Working hand-in-hand with Primary Care

A Provincial Strategy Delivered Locally in Communities across Ontario

Dipti Purbhoo, Toronto Central CCAC
Karyn Lumsden, Central West CCAC
Donna Ladouceur, South West CCAC
Barbara Busing, HNHB CCAC
A **Changing** Health Care Landscape
In Early Days of Home Care.....

Needed a Physician Referral for Home Care Services

Physician Letters

Now

Some relationship but mostly silos with opportunity to strengthen.....

In to the Future

Primary Care & CCAC integrated as one team for clients and families
Our Provincial Vision – CCAC Care Coordinators & Primary Care Working Hand in Hand
So Why is this so Important....... 

For the Clients/Families – One team, coordinated support and better health outcomes and help to stay at home for as long as possible

For the Care Coordinators – A support for Care Coordinators to care for complex clients in the community

For the Primary Care Providers – builds capacity in primary care to support more complex clients

For the System – to enable a strong health care system where clients/families are supported in the community and not hospitals or LTC
Our Provincial CCAC Collective Goal

- Advance a primary care integration strategy and implementation plan, across the province that ensures:
  - Leadership, support and adoption across all 14 CCACs
  - Supports high level consistency across the province in our approach to primary care integration
  - Demonstrates a strong collective CCAC voice
  - Aligns with Ministry/LHIN priorities
  - Positions CCACs to be successful and to deliver value in the Health Links

In other words...Our goal is to ensure every primary care physician in Ontario is connected to a CCAC Care Coordinator by March of 2015
## Key Components of the Strategy

<table>
<thead>
<tr>
<th>Connect Care Coordinators with Primary Care Physicians</th>
<th>Improve Communications</th>
<th>Primary Care Standards</th>
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<tbody>
<tr>
<td>✓ Connect Care Coordinators with FHTs, CHCs, group practices &amp; Solo-practice</td>
<td>✓ Physician letters to communicate client status (automation via CHRIS &amp; view access)</td>
<td>✓ Communication standards</td>
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<td>✓ Joint care planning between Care Coordinators and Primary Care</td>
<td>✓ Primary care communication materials (fact sheet, website)</td>
<td>✓ Standards for ensuring regular primary care follow-ups for clients</td>
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<td>✓ Single physician CCAC access (phone line, Care Coordinator number)</td>
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Provincial Primary Care Integration Principles By Population

Enablers across all populations:
- Use of consistent communication & notification to primary care with tools at key points in care:
  1) Admission
  2) Change of status
  3) Discharge
  4) LTCH placement
  5) Re-assessment with clinically specific triggered CAPs
- E-Health enablers

- Shared care & decision-making
- Joint home visiting
- Scheduled, regular care planning meetings
- Mobilize clinical specialty teams (CCAC and other HSPs)
- Ensures clinical information is shared across team
- Organize integrated care conferencing

*Principles of integration apply with less intensity for the Chronic client population

- Information & referral
- Notifications at key points in episode of care
- Screening for early identification of needs (advanced care planning)
- Consistent messaging

- Central contact number (Team/Client Services Assistant Role)
- Information & referral
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- Central contact number (Team/Client Services Assistant Role)
- Information & referral
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Our Guiding Principles for Delivering on our Strategy

• Provincial vision but local execution (One size will not fit all)

• Co-design primary care & CCAC Care Coordinator connections

• Using existing resources and building on existing initiatives (CCM, RRN, CCAC service providers)

• Pace change in a realistic way and deliver first in the Health Links

• Walk the talk – Deliver value on the ground
Connections with Primary Care

- Based on the partnership with primary care team (FHT, FHO or solo-doc) will be co-designed

- Will vary across CCACs and within CCACs (Not a one size fits all model)

- Some options include:
  - Dedicating a Care Coordinator to work as part of the primary care team
  - Liaison model with Care Coordinator acting as a link to the CCAC
  - Hybrid approach of the above two

- Models and tools will be shared amongst the CCACs
Engaging Primary Care is Critical….

Asking, listening and delivering

• **Asking:** What is most important to you in caring for your clients and how can we work together to achieve this goal?

• **Listening:** Tell us what’s working well & what are some opportunities to improve

• **Delivering:** Identifying goals and delivering solutions – short and long-term
What did we hear?

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
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
Strong Alignment with Ministry Priorities

- Strong alignment of the CCAC primary care strategy and Health Links & Seniors Strategy
- CCAC Primary Care integration strategy will be delivered through the Health Links
- CCAC Primary Care Strategy will help advance the Seniors Strategy
Some Examples of Primary Care & CCAC Integration in Action
Central West

- “embedded” care coordinators in FHTs
- End of June launch of communication/engagement strategies:
  - Physician back line to be launched
  - Physician web page
  - Physician newsletter
- Links with hospital compendium
- Meetings with hospitalist and family practice groups
- Linking primary care to healthline.ca
- Virtual care conferences and care debriefs with primary care present
- HealthLinks planning
- Attendance at local primary care education days
- Evolving the care coordinator model to facilitate attachments
Central West CCAC Primary Care Framework

- *Med Management
- Client Care Model
- Chronic Disease Management
- Experience Based Design
- CHC Partnership
- Solo Practice Physician Initiative
- PC LHIN Lead
- Building Rural Partnerships
- PRC linkage
- CW CCAC Physician Fact Sheet
- OMA Communique
- PC Introduction Letter
- * Physician Phone Line
- * LTC MD Engagement
- * HealthLine
- Family Health Team CM expansion
- CM Resource for CHC & Large Practices
- Care Connectors
- Medical Advisory Group/Lead
- Seniors Enhanced Caseload
- CHC Partnership
- Solo Practice Physician Initiative
- PC LHIN Lead
- Building Rural Partnerships
- PRC linkage
- Med Management
- Client Care Model
- Chronic Disease Management
- Experience Based Design
HNHB CCAC: Early Intervention Screener

- Recommendation from two key reports (Two Day ALC and Walker report) to screen individuals through ED and primary care physicians for earlier intervention
- Dr. David Walker, in his report, identified “The early identification of at risk seniors as a best practice”
- Two tools were developed by Researchers from the University of Waterloo - one for hospital ED’s and one for primary care physicians – based on RAI ED Screener.
- The tools were vetted, validated and piloted at 2 hospitals and 2 physician groups
- Evaluation and feedback obtained on the tool use and process, revisions made
- Six physician groups have adopted or are in the process of adopting
HNHB CCAC: Over 200 Care Coordinator Primary Care Attachments

<table>
<thead>
<tr>
<th>Program Goals</th>
<th>Maintain Client in Community</th>
<th>Provide Holistic Seamless Care</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Activities</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Monthly Meetings with Physicians</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Team Approach</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single CCAC Contact for Physician</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Proactive Joint Planning</td>
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</tr>
<tr>
<td>Caseloads Organized by Primary care site</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Immediate Outcomes</strong></td>
<td>Enhanced Rapport with Physician</td>
<td>Enhanced Legitimacy with Client</td>
</tr>
<tr>
<td><strong>Ultimate Outcomes</strong></td>
<td>Clients Maintained in Community</td>
<td>Health Problems Addressed Quicker</td>
</tr>
</tbody>
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South West CCAC Primary Care
Communication Strategy Highlights

Region-wide communication strategy developed; electronic and mail outs circulated to every single primary care provider in our region every quarter.

Home First Approach Works
Home First is an approach to care based on the idea that when a patient enters the hospital, every effort is made to help him or her return home on discharge. During the past year, more than 2,500 patients benefited from this approach in the South West – people who would otherwise have waited in hospital for a space in a long-term care home. Among the results:

- Patients told us they appreciated the opportunity to go home
- 43% of Home First patients were able to stay home with normal CCAC supports.
- The number of patients waiting in hospital for long-term care decreased from 157 in September 2011 to 77 in January 2013, a 50% reduction.
- At-home services cost less per day than hospital or long-term care per diem.

To refer a patient to Home First, talk to your care coordinator or call 1-800-811-5146.

Introducing the Intensive Home Care Team
In addition to its care coordinators, the South West CCAC now has a team of more than 40 Registered Nurses and Nurse Practitioners.

The team consists of:

- Rapid Response Nurses, who provide in-home care to high-risk patients within 24 hours of hospital discharge.
- Community Nurse Practitioners, who care for patients with more than one serious chronic condition, doing assessments, ordering tests and treatments, and connecting with family docs and specialists.
- Palliative Nurse Practitioners, who have specialized expertise in caring for patients who are approaching the end of their lives.

- Geriatric Resource Nurses, who have specialized expertise in promoting the holistic health of the elderly.
- Mental Health and Addictions Nurses, who work with school boards and others to support children and youth with mental health and addictions issues.

To make a referral to the Intensive Home Care Team for your patients, talk to your care coordinator or call the CCAC at 519-474-5751 or 1-855-474-5751.
South West CCAC: Primary Care Successes

• Client Screening Tool
• Electronic LTC Health Assessment Form
• Customized Client-by-Physician report

Health Links Partnerships:

• Participating in all of the planning meetings
• Contributing data to help inform the population of focus
• Assisting in the development of the service commitment and evaluation frameworks
Toronto Central CCAC: Primary Care Connection Strategy

Better access and communication for Primary Care.
- Dedicated CCAC phone number for physicians to access all home and community care services
- Communication with Primary Care about CCAC Clients
- Primary Care Fact Sheet with information about CCAC services and OMA Fee Codes
- Customized physician website

Focus CCAC Care Coordination with Primary Care:
- Enhanced care coordination
- Care coordination across the continuum
- System navigation and access to health care services

Connection with Primary Care for clients with complex needs:
- Working hand in hand with Family Physicians
- Joint care planning and shared decision making
- Case management across the care continuum
- Access to virtual clinical interdisciplinary teams in neighbourhood

Key Enablers:
- Health Care Connects
  - Attaching patients to physicians
- Health Line
  - Giving physicians direct access to health services information

You know those patients you worry about...
Call us
We’re here to help

Connecting Primary Care Physicians with Toronto Central CCAC – Announcing a Dedicated Phone Line.
416-217-3935

Hey! Primary care – we’re listening! We’re improving communication, access and linkage to your CCAC and community services.

It’s easy - one number access to all community information:
- Ask about a patient currently on our caseload
- Refer a new patient
- Connect with your Care Coordinator
- Find out about all community services
Team based care with primary care for home bound clients

Primary Care and CCAC Care Coordinators as partners

Joint care planning & shared assessments

Joint visits and team rounds

Point of care integration – Building one care team for clients
Let’s hear from Primary Care ....

Working Hand-in-Hand with Primary Care

Play video
Where do we go from here?

- Leverage CHRIS further
- Develop metrics/indicators
- Co-design with primary care
- Remember our clients!
- Be open about challenges and barriers & communicate them
- Share knowledge that can be spread
OUTSTANDING CARE – EVERY PERSON, EVERY DAY

Thank you & questions