Trying to Find the Right Path from Good to Great

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Toronto Community Care Access Centre

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The Ontario Context

Acute/Rehab/Community/LT Care

Primary Care/Public Health/EMS

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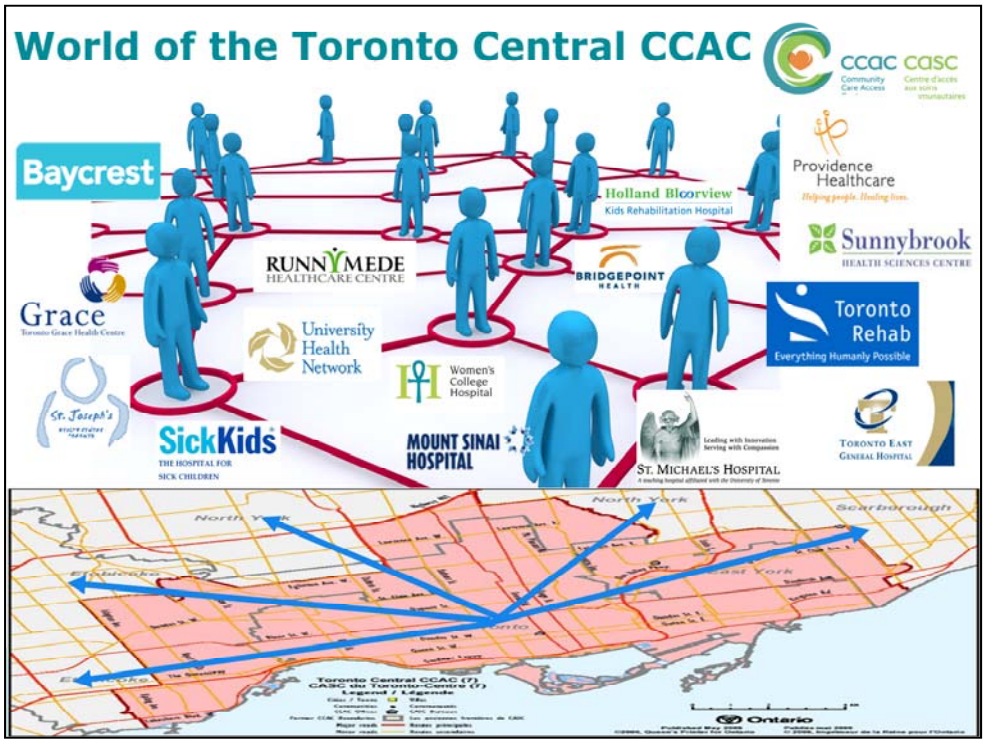
World of the Toronto Central CCAC
ccac casc
Community Care Access
Centre d'accès aux soins communautaires
Baycrest
Holland Bloorview
Kids Rehabilitation Hospital
Providence Healthcare
Helping people. Healing lives.
Sunnybrook
HEALTH SCIENCES CENTRE
RUNNYMEDE
HEALTHCARE CENTRE
BRIDGEPOINT
HEALTH
Grace
Toronto Grace Health Centre
University Health Network
Women's College Hospital
Toronto Rehab
Everything Humanly Possible
St. Joseph's
SickKids
THE HOSPITAL FOR SICK CHILDREN
MOUNT SINAI HOSPITAL
ST. MICHAEL'S HOSPITAL
Leading with Innovation Serving with Compassion
TORONTO EAST GENERAL HOSPITAL
North York
Scarborough
Etobicoke
East York
Toronto Central CCAC (*)
CASC du Toronto-Centre (*)
Legend / Légende
Ontario

CCAC Role in System Level Improvement

- Alignment to LHIN boundaries enables us to implement large-scale change with measurable impact
- Reach across the continuum, playing a central role in transitions between care settings
- Greater "elasticity" in the community to accommodate change compared to institutional settings
- Partnerships and expertise that bridge across traditional sector silos
- Flexibility to respond to emerging issues or crisis

Where to Start?

- Balance of Care
- Integrated Care
- Having Your Say

- Population Based Model
- Home First
- Integrated Care Models

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A Simple Improvement Strategy

ENHANCING THE CLIENT EXPERIENCE

KEEPING PEOPLE HOME GETTING PEOPLE HOME

QUALITY AS A CORE BUSINESS STRATEGY

PERFORMANCE GOALS:

- *Improved Client Experience*
- *Fewer clients waiting in acute hospitals for LTC*
- *Fewer Clients Being Designated ALC*
- *More high-risk clients are remaining in the community*

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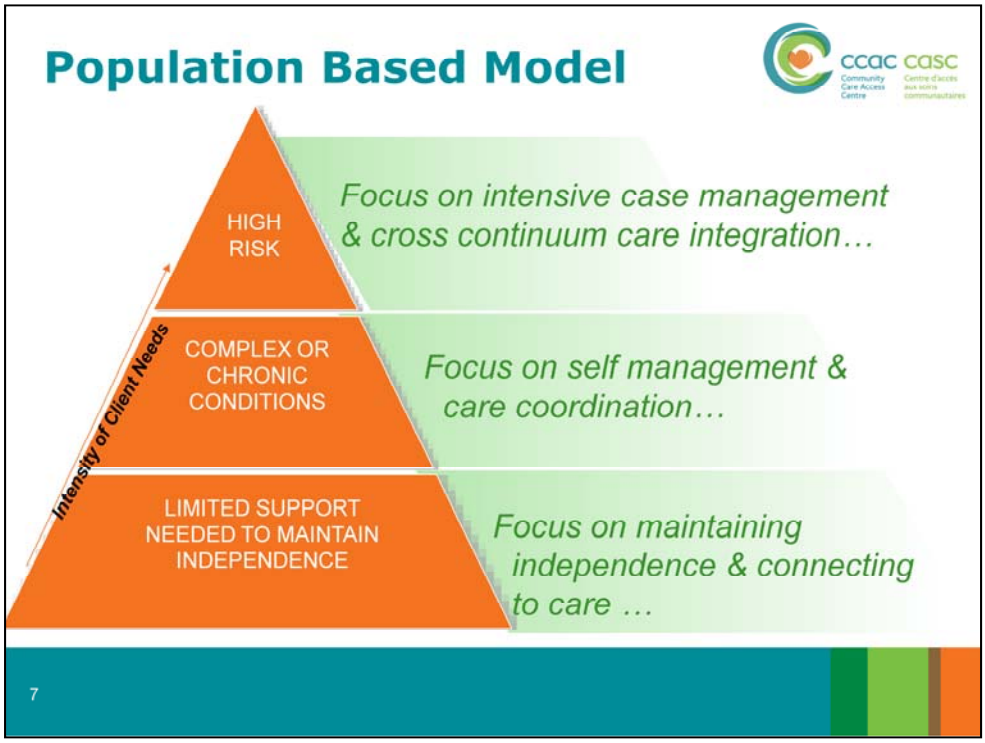
Population Based Model
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HIGH RISK
COMPLEX OR CHRONIC CONDITIONS
LIMITED SUPPORT NEEDED TO MAINTAIN INDEPENDENCE
Intensity of Client Needs
Focus on intensive case management & cross continuum care integration…
Focus on self management & care coordination…
Focus on maintaining independence & connecting to care …
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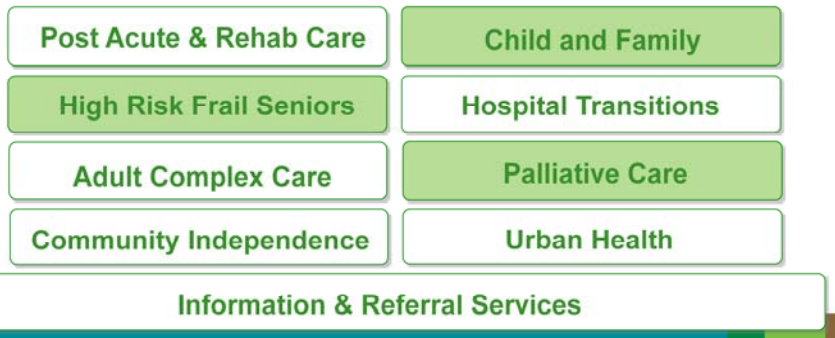
Population Based Model

- In 2009 TC-CCAC reorganized around key populations to improve the quality of care. This model has now been adopted across Ontario.
  - Greater ability to target and organize resources and activities
  - Deeper, more focused understanding of client populations
  - Improved ability to measure performance and outcomes



Home First is a philosophy, not a program

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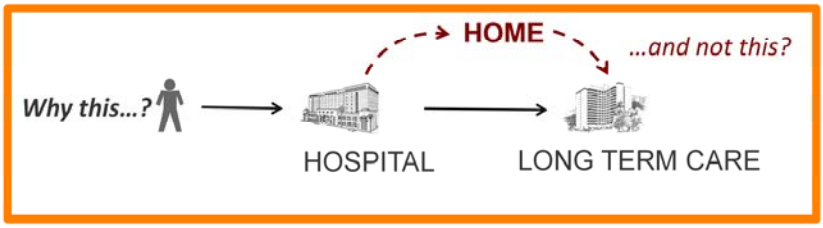
Community Care Access Centre / Centre d'accès aux soins communautaires

Home First

making home the first option after a hospital stay



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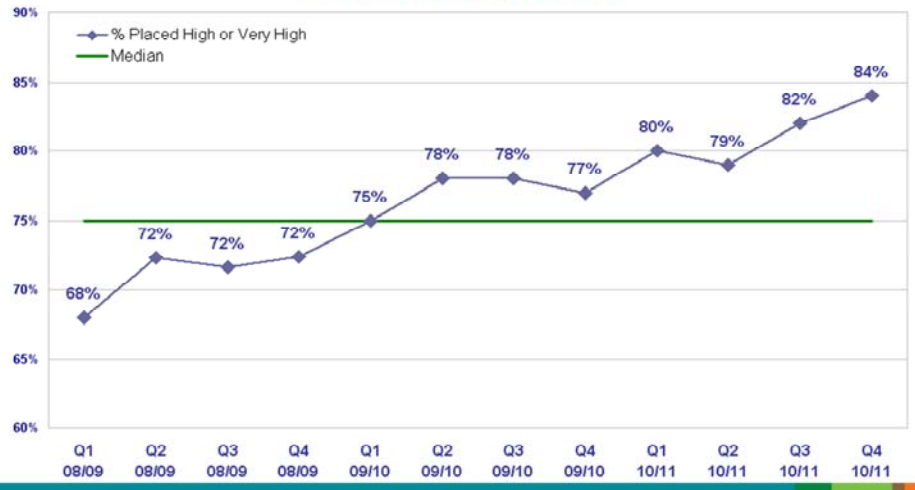
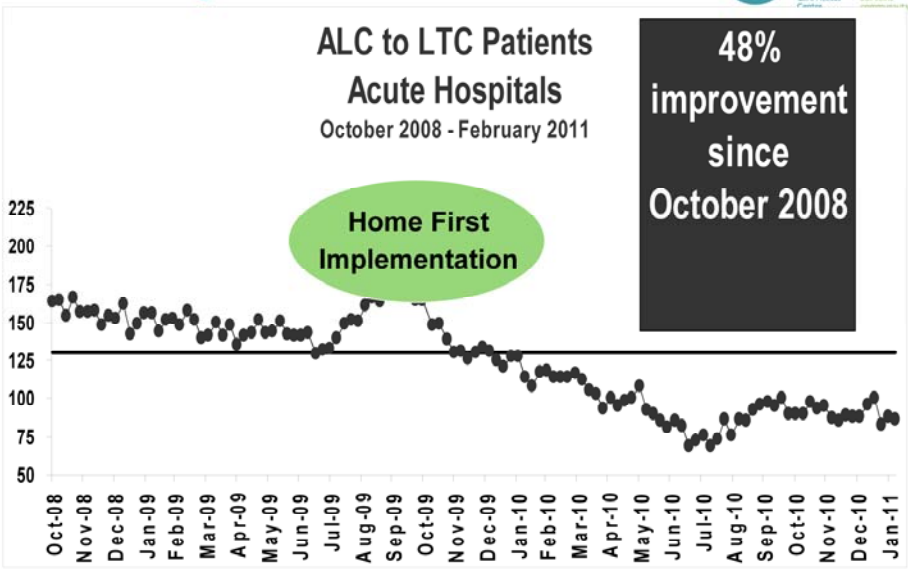
Some Early Results

Clients Placed in LTCHs with Scores of High or Very High as a Proportion of Total Clients Placed in LTCH in the Time Period
Q1 2008/09 - Q4 (Feb QTD) 2010/11



Some Early Results



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The Opportunity

Integrated Care

Emerg Department Wait Times	Alternate Level of Care Patients	Value & Affordability

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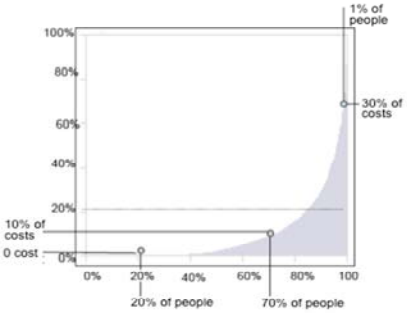
The Case For Change

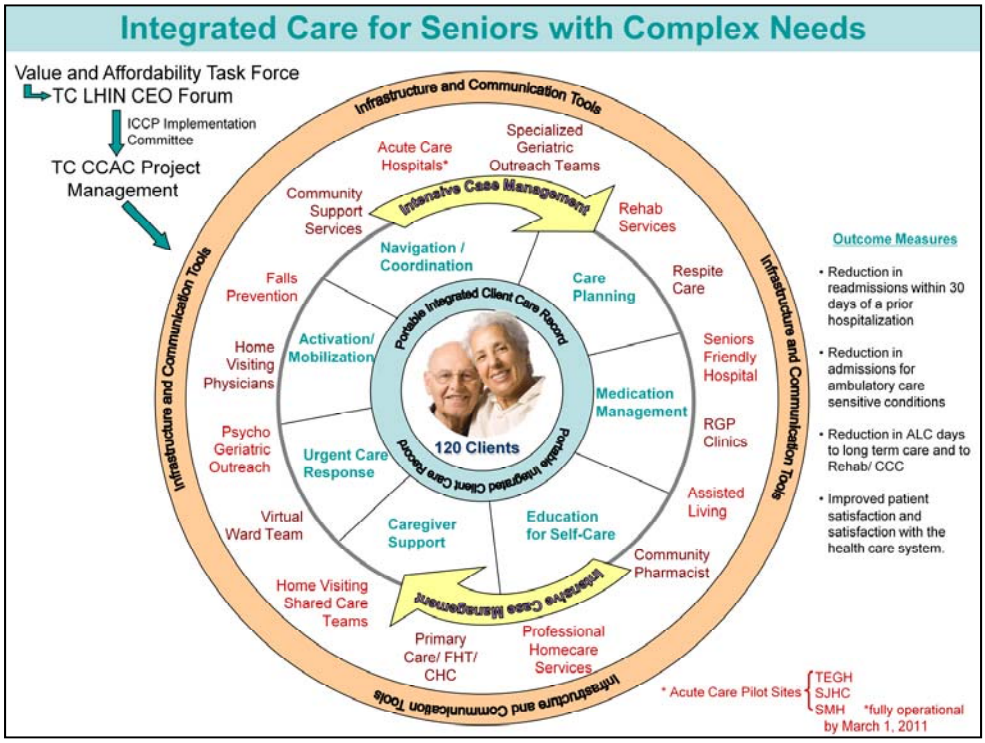
- TC-LHIN CEO Commitment
- Studies have consistently demonstrated that a
- Small number of patients with complex chronic conditions account for a disproportionate percentage of healthcare costs.

- Working as a system to more effectively respond to the needs of these patients at the
- "top of the pyramid" ***offer one of the most significant opportunities to improve value and drive sustainability.***



- *2007 Kaiser Permanente report estimates that **1% of the population account for 30% of total healthcare costs***
- *Recent Ontario review estimated that 0.3% of patients account for approximately 10% of hospital discharges and 40% of bed days*
- *Research indicates that those with those with multiple chronic conditions cost up to 7 times those patients with only one*

Integrated Care for Seniors with Complex Needs



Outcome Measures

- Reduction in readmissions within 30 days of a prior hospitalization
- Reduction in admissions for ambulatory care sensitive conditions
- Reduction in ALC days to long term care and to Rehab/ CCC
- Improved patient satisfaction and satisfaction with the health care system.

* Acute Care Pilot Sites { TEGH, SJHC, SMH *fully operational by March 1, 2011

Program Goals

•**The goals for clients:**

•To improve the overall experience of care and helping people to remain at home longer.

•**The goals for the system***:*

•To improve transitions and enhance quality by specifically reducing hospitalizations, reducing ALC days and improving client satisfaction and experience.

Key Principles

- Optimize the resources and capacity already in the system
- Scalability & Sustainability
- Align and link together existing initiatives serving the same population
- **Share accountability for outcomes.**

Client Selection Criteria for the top 1%

Use evidence based screening tools to screen for:

- Acute discharge with ACSC* (2 or more ACSC)
- Home care client with ACSC with high RAI scores (not hospitalized)
- Living within the TC LHIN
- Caregiver absent or requires support to continue in their caregiver roles
- Functionally and physically impaired, and or cognitively impaired
- Multiple co-morbidities
- Multiple medications of 10 or more +/- psycho-tropic Medications
- Falls
- Incontinence Management
- May have unstable medical conditions
- Social risk factors

***Ambulatory Care Sensitive Conditions (ACSC) Indicator Definition:** This definition focuses on a core group of 7 chronic ACSC The conditions include: **Asthma, Angina, Congestive Heart Failure, Hypertension, Epilepsy, Diabetes, Chronic Obstructive Pulmonary Disease (pneumonia)**

Analysis: Once selected, cross reference with:
•Sector distribution i.e. % with attachment to primary care, FHT, CHC, Pharmacy etc…
•Determine each clients care team – providers involved in "wrap around care"

Measuring Success

- Reduction in readmissions within 30 days of a prior hospitalization
- Reduction in admissions for ambulatory care sensitive conditions
- Reduction in ALC days to long term care and to Rehab/ CCC
- Improved patient satisfaction and satisfaction with the health care system.

A few lessons learned…

Why do we think its okay to let a 20-year old make choices…

But at 88...?

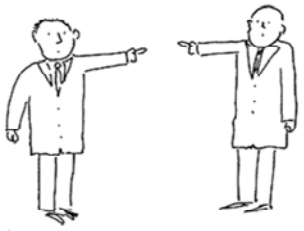
A few lessons learned…

ANECTODAL

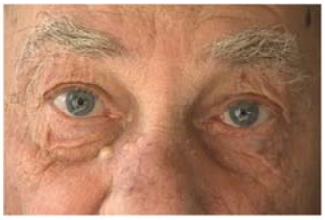
A few lessons learned…

A few lessons learned…

- *We have major cross sectorial trust issues – leadership at the highest levels is required to productively move us forward*



- *Only by understanding the experience through our clients eyes can we truly build better systems of care*



Moving Forward