Client Care Model

Board Meeting
April 25, 2012

Outstanding care – every person, every day
The Client Care Model is a framework that standardizes how we define, work with, and are accountable for five client populations. Each receive specific case management intensity, care planning and service that align with their care needs.
Why this? Why now?

- **Government**
  - April 2009: MOHLTC announces ALC / ER Wait Times priorities (i.e. Hospital Flow)
  - May 2009: Impact from Regulations removing PSW caps: higher utilization & programs like Home First

- **CCACs Provincial**
  - May 2009: CCAC Provincial Client Services Committee Analysis of Improved Care & System Sustainability

- **Local CCACs**
  - September 2010: 6 Proof of Concept sites test various populations and report evidence-based findings
  - May 2011: CCM implementation begins at each CCAC according to local needs and capacity

**Government**

- MOHLTC announces ALC / ER Wait Times priorities (i.e. Hospital Flow)
- Impact from Regulations removing PSW caps: higher utilization & programs like Home First

**CCACs Provincial**

- CCAC Provincial Client Services Committee Analysis of Improved Care & System Sustainability

**Local CCACs**

- 6 Proof of Concept sites test various populations and report evidence-based findings
- CCM implementation begins at each CCAC according to local needs and capacity
Our Place in the System

Clients were “our” clients

Clients are “system” clients
What is the value of CCM?

**Clients**
- Better outcomes
- Better experiences
- Smoother transitions

**Employees**
- Better care for clients
- CM more knowledgeable about specific population needs
- More clearly defined roles & accountability

**CCAC & System**
- Sustainability to address population aging and chronic disease management
- Accountability and performance management
- Enhanced integration with community services and primary care
Outcomes from other CCAC’s

Outcomes

• Higher likelihood of client dying in preferred place (Complex clients)
• Decreased Length of Stay for Community Independence clients
• Positive change in pain control and reduced social isolation for Complex clients

Satisfaction

• Clients and caregivers described feeling supported, especially during transitions
• CCAC staff benefit from focused approach to Case Management
• Improved provider-Case manager relationship (Complex)

Costs

• Costs for contracted services remained neutral
• Slight reduction in costs as per best practices (Short Stay)
# Complex Standards of Care Population

<table>
<thead>
<tr>
<th>Standards of Care</th>
<th>Population Definition</th>
<th>Anticipated Outcomes</th>
<th>Case Management Intensity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Caseload Size</td>
<td>1 or more health conditions</td>
<td>Maintain clients at home</td>
<td>High intensity Case Management</td>
</tr>
<tr>
<td>Initial Contact</td>
<td>Unstable &amp; unpredictable</td>
<td>Support clients &amp; families to achieve degree of stability in preferred care destination</td>
<td>Significant role in system navigation</td>
</tr>
<tr>
<td>Initial Assessment</td>
<td>Little or no support network</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Re-Assessment</td>
<td>High risks in more than one area</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Follow-up (General)</td>
<td>RAI-HC every 3-6 months</td>
<td></td>
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</tr>
<tr>
<td>Follow-up post ED/Hospital</td>
<td>7 days post-initial visit</td>
<td></td>
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<tr>
<td>Follow-up post CCAC discharge</td>
<td>&lt;48 hours (contact)</td>
<td></td>
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<tr>
<td></td>
<td>7 days (Home Visit)</td>
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</tr>
</tbody>
</table>
## Caseload Size
- 1 or more health conditions
- Unstable & unpredictable
- Little or no support network
- High risks in more than one area
- RAI score 17+

## Sub-populations:
- Adult
- Senior
- Palliative

## Example
Client with CP, Arthritis, Diabetes, Depression, falls
### Chronic

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<tr>
<td>Caseload Size</td>
<td>• 1 or more health conditions</td>
<td>• Maintain clients at home</td>
<td>• Moderate Case Management intensity focused on helping client manage health condition(s) &amp; preventing further decline</td>
</tr>
<tr>
<td>Initial Contact</td>
<td>• Direct-care needs are stable &amp; predictable</td>
<td>• Support clients &amp; families to achieve degree of stability in preferred care destination</td>
<td></td>
</tr>
<tr>
<td>Initial Assessment</td>
<td>• Client is self-reliant with support network</td>
<td>• Provide a support structure that promotes self-reliance (e.g. ADL assistance to keep clients in their home)</td>
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<tr>
<td>Re-Assessment</td>
<td>• RAI score 11-16</td>
<td>Example: Client with Alzheimer’s Disease and no behavioural problems</td>
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<tr>
<td>Follow-up (General)</td>
<td>• Sub-populations:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Adult</td>
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<td></td>
<td>• Senior</td>
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<td></td>
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<tr>
<td></td>
<td>• Palliative</td>
<td></td>
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</tr>
<tr>
<td>Follow-up post ED/Hospital</td>
<td>• 1 follow up in 1st month</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>• q 3 months</td>
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<tr>
<td>Follow-up post-CCAC discharge</td>
<td>• RAI-HC every 6 months</td>
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<tr>
<td></td>
<td>• &lt;72 hours (contact)</td>
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<td></td>
<td>• &gt; 7 days (Home Visit)</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Follow-up post-CCAC discharge</td>
<td>• &lt;6 weeks</td>
<td></td>
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# Community Independence

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<tr>
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<th>Population Definition</th>
<th>Anticipated Outcomes</th>
<th>Case Management Intensity</th>
</tr>
</thead>
</table>
| **Caseload Size** | - May have 1 or more health conditions  
- Capable of independent living  
- Stable support network and/or can be self-reliant  
- RAI score 1-10 | - Support clients to maintain their health & well-being  
- Foster a self-management approach & linkages to community-based resources. | - Moderate-to-low Case Management intensity  
- Focus towards increased independence via effective pathways & system navigation |
| **Initial Contact** | <72 hours | | |
| **Initial Assessment** | <14 days | | |
| **Re-Assessment** | RAI-HC annually | | |
| **Follow-up (General)** | Every 3-6 months | Sub-populations:  
- Stable At Risk  
- Supported Independence | |
| **Follow-up post ED/Hospital** | • <7 days for Supported Ind.  
• <72 hours for Stable at Risk | Example  
Elderly client with difficulty bathing independently | |
| **Follow-up post CCAC discharge** | <30 days | | |
# Short Stay

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<th>Case Management Intensity</th>
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</thead>
<tbody>
<tr>
<td>Caseload Size</td>
<td>• Require short-term education, care or support&lt;br&gt;• High potential to return to independence&lt;br&gt;• Stable &amp; predictable care trajectory</td>
<td>• Support clients with acute/rehabilitation needs to transition to self-care</td>
<td>• Low Case Management intensity</td>
</tr>
<tr>
<td>Initial Contact</td>
<td>&lt;72 hours</td>
<td></td>
<td></td>
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<tr>
<td>Initial Assessment</td>
<td>By exception only</td>
<td></td>
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<tr>
<td>Re-Assessment</td>
<td>n/a</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Follow-up (General)</td>
<td>• &lt; 1 month post admission&lt;br&gt;• on-going monthly as needed</td>
<td>Sub-populations:&lt;br&gt;• Acute&lt;br&gt;• Oncology&lt;br&gt;• Rehab&lt;br&gt;• Wound</td>
<td></td>
</tr>
<tr>
<td>Follow-up post ED/Hospital</td>
<td>&lt;7 days</td>
<td>Example&lt;br&gt;Clinic client – wound care</td>
<td></td>
</tr>
<tr>
<td>Follow-up post CCAC discharge</td>
<td>&lt;7 days</td>
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March 2012
Client Categorization For Existing Clients

April 2012
Develop CCM Team Structure

May 2012
Expression of Interest Process

June – Aug 24th
Caseload Reassignment & Education on Standards of Care

Aug 24th
Go-Live Date

Sept – March 2013
Phase Two: Monitoring, Evaluation & Revisions
Project Team Structure

CCM STEERING COMMITTEE

Implementation Committee
- Project Manager – Lead
- Senior Manager of Client Services
- People Team Lead
- Admin Process Lead
- CS Process Lead
- Client Service Manager(s)
- Quality Improvement Specialist
- Decision Support/System Integration
- Case Manager(s)
- Team Assistant(s)
- Director of Accelerated Response (Adhoc)
- Senior Manager of Finance (Adhoc)
- Senior Manager of Contracts (Adhoc)
- Client Service Manager of Palliative (Adhoc)
- Client Service Manager of Intake (Adhoc)
- Education Coordinator (Adhoc)

People Team
- Lead
- Manager, Human Resources
- Human Resource Coordinator
- Education Coordinator
- Communications Manager
- Facilities Coordinator
- Client Service Manager
- Case Manager
- Team Assistant
- Union Reps - Advisory

CS Process
- Lead
- Sub-working groups to address CS processes related to CCM implementation

Admin Process Team
- Lead
- Project Manager
- Senior Manager of IS
- Manager of IT
- Scheduling Coordinator
- Manager of Finance
Completed Tasks for Aug 24th CCM Go-Live date

- Creation of CCM Project Team Structure & breakdown of project task responsibilities
- Client categorization for existing clients
- Interim process for categorization of new clients prior to Aug 24th:
  - Community Case Managers to categorize at initial assessment
  - Resource Case Managers to categorize once new chart received
- Focus groups to help inform decisions around the new caseloads & team structure
  - Team Coverage model
  - Primary Care /Family Health Team linkage model
  - Rural Case Management factors
  - Retirement Home relationships
  - Rostering
  - IALP clients
Next steps for Aug 24th CCM Go-Live date

- Expression of Interest process & development of new caseload/team structure
- Determine process for categorization of new clients from point of Intake for Aug 24th Go-Live date
- Education on Standards of Care and Roles & Responsibilities for CM’s and TA’s specific to each population
- Identification & revision of local business processes
- Communication with clients & stakeholders
- Caseload reassignment
CHANGE MANAGEMENT

The overall goal of the Change Management Framework is that it acts as a vehicle to cement a WWCCAC organizational culture that is:

- Change resilient
- Supports a learning environment
- Committed to Continuous Quality Improvement
CCM ... From a process viewpoint

**CHANGE**: a movement, development, or evolution from one form, stage, or style to another  (Merriam Webster)

Something old stops

Something new begins
People are different....

Something new begins

Something old stops
Kotter’s 8-Step Model for Leading Change

1. Create a Sense of Urgency
2. Create a Guiding Coalition
3. Create a Vision for Change
4. Communicate the Vision
5. Empower People and Remove Barriers
6. Generate Short-Term Wins
7. Build on Gains
8. Anchor New Approaches in the Culture
People need time to “digest” change

- comfort / complacency
- shock / denial
- fear / anger
- negotiation
- depression / reality check
- curiosity / desire to know
- excitement / acceptance
- Adoption / evolution

Performance

Time
The Trapeze
Outstanding care – every person, every day