Improving Care for Seniors and Caregivers

Submission to the Seniors Care Strategy

September 6, 2012
Executive Summary

Seniors and their caregivers have widely varying needs that can range from simple information and education to complex care involving multiple health professionals and service providers. Most seniors do not plan for their advanced care needs and many seniors and their caregivers have difficulty navigating through the complex array of care and supports that are available through Ontario’s acute and community service system. Frail and elderly seniors and their caregivers need to know there is someone they can turn to who can coordinate all their care needs in a caring and compassionate manner.

Community Care Access Centres (CCACs) touch seniors and their caregivers at all stages of their care journeys and provide services ranging from information and referral to intensive support for seniors with highly complex needs. For the most complex seniors who receive multiple services and have care providers across multiple settings, CCACs are ideally positioned to provide comprehensive care coordination. With their border-to-border mandate in LHINs, CCACs are regional organizations with a local presence in over 200 sites across the province. CCACs have a presence in every hospital in the province, in primary care settings and are connected to every long-term care home as well as other community services. CCACs and their service provider partners are also present in the homes of thousands of seniors each day across the province and have a unique perspective on how seniors and their caregivers are managing in their day-to-day lives. As 14 distinct organizations, CCACs have demonstrated their capacity to work together to identify and act collectively on opportunities to improve the quality and consistency of the services that they offer. This enables successful local innovations to be shared and spread quickly. The following recommendations to improve seniors’ care are based on the collective experience of Ontario’s CCACs in caring for over 300,000 seniors each year:

RECOMMENDATION #1
Improve seniors’ access to information and referral
- Profile CCAC information and referral services in the upcoming quality campaign “No Place Like Home” and include a segment on the importance of planning for your elder years.

RECOMMENDATION #2
Improve access to care and caregiver support
- More flexible service models are needed that enable greater choice for seniors and their caregivers, including self-directed care and direct funding models for seniors who are able to purchase or employ their own care providers, enhanced caregiver respite options and financial relief for caregivers.
- Planning is needed to determine local capacity and ensure equitable access to community support services such as transportation, home support, meals, assisted living and adult day programs enabling seniors to have access to the most appropriate services to meet their needs.

RECOMMENDATION #3
Increase support and service availability for seniors with complex needs
- Confirm the CCAC role as the care coordinator for the most complex seniors who need multiple services and are served by multiple providers in multiple settings, with a mandate to follow seniors across the continuum to ensure continuity and safe transitions, avoiding unnecessary hospital visits.
- Enable the provision of up to 24/7 care for limited periods of time to facilitate early discharge for seniors and ensure there are mechanisms to enable transitions to more appropriate care levels or settings when seniors need ongoing round-the-clock care.
- Increase the specialized care capacity in long-term care homes to support the needs of complex specialized populations (e.g., clients with mental health issues and complex behaviours).
- Develop comprehensive policy to address equity and consistency in transitional care, whether it is provided in hospitals, long-term care homes or retirement homes.
Introduction

In *Ontario’s Action Plan for Health Care*, the Government made a commitment to launch a Seniors Care Strategy “with an intense focus on supporting seniors to stay healthy and stay at home longer; reducing strain on hospitals and long-term care homes.”\(^1\) Ontario’s Seniors Care Strategy will help older Ontarians stay healthy, live at home longer and receive the right care at the right time and in the right place. A central part of this strategy is expected to focus on the need for provincial leadership in care coordination for Ontario’s seniors. One area of focus is improving the coordination and integration of care to have a *meaningful* impact on emergency department wait times and hospital and long-term care utilization. The Action Plan identifies the need for “Care Co-ordinators that will work closely with health care providers to make sure the right care is in place for seniors recovering after hospital stays to reduce readmissions.”

Seniors’ Needs

Within the next 30 years, the proportion of those over age 80 is expected to increase considerably, and the number of seniors with a disability and requiring assistance could double. In addition, the narrowing gap in life expectancy between men and women suggests that the number of older spouses caring for their disabled partners will increase. At the same time, the availability of family caregivers will likely decrease as a result of smaller families, more seniors without children and the demands of work on adult children\(^2\).

Most people do not plan for their advanced care needs as they age and families often do not know where to start when they are confronted by a serious illness or cognitive decline. Seniors and their caregivers have widely varying needs that can range from simple information to education to help them remain healthy, independent and manage their own care to complex care and support involving multiple health professionals and service providers.

Frail and elderly seniors and their caregivers need to know there is someone they can turn to who can coordinate all their care needs in a caring and compassionate manner. As seniors’ needs increase in scope and intensity, CCACs are ideally positioned to provide comprehensive care coordination for them across the continuum of care.

At the simplest level, seniors and caregivers want to know what services are available to them – and where and how they can be accessed – whether it is assistance at home or in the community, caregiver support, financial support services, transportation or even assistance finding shelter. Sometimes an online self-serve inventory of the services available is sufficient; other times assistance may be needed to explore the full scope of options available.

Seniors in the early to middle stages of age-related functional or cognitive decline, or who are living with a chronic health condition may require assistance in accessing timely and appropriate care and support. They may also benefit from a comprehensive assessment and care plan that considers their needs and their caregivers’ needs, as well as factors like safety at home and safe medication use. At this stage, comprehensive assessment, proactive care planning and strong linkages with primary health care providers can prevent crises and caregiver stress.

As a senior’s needs and associated services become more complex and involve multiple providers, seniors and their caregivers may need an advocate who understands these needs and, in collaboration with the full scope of primary and specialty care providers, can facilitate and coordinate timely and organized care and support across the continuum. In cases where a senior can no longer be supported at home, or is returning home following a hospitalization, transitions must be well planned and executed so that there is no interruption of care in order to prevent avoidable hospital admissions/readmissions.

---

\(^1\) Source: *Ontario’s Action Plan for Health Care* (2012)

Ontario’s CCACs provide a single point of access to a wide-range of information, services and supports. For those who need it, CCACs provide care coordination to help seniors and their caregivers across the continuum of care. Professional care coordination provided by CCACs involves a combination of intensive case management, system navigation and care delivery tailored to the nature and intensity of a person’s health and social needs and supported by relationships with health and community service providers across the health care system.

The following sections focus on the range of needs of seniors and their caregivers and highlight the role of CCACs within the health care system in ensuring that seniors’ needs are met, enabling them to stay healthy and at home longer.

### 1. Seniors’ Access to Information and Referral

Seniors, their caregivers and health system providers need a user-friendly, 24/7 single point of contact for information and referrals to a comprehensive inventory of services, including:

- Information to maintain health and wellness, especially for age-related conditions (e.g., prevent falls, cope with dementia and manage chronic diseases such as diabetes, incontinence and other age-related conditions).
- Information on the full range of local services available to address their needs (e.g., diabetes clinics, elderly persons centres and other community support services), as well as provincial programs (e.g., Ontario Drug Benefit, MedsCheck) focused on seniors’ care.
- When appropriate, assistance with referrals to make connections with needed care and support, including help finding a family physician.

### Supporting Ontario’s seniors

CCACs provide multi-media self-serve options including [www.310CCAC.ca](http://www.310CCAC.ca) and the telephone-based 310-CCAC. The information available through CCACs goes beyond the primarily municipal information offered through 211. Through CCACs, clients and caregivers are referred to the full range of community services available across the province, including, for example, self-management supports and tools, medical and clinical care and services (e.g., primary care, specialists, physiotherapists, occupational therapists, nurses, social workers, mental health professionals, geriatric specialists, clinics for chronic disease management such as diabetes, end-of-life care) and community supports such as respite care, meals, transportation, social services, tax credits, financial planning, abuse prevention, counseling and home renovations to make sure the home environment is safe.

Online self-serve sources of information are useful for many and promote self-management. However, Ontario’s health care system is complex and there are a wide range of services and service providers available to seniors. Some seniors need personal assistance analyzing their needs and identifying and connecting to the available options to arrive at the right solutions to meet their needs. All CCACs also offer an Information and Referral (I&R) service that provides access to knowledgeable staff who have specialized training in I&R processes, protocols and standards to help seniors work through the available options, determine the most appropriate mix of services and make referrals as needed. Many CCAC I&R staff are AIRS certified.

All CCACs have Care Connector programs that link individuals in need with a primary care provider (i.e., family physician or nurse practitioner). Between February 2009 and December 2011, CCACs linked over 109,000 Ontarians with a family health care provider, including over 8,100 Ontarians with high needs through the Health Care Connect Program.

---

3. AIRS (Alliance of Information & Referral Systems) certification is a professional credentialing program for individuals working within the information and referral sector.


**Doing more to support seniors**

Over the next year, CCACs will be enhancing their I&R services through the implementation of the healthline.ca. Building on the success of the healthline.ca in the South West and Champlain CCACs, this project will create a single provincial database of more than 50,000 health service profiles and a common provincial portal designed to guide users to local resources.

For seniors and their caregivers, this will provide:

- An easy and quick way to find health information based on geography, topics or Google searches to help people manage their own care
- Tools to support self-referral
- Accurate and up-to-date information
- Service profiles with a wealth of information, including video links and mapping features

It will also provide family physicians and other health service providers with a reliable source of information about the services available in their communities.

**What more is needed**

It is recommended that the Ministry and LHINs fully market the CCAC information and referral service as part of the upcoming quality campaign “No Place Like Home”. The marketing plan should include a segment on the importance of planning for your elder years.

**2. Connecting seniors to care and caregiver supports**

As they age and become frailer, seniors and their caregivers need timely access to appropriate care and supports to help them stay at home longer or return home after an emergency department visit or admission to hospital. Given the complexity of the community service system and varying capacity (e.g., waitlists for some services), having one organization that can provide information about and a connection to a full range of services greatly benefits seniors and their caregivers.

**Supporting Ontario’s seniors**

CCACs help seniors and their caregivers by providing:

- A single point of contact for provincially funded home care services, access to nursing and personal support in residential hospices and admission to a long-term care home. CCACs are currently implementing an expanded connector role to coordinate access to adult day programs, assisted living and supportive housing programs at a regional level.
- Care coordination and leadership in comprehensive assessment, care planning and system navigation.
- A single point of accountability for the quality and effectiveness of the services provided in achieving the desired health outcomes for complex seniors.

CCACs employ regulated health care professionals who provide home and community care and facilitate integration across a senior’s care team. They apply their clinical background, extensive knowledge about the home and community care system and standardized tools to thoroughly assess each person’s needs, based on their medical condition, environmental and social factors and support network to plan for individualized care.

In partnership with over 100 home care service provider agencies, CCACs provide professional and support services to meet the needs of 616,000 seniors, younger adults and children every year. They work closely with health care providers across the full continuum of care, including primary care providers, hospitals, community support services, long-term care homes, regional geriatric centres, adult day programs, supportive housing/assisted living programs and others to coordinate seniors’ care.
CCAC Care coordinators are *silo-busters* who bring community services and health service providers together to support frail and elderly seniors and their caregivers. With one in each LHIN, Ontario's CCACs have become a critical link in Ontario's health care system that connects seniors to services in local communities across the province.

**Doing more to support seniors**

- CCACs are improving integrated care for seniors by building strong connections to the primary care system. CCACs currently have care coordinators attached to a growing number of primary health care providers, including dedicated staff working in over one-third of the family health teams and many community health centres across the province to improve integrated care delivery and support more effective chronic disease management. The primary care system in Ontario is still developing. While family physicians are increasingly working in family health teams and other group practice models, the majority of family physicians still work in solo practice. Practices also differ significantly in the make-up of their patient populations. CCACs have developed successful strategies for engaging primary care providers and building partnerships tailored to the specific needs of the practice. As noted above, in some practices that serve a significant number of high-risk seniors, this may mean a dedicated CCAC care coordinator attached to the practice; in others, regular visits by the care coordinator to the practice to discuss shared patients, joint care conferences and joint home visits are better solutions.

> "While CCACs are well-regarded for their efforts to organize team-based care for the frail elderly, palliative care patients and patients needing placement in a long term care facility, in some parts of the province, case managers have also been providing supports to family practices to access community-based resources for individual patients."
> -Bringing the Pieces Together, Ontario College of Family Physicians

- A key strategy aimed at improving access to care for frail seniors is an increase in physician house calls. Physician home visits can have a significant impact on care for frail seniors, but the highest benefit is received when there is close collaboration between the visiting physician, the CCAC care coordinator and the in-home care team.

- CCACs also have care coordinators attached to every hospital in the province, in both emergency departments and inpatient units. These dedicated care coordinators work directly with hospital staff to facilitate early identification of seniors who can be transitioned home, carry out collaborative discharge planning and ensure appropriate post-discharge care and follow-up is in place.

- CCACs are also investing in programs to provide *virtual health care* through remote monitoring (e.g., telehomecare) and building on the resources available through the Ontario Telemedicine Network. Evaluation has demonstrated that telehomecare, when delivered as a component of the home care intervention for people with chronic health conditions, can reduce costs and improve outcomes.

> "A third fewer Ontarians are hospitalized today than 16 years ago due, in part, to the coordinated care of CCAC staff in 211 hospital sites across Ontario, who focus on keeping people out of the hospital and living safely at home with the help of community supports."
> -Tom Closson, Former CEO, Ontario Hospital Association

---

5 The North East CCAC's Telehomecare project allows for nurses to aid clients with chronic disease to develop self-management skills via remote monitoring and physician management, as well as the co-location of North East CCAC staff within family health team offices, community health centres, and the North East Specialized Geriatric Services office.

Innovating to improve services for seniors

Building on their expertise in assessment, care planning and managing access to home care, long-term care and residential hospices, CCACs have received an even broader mandate from Government to manage access to adult day programs, assisted living and supportive housing and to support transitions to complex continuing care and inpatient rehabilitation services, making CCACs a one-stop point of contact and a single point of accountability for seniors, caregivers and health care providers across a broader continuum of services.

By March 2013, CCACs will have completed implementation of a population-based client care model with standards of care based on the needs of specific client populations and sub-populations. CCACs and their service provider agencies are also working together to test best-practice outcome-based care pathways and outcome-based payment models for specific client populations, starting with wound care and total hip and knee replacements. This joint initiative – Quality and Value in Home Care – will result in sustainable system change built around new contracts, new funding and payment models and new outcome-focused performance indicators. In 2012, CCACs and their home care service providers will start to transition to a new contract which will enable the delivery of integrated, high-quality, outcome-based care, supported by a shift toward outcome-based payment.

CCACs are working with the community support services system to develop a framework for shared assessments to align practices with respect to the Inter-RAI suite of assessment tools and ensure streamlined business processes so that assessments are not repeated unnecessarily.

Protocols with emergency medical services and alerts in emergency department information systems are being used in many places that identify clients at risk and automatically connect them to a CCAC care coordinator or directly to the needed care and support, this can reduce avoidable hospitalizations.

Sometimes a simple change can make a significant difference in the quality of a senior’s experience with the health care system. For example, the Toronto CCAC and its providers of personal support services are “Changing the Conversation” from a task first to a talk first approach by asking three simple questions:

- At the beginning of the visit, “What is the most important thing I can help you with today?”
- Ten minutes before the end of the visit, “Is there anything else I can help you with today? I have the time.”
- When the worker leaves, “Is there anything you’d like me to tell the agency?”

CCACs are committed to ongoing quality improvement and have developed standard performance measures to enable local and provincial outcome monitoring. Work is underway in partnership with LHINs to identify benchmarks associated with key measures. Ontario is the first Canadian province to report publicly on the quality of home care services. Health Quality Ontario recently posted its second annual report on the quality of CCAC services and CCACs released their second quality report earlier this year.

What more is needed

With relatively small investments and changes to current practice, policies and regulations, services could be improved to better meet the needs of our aging population. For example:

- Many seniors and their families have the desire and ability to manage their own care plans, and can often make resources go much farther than the formal system. More flexible service models are needed that enable greater choice for seniors and their caregivers, including self-directed care and direct funding models that enable seniors to purchase or employ their own care providers.
WHAT MORE IS NEEDED, CONTINUED

- The results of the standardized assessments carried out by CCACs can be leveraged to keep physicians informed about opportunities to improve preventive care for their patients, for example, by identifying seniors who are not up to date on influenza immunization or breast screening.
- At times, the OHIP requirement for a physician referral to specialists can become a barrier to timely access. Further expanding the scope of practice for other regulated health professionals to enable referral to specialized care or multi-disciplinary teams, such as specialized geriatric assessment clinics, would enable more timely connections and support for clients.

Other recommendations to improve care for seniors include:
- Not all seniors require in-home health care or care coordination. For many, assistance with home maintenance, meal delivery, transportation or other community support services are the best solutions to meet their needs. These services can also be important components of a comprehensive care plan for seniors with complex needs. For seniors who can no longer manage with scheduled home visits, assisted living services can mean the difference between living at home and moving to long-term care. Planning is needed to ensure equitable access and capacity in these services across the province. Further analysis and dialogue between government, LHINs, CCACs, community support services providers and seniors themselves is also needed to consider the most appropriate system to provide care for seniors with less complex support needs.
- Caregivers, including families, partners and friends are the foundation of the support system for most seniors and their needs must be considered. Caregivers need:
  - More flexibility and choice in their respite options.
  - Increased access to information and education.
  - Efforts to minimize their financial burden, including more flexible tax breaks that recognize the out of pocket expenses of caregivers who may not co-reside with the senior that they care for.
  - Incentives for employers to provide flexible, supportive work arrangements for workers who are caregivers.

3. Supporting seniors with complex needs

The majority of seniors, even those with complex needs, want to stay in their own homes as long as possible. Caregivers for high-need seniors are the first line of support, generally reaching out to the community and the health care system when they have no other choice. It is extremely important that caregivers be supported so that they too remain healthy and can continue supporting their loved one at home.

Frail high risk seniors and their caregivers need an advocate to ensure that their care needs are monitored and coordinated across the continuum of care, that services are adjusted as their needs change and that all members of the care team are working together to achieve the client and family’s goals. For these families, more intensive care coordination is needed to ensure integrated care and smooth transitions across services and care settings.

Supporting Ontario’s seniors

Increasingly, CCACs are working with the highest need complex and at risk seniors, including seniors who require intensive care and support to return home after a hospitalization or who are at risk of hospitalization as the result of dementia, chronic diseases, and multiple conditions. In addition to hands-on care coordination, CCACs have made investments in technology and information systems to enable the sharing of client information across the full care team, facilitating the coordination of care. All CCACs use one client information system, our Client Health Related Information System (CHRIS) that integrates assessment, care planning and service delivery information. Through a secure portal— the Health Partner Gateway — CCACs are safely sharing electronic health information with 4,000 health care providers to support coordinated care delivery in full compliance with the Personal Health Information Protection Act, 2004.
“Physicians who work with complex patients know that a good case manager is invaluable.”
-Dr. Irfan Dhalla, St. Michael’s Hospital

Note: The title of case manager has been replaced with care coordinator

Doing more to support seniors

Having a single point of contact for comprehensive assessment, care planning, discharge planning, eligibility determination for alternate care settings and coordination of transitions helps to reduce confusion for seniors and their caregivers, reduce duplication in the health care system and improve efficiency by building on the CCACs’ proven expertise in system navigation and strong relationships with other health service providers.

Across the province, CCACs are expanding and refining their role in care coordination and navigation to better support complex seniors and their caregivers:

- CCACs have recently improved the delivery of in-home care through the addition of nurse practitioners, clinical nurse specialists and rapid response nurses for our most complex clients—those with advanced dementia, multiple chronic diseases, mental health issues or complex wounds, as well as clients requiring end-of-life care. Through the new Rapid Response Nursing Program, CCACs will follow complex seniors out of the hospital, visit them within 24 hours of their discharge and ensure that appropriate follow up care is in place, including an appointment with their family physician. These new resources will ensure continuity in planning, care and communication to improve the transition of complex patients back to the community. The addition of CCAC nurse practitioners with expertise in palliative care will also facilitate care connections across sectors, in particular between in-home care teams and primary care providers to improve the quality and continuity of end-of-life care for complex seniors.

"CCAC care coordinators rally the support of every type of health care provider a patient may need, including family physicians, nurse practitioners, specialists, registered nurses, pharmacists, nutritionists and therapist, to help optimize their strengths and connect people to the best care for their specific needs."
- Tom Closson, Former CEO, Ontario Hospital Association

- CCACs deliver strategies and special programs to support complex seniors to return from hospital or stay safely at home. The adoption of a “Home First” philosophy across the province and related programs and services such as virtual wards, Acute Care for Elders (ACE), Wait at Home and Home Independence have significantly reduced pressures on hospitals in patient units and emergency departments. “Home First” is built on a simple premise – life changing decisions about long-term care should not be made in hospital, but only after all community service options have been explored. Originally developed by the Mississauga Halton CCAC, “Home First” has been recognized as high impact practice by the Canadian Home Care Association and has influenced the development of similar approaches in other provinces.

Innovating to improve services for seniors

In some areas of the province, CCACs have taken a leadership role in developing inter-disciplinary, cross-agency outreach teams to assist high-risk seniors with complex needs to prevent or manage a crisis situation — and potentially admission to an acute care hospital. For example, the Central West CCAC is developing a community crisis SWOT team — a cross-functional, multi-disciplinary partnerships with emergency services, hospitals, mental health organizations, the Alzheimer’s Society and others.

---

8 The Rapid Response Program is a new initiative to ensure effective transitions from acute to home care for two target populations, including frail adults and seniors with complex needs and/or high risk characteristics.

9 A Central West CCAC program to address the needs of older adults who wish to remain independent at home but who are experiencing difficulties performing essential activities such as bathing and dressing.
What more is needed

- Frail seniors who are discharged from hospital often need substantial support, at least during the initial recovery period. At times, the regulated service maximums can be a barrier to enabling timely discharge of these high-need patients. When hospital beds are at a premium, the ability to provide up to 24/7 care for limited periods of time to enable early discharge is needed, even for clients who are not waiting for long-term care placement. However, this level of support is not sustainable over the long term, so mechanisms are also needed to enable transitions to more appropriate care settings when seniors need ongoing round-the-clock care.
- Accelerated investment in home and community care, including assisted living, is needed that recognizes the higher costs associated with serving complex seniors to stay at home.
- As community capacity increases and as seniors, even those with high needs, are living in their own homes longer, long-term care homes are serving increasingly complex specialized populations. New service and funding models are needed in the long-term care system to ensure that specialized populations (e.g., medically complex, clients with mental health issues and complex behaviours) have access to care and the services that they need.
- Additional “assess and restore capacity”. In some communities, seniors who cannot be discharged home from hospital to wait for a long-term care bed are receiving intensive transitional care in retirement homes. In some cases, the services are provided through CCACs, in others through hospital funding. These programs operate outside existing policy for transitional care and can create a significant financial burden for seniors and their families. Comprehensive policy is needed to address equity and consistency in transitional care whether it is provided in hospitals, long-term care homes or retirement homes.
- For the most complex seniors, there is considerable benefit in a recognized care coordinator with a mandate to follow seniors across the continuum. This suggestion is fully aligned with the Ontario College of Family Physician’s (OCFP’s) recommendation for virtual teams to support the implementation of the concept of the patient’s medical home. The OCFP sees the CCAC care coordinator role as being expanded to be “embedded in practices to organize access to the various services that individual patients require.”
- With a well-supported care coordination strategy for our highest-need seniors, both our clients and Ontario’s health care system will benefit from:
  - Better outcomes for seniors who will more consistently receive the right care, in the right place, at the right time;
  - Improved access through comprehensive needs assessment, care planning, referral and service delivery;
  - More efficient coordination of care, building on existing infrastructure and resources;
  - More equitable access to services due to consistent application of provincial eligibility standards; and
  - More appropriate utilization of scarce health care resources (e.g., shorter hospital stays, fewer emergency department visits, fewer acute admissions, lower long-term care home utilization).

In Summary

The needs of seniors and caregivers vary greatly depending on their age and health status, and while there are many doors leading to a range of services in Ontario, there is an enormous benefit in having one place to go for information, referral, services and care coordination.

Although many organizations provide care coordination, or participate in elements of CCAC-led care coordination, CCACs are in the best position to continue to be the recognized provincial care coordinator for seniors with complex needs and to expand this role to better meet the needs of our most vulnerable populations.

10 Bringing the Pieces Together: A Strategy to Transform Primary Care, Ontario College of Family Physicians. 2012.
IN SUMMARY, CONTINUED

With their unique border-to-border mandate in LHINs, CCACs are regional organizations with a local presence in homes and communities across the province, with over 200 local sites. CCACs have a presence in every hospital in the province, in primary care settings and are connected with every long-term care home, as well as with adult day programs, assisted living and supportive housing providers, residential hospices and other community support services. With only 14 organizations, CCACs have the capacity to work together to identify and act collectively on opportunities to improve the quality and consistency of the services that they offer. This enables successful local innovations to be shared and spread quickly.

CCACs have the infrastructure, technology, resources and processes to maintain and expand the evolving care coordination role to meet the needs of seniors and their caregivers. By building on these existing platforms and systems, Ontario can quickly and cost-effectively expand the care coordination role even further to enhance seniors’ access to care.

CCACs, in close collaboration with the full range of health service providers, continue to develop innovative and successful programs designed to keep seniors healthy, advance chronic disease management, provide specialized supports for the most complex seniors and their caregivers, and improve system capacity to care appropriately for seniors in partnership with primary and acute care. These investments can be leveraged to support additional system improvements.

"CCACs serve as the point of access for care in the community. The role of the CCAC case manager as a system navigator needs to be strengthened and positioned to complement the appropriate clinician as the clinical manager responsible to facilitate safe and appropriate care and care transitions."

-Ontario Home Care Association (OHCA)