Trying to Find the Right Path from Good to Great

Stacey Daub, CEO
Toronto Community Care Access Centre

HSPRN Conference
March 29, 2010
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
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
Population Based Model

- **HIGH RISK**
  - Focus on intensive case management & cross continuum care integration...

- **COMPLEX OR CHRONIC CONDITIONS**
  - Focus on self management & care coordination...

- **LIMITED SUPPORT NEEDED TO MAINTAIN INDEPENDENCE**
  - Focus on maintaining independence & connecting to care...
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

### Services

- Post Acute & Rehab Care
- Child and Family
- High Risk Frail Seniors
- Hospital Transitions
- Adult Complex Care
- Palliative Care
- Community Independence
- Urban Health

Information & Referral Services
Home First is a philosophy, not a program

Home First
making home the first option after a hospital stay

Why this...?

HOME

...and not this?

HOSPITAL

LONG TERM CARE
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 (Prel QTer) 2010/11

<table>
<thead>
<tr>
<th>Quarter</th>
<th>% Placed High or Very High</th>
<th>Median</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1 2008/09</td>
<td>68%</td>
<td></td>
</tr>
<tr>
<td>Q2 2008/09</td>
<td>72%</td>
<td></td>
</tr>
<tr>
<td>Q3 2008/09</td>
<td>72%</td>
<td></td>
</tr>
<tr>
<td>Q4 2008/09</td>
<td>78%</td>
<td></td>
</tr>
<tr>
<td>Q1 2009/10</td>
<td>78%</td>
<td></td>
</tr>
<tr>
<td>Q2 2009/10</td>
<td>77%</td>
<td></td>
</tr>
<tr>
<td>Q3 2009/10</td>
<td>80%</td>
<td></td>
</tr>
<tr>
<td>Q4 2009/10</td>
<td>78%</td>
<td></td>
</tr>
<tr>
<td>Q1 2010/11</td>
<td>82%</td>
<td></td>
</tr>
<tr>
<td>Q2 2010/11</td>
<td>84%</td>
<td></td>
</tr>
<tr>
<td>Q3 2010/11</td>
<td>84%</td>
<td></td>
</tr>
<tr>
<td>Q4 2010/11</td>
<td>84%</td>
<td></td>
</tr>
</tbody>
</table>
Some Early Results

ALC to LTC Patients
Acute Hospitals
October 2008 - February 2011

Home First Implementation

48% improvement since October 2008
<table>
<thead>
<tr>
<th>The Opportunity</th>
<th>Integrated Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emerg Department Wait Times</td>
<td>Alternate Level of Care Patients</td>
</tr>
<tr>
<td>12</td>
<td></td>
</tr>
</tbody>
</table>
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 total days
- Research indicates that those with those with multiple chronic conditions cost up to 7 times those patients with only one
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 AIC 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 client's 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 healthcare system
A few lessons learned...

Why do we think it's 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