Canadian Home Care Association

High Impact Practices

www.cdnhomecare.ca

A Journey to Enable Better Care

Creating an efficient and mobile care coordination team

About High Impact Practices

The Canadian Home Care Association (CHCA), as a national voice, promotes excellence in home care through leadership, awareness and knowledge to shape strategic directions. The Association is committed to facilitating continuous learning and development throughout the home care sector to support and promote innovative and effective practices across Canada.

During the CHCA's annual Home Care Summit, health care leaders from across Canada and abroad share new and emerging approaches to home care and engage in dialogue about their experiences so that leading practices from across the country and, around the world, can be examined and adopted. Every year there are initiatives that stand out – those that clearly will impact the health care system. The potential of these practices is such that home care stakeholders want to hear more and are eager to explore the applicability within their respective jurisdictions. Building on the momentum of the Home Care Summits and recognizing the potential "ripple effect" of expanding the dissemination beyond the Summit participants, the CHCA has undertaken to document and publicize a selection of these innovative practices from across the country as High Impact Practices.

EACH OF THE HIGH IMPACT PRACTICES:

- **Promotes** home care that provides evidence-informed service delivery directed toward the achievement of health outcomes in the settings that best support the individual, and family
- **Enhances** the effectiveness of home care
- **Raises the awareness** of the ways that home care contributes to an effective health care system
- **Mitigates** rising health care costs and accentuates existing resources and expertise
- **Enables sharing** and transferring of knowledge, expertise and experience through networking and peer-to-peer learning.

Thank-you to our High Impact Practices Partners…

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A Journey to Enable Better Care

Summary

Presented by representatives from the Toronto Central CCAC and SIMS, their Information Technology and Information Management provider[1], this initiative achieves increased client care by leveraging technology to support business processes.

The *Journey to Enable Better Care* is about changing the fundamental way work is conducted in order to reach more clients in the communities where they live, without adding to cost and without increasing staff. It arose from an organizational commitment to continuous quality improvement, internally and with partner organizations.

The initiative moved practice in the Toronto CCAC from:

- One in which there was high degree of variability in practices with multiple paper based processes and tools to the application of logic to drive and support service and care standards using digital tools and streamlined processes
- Working in a centralized office to a mobile work force integrated in the community with real time access to client information heavy reliance on voicemail and fax technology to electronic notifications and reminders
- Central and remote connectivity through satellite and main office locations to provider portals to access and contribute to client charts through central, remote and wireless connectivity to all network resources
- Applications designed with on-line and off-line functionality to those with "always on" functionality.

As a result of the *Journey to Enable Better Care*, the Toronto CCAC care coordinators are integrated in the communities they support, working more closely with providers and are spending more time with clients in their homes. Staff are using laptop devices with wireless connectivity enabling timely access to the common provincial assessment instruments and Information and Referral databases.

Toronto Central CCAC

The Toronto Community Care Access Centre (CCAC) is one of fourteen CCACs in Ontario. CCACs are local organizations funded by the Ministry of Health & Long-Term Care to provide an access point to health and community support services for individuals with post acute, rehabilitation, long term supportive or end of life care needs. The CCAC plays a critical role in connecting people to a wide array of services and coordinates these services across the continuum of care.

The Toronto Central CCAC is responsible to serve 1.1 million people and compared to the provincial average its jurisdiction has a:

- Higher proportion of newcomers and immigrants (43%)
- Higher level of education (56% have post-secondary)
- Higher proportion of the population living in low income (22%)
- Greater proportion of young adults (age 25-39)
- Lower proportion of children and youth (age 0-19)
- Great percentage of single-parent families
- Lower prevalence of obesity/overweight and arthritis/rheumatism and chronic bronchitis
- Lower age-standardized hospitalization rate

For more information on the Toronto Central CCAC:
http://www.ccac-ont.ca/Content.aspx?EnterpriseID=7&LanguageID=1&MenuID=1

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Project Background

With the realignment of Community Care Access Centres (CCACs) in Ontario in 2007, the Toronto Central CCAC's population served doubled in size. The Toronto Central CCAC has the highest concentration of academic and community health providers with which to work and with the pressures on the acute system had seen a 20-30% increase in referrals year over year.

Community Care Access Centres employ care coordinators responsible for conducting comprehensive assessments of individuals' (of all ages) support needs in order to connect them to, and coordinate their, care. The Toronto Central CCAC operates seven days per week and coordinates care for 38,000 clients per year. The activities encompassed by care coordination (also known as case management) include: assessment and reassessment; engagement and relationship building; information and referral; service planning and monitoring; discharge; outreach; and, coordination and communication.

Toronto Central CCAC believes that clients value:

- Choice
- Caring / empathy
- Safety
- Partnership
- Respect

With the aging population and human resource shortage and only modest funding increases, the Toronto Central CCAC knew that it had to find new ways of meeting the demand. The challenge was to find strategies that did not draw against client care expenses. The CCAC had a history of adopting administrative efficiencies in order to meet their escalating demand – an early adopter of information technology solutions, the CCAC had fully deployed laptops to their case managers in 2001 and embarked on a series of initiatives to improve record keeping and reduce the amount of time spent by staff on paperwork. The CCAC had also undertaken a re-organization of responsibilities amongst its staff in order to streamline communication through the Team Assistant; and had created significant efficiencies through the centralization of its equipment and supplies ordering and delivery processes.

The challenge was to adapt care coordination to address the increasing demand being placed on the system and respond to the expectations of a more informed health care consumer. Today's health care consumers increasingly want to have more active awareness and involvement in their health care. They want more control and choices; to be involved in determining their care plans and exploring the options for care. Health consumers of today expect accurate health information that is readily accessible regardless of the venue of care and most importantly, they expect that the various care providers have the most current information and are able to communicate with each other in a timely manner. Protection of privacy and elimination of undue risk are a given.

Implementation

The *Journey to Enable Better Care* initiative was launched by the Toronto Central CCAC in 2007. There were three key approaches undertaken: 1) reorganization of caseload; 2) establishment of virtual workspaces; and, 3) enhancement of information technology.

The goal was to eliminate the variability in practice and the multiple processes and largely paper based tools across the organization, which was in part created through the re-alignment of the CCACs. In addition, the CCAC wanted to be better integrated into the community without compromising the ability of staff to access client information.

1)Reorganization of caseload

Client services were re-oriented in order to better segment the client base to focus on the specific needs and client experience of unique populations. The initial segmentation included the creation of client focused teams to support individuals with acute (short stay) or chronic needs (long stay). Further segmentation will occur over time to allow a strong focus on high risk high needs populations, to develop stronger partner relationships around key client populations and to allow staff to develop a deeper appreciation and improved approach to client care. Other key areas of population focus include frail seniors and adults with chronic conditions. The organization will continue to evolve its client segmentation model over time to develop strong supports for clients.

2)Establishment of virtual workspaces

A key component of the *Journey to Enable Better Care* was to support staff mobility recognizing their need to work from the office, a satellite location, home and or the client's home in the community. Four community offices from which staff could work were created to support 'hoteling' functions. In other words, desks were not assigned to the care coordinators or their managers. The community office was designed to accommodate approximately one half of the staff at one time. The space consists of drop in space for staff and managers and has a couple of large and small spaces for meeting with clients and other members of the health team and/or for training. The space may also be used by community partners and service providers. Administrative and support functions such as human resources, payroll, occupational health and staff training are present on site at regularly scheduled times and staff are provided with keys in order to access the office during off hours.

The creation of community offices allowed the CCAC to avoid a major expansion in a centralized location and to shift to the community as the focus of staff's work. Community offices allow the teams to work more closely aligned in the field; and allow staff to spend less unproductive time in travel or traffic jams that is the reality of a large urban city.

3)Enhancement of information technology

Core functions which support and enable CCAC care coordination – call management, data support and placement services, were centralized and automated as a key enabler to creating a mobility-based model. Centralized call management for urgent client matters and new non-urgent referrals was established. The customer service representatives collect basic demographic information on new clients, confirm service for existing clients, respond to concerns and feedback, and follow-up with clients.

A centralized data support team responsible for service ordering, administrative functions and electronic file management was established enabling staff access to the electronic file whether in the office of the community.

A centralized placement team is responsible for maintaining the relationships with the long term care homes and managing the wait lists. The team also coordinates the short stay (patients with service needs of less than three months) and convalescent care (for patients with short stay service needs and having rehab potential) programs and is part of the bed call management team (which is in charge of offering long term care accommodation to an approved applicant).

The key tool supporting the mobile workforce is the Care Coordination Portal. It is the electronic system that hosts the client record and supports overall case management of clients (group and individual) throughout their care encounter and across multiple encounters. There are several features of the portal that assist staff to be more productive while in the field. These include:

- Caseload listings which provide at a glance caseload management. Staff have the ability to classify and sort their clients using a work queue status to reflect their stage of care.
- Group calendaring which allows team members to coordinate schedules through visualization of each other's commitments
- The ability to develop comprehensive service plans which include the care coordination goals that are linked to plans of both funded and community-based services.
- Notifications and reminders that "queue" staff to key case management tasks ensuring rigorous practice and policy adherence. Care Coordinators are reminded of overdue equipment, clients on hospital hold, when new documents are uploaded, or when clients placed in LTC home require 6 week follow up calls.
- Document management functionality which enables the uploading and management of historical paper charts and any new external documentation.
- Workflow automation which is tied to the progress note which enhances teamwork.
- Notifications of any activities performed for clients by the office-based teams. For example, incoming urgent calls may be handled by the Client Service Centre and the community Care Coordinator is notified to review this documentation.

The Care Coordination Portal includes functionality that ensures the privacy and security of client personal health information is maintained. All access of the electronic record is audited in the applications. Staff accessing a client record are reminded of this fact and are issued a privacy challenge to ensure they have just and sufficient cause to access a client chart. Client privacy alerts allow staff to document any restrictions that have been placed on the use or distribution of personal health information.

Any risks or threats to the safety of clients, staff or providers can be clearly documented in the Precautions and Risks section of the file. This information can also be updated should conditions change and the risk is no longer present.

In addition to creating the electronic client record accessible through the Care Coordination Portal; providing laptops; and establishing community offices, the staff were equipped with wireless high speed cards and connected to the CCAC network through a virtual private network so that they are able to access network resources from any location.

Key Success Factors

Fundamental to the success of this initiative is the commitment to continuous quality improvement and learning by the Toronto Central CCAC. The CCAC staff determined that they needed to:

- Focus on improved standards of service – listening to clients and caregivers with a commitment to understanding and improving their experience.
- Do what's mission critical – build expertise; focus on core strengths and partner to deliver the rest.
- Empower staff – simplify processes and empower staff to deliver exceptional service and quality, enabling decision making at point of care.
- Maximize knowledge and technology – develop effective tools and processes that optimize the use of available resources.

Specific to the technology applications it was vital that:

- Business process and redesign efforts be tightly linked
- Formal integration of the business and technical teams occur through the appointment of business leads and application owners
- Tests of the change be undertaken prior to full scale implementation
- Usability studies be conducted
- An iterative approach introducing incremental improvements be used

Outcomes

The Toronto Central CCAC workforce has made the transition to a new model of service delivery. Coordinators are integrated in the communities they support and spending more time with clients in their homes. They work on laptop devices with wireless connectivity and use standardized processes and procedures, including the common provincial assessment instruments, and Information and Referral databases. Care Coordinators share their community offices with providers and in so doing are achieving strengthened linkages.

CCAC managers have had to develop new skills to support their virtual teams. No longer being able to see their staff in person on a daily basis at the office, the managers have employed a number of new approaches:

- Email, phone and videoconferencing are the more common modes of communication and managers have had to learn how to be accessible and approachable using these tools.
- Managers travel more, ensuring that they are available to work with staff in community offices as opposed to requiring that the staff come to a central office.
- Because they cannot see their staff and know what is happening, managers request regular updates.
- Performance assessment is focused on outcomes achieved as opposed to tasks.
- Novice staff are paired with peers for support and training to CCAC procedures.
- As technology is vital to the staff`s work, managers have had to become comfortable with technology and able to provide basic troubleshooting.
- Managers have needed to find new opportunities for social and informal networking.

Impact

The mobility strategy has fundamentally changed everything about how the Toronto Central CCAC conducts its work. Effective change management principles helped staff to make this transition to the new model more effectively. Overall strategy and timelines were communicated to all staff so they had a clear understanding of the goal and necessary intermediate steps.

The SIMS Partnership

Shared Information Management Systems (SIMS) is a network of health care organizations in Toronto that manage their information technology and management services as one integrated group sharing resources and implementing solutions contribute to a coordinated and integrated health care delivery system. The Toronto Central CCAC has been a partner since 2003. Today there are 13 partners.

The approach was based in quality improvement methodology whereby lessons were learned and adopted through staged implementation of successive pilot projects. Staff was supported with training, workload relief during training, access to subject matter experts for workflow and process concerns and to the technical teams in person or by pager 24/7.

The combination of electronic tools and mobility strategy has had a number of impacts on how staff work together. Professional staff are more appropriately engaged and through better utilization of Team Assistants, the staff are relieved of administrative and clerical tasks. There is improved clarity of role and function between Coordinators and Team Assistants. There is greater emphasis on customer service by all staff.

The timeliness of actions and work by team members is more transparent and as such issues can be more readily highlighted and addressed.

To a large extent, the changes are transparent to clients, however, as was anticipated, client feedback indicates that they have smoother access to care and better service. They only need to tell their story once, for example.

Ultimately the CCAC's goal is to modify practices to make them more client-centric and so it is important to understand the personal impact to clients. The Toronto Central CCAC has undertaken to call their short stay acute clients to understand their experience as a result of changes in business process at the CCAC. The CCAC is planning to explore the client experience to understand how technology has impacted on the case management. The CCAC is also working the Change Foundation[2] to conduct research on clients who have been placed from hospital in order to understand how they felt about the placement experience.

The CHCA defines home care

as an array of services, provided in the home and community setting, that encompass health promotion and teaching, curative intervention, end-of-life care, rehabilitation, support and maintenance, social adaptation and integration and support for the informal (family) caregiver.

Conclusion

The *Journey to Enable Better Care* demonstrates improvement to client outcome through the integration of providers and commitment of staff to organize work differently. The Toronto Central CCAC recognizes that new approaches are required to respond to the ne needs of the health care consumer of today and tomorrow; and that achieving new approaches comes with innovative thinking. Leveraging technology and secure portals is the way forward.

For more information on the CHCA's High Impact Practices or other initiatives, contact **www.cdnhomecare.ca**

End Notes:

[1] Presentation at the CHCA 2007 Home Care Summit by Camille Orridge, Executive Director Toronto CCAC; Rimmy Kaur, Project Director, SIMS; Doug Moffat, Manager Client Services

[2] For more information about the Change Foundation go to www.changefoundation.ca

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