

Hamilton Niagara Haldimand Brant
Community Care Access Centre



Centre d'accès aux soins communautaires
de Hamilton Niagara Haldimand Brant

Hamilton Niagara Haldimand Brant (HNHB) Community Care Access Centre (CCAC):

Partnering for System Change

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Ontario

Presentation Overview

- CCAC's Role in the System
- How we do our work
- About HNHB
- Provincial Perspective
- ALC & CCACs
- LHIN Partnerships
- CCAC Programs: Hospital Avoidance & Early Discharge
- Challenges and Opportunities

CCAC's Role in the System

- Provide **information and referral** about community home and support services
- Support people to live at home independently through in-home **services**
- When clients can no longer live at home, identify and discuss available options
- Support clients through the application and **admission process to a long-term care home**

For our hospital / system partners this helps to:

- Avoid unnecessary visits to Emergency Departments (EDs)
- Prevent hospital admissions
- Support shortened hospitalizations
- Match clients / patients to appropriate resources

CCACs and Client Care

- Case Managers are regulated health professionals (RN, OT, PT, SW)
- Each client receives individual assessment – in person / in home / in hospital
- Comprehensive care plan developed in partnership with client and family
- Coordinate delivery of care and provide linkages to community support services

Our Region



Hamilton Niagara Haldimand Brant
Community Care Access Centre **CCAC**

CASC Centre d'accès aux soins communautaires
de Hamilton Niagara Haldimand Brant

HNHB CCAC: 2007 / 08

Served 78,636 unique individuals

Equals 1 out of every 18 persons

1 out of every 4 persons - 75 – 84 years of age

1 out of every 2 persons - 85 + years of age

A Provincial CCAC Perspective

- Fourteen CCACs in Ontario; same boundaries as Local Health Integration Networks (LHINs)
- With the Ontario Association of Community Care Access Centres (OACCAC), we are working together to align our client service delivery models
- ALCs – on CCAC agenda provincially
 - Several CCACs participating in Change Foundation project regarding improving transitions from hospital to 'home'
 - Partner in Flo Collaboratives
 - Partners in local ALC Committees

System Issues – ALCs for CCACs

- Range of available community options
- Wait lists for LTC Homes: Supply and Demand
- Caregiver supports
- Human resources
- Patient choice

Working with Our LHIN Partners

HNHB ALC Steering Committee

- Co-Chaired by HNHB CCAC and Hamilton Health Sciences (HHS)
- Membership includes representatives from CCAC, hospitals, LTC homes, retirement homes and community support agencies
- Committee reports to the HNHB LHIN
- Initial area of focus:
 - Designation, Measurement and Evaluation: RLC
 - Slow Stream Rehabilitation Demonstration Projects: preventing decline
 - Education: client, family, service providers

Strategic Plan

- Informing the LHIN-wide plan

Hospital Avoidance : CCAC and partners

1. Emergency Department CCAC Case Managers
2. Home to Stay
3. Family Health Team
4. EMS

Early Discharge: CCAC and partners

1. 1A Hospital Crisis
2. Personal Support and Homemaking:
Extraordinary category for those waiting
for placement
3. Slow Stream Rehabilitation
4. Geriatric Transitional Program

Early Discharge – cont.

5. Placement from Hospital
6. Home to Stay
7. Assisted/Transitional Living
8. Flo Collaborative

Challenges & Opportunities

- Human resources – community care capacity and best practices
- Basket of services in each community
- Sharing of information and data (e-health)
- Lag time from service / program concept to implementation
- Alignment (not duplication) of services

Final Remarks

It takes all health system partners collaborating to ensure clients get the **right** care at the **right** time in the **right** place

CCACs have an important role to play in matching clients and resources across the continuum of care

Questions

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