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Integrating CCAC as part of your health care team

Strengthening the team beyond the FHT

October 16, 2012

Anita Cole, Regional Client Services Manager, South West CCAC

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Partnering to Improve Care

- "There's a very important symbiotic relationship between the CCAC and primary care, we need one another and benefit from one another. It's important that we understand who does what and what's happening where. Informal interactions really help with that."
  - Dr. Joshua Shadd, palliative care specialist and professor at UWO's Schulich School of Medicine.

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What does Primary Care/CCAC partnership look like?

- Physicians and Case Managers working as partners, both focussed on population health, assessment and care connection
- Interdisciplinary, collaborative hubs which keep people out of hospital and long term care, and support optimized health and independence in the home/community

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The Shift:

- Primary Care is a strategic and operational priority for the South West.
- CCAC supports primary care as an access point, through system navigation, connecting people with the right care at the right time in the right place at the right cost
- Shift from a passive relationship to an active relationship.

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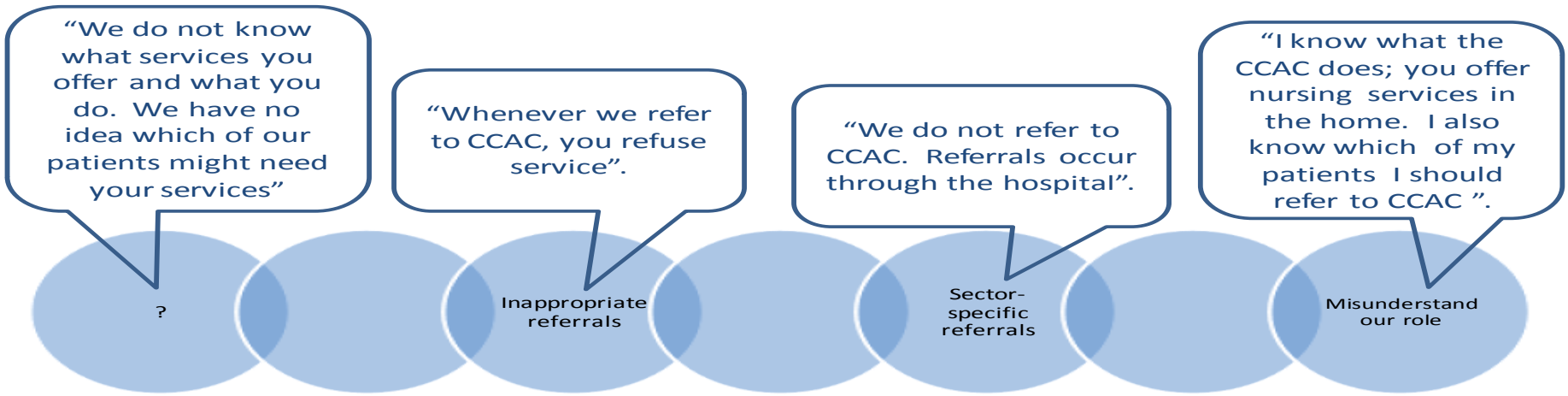
Clarification of CCAC's role



As each new primary care team joined the *Partnerships for Health* project, it was evident that there was not a clear understanding of the CCAC role within the healthcare system.

"Before Partnerships for Health, I would have not hesitated to offer medical care for a client who had lacerations due to a fall and send them home just to have them return again and again and never ask why they fell in the first place and to ask if they had supports at home. Now, it's become part of my practice – to ask patients who we see frequently, if they have the necessary supports in the home."

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The CCAC as System Navigator

- Ontario's CCACs are uniquely suited to this role
  - Case Managers work across geographic and institutional boundaries, at the transition points, border to border, cradle to grave
  - They provide full medical, social and functional assessments
  - They work collaboratively with partners in every part of the system, from primary care physicians and hospitals to long-term care homes and community support agencies
  - Can mobilize all the system resources and destinations
  - Linked through a single provincial Electronic Health Record system "CHRIS"
  - Share an integrated provincial system of health program and service information "thehealthline.ca", the engine for system navigation

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What worked in the South West: Primary Care and CCAC

- Partnerships for Health has given us a solid foundation, improving care for >6,500 people with diabetes by:
  - **applying the Ontario CDPM framework**
  - **strengthening partnerships between the CCAC and the family physician, and other members of the care team**
  - **sharing information across the continuum of care**
  - **engaging patients in self-care**
  - **enabling improved information management**
- $8M Ministry of Finance for Project Team to lead change and for full evaluation of clinical and economic impact
- Involved 74 primary care practices (FHTs, CHCs, sole practitioners)
- Implemented Jan 2008 to March 2011
- Supported since then by Partnering for Quality

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What was the Impact?

An independent pre-post evaluation demonstrated statistically significant improvements in:

- 10 of 11 clinical & process of care indicators including -
  - Statistically significant % of clients achieving LDL & blood pressure in alignment with clinical guidelines within 12 months of joining initiative
  - Statistically significant higher team functioning
  - Statistically significant improvement in adherence to clinical practice guidelines
  - Statistically significant improvements on effort for early prevention & disease management
- Improved use of information technology to deliver care

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What did South West CCAC do (and continues to spread)?

- Case managers attended on site as integrated member of primary care team, rather than just fax/phone
  - "rounds" to discuss clients needing additional supports
  - increased understanding of roles and services available
- Attended learning opportunities hosted by PFH/PFQ
- Member of improvement teams, implementing changes in screening, early identification, system navigation, common client education, care coordination, clinic days
- Improved communication and information exchange including ehealth enablers such as eReferrals to CCAC, sharing from CCAC electronic record to physician EMR, ehealth coaches
- Developed and tracked key measures of population health by physicians and CCAC

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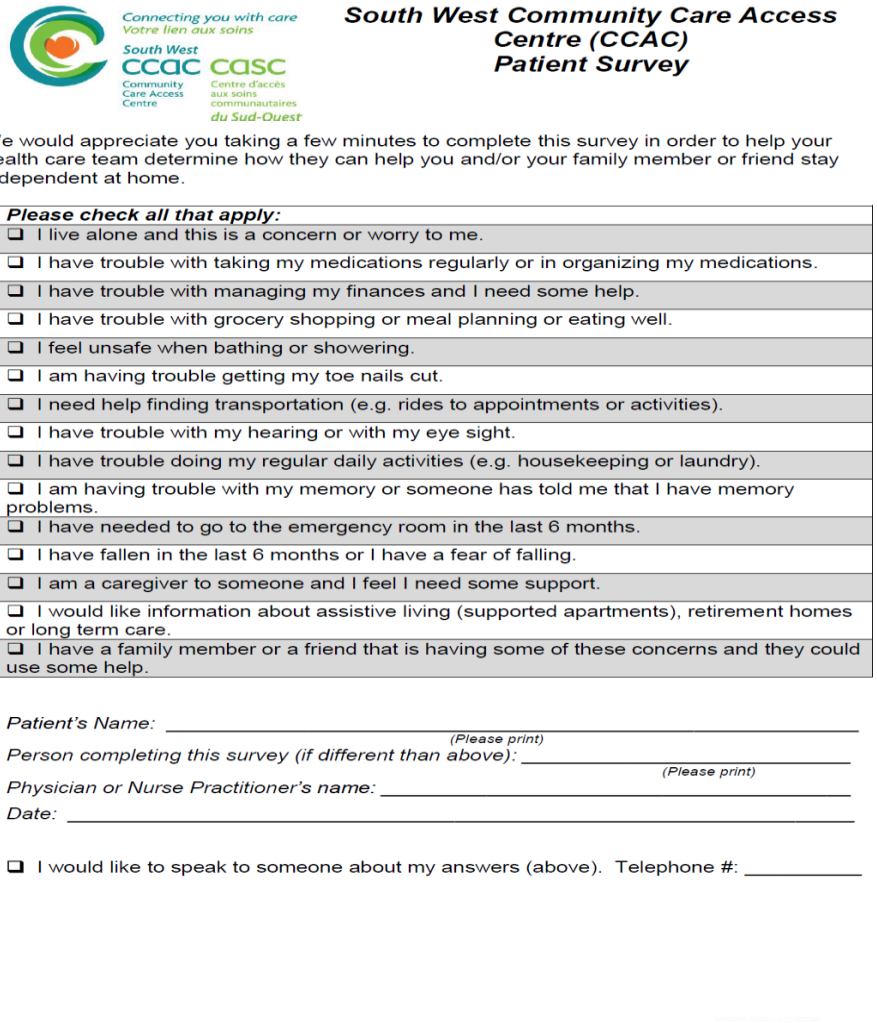
Screening and Early Identification

Small tests of change (PDSAs) began to identify individuals in primary care with potential unmet care needs.



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South West Community Care Access Centre (CCAC) Patient Survey

We would appreciate you taking a few minutes to complete this survey in order to help your health care team determine how they can help you and/or your family member or friend stay independent at home.

Please check all that apply:
❑ I live alone and this is a concern or worry to me.
❑ I have trouble with taking my medications regularly or in organizing my medications.
❑ I have trouble with managing my finances and I need some help.
❑ I have trouble with grocery shopping or meal planning or eating well.
❑ I feel unsafe when bathing or showering.
❑ I am having trouble getting my toe nails cut.
❑ I need help finding transportation (e.g. rides to appointments or activities).
❑ I have trouble with my hearing or with my eye sight.
❑ I have trouble doing my regular daily activities (e.g. housekeeping or laundry).
❑ I am having trouble with my memory or someone has told me that I have memory problems.
❑ I have needed to go to the emergency room in the last 6 months.
❑ I have fallen in the last 6 months or I have a fear of falling.
❑ I am a caregiver to someone and I feel I need some support.
❑ I would like information about assistive living (supported apartments), retirement homes or long term care.
❑ I have a family member or a friend that is having some of these concerns and they could use some help.

Patient's Name: _____ (Please print)

Person completing this survey (if different than above): _____ (Please print)

Physician or Nurse Practitioner's name: _____

Date: _____

❑ I would like to speak to someone about my answers (above). Telephone #: _____

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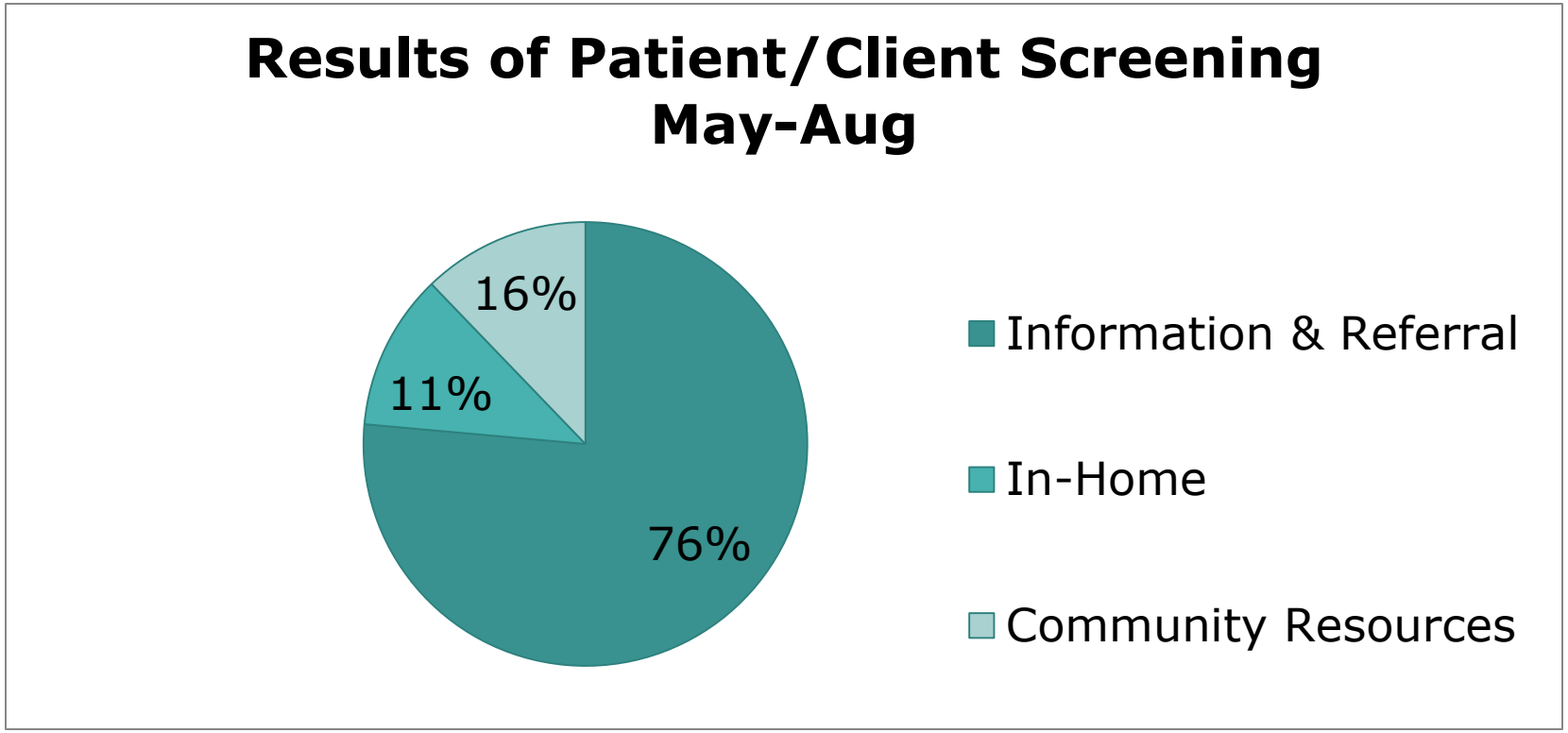
Results of PDSA's completed using the screening tool.



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Communication Tools– Client by Physician Reports

Physician - Client Report - Updated Nov 15, 2010

Physician Name	Client Surname	Client Firstname	HCN	Caseload Case Manager	Primary Diagnosis	Service	Diagnosis
DALAL, VIKRAM	[redacted]	[redacted]	[redacted]	L-Comm ‡ Dodge, Diane	FRACTURE UPP END HUMERUS CLOSED	Home Support	ANEMIA UNSPECIFIED
							ATRIAL FIBRILLATION AND FLUTTER
							CONGESTIVE HEART FAILURE
							CONSTIPATION
							DEBILITY UNSPECIFIED
							ESSENTIAL HYPERTENSION UNSPEC
							FRACTURE UPP END HUMERUS CLOSED
						Physiotherapy	ANEMIA UNSPECIFIED
							ATRIAL FIBRILLATION AND FLUTTER
							CONGESTIVE HEART FAILURE
							CONSTIPATION
							DEBILITY UNSPECIFIED
							ESSENTIAL HYPERTENSION UNSPEC
							FRACTURE UPP END HUMERUS CLOSED
	[redacted]	[redacted]	[redacted]	L-Short SI (blank)	OTH/UNSPEC INJ SHOULDER/UPP ARM	Occupational T	OTH/UNSPEC INJ SHOULDER/UPP ARM
						Physiotherapy	OTH/UNSPEC INJ SHOULDER/UPP ARM
	[redacted]	[redacted]	[redacted]	L-Comm ‡ Salomons, Bonnie	OTH GEN ISCHEM CEREBROVASC DIS	Nursing	BENIGN ESSENTIAL HYPERTENSION
							CARPAL TUNNEL SYNDROME
							OTH GEN ISCHEM CEREBROVASC DIS
							UNSPECIFIED DEFICIENCY ANEMIA
						Occupational T	BENIGN ESSENTIAL HYPERTENSION
							CARPAL TUNNEL SYNDROME
							OTH GEN ISCHEM CEREBROVASC DIS
							UNSPECIFIED DEFICIENCY ANEMIA
	[redacted]	[redacted]	[redacted]	L-Short SI Noel, Suzanne	PNEUMONITIS INHAL FOOD/VOMIT	Nutritional Ser	PNEUMONITIS INHAL FOOD/VOMIT
						Physiotherapy	PNEUMONITIS INHAL FOOD/VOMIT
	[redacted]	[redacted]	[redacted]	L-Comm ‡ Dodge, Diane	SECONDARY PARKINSONISM	Home Support	ABNORMALITY OF GAIT
							COGNITIVE/PERSON CHANGE OTH TYPE
							OTH MUSCULAR DYSTROPHY/MYOPATHY
							POSTINFLAMMATORY PULM FIBROSIS
							SECONDARY PARKINSONISM
	[redacted]	[redacted]	[redacted]	L-Comm ‡ Dodge, Diane	OTHER GENERAL SYMPTOMS	Occupational T	CONGESTIVE HEART FAILURE
							CORONARY ATHEROSCLEROSIS
							DIABETES MELLITUS WITHOUT COMPL
							ESSENTIAL HYPERTENSION UNSPEC
							OTHER GENERAL SYMPTOMS
							PERSONAL HISTORY OF ARTHRITIS
						Social Work	CONGESTIVE HEART FAILURE
							CORONARY ATHEROSCLEROSIS
							DIABETES MELLITUS WITHOUT COMPL
							ESSENTIAL HYPERTENSION UNSPEC
							OTHER GENERAL SYMPTOMS
							PERSONAL HISTORY OF ARTHRITIS
	[redacted]	[redacted]	[redacted]	E-Short S Chatfield, Karen	OTH MALIGNANT NEOPLASM STOMACH	Home Support	OTH MALIGNANT NEOPLASM STOMACH
						Nursing	OTH MALIGNANT NEOPLASM STOMACH
						Nutritional Ser	OTH MALIGNANT NEOPLASM STOMACH
	[redacted]	[redacted]	[redacted]	L-Comm ‡ Ducharme, Mary	ALZHEIMER'S DISEASE	Adult Day Prog	ALZHEIMER'S DISEASE
							CARCINOMA IN SITU OF PROSTATE
	[redacted]	[redacted]	[redacted]	L-Comm ‡ Dodge, Diane	AC ILL-DEFINED CEREBROVASC DIS	Home Support	AC ILL-DEFINED CEREBROVASC DIS
							MALAISE AND FATIGUE
Grand Total							

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Communication Tools: RAI Outcomes Report

Name: [redacted]

HCN:

Date Of Birth: [redacted]

Date Of Assessment: March 8, 2012

Reason for Assessment: Follow-up assessment

	COMMENTS
FUNCTIONAL PERFORMANCE	
Activities of Daily Living	* Client reports difficulty in dressing * Client reports difficulty bathing
Instrumental ADL's	* Impairment of IADL's noted * Client reports difficulty in meal preparation * Client reports difficulty in managing medications * Client reports difficulty in transportation * Client reports difficulty in shopping
Physical Activities Promotion	
Institutionalization Risk	
COGNITION AND MENTAL HEALTH	
Cognition	* Impairment of cognition suspected

Results of enhanced partnerships:

- Before more formal partnering with Primary Care, 33% of partners reported communication with CCAC met expectations

- Since the renewed partnerships, Partners survey results:
  - 100% partners report enhanced communication
  - 100% of Physicians say having a case manager integrate with the team enhances patient care
  - 89% say it facilitates timely referrals
  - 93% say it enhances their knowledge of community resources

- CCAC Staff survey results:
  - 82% say communication has improved
  - 80% indicate that collaboration has improved

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Results of enhanced partnership:

CCAC evaluation showed:

- Reduced emergency room visits and hospital admissions 5% per year
- Attached orphan patients with diabetes with family physicians
- 26% increase in referrals to CCAC from primary care
- 5% increase referrals by CCAC to community supports
- 100% of physicians say having a case manager as part of the care team enhances patient care

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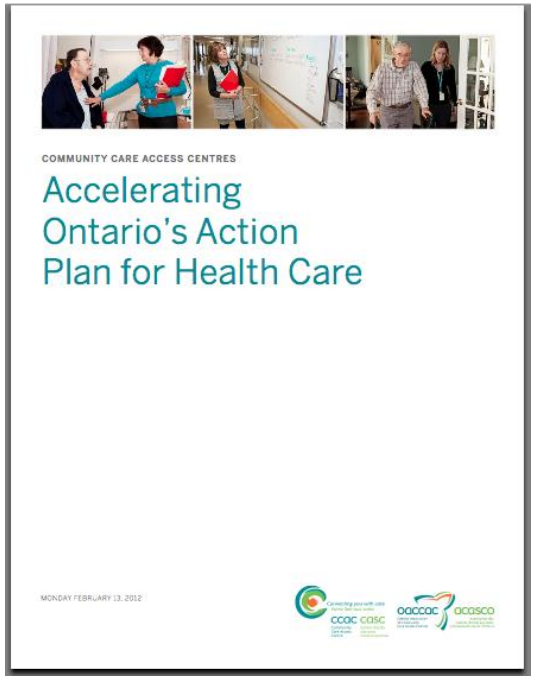
What's next? Accelerating Ontario's Action Plan

- All CCACs share the same vision
- Some are further ahead but all CCACs moving forward together based on these recommendations to government
  - Integrate family health care into the LHINs including a robust care coordination model supported by CCACs
  - Focus on the complex needs of an aging population through cross-system intensive CCAC case management
  - Drive quality and accountability through innovative patient-based funding models



All clients/patients – Primary Care

- CCAC is part of the primary care team – on site on a regular basis, as a known partner and supporter
- Regular review of common clients/patients
- Improving screening and early identification
- Better care coordination and connection
- Electronic exchange of information

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We are moving forward

- 32 care coordinators matched with 109 physicians in 35 practices
- Commitment is to have on-site care coordinators with all 600 primary care physicians
- 150:600
- Physician Bulletin going out now inviting interest

The Challenge for all of us

- How do we all support the significant cultural and operational changes required to enable effective partnerships of primary care, CCAC and broader system partners?
  - Partnership development, process and quality improvements
  - Electronic enablers
- CCACs need to connect with physicians, how to do that?
  - South West CCAC goal to have regular on site presence of the case manager with all physicians (another 600)
  - In the meantime, or beyond that, how do we effectively partner and communicate?
  - Communication is key, but also a challenge
- We then can mobilize regarding the 1% of people who consume 34% of system costs, this is our biggest opportunity

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Resources

Link to South West CCAC's Primary Care site:
http://www.ccac-ont.ca/Content.aspx?EnterpriseID=2&LanguageID=1&MenuID=1

Primary Care-Partnership for Health August 2012 (handout)

Link to Ontario's Accelerated Action Plan
http://www.ccac-ont.ca/upload/on/general/CCAC_Accelerating_Action_Plan.pdf

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Questions?

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