deliver what is most important to every client

- Bridge gaps between providing and coordinating agencies so that the patient experiences smooth transitions and so that the CCAC has strong relationships that they can “tap” into to pull strings for patients
- Engage primary care providers
- Clear communication between clients or those who feel they should be clients
- Ask clients how best to execute on this

Draft Strategic Direction #2

We will support our clients to live the fullest and healthiest lives possible

- Fullest is defined by the patient. It will be important to understand what fulfills the patient. As for healthy lives, a strong focus should be placed on health prevention, otherwise patients are not living their healthiest lives
- In discussions with clients – will need to set realistic expectations that are achievable. Quality of life outcomes are very important
- Identify the desired health outcomes you are looking for in this new health and wellness focus
- Initiatives which increase face-to-face contact with patients and families might be beneficial in achieving this goal

Draft Strategic Direction #3

We will unleash the potential of our people

- Finding out what your employees like and don't like about the CCAC, and working hard to make the CCAC a better place to work for everyone
- Perhaps a chance for service provider staff to meet CCAC staff on non-territorial grounds even once a year to create collaborative team relationships
- Hire staff that are open to thinking outside the box
- Focus on your internal staff first – if they feel they are truly working to their full potential it will no doubt impact on their provider partners

Draft Strategic Direction #4

We will drive the highest possible care integration for our client populations who need it the most

- Integrate with primary care
- Forging better relationships with long-term care homes and creating accountability agreements to evaluate and process are an absolute must
- Reviewing communication processes with agencies. Is there an electronic solution, an iphone app for clients
- Define the client groups who need it most



Toronto Central

CCAC CASC

Community
Care Access
Centre

Centre d'accès
aux soins
communautaires
du Centre-Toronto

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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