

Toronto Central **LHIN**

Advancing the Integration of Health Care Through Health Links

# TC LHIN – CSS Sector Meeting

May 27<sup>th</sup>, 2013



*Transforming the system for your health.*



# Opening Remarks

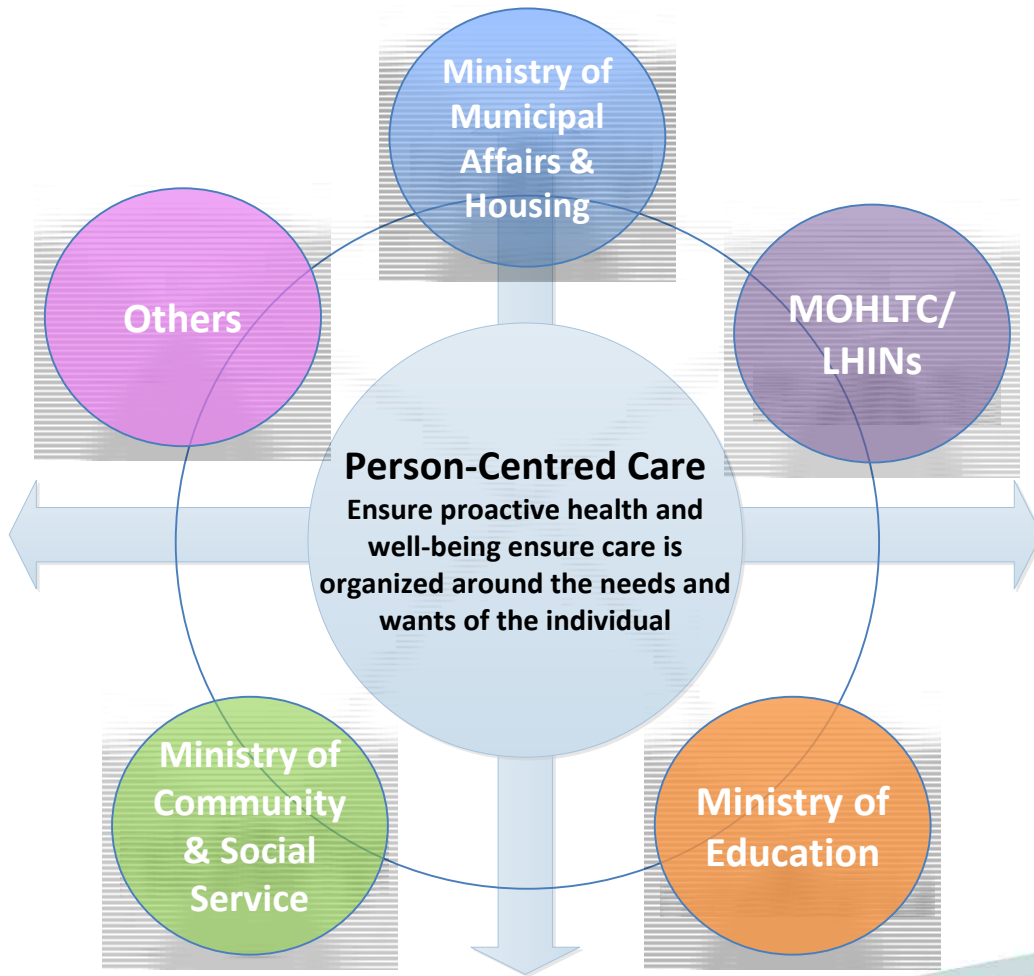
Camille Orridge

CEO, Toronto Central LHIN

It is not the strongest of  
the species that survives,  
nor the most intelligent  
that survives. It is the one  
that is the most adaptable  
to change.

- Charles Darwin

# Transforming the System – *Person-Centred Care*



To achieve a healthy, well population, all sectors need to work together to meet people's individual and collective needs.

# Some Basic Truths

- Health quality can and must be better.
- Current system cannot support changing demographics.
- Our system is not really a system .... and it's costly.
- Health systems have focused on managing hospitals and not the health of populations.
- How we fund and evaluate our system is changing. **It is no longer simply based on whether services were delivered, but whether they are the right services by the right provider, and produce an acceptable outcome.** Patients, providers and government are demanding accountability for quality, client experience, and cost.
- This is shining a light on unnecessary utilization and the need to improve transitions and collaboration across the continuum. **Systems are being forced to integrate.**

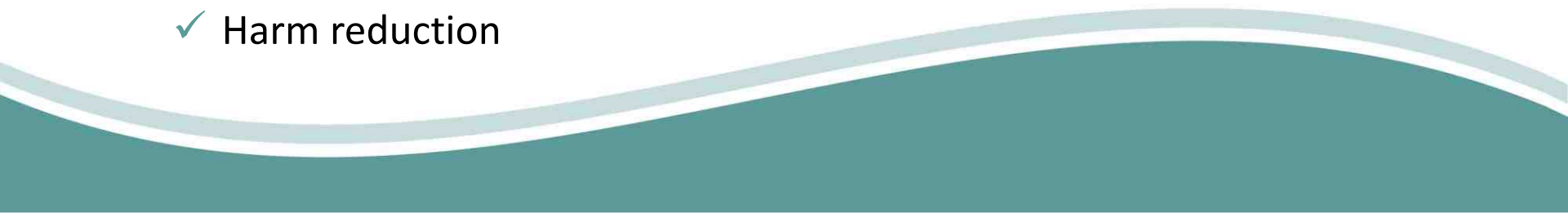
# Client Engagement Participants

**Sessions with nearly 200 clients and caregivers about new models for CSS and CMHA**  
including:

- **Focus group** with 18 clients with *Voices from the Street*
- Meeting with 27 **complex at-risk clients** from diverse seniors groups including:
  - Afghan-Canadian Seniors Centre
  - Bangladeshi-Canadian Community Services
  - 200 Wellesley Street East
  - St. Jamestown Seniors Group
  - St. Kitts Association-Toronto
  - 55 Bleecker Street
  - Thorncliffe Filipino Canadian Seniors Club
  - Islamic Social Services and Resources Association
  - Community Matters
  - Centre d' Echange Culture Africain de l'Ontario
- **Peer-led interviews** with 26 Regeneration House tenants
- **Interviews with 6 caregivers** of people with Alzheimer's
- **Session with 25 seniors** at Centre d'Accueil Heritage Adult Day program
- **Interviews with 5 clients** led by PARC peer outreach workers.
- **Interviews with 4 Aboriginal youth.**
- **Sound Times interviews** with 14 people with complex mental health and addictions challenges.

# What do Clients Want?

## What is working well and should be maintained and strengthened?

- ✓ Peer support!
  - ✓ Volunteer, community-led programs
  - ✓ Congregate services
  - ✓ Support, ability to become self-reliant
  - ✓ Transportation that is customized, reliable and flexible – e.g., accommodates people with dementia
  - ✓ Good case managers who understands and treats clients as “more than an illness”
  - ✓ Harm reduction
- 
- A decorative graphic at the bottom of the slide consisting of two overlapping wavy lines. The top line is a light teal color, and the bottom line is a darker teal color. They create a sense of movement and flow across the width of the slide.

# What do Clients Want?

## What Changes are Most Important?

### Addressing Access Barriers

- **Limited hours of operation don't work** for complex seniors, people with mental illness and addictions
  - Nowhere to go but ER in middle of the night.
  - Drop-ins need longer hours
- **Wait times affect health**
  - Long waits for specialists.
- **Non-English speaking clients have difficulty** getting connected to family physicians

### Communications

- **Clients and professionals need to understand one another.**
  - Language support indispensable.
- **Many seniors don't know about local services**
  - One simple number, one reliable and complete resource needed.
- **Even the most complex clients want help to help themselves.**
  - People want practical information and to be taught how to manage their care; to be treated by their provider as a partner.



# What do Clients Want?

## What Changes are Most Important?

### Peer Support

- **Volunteers necessary part of people's health, wellbeing and recovery from mental illness and addictions**
  - e.g., coaching about what services are available and how to find your way around the system.

### Caregiver Support

- For example - training in how to transfer clients in and out of bed, more equipment, additional hours of paid caregiving.

### Community

- **There are opportunities for communities to help themselves;** use community resources differently.
  - one idea - Islamic Centres can be used for health activities.

### Services that:

- **Promote self-sufficiency/resiliency and do not create dependency**
  - E.g., supportive housing policies can hold people back
- **Are culturally sensitive.**
- **Are safe, high quality, person-centred across the continuum**
  - E.g, detox centres save lives, but clients find some unsafe, uncaring environments.

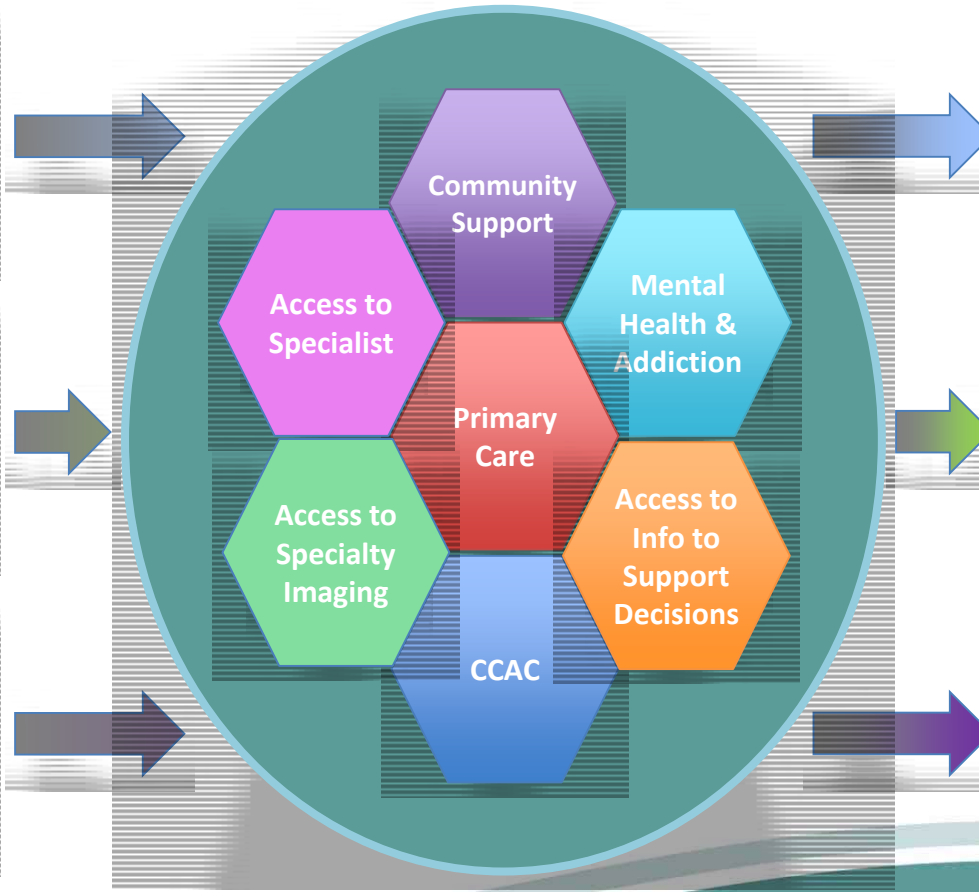
# Building the Supports to Achieve the Transformation

## Point of Departure

Patients and families who are not intimately involved in their care, and whose voice is not listened to

Providers operating with varying levels of alignment & standardization between each other

Governments supported by loose senses of accountability with little reassurance investments made yield the benefit and impact



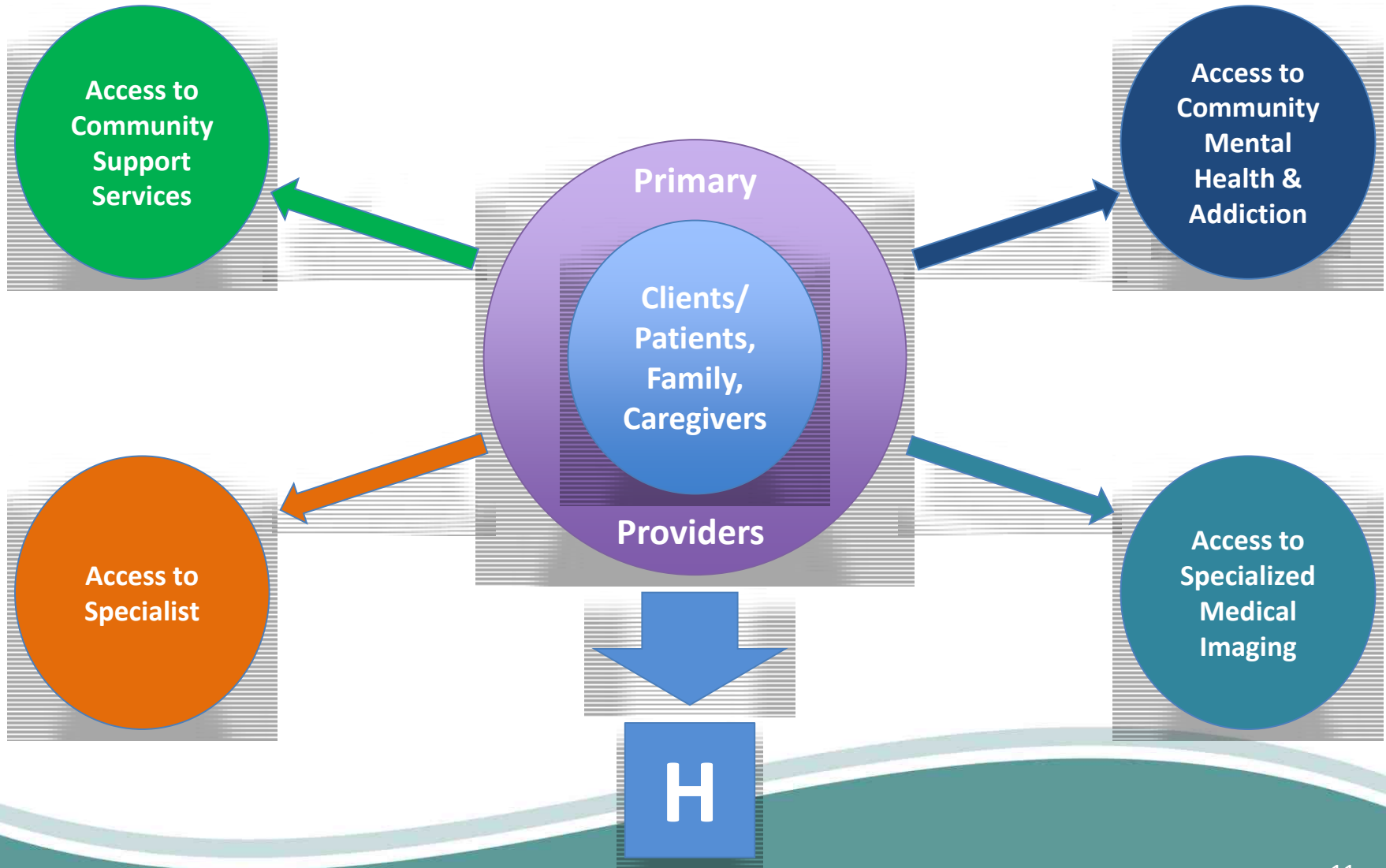
## Point of Arrival

Patients and family who are active participants and drivers in their care; who are informed; always listened to; and respected

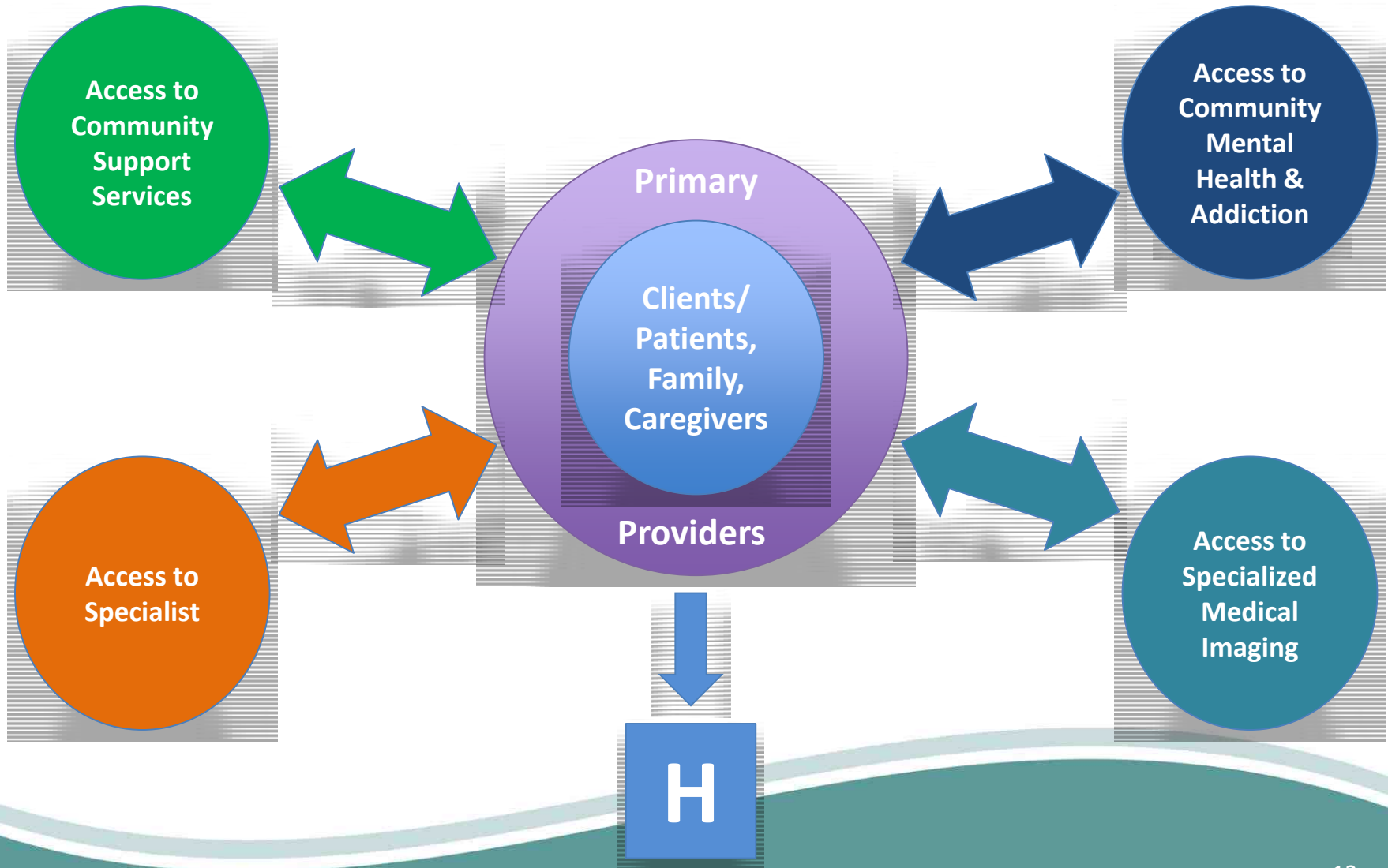
Providers operating in a tightly aligned system of care where providers know how to connect to others at the right time and with warm handoffs

Governments have concrete measures to assess impact, ensure resources are placed in areas of need; and can assess value for investment

# A Simplified View of Intent & Objectives



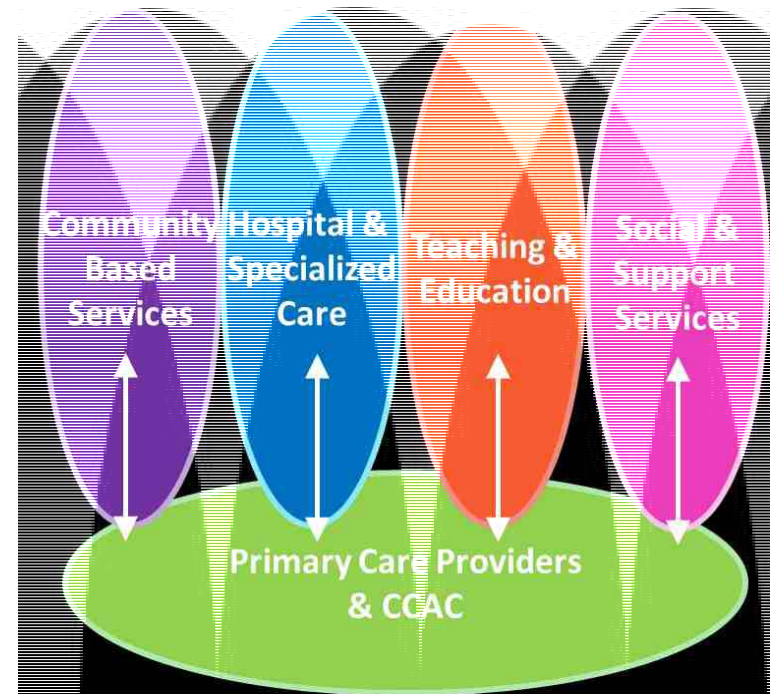
# A Simplified View of Intent & Objectives



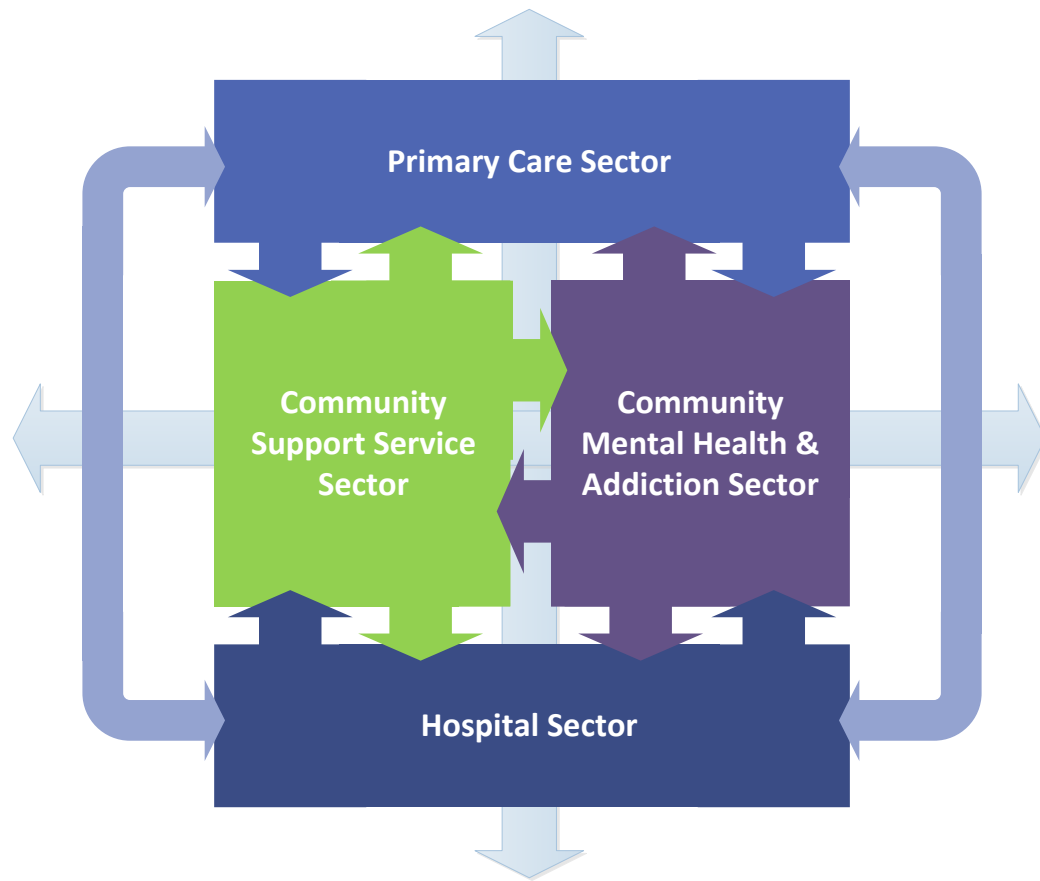
# Building on Past Work to Ensure Inter-Sectoral Integration

Advancing the Integration of  
Primary Health Care

***The Providers of the Toronto Central LHIN will provide personalized, seamless, timely, comprehensive, and high quality primary care to its population through collaboration across the system to advance improved patient outcomes and improved patient experience in the context of a sustainable health care system.***



# Transforming the System – With Health Getting Its Shop in Order



## **Primary Care Sector**

4 Primary Care Health Links being deployed

## **Community Support Service Sector**

New CSS Blueprint being developed

## **Community MHA Sector**

New CMHA Blueprint being developed

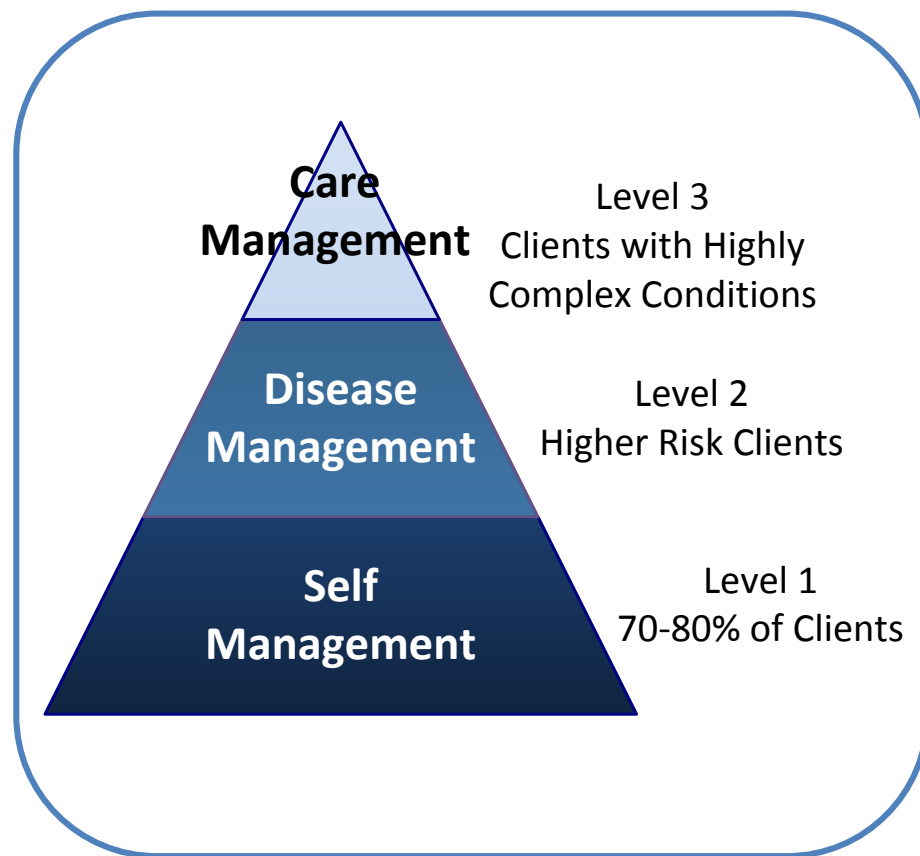
## **Hospital Sector**

New Specialist Access and Medical Imaging Access Blueprint being developed

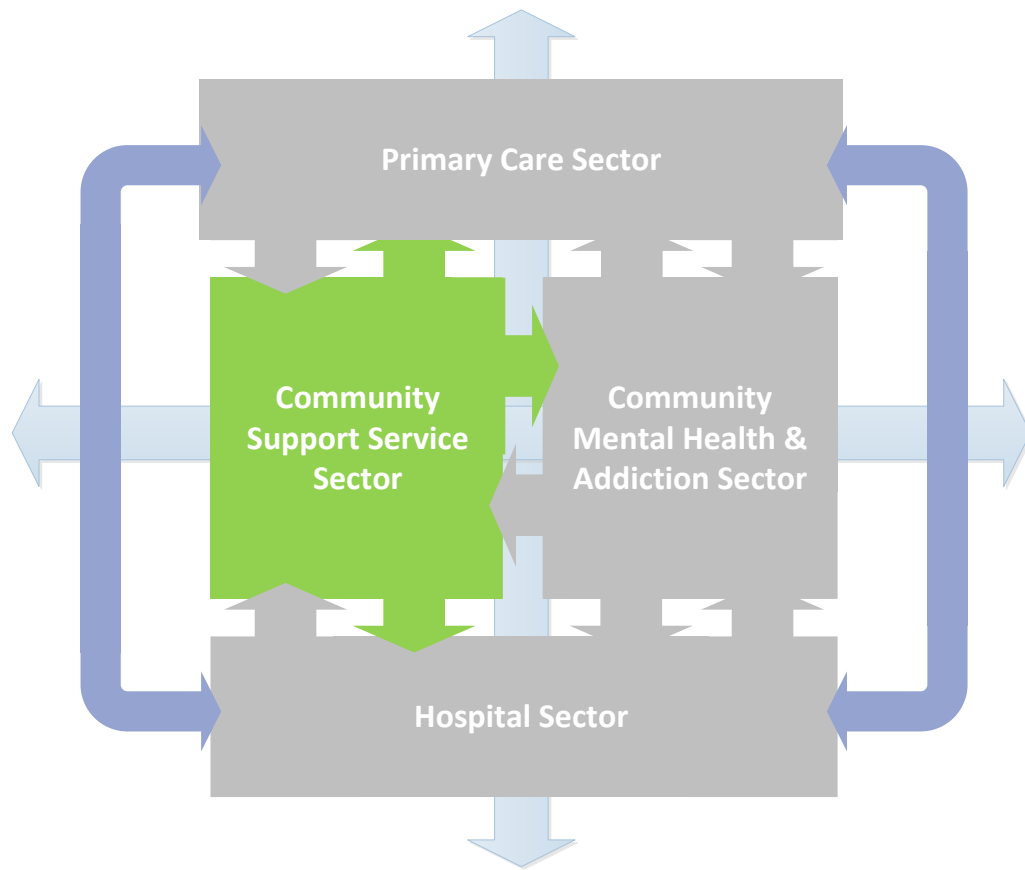
# A Starting Focus: On the Complex and At-Risk

There are many definitions for the target population – **Complex and At-Risk of Becoming Complex**

- The most complex clients with the greatest needs are the ones the health care system is failing the most. Many are not receiving appropriate care and are not in the right place of care. Care is fragmented.
- Highest users of health care resources are those who, when ranked, have the greatest expenditures associated with their health care utilization. *These high users include many individuals for whom costs cannot easily be reduced.*



# Transforming the System – With Health Getting Its Shop in Order





# Community Support Services Sector

## Work of the Working Group

Mandate: to develop a concrete plan to connect a population of *complex and at-risk clients to needed services* resulting in **increased access, improved coordination, and enhanced care management**.

The CSS Sector Working Group has met 5 times to date to help define:

- Guiding principles to support the design of a future model;
- Identifying the target population for who will be served;
- Identifying core services that will be supported by clear expectations of outcomes;
- Drafting a blueprint to guide future design and implementation planning work.

Work must build on available on planned developments.

# Community Support Services Sector

## Drivers for Change

- Provision of any support service must **look beyond the medical conditions** of an individual and consider socio-economic factors – this is complicated
  - **Time and geographic access are major barriers** to keeping health care appointments.
  - “Patients are less likely to see a healthcare service at the first sign of problem because of the **personal financial burden**”
- **Sharing, communicating and transferring information** across the continuum is not efficient, streamlined, or effective – this affects how decisions are made and creates duplication the system cannot afford
- **Transitions across sectors** is challenged because it is sometimes not clear who is navigating – need for greater and clearer levels of system-wide accountability
- Clear **disparities exist in some communities and neighbourhoods** limit appropriate access to key community services close to where people live – need new innovative models to deliver care where it is needed, reflective of culture
- Providers and Clients must be able to **more easily access the services they need, when they need it**

# CSS Sector Working Group Principles

The Working Group confirmed that business must be done differently.

Principles were established and grouped into the following four (4) categories:

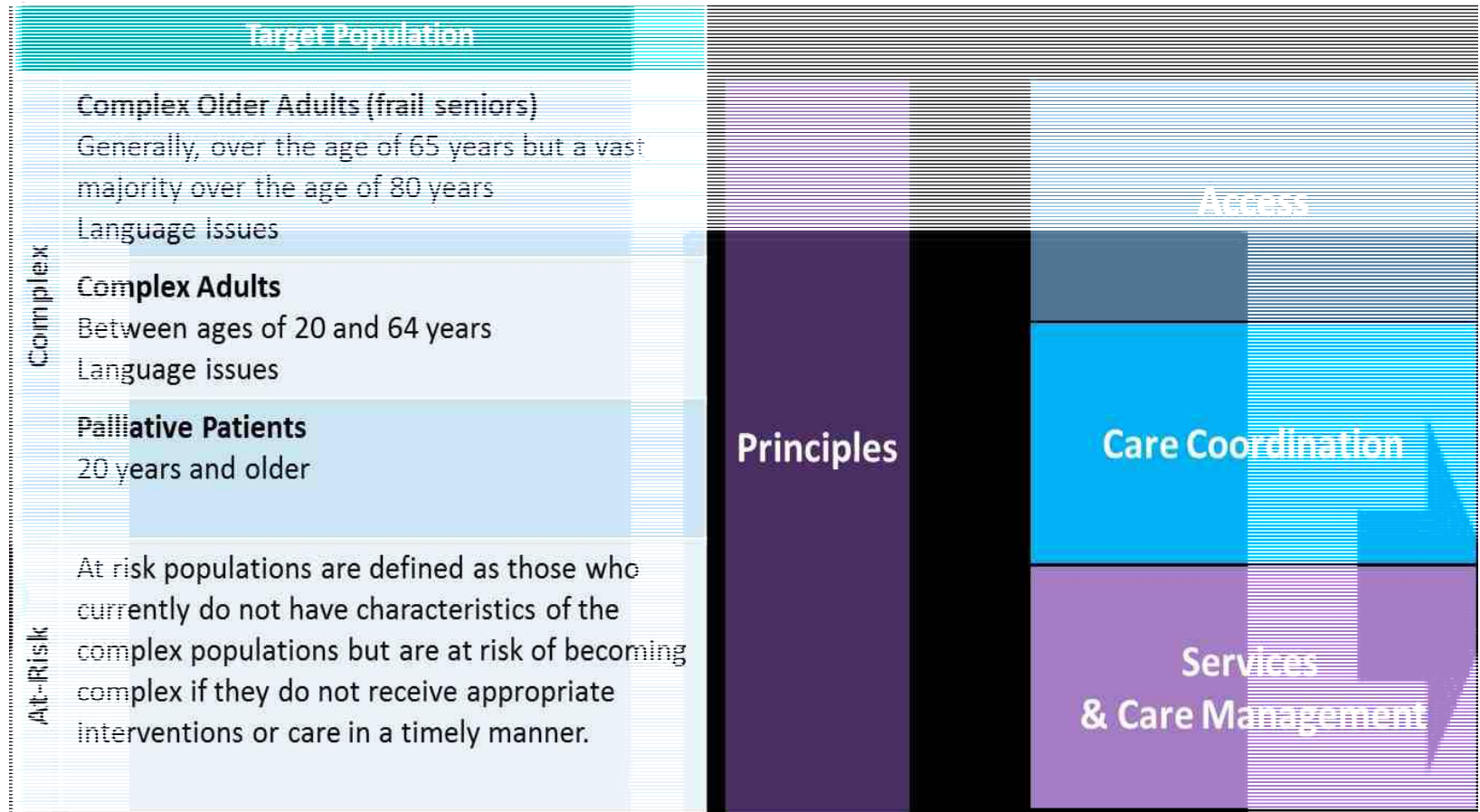
It's About the Client and Their Needs ... ➡ **Client Centred Care**

It's About Providers Working Together to create a single plan ... ➡ **Integrated Care Planning and Coordination Amongst Providers**

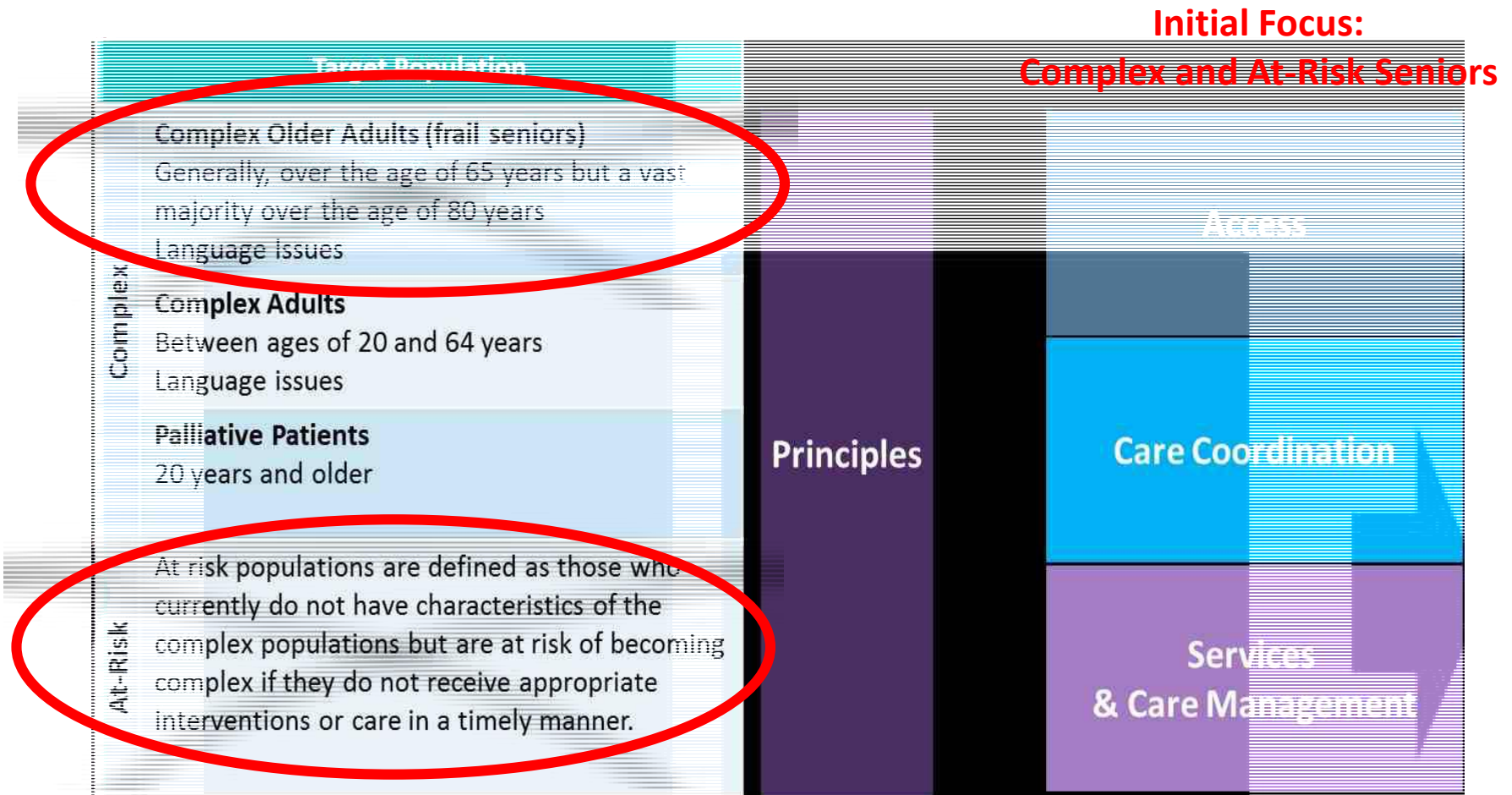
It's About a Important Relationship Between Clients and Their Providers ... ➡ **Coordinated Care Planning Focused on Client Provider Relationships and Interactions**

It's About Ensuring Outcomes are Met ... ➡ **Clear Accountability**

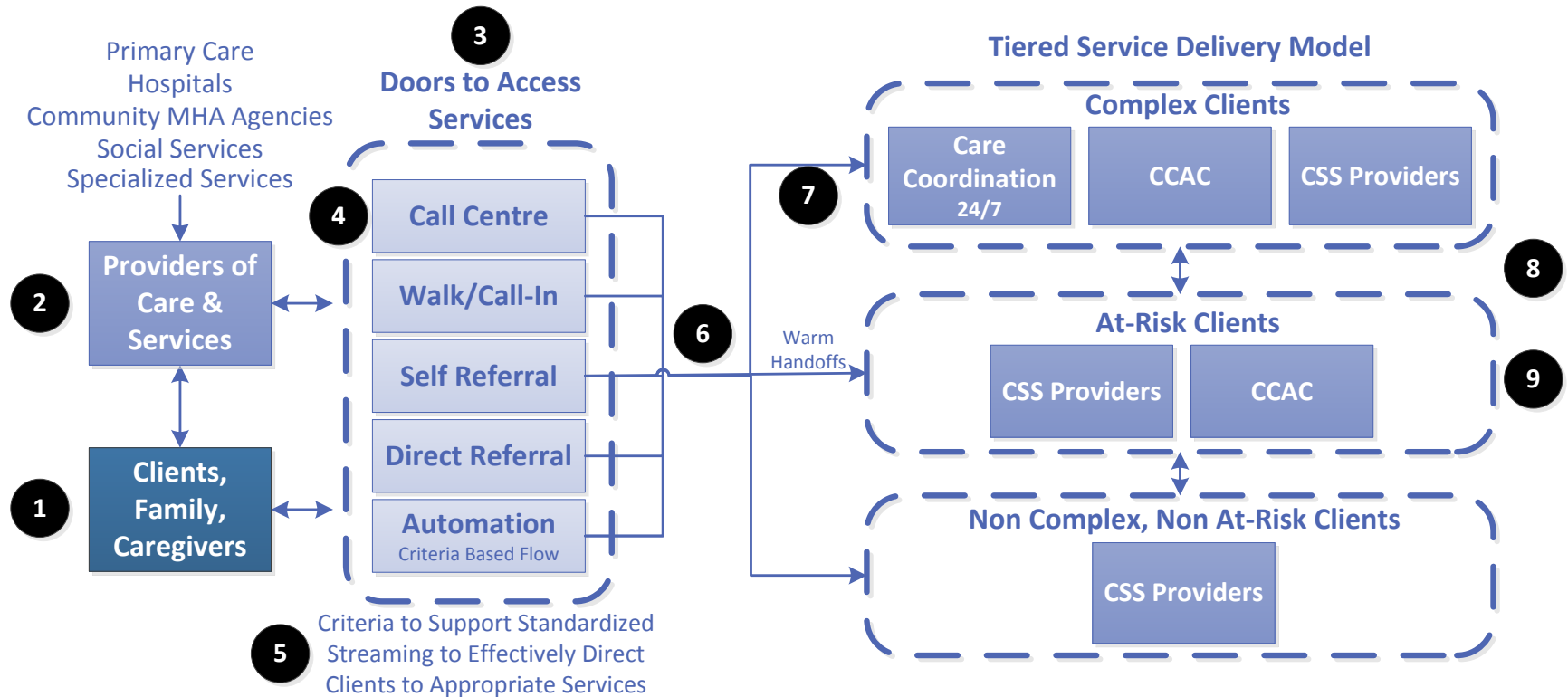
# Understanding the Population Served



# Understanding the Population Served



# Enhancing Community Support Service Capacity to Connect Complex & At-Risk Clients to Services to Increase Access, Improve Coordination, and Enhance Care Management



- 10 Change Management Capacity and Support is Developed to Support Implementation and Ongoing Operations
- 11 Standardized Communication Protocols & Processes Across Circle of Care is Consistent Across All Organizations
- 12 Public/Caregiver Education CSS Sector Education Primary/Hospital Education
- 13 Supporting Technologies & Infrastructure to Support Sharing of Information and Support Coordination of Services
- 14 Data & Information to Support Planning & Decision Making and to Ensure System is Accountable and Transparent

1

A culturally responsive approach to service delivery where clients are acknowledged and valued

2

All providers know what's out there and how they can access services to enable informed decision making

3

Build multiple points of access using pathways that enable informed choice, where every door leads to services

4

One number to call when you don't know who to call to ensure timely & appropriate access. This does not take away from the ability to directly refer

5

Facilitates a more holistic engagement and equitable access process through standardized intake and assessment that leverage existing screening processes, and support capacity management resulting in better transitions of clients across multiple providers

6

Effective, comprehensive coordination that extends beyond any single agency's walls to enable better transitions and handoffs

7

Ensuring clarity for who is responsible for a client at any point in time, and building capacity to transition responsibility were required

8

System of care must support the changing needs of clients by being able to escalate/de-escalate services based on needs of the client

9

Building specialized capacity and expertise with greater economies of scale to delivery services for a broader region

10

Building capacity and expertise to support the necessary shifts in culture, processes, and thinking through an enhanced change management capacity

11

Confirming and clarifying the Circle of Care. Creating new ways and understanding for how providers communicate with one another to close the gaps between providers

12

Public and caregivers are educated and informed, and programs are marketed in plain English. CSS sector understand who provides what, and knows where to get answers from. Sector has trust that Primary care and hospitals have enhanced CSS expertise and capacity

13

Technology will enable and integrate providers together to ensure information is pushed to all corners of the system to enable informed decisions

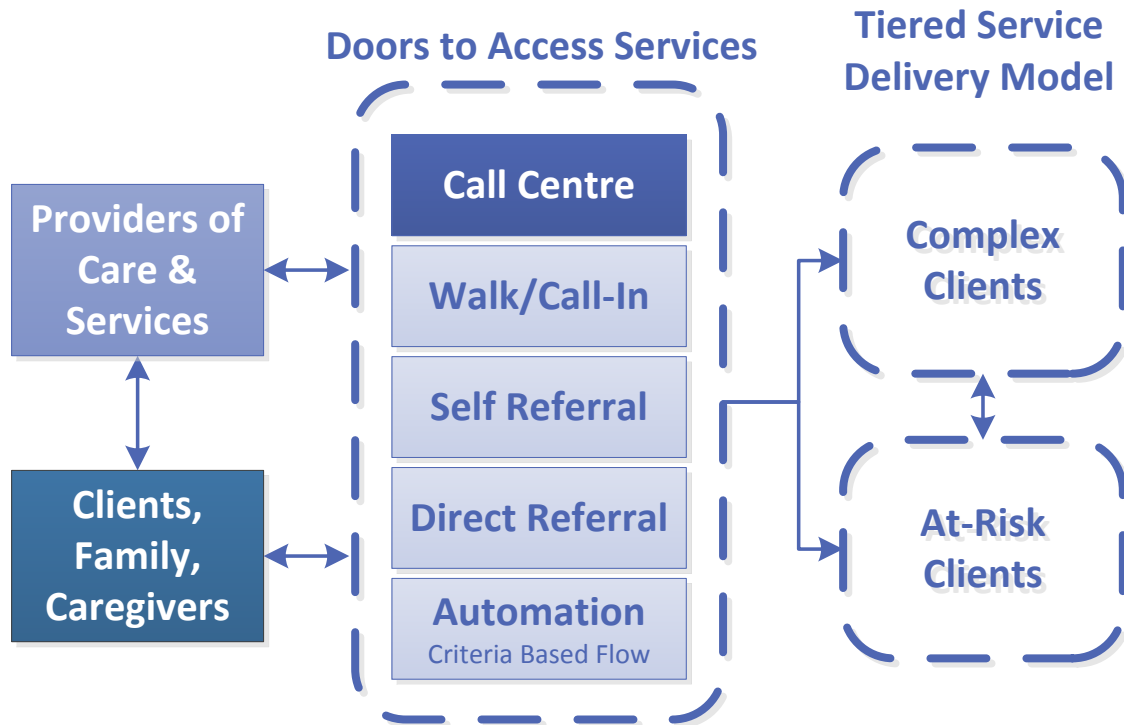
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Data and information will be collected, shared, and used to support effective decision-making to continually adjust and improve the system where it is needed. System will be able to demonstrate benefits and support accountability requirements



## Access

### Enhancing Community Support Service Capacity to Connect Complex and At-Risk Clients to Services to Increase Access, Improve Coordination, and Enhance Care Management

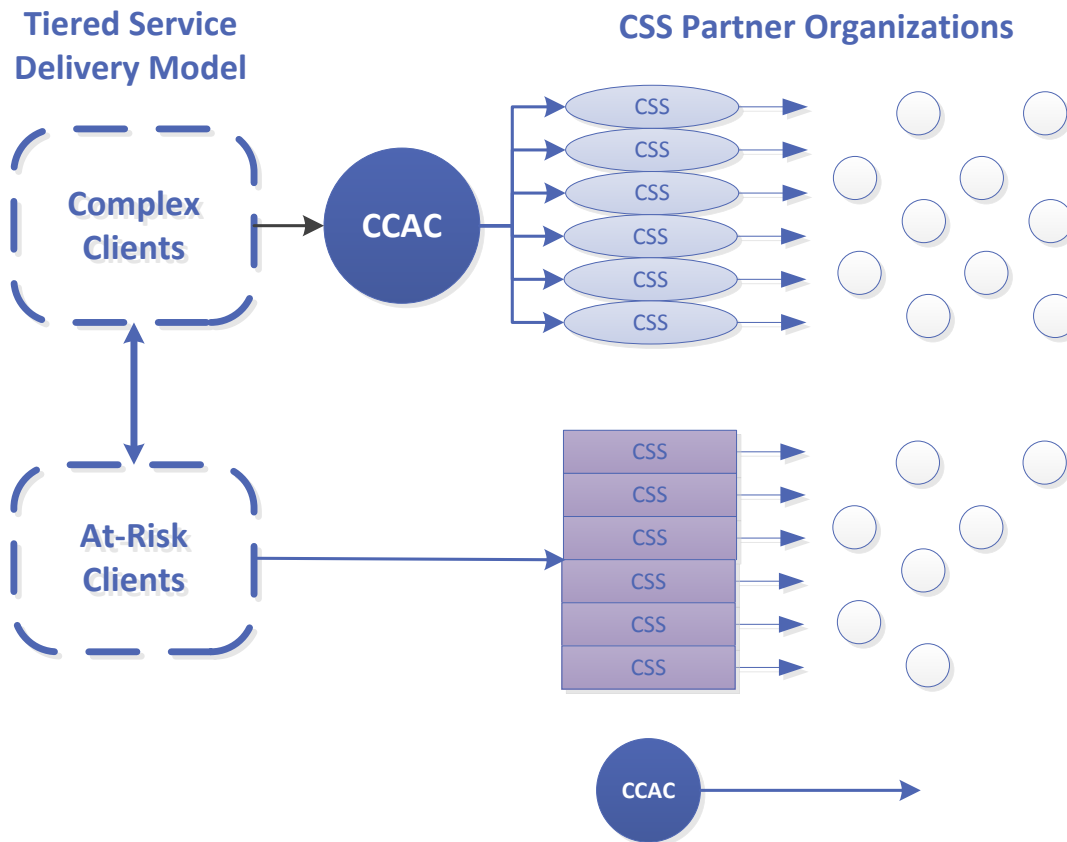


- Multiple doors leading to services accessible for clients, families and providers
- A Call Centre for those unsure for how to access services
- Standardized protocols to ensure consistency and clarity for how to access services
- Clear criteria for how to identify complex from at-risk clients



## Care Coordination

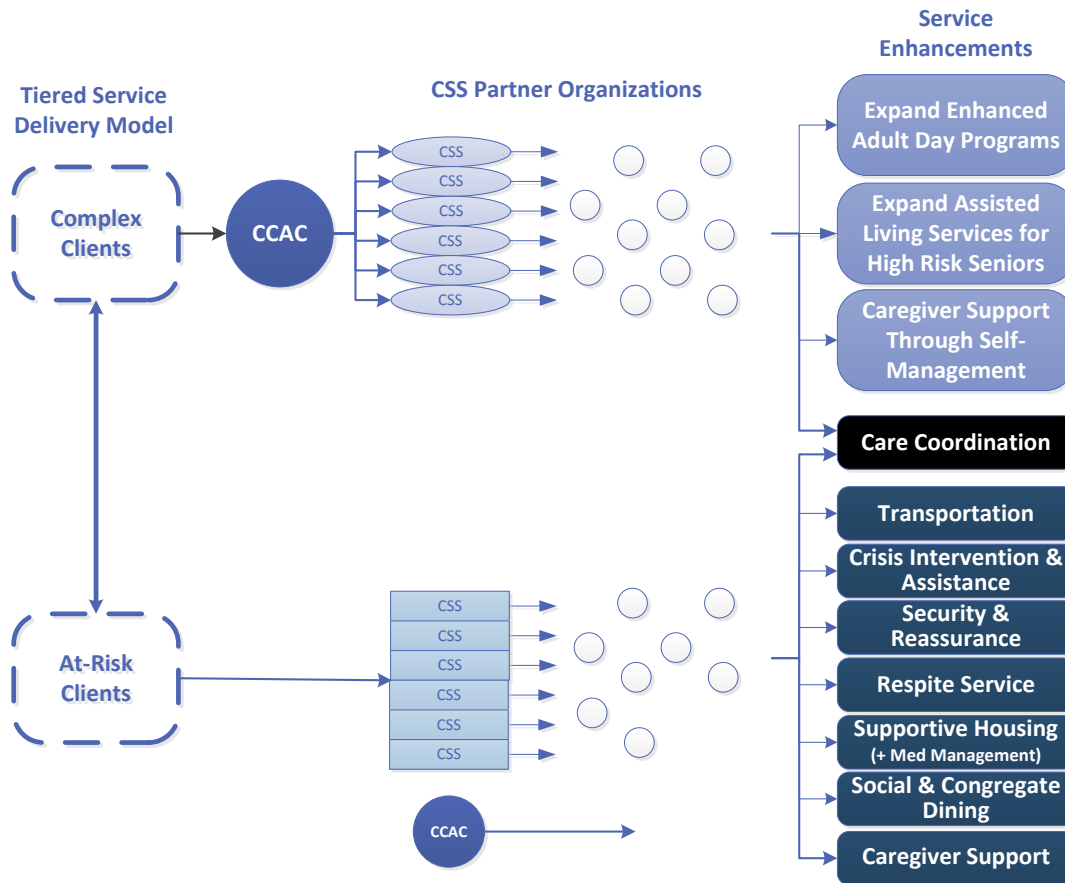
### Enhancing Community Support Service Capacity to Connect Complex and At-Risk Clients to Services to Increase Access, Improve Coordination, and Enhance Care Management



- For complex clients, CCAC will take the lead and will work with selected CSS Lead Organizations to coordinate care
- For at-risk clients, CSS and CCAC will collaboratively be responsible for developing standards for care, being “point organizations”, and for working with sector to enhance consistency.

## Services & Care Management

# Enhancing Community Support Service Capacity to Connect Complex and At-Risk Clients to Services to Increase Access, Improve Coordination, and Enhance Care Management



- Service enhancements for the coming year will be focused on senior complex and at-risk
- For complex, eADP, AL-HRS, and Caregiver Support.
- For at-risk, transportation, crisis intervention & assistance, security & reassurance, respite, supportive housing, social & congregate dining, caregiver support.
- For other populations, 13/14 will focus on planning
- Services will be further expanded based on funding

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