Connecting you with care
Votre lien aux soins
ccac casc
Community Care Access Centre
Centre d'accès aux soins communautaires

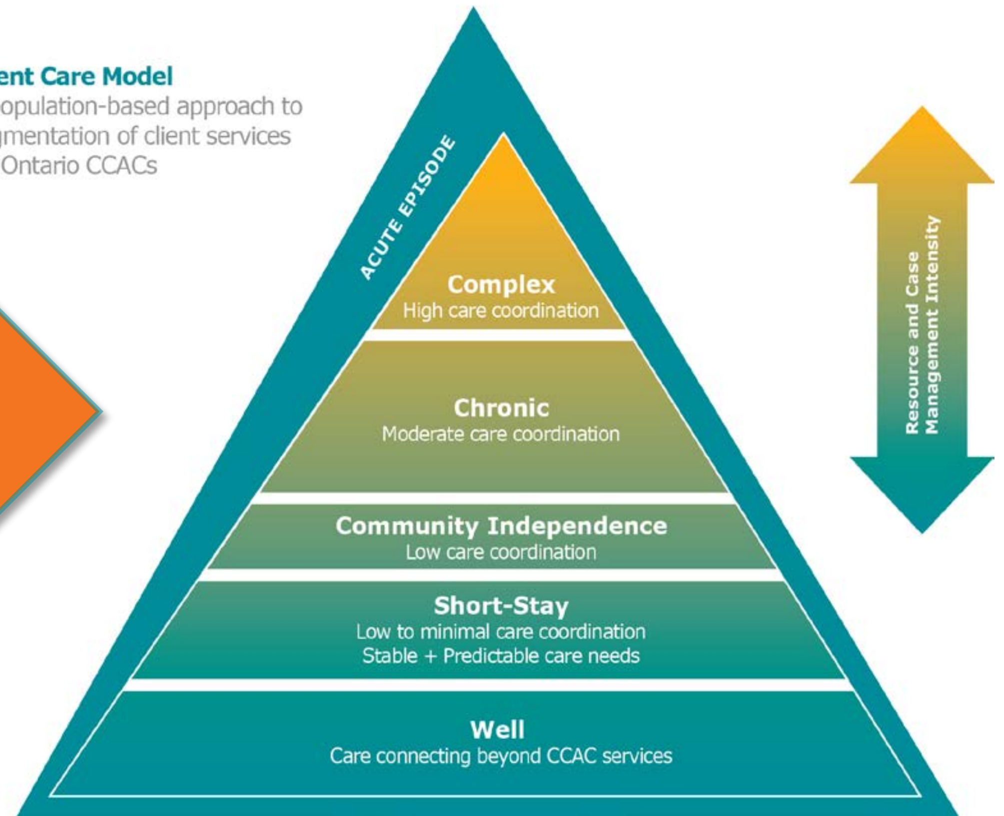
Client Care Model

Board Meeting
April 25, 2012

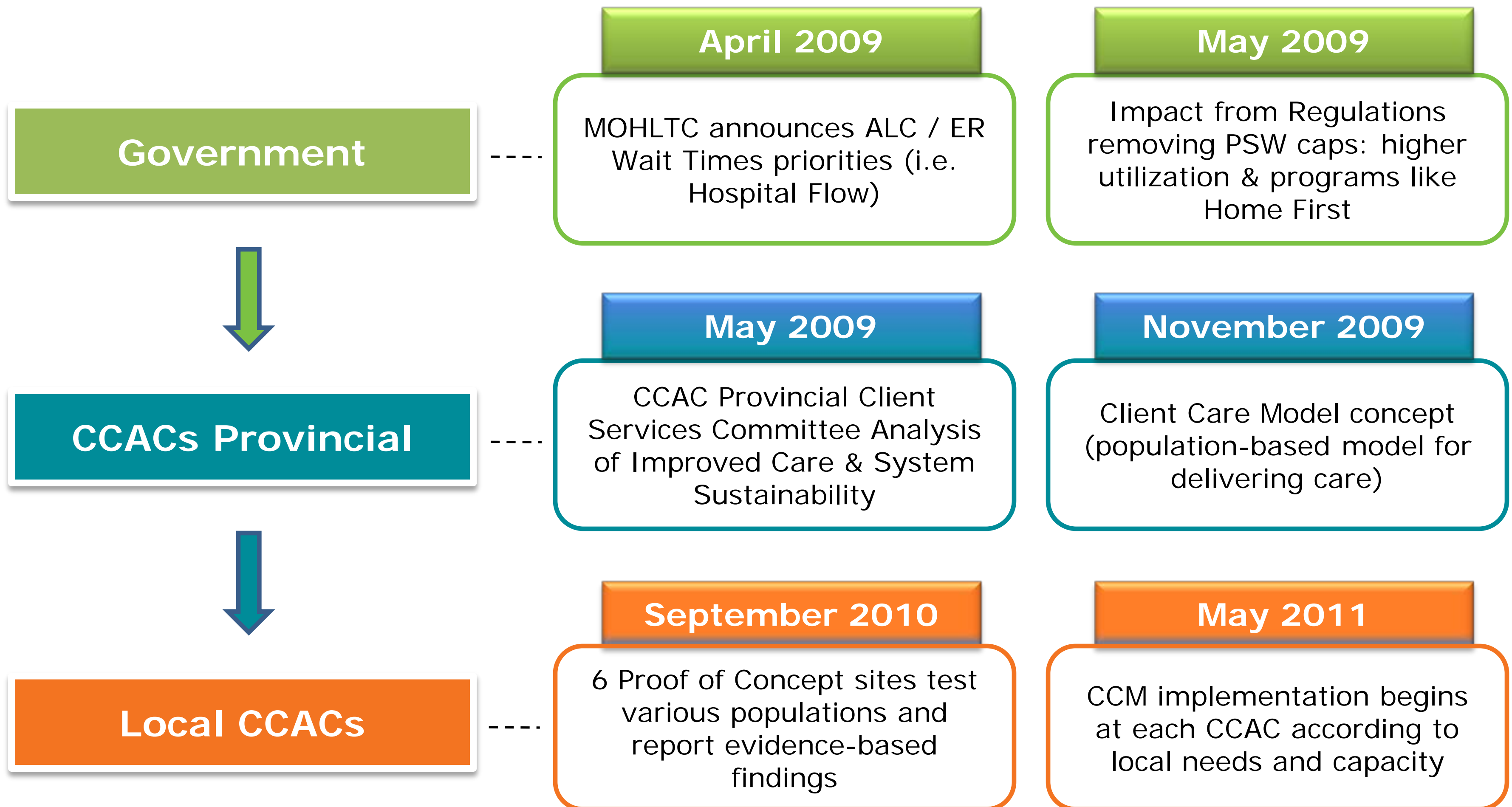
Outstanding care – every person, every day

The Client Care Model

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?



Our Place in the System

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

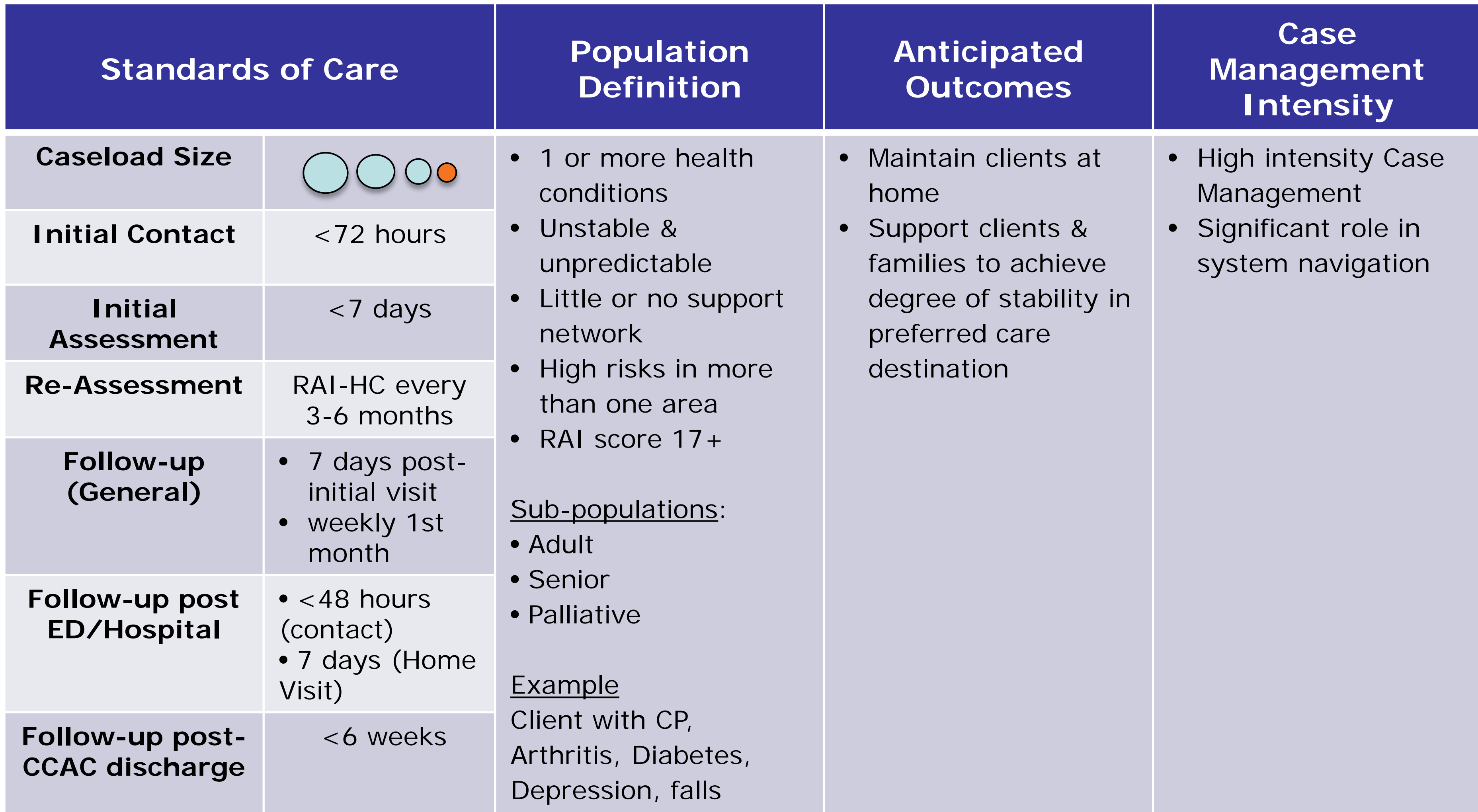
Satisfaction

- 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

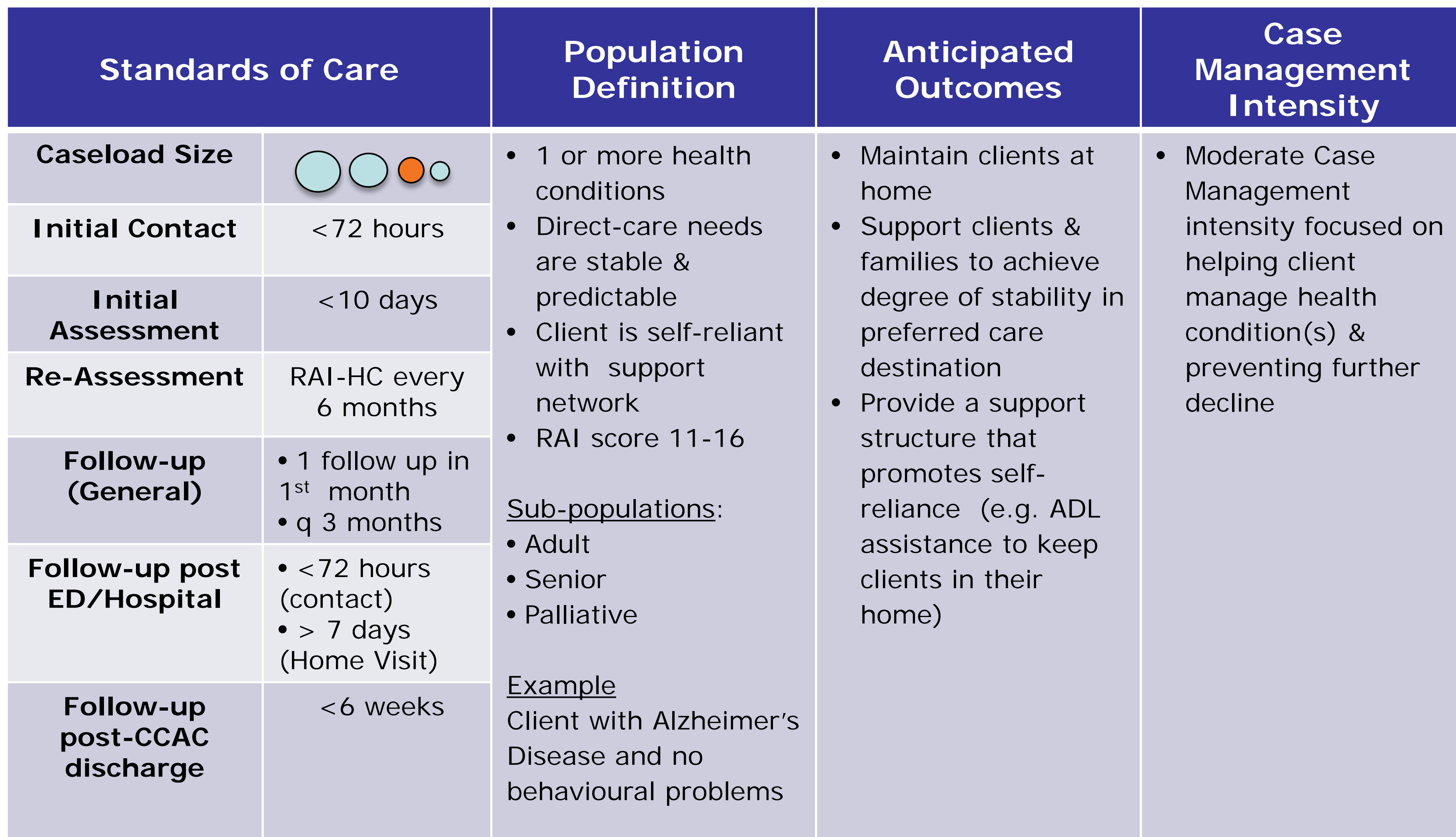
- Costs for contracted services remained neutral
- Slight reduction in costs as per best practices (Short Stay)

Complex



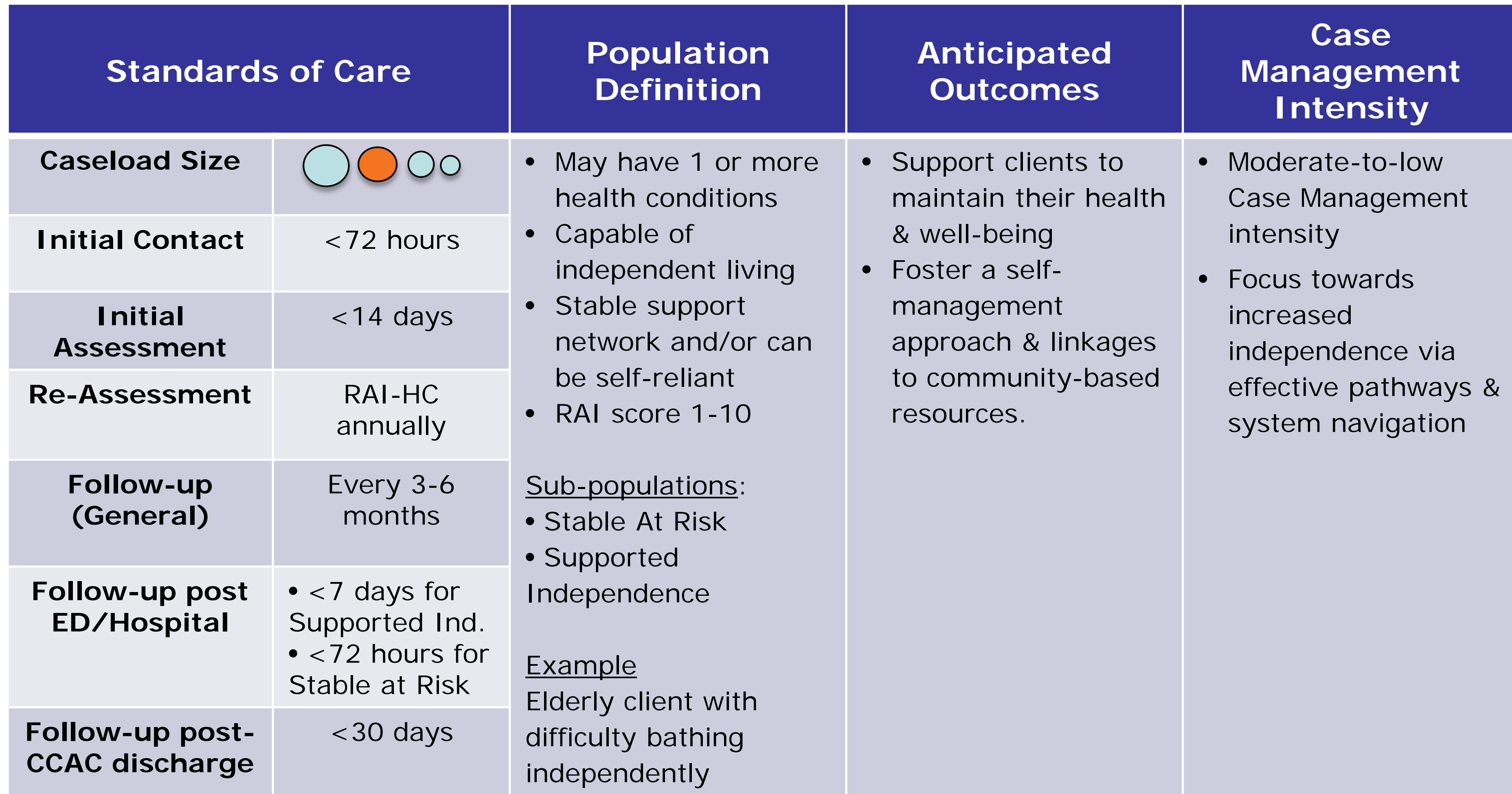
Standards of Care		Population Definition	Anticipated Outcomes	Case Management Intensity
Caseload Size		• 1 or more health conditions • Unstable & unpredictable • Little or no support network • High risks in more than one area • RAI score 17+ Sub-populations: • Adult • Senior • Palliative Example Client with CP, Arthritis, Diabetes, Depression, falls	• Maintain clients at home • Support clients & families to achieve degree of stability in preferred care destination	• High intensity Case Management • Significant role in system navigation
Initial Contact	<72 hours			
Initial Assessment	<7 days			
Re-Assessment	RAI-HC every 3-6 months			
Follow-up (General)	• 7 days post-initial visit • weekly 1st month			
Follow-up post ED/Hospital	• <48 hours (contact) • 7 days (Home Visit)			
Follow-up post-CCAC discharge	<6 weeks			

Chronic



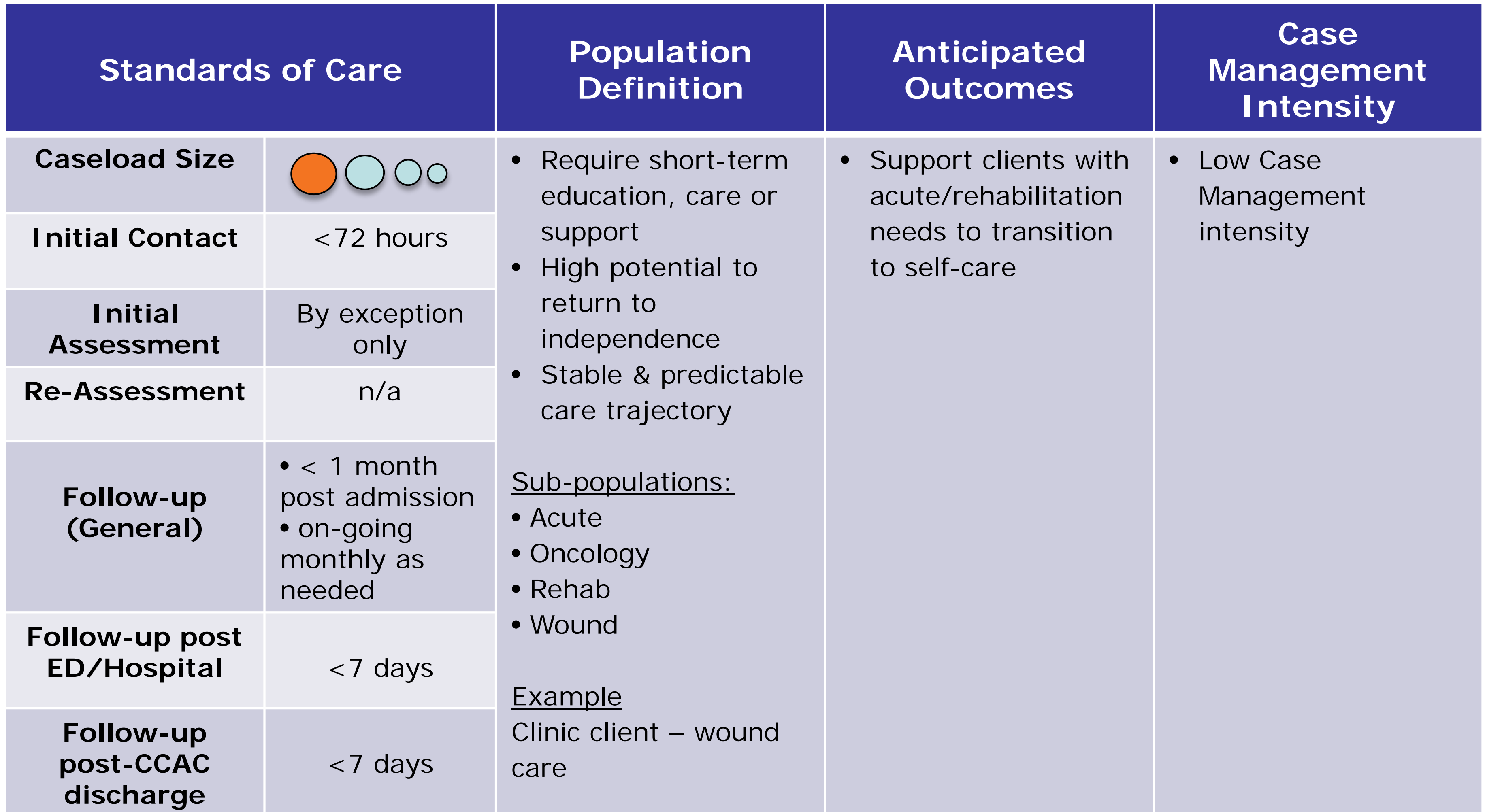
Standards of Care		Population Definition	Anticipated Outcomes	Case Management Intensity
Caseload Size		• 1 or more health conditions • Direct-care needs are stable & predictable • Client is self-reliant with support network • RAI score 11-16 Sub-populations: • Adult • Senior • Palliative Example Client with Alzheimer's Disease and no behavioural problems	• Maintain clients at home • Support clients & families to achieve degree of stability in preferred care destination • Provide a support structure that promotes self-reliance (e.g. ADL assistance to keep clients in their home)	• Moderate Case Management intensity focused on helping client manage health condition(s) & preventing further decline
Initial Contact	<72 hours			
Initial Assessment	<10 days			
Re-Assessment	RAI-HC every 6 months			
Follow-up (General)	• 1 follow up in 1st month • q 3 months			
Follow-up post ED/Hospital	• <72 hours (contact) • > 7 days (Home Visit)			
Follow-up post-CCAC discharge	<6 weeks			

Community Independence



Standards of Care		Population Definition	Anticipated Outcomes	Case Management Intensity
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 Sub-populations: • Stable At Risk • Supported Independence Example Elderly client with difficulty bathing independently	• 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			
Follow-up post ED/Hospital	• <7 days for Supported Ind. • <72 hours for Stable at Risk			
Follow-up post-CCAC discharge	<30 days			

Short Stay



Standards of Care		Population Definition	Anticipated Outcomes	Case Management Intensity
Caseload Size		• Require short-term education, care or support • High potential to return to independence • Stable & predictable care trajectory <u>Sub-populations:</u> • Acute • Oncology • Rehab • Wound <u>Example</u> Clinic client – wound care	• Support clients with acute/rehabilitation needs to transition to self-care	• Low Case Management intensity
Initial Contact	<72 hours			
Initial Assessment	By exception only			
Re-Assessment	n/a			
Follow-up (General)	• < 1 month post admission • on-going monthly as needed			
Follow-up post ED/Hospital	<7 days			
Follow-up post-CCAC discharge	<7 days			

ccac casc
Community Care Access Centre
Centre d'accès aux soins communautaires

WWCCAC Timelines

March 2012
Client Categorization
For
Existing Clients

April 2012
Develop
CCM Team Structure

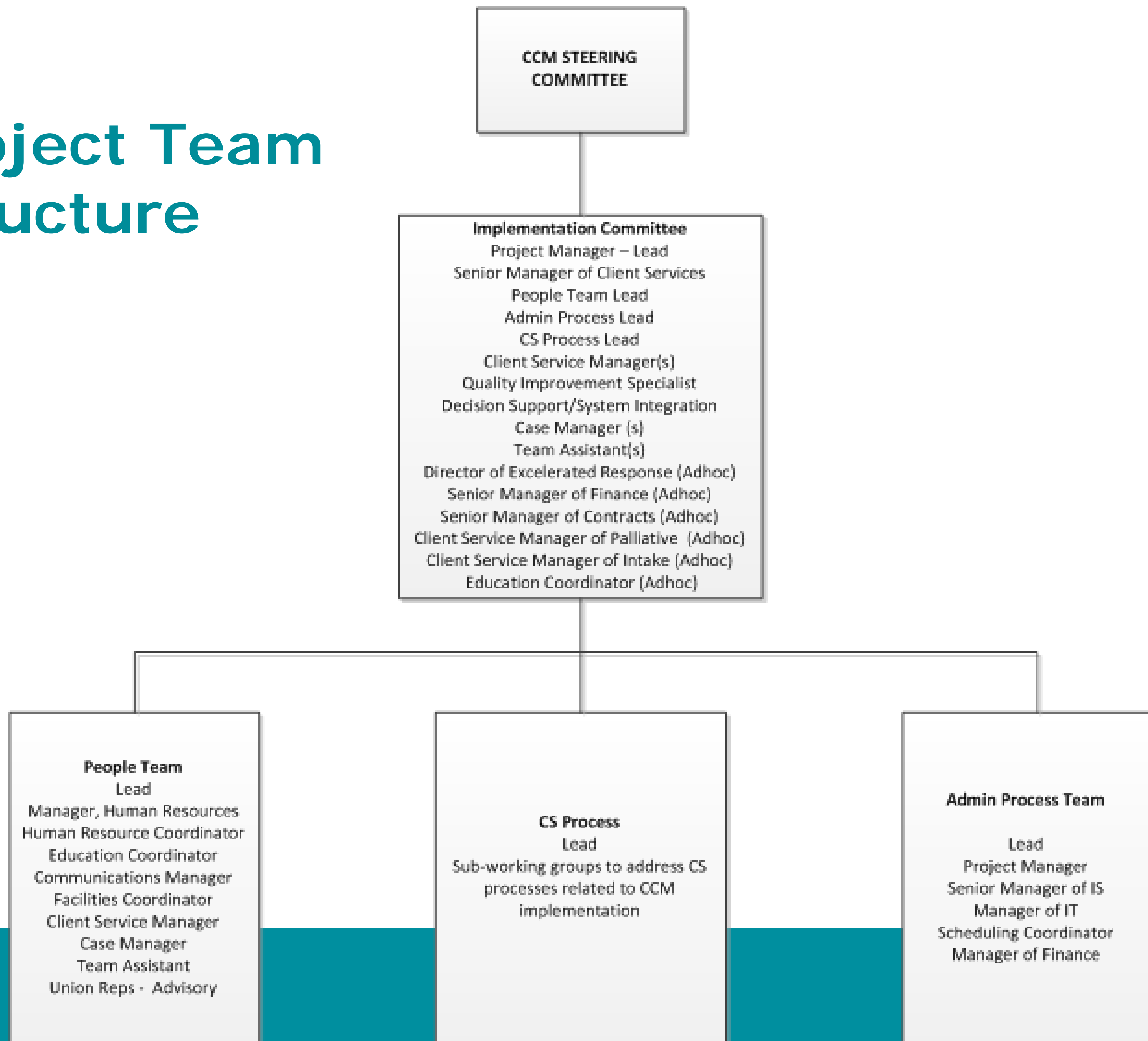
May 2012
Expression of Interest Process

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



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

Connecting you with care
Votre lien aux soins
ccac casc
Community Care Access Centre
Centre d'accès aux soins communautaires

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

CCAC CASC
Community Care Access Centre
Centre d'accès aux soins communautaires

People are different....

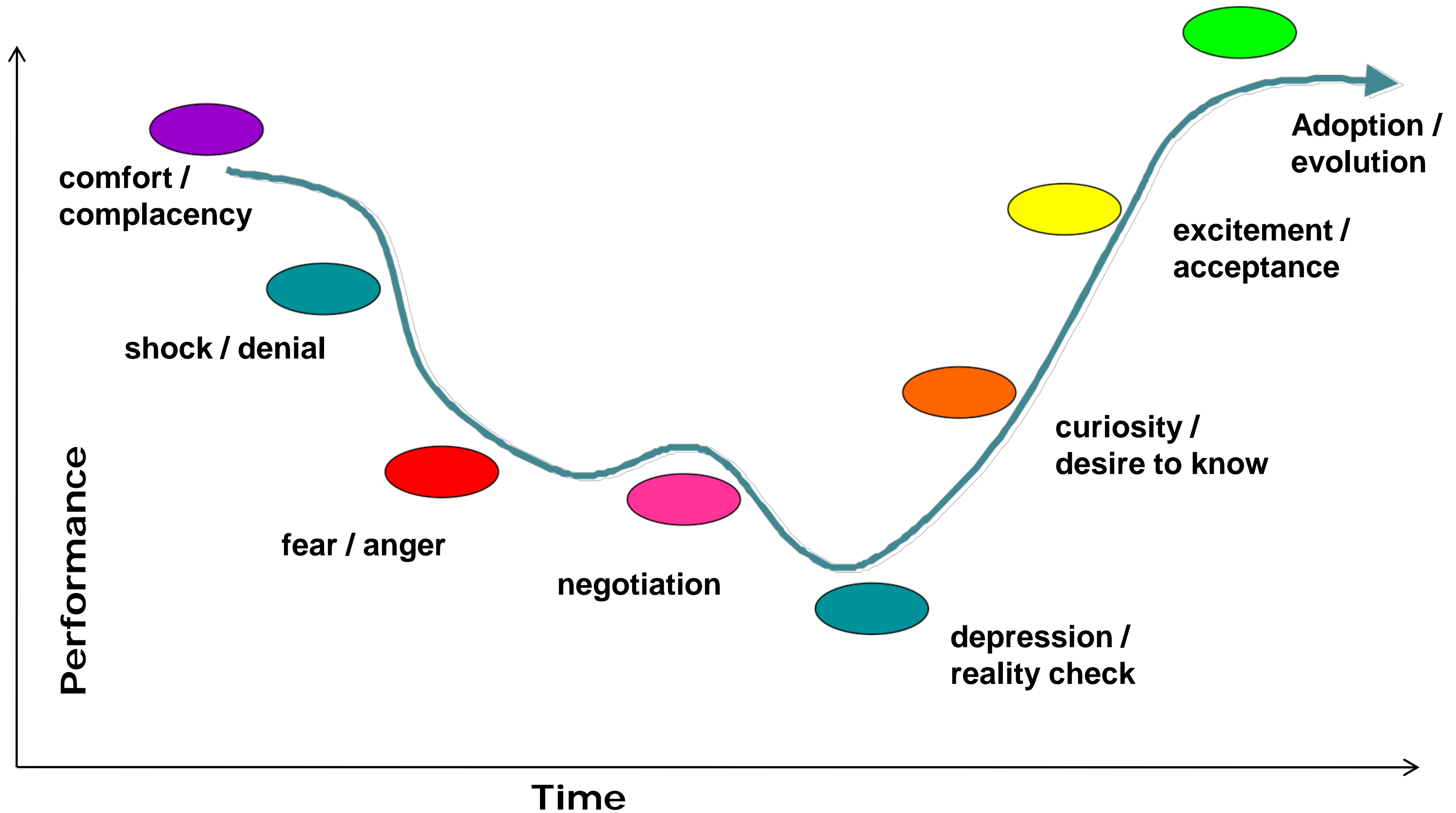
Something old stops

Something new begins

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



The Trapeze

Outstanding care – every person, every day