2012-2013 in Review:

OACCAC & CCACs working towards a sustainable health care system

Working as a team with our many partners across Ontario's health care system, the Ontario Association of Community Care Access Centres (OACCAC) and Community Care Access Centres (CCACs) are helping transform health care to better serve Ontario families.

As a not-for-profit member and shared-services organization, the OACCAC supports its members, Ontario's 14 CCACs, and their partners, in providing high-quality home and community care to people across the province. The OACCAC advocates for better patient care and helps CCACs develop innovative and cost-effective ways to provide people with the care they need when they need it.

Key Highlights 2012-2013

Supporting Ontario's most vulnerable populations

Every year, CCACs continue to see more high-risk patients who need higher and higher levels of care: their health needs are more acute and the interventions and support they need are more complex than ever before. No matter how complicated Ontarians' health care needs are, they would still prefer to be in the comfort of their own home with appropriate supports, rather than any other settings, for as long as possible.

The OACCAC supports CCACs to develop provincial approaches to the implementation of care innovations. This ranges from shared principles to implementation roadmaps. This year, the OACCAC supported CCACs as more nurses are being hired to provide additional frontline care to our most vulnerable patients: frail seniors and adults and children with complex, serious illnesses as well as those needing end-of-life care. These nursing programs include:

- ***Rapid Response Nursing*** – Registered nurses support patients with high care needs as they transition home from hospital. Services include a home visit 24 hours post hospital discharge, medication reconciliation, comprehensive nursing assessment, patient/family education, and linkage with primary care physician for seven day post discharge primary care follow-up. The goal of the program is to reduce 30 day readmission rates.
- ***Palliative Care Nurse Practitioners*** – Nurse practitioners provide support to primary care physicians to ensure earlier identification of palliative patients and provision of palliative care support. The goals are earlier identification of palliative patients, increase number of patients supported to die at home and reduce avoidable emergency department/hospitalization for palliative patients.

Through a partnership with district school boards across the province, CCACs are also providing direct nursing support for students with mental health and addiction issues:

- ***Mental Health and Addictions Nurses*** – Through funding from the Ministry of Health and Long-Term Care, qualified mental health and addiction nurses provide direct care to students with mental health and addiction issues. This investment in caring for children is part of a comprehensive Mental Health and Addictions Strategy, with the first three years focused on children and youth.

Working together to deliver patient-centred care

Quality and Value in Home Care, a collaborative initiative in the home and community care sector, brings improvements in the delivery of person-centred, quality care while supporting government policy for maximizing value for money.

Through this initiative, CCACs and their service provider organization (SPO) partners are working together to achieve sustainable system transformation. On October 1, 2012, CCACs and their SPO partners successfully implemented new performance-based contracts. A modernized contract allows us to gather information about the quality of care patients are receiving, so that it can be continuously improved upon.

In addition, exciting work is currently underway to develop even better ways to ensure the right outcomes for the individual needs of patients. CCACs and their SPO partners are implementing standardized care pathways that link payment to the achievement of specific health outcomes for patients. Testing of outcomes-based pathways for wound care and hip and knee replacement patients began in October 2012 and has involved five CCACs.

Building partnerships to fill gaps and working together to enhance team-based support for patients

Supporting people as they move from one part of the health care system to another, CCACs are already working hand in hand with other care partners to ensure patients' needs are met throughout their full care experience.

The OACCAC is supporting CCACs to strengthen and enhance partnerships with primary care providers in the community so that together, they can better fill gaps, especially for the most vulnerable patients, and build stronger teams of support around patients by enhancing communication and information sharing. This also advances Ontario's goals of decreasing hospital stays, avoiding unnecessary hospitalizations, improving transitions between care settings, and supporting healthy aging at home, which helps to avoid early admittance to long-term care – freeing beds for those who need them most.

Partnering to improve care transitions through Ontario's Health Links

Health Links are a new and innovative way of partnering to deliver care for those who are heavy users of the health care system. CCACs are partners in all Health Links in the province, taking different roles as the partners come together to design the Health Link appropriate to their patients. The OACCAC is

working with CCACs to develop a comprehensive service offering to ensure that CCACs are strong collaborating partners in the development of Health Links and are able to maximize their contribution to the high need patient populations that are the focus of the Health Links approach. This includes improved communication with primary care throughout transitions from one care setting to another, and a population-focused approach to care coordination and support through technology.

Creating efficiency by leveraging technology

The OACCAC has worked with CCACs to implement existing and new technologies to create efficiencies and foster collaboration with their health partners. This year, great strides have been made supporting care integration, connecting the CCACs platform with our health care partners to support patient care, and replacing paper and fax with timely and accurate electronic information.

A quality improvement initiative called *Transformation Begins at Home* aims to improve patient care by eliminating duplicative procedures, such as multiple assessments (people don't want to tell their stories over and over again), and enhancing efficiency to get greater value for every health care dollar spent.

Now implemented across all CCACs, assessment sharing leverages technology to enhance the patient experience and enables a team-based approach to care, ensuring more coordinated, smoother transitions for people as they move between care settings.

Helping people quickly and easily get the care and health supports they need, CCACs are working with their community partners to provide a single point of access to adult day programs, assisted living, and complex care and rehabilitation beds, in addition to long-term care homes. Referrals to community and long-term care homes through Client Health Related Information System (CHRIS) and Health Partner Gateway (HPG) have helped to streamline the referral process.

CCACs have the mandate provincially to provide information and referral services to the people of Ontario. With the final CCACs launching the thehealthline.ca in early summer, a one-stop-shop to help patients navigate the health services they need in their communities is in place across the province.

Recognizing health information as a public good, the CCACs and thehealthline.ca are committed to working in partnership to ensure information is collected only once, shared freely and that thehealthline.ca integrates local information from reputable sources like Connex Ontario. Seventeen Community Information Centres share data with nine regional thehealthline websites and thehealthline.ca data is shared to support local 211 data collection and provincial 211 services.

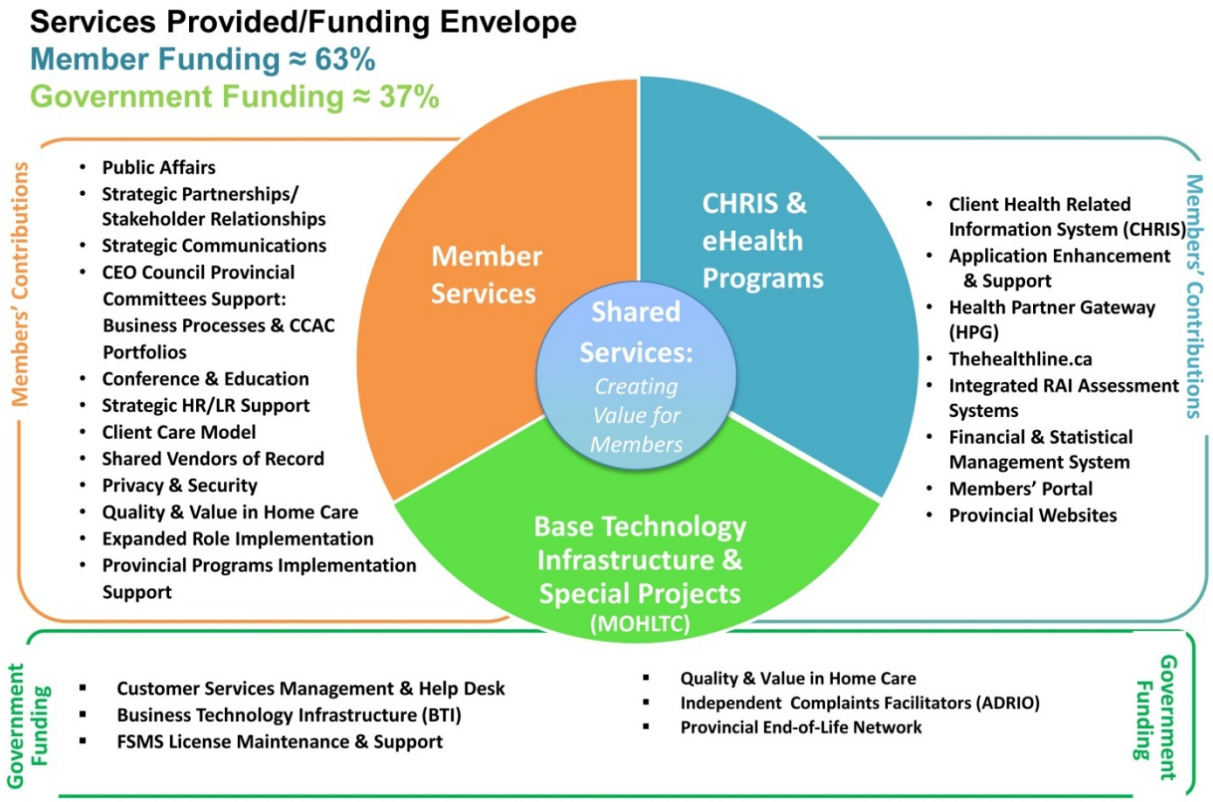
With continued investment from CCACs, together thehealthline.ca Information Network, the OACCAC, the individual CCACs, and their local partners have created a sustainable model for continued quality and enhancement of this rich information resource.

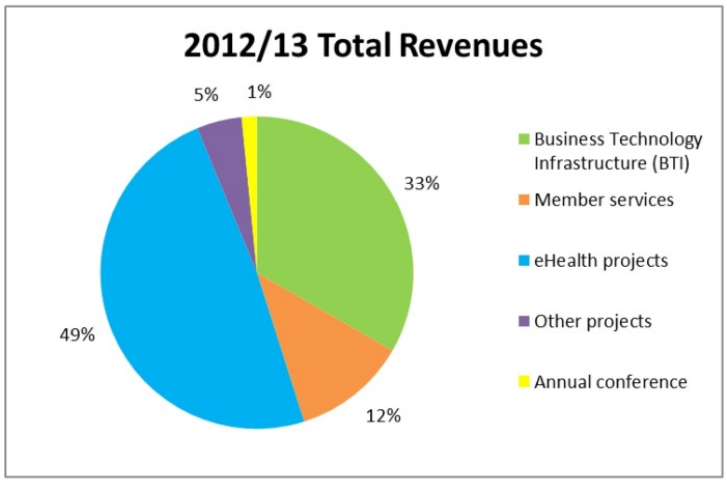
OACCAC Funding and Services

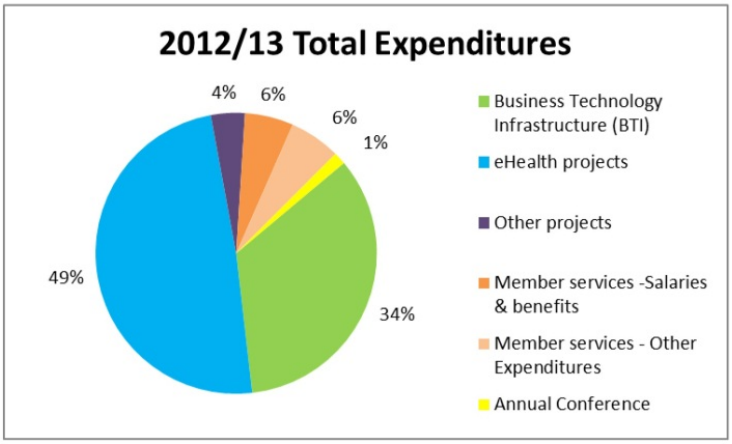
The OACCAC's mandate is to provide its member CCACs with leadership, innovative programs, solutions and services they need to continue to advance excellence in integrated care and deliver enhanced quality, accountability and health outcomes for Ontarians.

To meet this mandate, the OACCAC receives approximately 63 per cent of its budget for designated shared services from members' contributions and the approximate remaining 37 per cent from government funding.

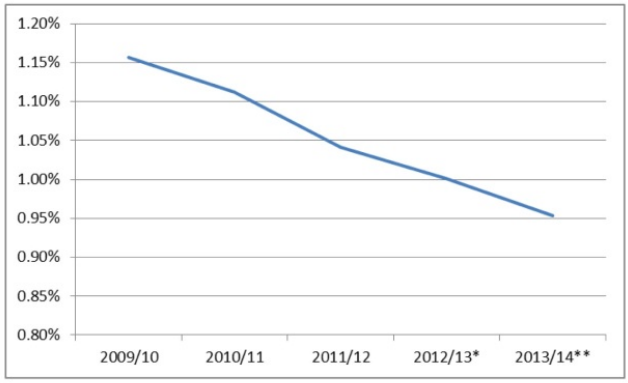
Member funding is allocated to member services, as well as development, deployment, maintenance and support of CHRIS and other eHealth programs. In fact, total OACCAC member contributions for core and eHealth services have held flat since 2008/2009 at approximately $21 million and are actually declining as a percentage of total provincial funding. Government funding supports base technology infrastructure and special projects implemented in collaboration with the Ministry of Health and Long-Term Care.







Total OACCAC Member Contributions for Core Services and eHealth have been held flat since 2009/2010 and are therefore declining as a percentage of total provincial CCAC funding.



* Assume 4% increase in base funding in 2012/13
** Assume 5% increase in base funding in 2013/14