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

Working hand-in-hand with Primary Care

Creating One Team

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What We Have Learned from Leading Integration for Four Years?

To have a strong Healthcare System we need to better integrate Primary Care.

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Our Aim

Supporting populations with complex needs with better care at home in their communities, utilizing existing resources

OUR APPROACH

Creating One Team Through the Eyes of...

For the client/family

- Seamless care
- One team approach

For the providers

- One team approach
- Built around client and family needs

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Policy Considerations

- How do we design our system to **deliver the best value** for clients and their families so that they experience the multiple parts of the system as '**ONE TEAM**'?

- How do we **design incentives** to ensure:
  - capacity to deliver high performing home and community care?
  - providers work in an integrated model?

- How do we look at **accountability models** so we move from organizational or sector accountabilities to integrated accountabilities tied to the client/family experience?

Delivering integrated care across the continuum of care at the point of care…

At home, in the community

When necessary, the transition

Acute, CCC or Rehab

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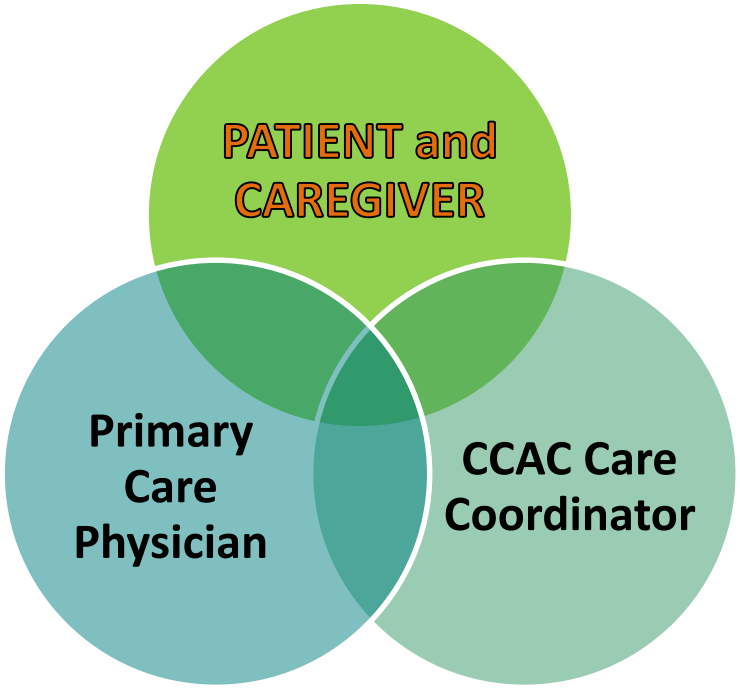
CCAC and Primary Care Working Hand in Hand

Key Strategic Enablers:

- Communications & Engagement
- E-Health
- Operational Tools
- Performance Indicators



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Overarching Goal

- Create one team for our clients and families and improve their experience, outcomes and quality of care;
- Improve the experiences of primary care partners;
- Improve the experience of the community teams with primary care; and

Building a collaborative team of support for populations with complex needs to live and thrive in their communities

Ensuring the success of both primary care reform and the modernization of home and community care.

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We are well on our way....

- 637,000+ clients/year
- Dedicated care coordinators in 1/3 of FHTs and 1 in 5 CHCs
- 230+ dedicated CCAC care coordinators in FHTs and CHCs
- Nurse practitioners in most CCACs
- ½ of CCACs are leveraging technology to share patient information with primary care
- Provincial CCAC Primary Care Fact Sheet
- Primary Care Communication Standards

CCACs help patients find primary care providers

134,500 people

13,300 with high care needs

Since Health Care Connect launched in February 2009, 134,500 patients have been connected to a primary care provider, including over 13,300 patients with high care needs.*

Working together to build a stronger care team

Care Coordinators

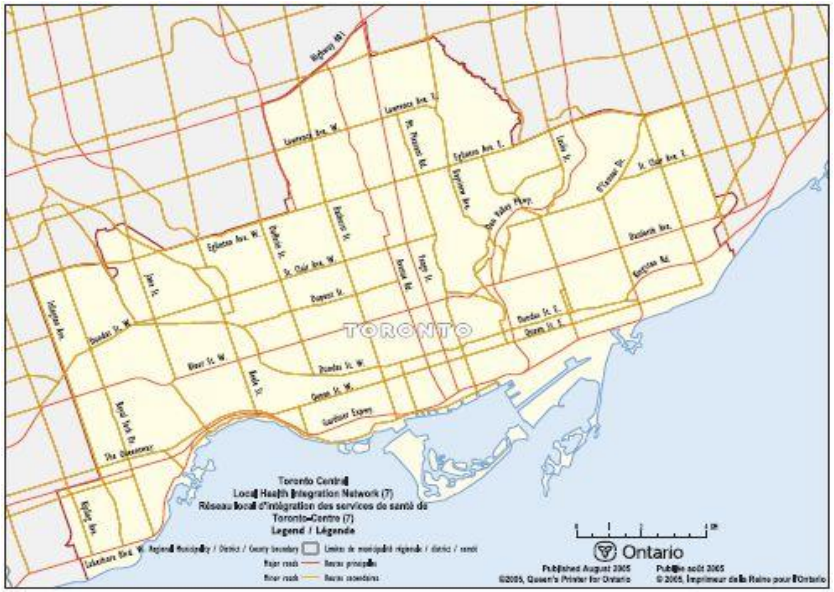
Family Health Teams

CCACs have dedicated care coordinators working with one-third of family health teams and growing.

Toronto Central CCAC - Who We Are

An Urban CCAC…

- Our community consists of **1.15 million** residents in the Toronto area
- Highest rates of **diversity** and **low income** and single parent families - urban population
  - **20%** of children live **below poverty line**
  - **36%** of households have **low incomes**
  - **40%** of Ontario's **homeless population** live in Toronto
  - Incredible **diversity** with over **100 languages** spoken across the region



Partnering In A Complex System

22 Hospitals, 74,000+ transitions, 57% to other CCACs

41 long-term care homes operating at 99% occupancy

1200+ primary care providers (13 Family Health Teams, 18 Community Health Centres, and 600 solo-practice physicians)

100+ Community Support Services

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Key Components of TC CCAC Strategy

Connect Care Coordinators with Primary Care Physicians

- ✓ Connect Care Coordinators with FHTs, CHCs, group practices & Solo-practice
- ✓ Joint care planning between Care Coordinators and Primary Care

Improve Communications

- ✓ Physician letters to communicate client status (automation via CHRIS & view access)
- ✓ Primary care communication materials (fact sheet, website)
- ✓ Single physician CCAC access (phone line, Care Coordinator number)

Primary Care Standards

- ✓ Communication standards
- ✓ Standards for ensuring regular primary care follow-ups for clients

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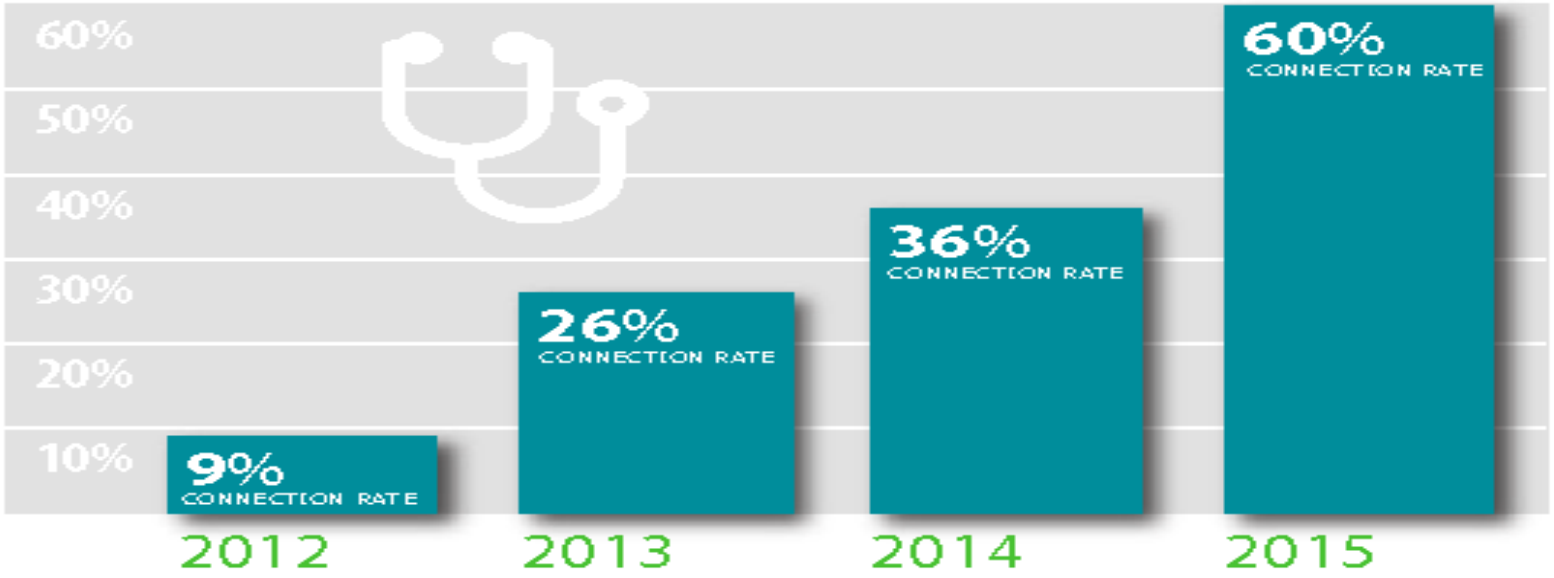
Toronto Central CCAC
Where We Are At In Our Journey

- Dedicated Care Coordinators in 26 out of 30 of Toronto's Family Health Teams and Community Health Centres

- 40+ Care Coordinators connected to 60% of all primary care physicians in TC LHIN, including physicians in non FHT/CHC Practices

- 550+ calls to the dedicated Primary Care



2010 - 2012

First integrations for our most complex populations

2013 - 2015

Connection of Care Coordinators to all FHTs and CHCs

2015 onward

Relationships with all Primary Care Providers with shared clients

Incremental Build To Drive 'One Client, One Team' Approach

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eHealth – A Cornerstone of the Strategy

Where can we have the most impact?

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Engaging Primary Care is Critical….

Through Asking, Listening and Delivering, we learned that our Primary Care Partners want:

- An understanding of CCAC services & supports
- Information about their patients
- Easy access to the CCAC
- Help for their complex patients
- Help with navigating other health care resources for their patients
- Teamwork with CCAC Care Coordinator and the home care team

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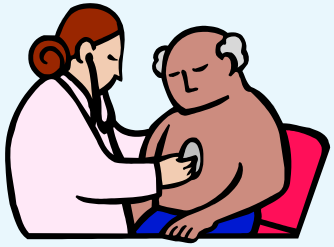
The landscape



Primary Care
EMR

Discharge summaries
ED reports

Specialist notes
Specialist referrals

DI results & reports

Lab results

CCAC Services
LTC Placements

Medication history

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Trends and influencers

- mHealth
- Consumer IT expectations
- Regional EHRs
- Consolidation of EMR vendors

The challenge

- Information sharing – but not too much
- Notification of patient events and transitions
- Support for developing and sharing coordinated care plans for the patients with the most complex needs
- Proliferation of access points and portals

Recent initiatives

oaccac acasco

yammer
The Enterprise Social Network

- CHRIS
- Health Partner Gateway
- Community Health Portal

CONNECTING GTA

- EMR implementation for integrated home-based primary care team

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An Integrated Care Team

Complex Care Patient

- 75-year-old woman
- Lives alone
- Hospitalized for COPD complications
- Multiple medications

Current communication methods:

- Paper-based charts
- Fax
- Pager
- Telephone
- Emails
- Instant Messaging

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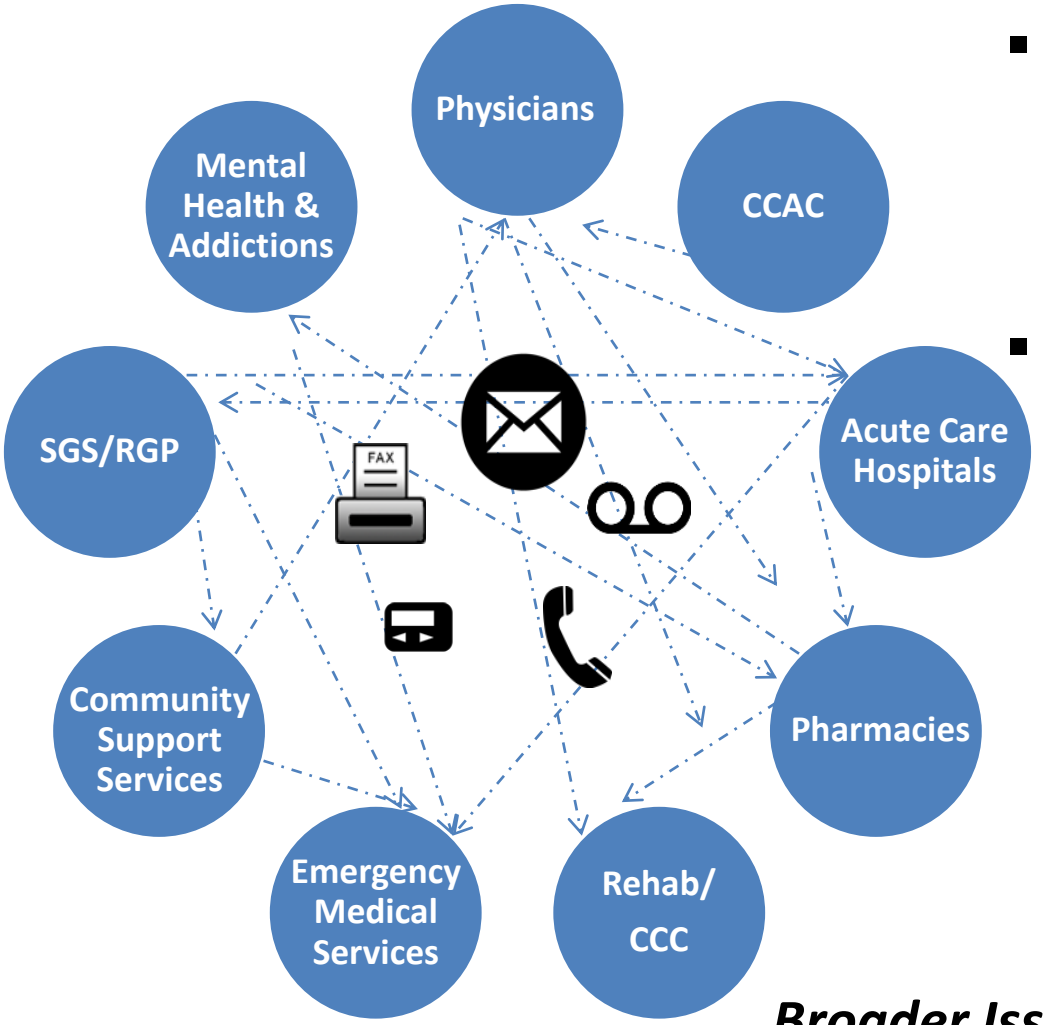
Challenges with Current Communication Strategies



- ***Synchronous?***
  - Phone Tag
  - Highly Inefficient to Make Contact
- ***Typical Asynchronous?***
  - Often 1:1 – Need 1:Team and Team:Team
  - Faxes/Charts good for "telling"; not "discussing"
  - Poor documentation of decisions (hidden)
  - Core team members easily forgotten on "CC:" list

Broader Issue: Even strong communication strategies are often silo'ed within institutional boundaries and role definitions.

Translating Clinical Requirements into Technical Specs

Provider Needs

Technical Specs

Enabling point-of-care integration

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Technology is rarely the silver bullet…

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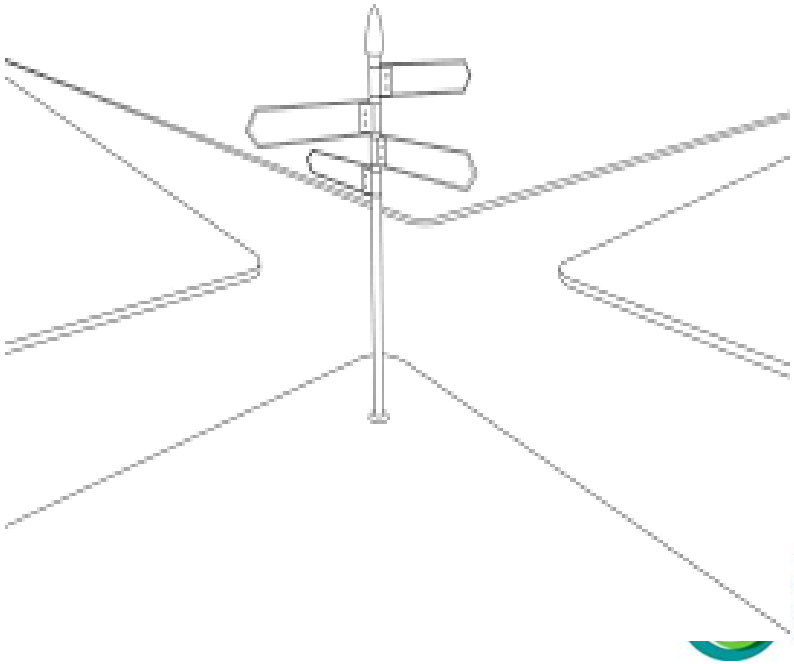
When is Communication Most Crucial?

- What kinds of patients?
- At what specific points in the care path?
- Who are the critical team members who need to be involved?



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eHealth – A Cornerstone of the Strategy

Where are we going?

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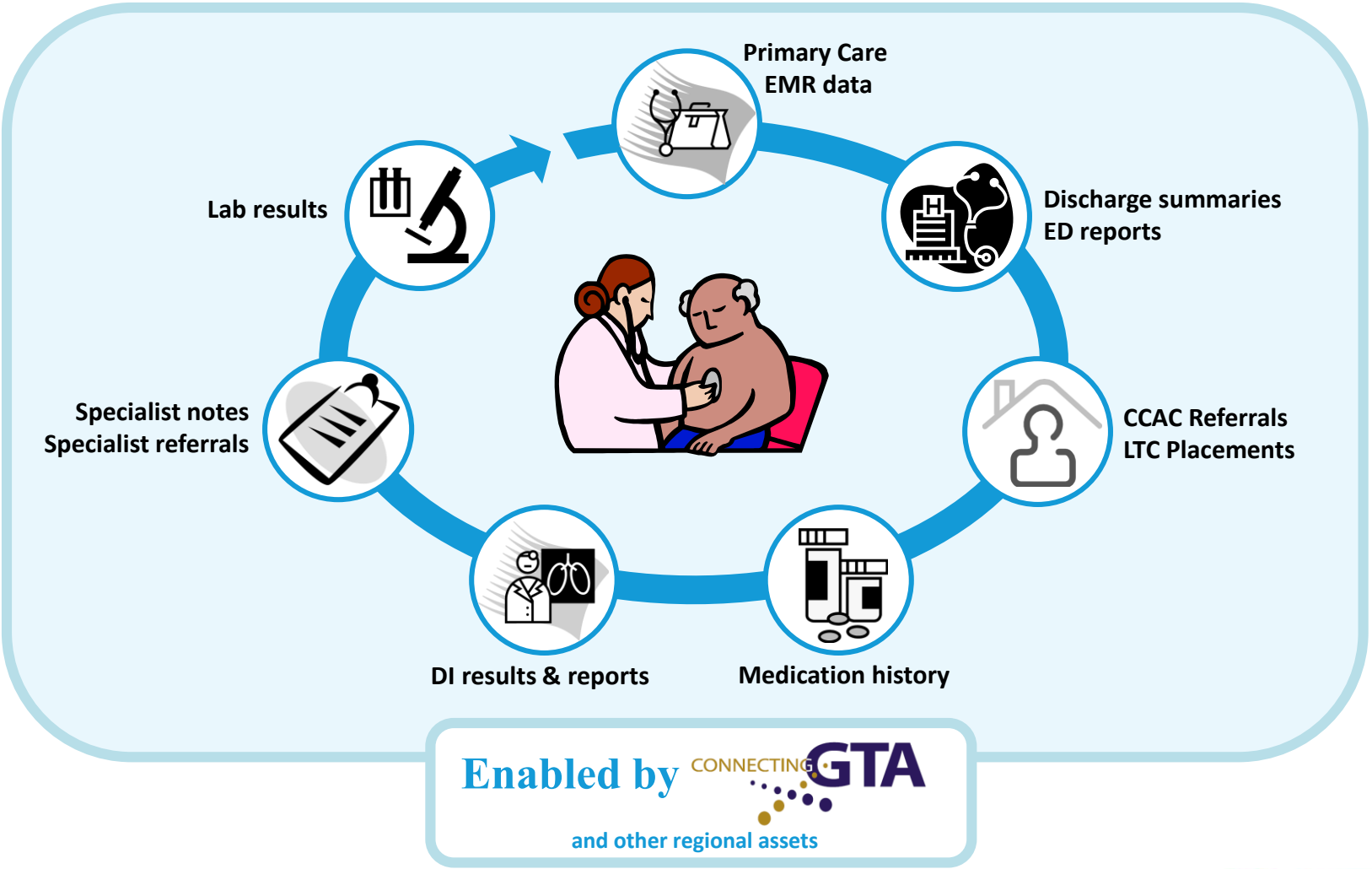
Vision: Seamless access to consolidated patient information across the care continuum



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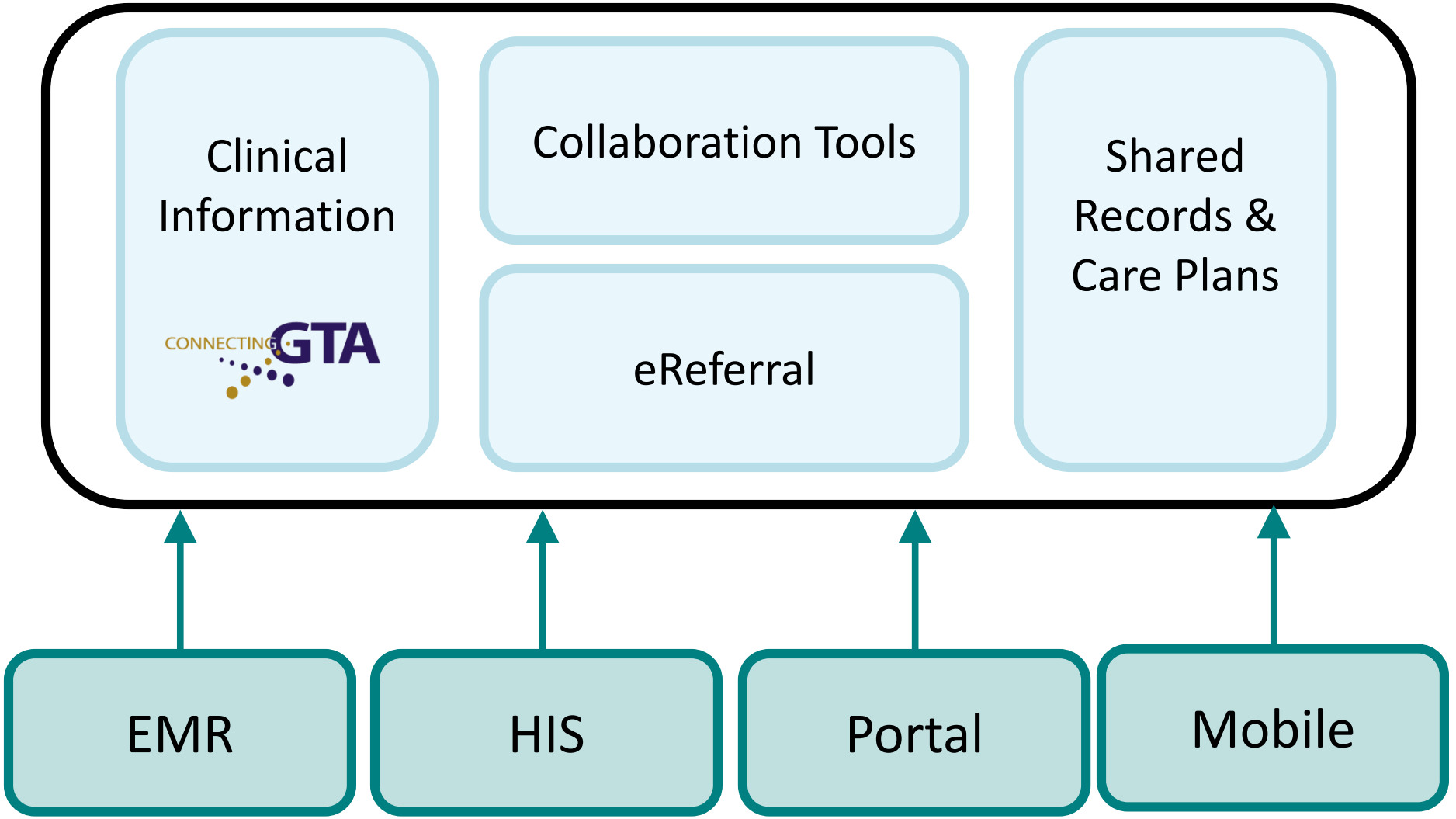
Vision: Single point of access to multiple tools



How can we lower the barriers?

- **Easy to lose people if the process to join makes it at all cumbersome**
  - Accessing participants to get them signed up
  - Participation Agreements to address privacy concerns
  - Authentication Process
  - Technology glitches & challenges early in the adoption cycle

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Implications for Our Integration Efforts

- Not about technology, it is about changing human behaviour
- Let's look at who the TEAM is from our patient's perspective
- In complex adaptive systems, there are many ways to reach the same objective
- We already have lots of tools, we need to use them more effectively
- Focus on removing barriers

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Questions?

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