Innovating for Better Care

South West Community Care Access Centre

2012-2013 Report to the Community

Connecting you with care
Votre lien aux soins

South West
CCAC
Community Care Access Centre

CASC
Centre d'accès aux soins communautaires
du Sud-Ouest

Connecting you with care
Votre lien aux soins

South West CCAC / CASC
Community Care Access Centre
Centre d'accès aux soins communautaires du Sud-Ouest

Our Vision

Outstanding care – every person, every day.

Our Mission

To deliver a seamless experience through the health system for people in our diverse communities, providing equitable access, individualized care coordination and quality health care.

On the Cover: Brian, who suffers from ALS, his wife Barb and Sheba the dog are happy to be together at home in Exeter, thanks to the work of the South West CCAC and its partners.

A Message from Mary Lapaine, Board Chair, and Sandra Coleman, CEO

Mary Lapaine, Board Chair

Sandra Coleman, CEO

It has been an eventful year!

At the provincial level, we saw home and community care heralded as a key part of health system transformation. We saw a new Seniors Strategy with home and community care at its heart. With Health Links, we saw the development of a new approach to caring for the most complex patients in the system by working better as partners.

In the South West, the way we deliver care changed, and our role broadened and deepened. We achieved the highest level of accreditation. We saw the Home First philosophy flourish in communities across the South West, keeping hundreds of people at home and reducing Alternate Level of Care beds (ALCs) to historic low levels. We developed new ways to collaborate with our care providers and system partners. We became a virtually paperless organization. We saw a homegrown information resource, thehealthline.ca, roll out across Ontario.

Through it all, two things did not change: our commitment to the principles of Client-Driven Care, and our belief in the importance of innovation.

We know that the best way to provide outstanding care is to develop a shared understanding and to co-create strategies with our patients and their caregivers. We also know that in a world of finite resources, we must constantly challenge ourselves to look critically at what we are doing and find new and better ways to support our patients.

In this report, you will read about the achievements of the past year, and about the understanding, collaboration, compassion and innovation that made it possible.

Our heartfelt thanks to the patients, caregivers, Board, staff, care providers, system partners and the South West LHIN, all of whom worked alongside us during 2012-2013. It is remarkable what a small group of people can do when they are all focused on outstanding care — every person, every day.

Board Members: Seated (left to right): Ed De Decker, Vice-Chair, Mary Lapaine, Board Chair and Sandra Coleman, CEO. Back row (left to right): Bonnie Monteith, Donald Keillor, Glen Elliott, Linda Ballantyne, Board Secretary, Jean Peacock, Brian Hadley, Evelyn Harris-Williams, Past Board Chair, Andy Werner and Dr. Claude Lanfranconi, Board Treasurer

Welcome to the South West Community Care Access Centre (CCAC)

The Home Care Experts

Community Care Access Centres (CCACs) get people the care they need to stay well, heal at home and stay safely in their homes longer. When home is no longer a choice, we help people make the change to other living arrangements.

CCAC care coordinators are dedicated health professionals. Through home visits and regular check-ins, they help decide the right care and supports with patients. They work closely with family doctors, hospitals, community groups and others to support patients through their journey. They also work hand-in-hand with patients and caregivers to understand the challenges they face and co-create ways to deal with them.

CCAC by the Numbers

The South West CCAC:

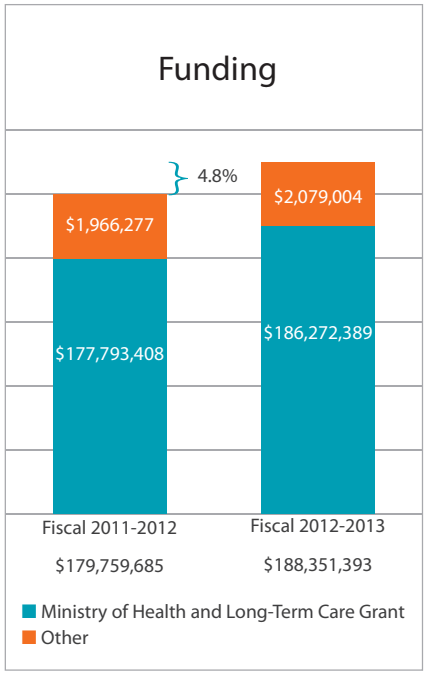
- Cares for more than 60,000 patients – or one in 17 people living in the South West – each year
- Employs more than 700 staff
- Partners with 19 hospital corporations, 12 service provider agencies, 76 long-term care homes, 19 Family Health Teams, six Health Units, five Community Health Centres, 60 Community Support Service Agencies, nine School Boards, more than 700 primary care physicians, several emerging Health Links collaboratives and thehealthline.ca

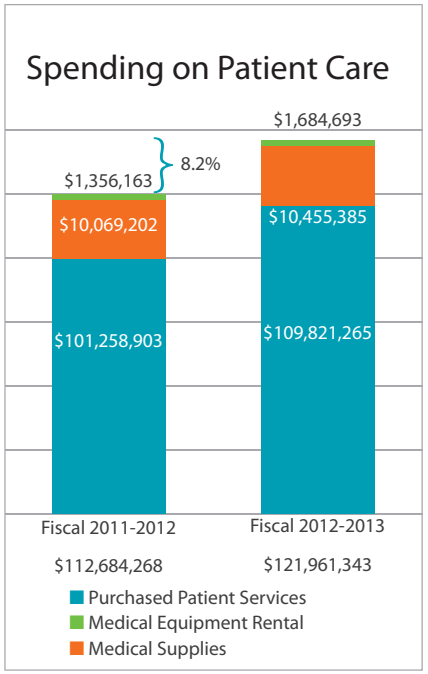
Each month, the CCAC:

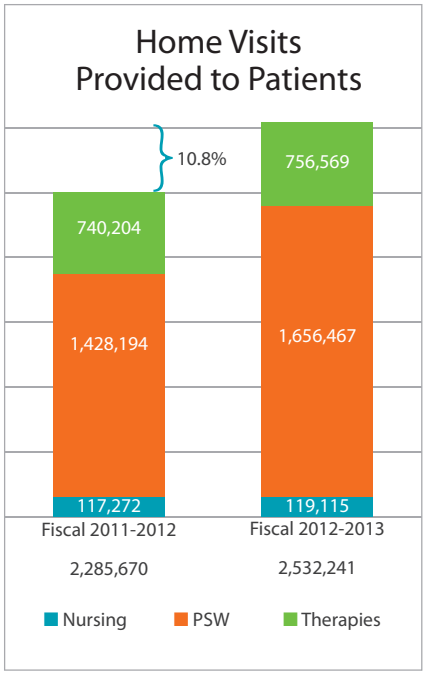
- Helps more than 1,600 patients get from hospital to home
- Helps more than 200 patients find a place in a long-term care home
- Receives more than 3,500 referrals for home care
- Provides services to more than 20,000 patients
- Makes hundreds of referrals to our community support partners

How the South West CCAC is accountable in getting people the care they need to stay well, heal at home and stay safely in their homes longer.

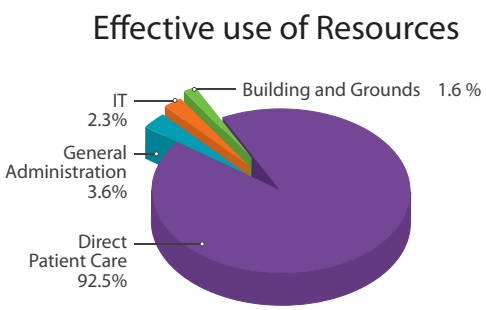
With an additional 4.8% in new funding in 2012-2013, the South West CCAC was able to increase spending on patient care by 8.2% and to increase the number of home visits by 10.8% over the previous fiscal year.

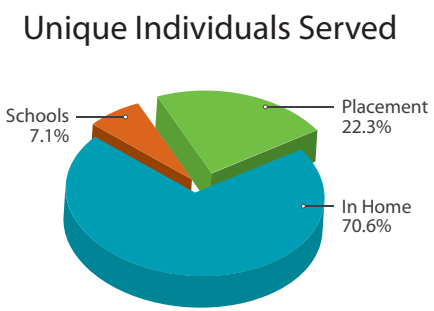


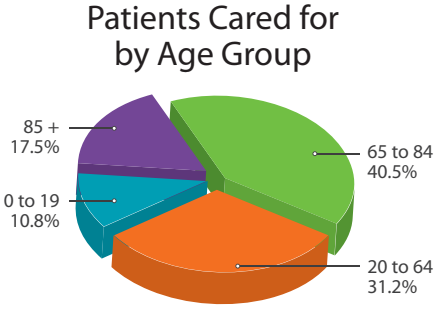




For every dollar the CCAC receives, 92.5 cents is spent on direct patient care. Of the patients the CCAC serves, 70.6% receive care in home, where they most want to be. Of the care the CCAC provides, 58% is to seniors, a vastly growing population.







Our Strategic Directions

It's been said that if you don't know where you're going, you'll never get there. The South West CCAC is committed to four Strategic Directions. Every year, we measure and summarize our progress on each of these Directions in our Performance Measurement Framework. In this Report, we expand on the Framework, highlighting a wide range of achievements in each Direction.

Performance Measurement Framework 2012-2013

Strategic Direction	Goal Statement	Outcome	Target
Strategic Direction 1.0 Provide Safe, Effective, High Quality, Client-Driven Care	1.1 We deliver high quality care: 'help me'.	**80%** of all wound care patients receive the number of nursing visits on the care pathway.	**≥75%**
	1.2 We deliver safe care: 'keep me safe'.	**One** Adverse Event occurs per 1,000 patients.	**≤1**
	1.3 We engage patients and caregivers: 'be nice to me'.	**94%** of patients are satisfied with their CCAC service.	**≥90%**
Strategic Direction 2.0 Work Well with Partners	2.1 We effectively connect patients with appropriate supports.	Patients with very high needs receive their first visits within the service priority timeline: • **97%** met for Nursing • **86%** met for Personal Support • **91%** met for Therapies	 **≥98%** **≥90%** **≥92%**
	2.2 We respond to our partners' needs.	169,274 hospital days were saved by people getting care at home instead through the *Home First* approach.	Baseline
	2.3 Partnerships result in integrated patient solutions, furthering the Integrated Health Services Plan in the South West.	**85%** of the people who moved into a long-term care home had high or very high needs that could only be met in long-term care.	**≥79%**
Strategic Direction 3.0 Be a Great Place to Work	3.1 Employees are satisfied and engaged.	**60%** of staff are satisfied with the CCAC.	**≥60%**
	3.2 We support a healthy and safe work place.	**87%** of staff report that the CCAC promotes a healthy and safe working environment through the provision of standards, training, and wellness offerings.	**≥85%**
Strategic Direction 4.0 Use Resources Wisely	4.1 We ensure value for money, using the principles of economy, efficiency and effectiveness to achieve our goals.	The CCAC completed the fiscal year with a **0.012%** surplus.	**≤2%**
	4.2 We are increasing productivity through innovation and technology.	After consolidating the Access function from six offices to two hubs, staff in the Access Team completed **4.2** patient care assessments per day.	**≥4**

Providing Safe, Effective, High Quality Client-Driven Care

Highlights

- We achieved the highest possible score in our first ever accreditation. (See story on page 9.)

- We supported more complex and chronic patients, helping them stay safely at home. The number of patients with a MAPle score (an evidence-based assessment tool) of high or very high being supported at home by the CCAC rose from less than 4,000 in the first quarter of 2011-2012 to almost 5,000 by the third quarter of 2012-2013.

- People felt well cared for: More than 94% of our patients rated their care as good or excellent.

- People got care in a timely fashion. Of patients coming home from hospital, 93% received their first visit within five days, and 97% of all very high priority nursing patients received their first visit within the target timelines.

- More people were able to get home from hospital instead of waiting there for long-term care. This year, more than 400 patients with complex health issues went home on the new Intensive Hospital to Home bridge plan, of whom approximately two-thirds were able to remain at home on normal CCAC care plans.

- More people were empowered to manage their own conditions. More than 400 patients and caregivers attended seminars offered by the CCAC's Chronic Disease Centre of Excellence. More than 600 new people registered to use the online Self Management Tool Kit.

- We re-organized based on the needs of patient populations to ensure that those who need care most, get it. (See story on page 13.)

- We developed the Intensive Home Care Team, expanding the amount of direct clinical care we are able to provide. The team consists of more than 40 Registered Nurses and Nurse Practitioners who work in partnership with care coordinators and primary care physicians to provide medical and functional assessment and monitoring and medication review for CCAC patients in the community.

- We helped patients navigate the system by putting information about long-term care home waiting lists online on a monthly basis.

HEROES HAILED

"It takes a very special person to care for Krista. Janna is one of those people. She just beams, and Krista beams back when she walks in the room. It's hard to put into words, but there's definitely a bond there."

That's Rick McEllistrum, talking about Janna Massong, the personal support worker who has been caring for his daughter Krista, a 22-year-old woman with severe disabilities, for the past three years. Massong was one of more than 600 extraordinary people nominated across the South West as Heroes in the Home.

The program, now in its tenth year, recognizes professional care providers and friends and family members who support people to live at home. Every nominee is honoured at special events, held this year in London, Stratford and Owen Sound during November. "The Heroes' stories are deeply moving," says CCAC CEO Sandra Coleman. "They inspire us all to work harder and care more."

The Heroes in the Home program has proven so successful it has been adopted by several other CCACs across Ontario. In September it was recognized as a National Leading Practice by Accreditation Canada.

Janna Massong has a special bond with her patient Krista McEllistrum.

ACCREDITATION ACED!

"The South West CCAC has so many strengths – your beautiful Compass, amazing tools and processes to identify and track risk, good emergency planning, practices to ensure client and staff safety in the community, quality improvement tools and data, amazing human resources everywhere, and a unique way of working together. I encourage you to share your story – to explain how you live Client-Driven Care, and how you manage to do it in a way that exudes heart but is balanced with the realities of your environment."

Those are the words of Karen Ingebrigtson, lead Accreditation Canada surveyor, during her de-brief to South West CCAC staff in October after a three-day site visit.

Through the year-long accreditation process, the CCAC evaluated its performance against national standards of excellence. Every member of the organization, from the CEO to the frontlines, was involved in thinking about issues of quality and safety and preparing for the site visit. Cathy Kelly, the Regional Manager, Client Services who led accreditation preparations in her portfolio, says that an overall lens of patient safety and quality drove the preparation work done by her colleagues. "We wanted to implement whatever strategies we could to ensure that our patients have the best quality of care," she says.

During the site visit, surveyors visited staff and patients, met with system partners, leaders and frontline staff in London, St. Thomas, Woodstock and Stratford, and examined reams of documents. Before she left, Ingebrigston told CCAC staff that they had met all but one of the 344 standards required for accreditation. Two weeks later, the CCAC received formal notice that it had earned a four year accreditation award "with exemplary standing."

Working Well with Partners

Highlights

- With strong support from the South West LHIN, we helped hospitals move patients through the system more quickly.
  - The Home First approach helped reduce Alternate Level of Care beds (ALCs) in the South West to 8.9%, one of the lowest of any LHIN in the province, and saved more than 13,000 hospital days. (See charts showing the impact of Home First beginning on page 17.)

- We partnered with primary care physicians and Nurse Practitioners.
  - Care coordinators were on site on a regular basis with 200 family physicians across the South West, a 36% increase from the previous year.
  - Partnering for Quality supported 167 physicians with eHealth and quality coaching, an increase of 53% from the previous year.
  - CCAC Care Connectors continued to connect patients with family physicians. As of March 31, 2013, more than 22,000 orphan patients were matched.

- We worked with partners to improve care coordination for complex patients. The CCAC played a key role in the development of the Perth Huron Health Links readiness assessment and business plan, and is supporting Health Links development in London, Middlesex, Grey-Bruce, Oxford and Elgin. (See story at right.)

- We worked with our partners in complex continuing care, rehabilitation, Adult Day Programs, and Assisted Living and Supportive Housing to improve coordination and ensure equitable access, so that patients have the care they need, when and where they need it.

- We supported 10 formal research projects, which will ultimately improve the quality of care for all patients.

- We worked with our partners to make major quality improvements across the system and earn recognition for them. The CCAC played a role in all three projects recognized through the South West LHIN 2012 Quality Awards: the Shaken Baby Syndrome Prevention Project, eShift, and the Regional Hip Fracture Project. We were also part of the two 2013 Quality Awards, which recognized Home First and work at St. Thomas Elgin General Hospital to streamline processes in the Emergency Department.

- We celebrated the excellence of all our system partners at three Heroes in the Home events. (See story on page 9).

BREATHING EASY

Brian has Amyotrophic Lateral Sclerosis (ALS) and is dependent on a ventilator to breathe. When his lungs collapsed in 2012, his life hung in the balance for months. He spent weeks in the Intensive Care Unit in Stratford, and more time in Critical Care at University Hospital in London. He was expected to move to a long-term care home because of the ventilator, but his wife Barb had other plans. "He wanted to come home, and I promised him that he would," she says firmly. The couple are living in an apartment in Exeter, Ontario.

CCAC care coordinator Laurie Henderson says it takes a multi-disciplinary team of doctors, nurses, therapists, Nurse Practitioners and community support services to keep Brian safe and comfortable at home. Annie Morris, a Nurse Practitioner with the CCAC, monitors Brian's medical condition carefully and connects a medical team that includes Brian's family doctor, the ALS clinic and the respirologist. The goal, she says, is to prevent Brian from having to go to the emergency department by heading off problems before they develop.

Henderson says Barb's determination is the secret to supporting Brian at home. "She's very protective and a great advocate for him. We build the supports around them, so that they feel safe and supported."

LINKING FOR BETTER CARE

Health Links is an innovative new province-wide initiative focused on improving care for the five percent of people who are high users of health care by improving collaboration among health professionals. The CCAC is playing a key role in the development of Health Links in the South West.

The Perth County Health Link was the first to move forward in our region. As part of the plan submitted to the Ministry in February 2013, the CCAC agreed to:

- Have care coordinators on site with primary care practices on a regular basis
- Communicate health updates with primary care physicians at key transition points in Health Links patients' journeys
- Provide intensive care coordination for Health Links patients
- Provide in-home nursing visits within 24 hours of hospital discharge
- Provide ongoing nursing consults in the community, supporting complex patients to avoid unnecessary visits to the Emergency Department and hospital admissions
- Ensure all appropriate community supports are available to support patients
- Support primary care practices with quality improvement and eHealth coaching
- Provide full access to our information management, technology, procurement and corporate services

"It's a comprehensive commitment, and one that clearly illustrates how much we have to offer these complex patients and our partners in care," says Nancy Dool-Kontio, Senior Director of Strategic Planning & Integration. "We look forward to getting started!"

The CCAC is also supporting the development of Health Links in Grey-Bruce, London, Middlesex, Elgin and Oxford.

Being a Great Place to Work

Highlights

- We helped our staff stay healthy and safe.
  - Wellness sessions were offered on Managing Stress and Dealing with Difficult People.
  - We continued to belong to the Safety Group. In a survey, 97% of staff members said they had a good understanding of the health and safety policies.
  - 87% of CCAC staff members reported that the organization promotes a healthy and safe working environment.
  - Several sessions on occupational health and safety were held throughout the year.

- We provided staff with opportunities to learn and exchange ideas.
  - Quality Improvement Leadership Teams (QILTs) in Grey-Bruce, Huron-Perth-Oxford, and London-Middlesex-Elgin played an important role in implementing the population-based model and monitoring performance indicators, enabling staff members at all levels to contribute to ongoing quality improvement.
  - After the annual learning symposium in June with our Adult Day Program and Assisted Living community partners, 97% of attendees said they had a better appreciation of the roles, services and challenges of providing care, and 90% said it was an effective use of their time.
  - In-service sessions were held on:
    - CHRIS
    - Document management
    - Service planning
    - Bed board management
    - RAI CHA
    - Changes to the HPG portal
    - Placement
    - New medical equipment and supplies vendors
    - Attendance management program
    - Client-Driven Care
  - Day-long workshops were held to reinforce the Client-Driven Care Approach and introduce a comprehensive new tool kit. The day included an inspirational video and the "To Be List," a pocket-sized reminder of the CCAC's principles of care.
  - Weekly reflective practice meetings encouraged staff members to focus on best practices and quality improvement.

- We helped our leadership team develop. All members of the leadership team completed the Advancing Health Leadership program through Royal Roads University.

- We built a spirit of teamwork, through events such as the accreditation prep rally and post accreditation celebration and holiday events. Staff turnover remained very low at less than 3%.

FINDING PEACE IN THE FINAL DAYS

CCAC Regional Manager Jennifer Fazakerley has experienced one of the most devastating blows life can deliver – the loss of her beloved husband Rob at the age of 46.

With the help of the CCAC's Grace Bradish, an experienced palliative care Nurse Practitioner, and Helen Butlin-Battler, a spiritual care specialist who works with the London Cancer Clinic, Jennifer and Rob found peace in their 14-month journey from diagnosis. Jennifer used emails, called Rob Updates, to keep in touch with the legion of friends and colleagues who shared the journey with them. "The messages in the emails were simple," she says. "One day at a time, quality not quantity of life, it's all about family and human connection. But people who received the emails often told me that they changed their lives."

Jennifer's book about the experience, *Just Stay… A Couple's Last Journey Together*, was launched on September 25. Jennifer and her co-authors shared some of its contents at an international conference in July 2010 and hope to do more work with palliative care groups in the years ahead. "Because of Rob I was able to approach a terrible situation in a very unique way, and I'd like to see other people do that too," says Jennifer.

Jennifer Fazakerley (above) with her husband Rob.

PLANNING CARE AROUND NEEDS

"It's challenging to adjust to a whole new way of delivering our services, but I believe we will see some real benefits from this approach. The important thing is that we're there for the patients who need us most, focusing on their needs and outcomes."

That's care coordinator Sandra Lawler, talking about the implementation of Population-Based Client-Driven Care (PBCDC). PBCDC is a new model of care based on the needs of specific patient populations, rather than geography. Each care coordinator works with a specific patient population, ranging from Complex and Chronic to Community Independence and Short Stay. Those working with higher needs patients have smaller caseloads, enabling them to spend more time with the people who need care most. The new approach was rolled out between August 2012 and March 2013.

"The benefit of the population approach is that we'll be more specialized," says Complex Care Coordinator Lynda Neil. "Whatever group we're looking after, we'll have an area where we really feel comfortable." Ashley Locke, a Client Services Assistant (CSA) with the Complex team, agrees. "Now that we're working within our population group, it will help the care coordinators and the CSAs help patients the best way we can."

Using Resources Wisely

Highlights

- The CCAC spent 3.6% of its budget on administration.
- We delivered a significant return on investment. The CCAC received an additional 4.8% in new funding, but increased spending on home visits by 8.2% and increased the number of home visits by 10.8%.
- eShift continued to expand, ensuring that more patients can benefit from this innovative way of supporting palliative patients overnight. (See story on page 15.)
- We went virtually "paperless" with the introduction of additional electronic tools, including updates to CHRIS, Docushare, and electronic referral among partners.
- We consolidated access, placement and short stay teams into hubs, to improve service and efficiency. (See story on page 15.)
- We did a Request for Proposal for medical supplies and equipment, resulting in better quality care and estimated savings of $2 million per year.
- We shared our knowledge and technology with CCACs across Ontario. Thehealthline.ca, a website developed in the South West, was deployed province-wide, providing accurate, cost-effective access to health services information.
- We managed our budget well, ending the year with a surplus of 0.012%. As requested by the Ministry, we reduced executive office expenses by 10%.
- We continued to expand our cost-effective Flex-Clinics, growing from 24 to 33 clinics, with a 34% increase in visits. Estimated savings are more than $740,000.
- We continued to make wound care more effective and efficient, through product selection, development of best practice care pathways, education and engagement, saving more than $500,000 this year.
- We improved the efficiency of our "back office" operations, by reducing billing errors by 50%.

COMING TOGETHER

PHO Access Team

"I understand the difficulty of navigating through the health system," says Charlene Lancaster, a care coordinator with the Short Stay Team, "and I like being able to help people get the care they need and still maintain their independence."

Lancaster and her fellow team members provide telephone assessment and care planning for patients with stable, short-term care needs. Her focus had been on London, but now that short stay services have been consolidated, she has learned about the South West region as a whole. "You learn that even though things are the same, they're very different," she says. "We're learning a lot from one another."

During 2012-2013 the CCAC consolidated the telephone-based work in long-term care placement and short stay services to London, and all telephone-based access services – initial inquiries, referrals, and telephone assessments – to Stratford and London. Consolidation has allowed service hours to expand to seven days a week, with some evening hours, within the same resources.

"Great things have come from this change," says Jane Clement-Spurr, Client Services Manager with the Access Team in Stratford. "Everybody brought strengths, and we ended up with the best from each team."

COMPASSION THROUGH TECHNOLOGY

Ella was a retired university professor in her 80s. She had lived in her own house in Owen Sound for more than 30 years. She ended up in hospital after a fall, but was determined to spend her final days at home. Ella was referred to the eShift program, which uses iPhone technology to link specially-trained personal support workers in the home with a nurse. The day before she died Ella said to her care coordinator, "Thank you, the only thing that really mattered to me was to be able to die at home, and you made that possible."

The innovative eShift program, developed by the South West CCAC and its partners, has attracted national attention. It enables one nurse to provide overnight care to several palliative patients at a time, so that more people can choose to die at home. Thanks to additional funding from the South West LHIN, the program is now available across the South West, serving approximately 60 patients.

In August 2012, the eShift program was selected as an Accreditation Canada National Leading Practice, acknowledging it as a "sustainable, creative and innovative service" of national significance.

Home First First with Patients

"It took a village to get Norman home. It's a partnership and it works very well. It just shows what a village can do!"

That's Peggy Patterson, whose husband Norman returned home from hospital as part of the CCAC's new Home First approach. Peggy is legally blind. Norman has Parkinson's disease and spent some time in hospital after a total knee replacement and bad medication reaction.

Home First is an approach to care based on the idea that when a patient enters the hospital, every effort should be made to help him or her return home on discharge. During 2012 as many as 800 people a month were supported at home rather than in hospital, thanks to Home First. The number of people waiting in hospital decreased from 157 in September 2011 to 77 in January 2013, a 50% reduction. The acuity level of people moving into long-term care increased, as did the acuity level of people being supported in the community.

Premier Kathleen Wynne visited the Pattersons at home to mark her government's increased investment in home care. "In order to provide the best care for people who want to be in their homes, we have to change the system," she said. "And that's what we're doing. In addition to the quality of life that is so much enhanced for people like Norman and Peggy, this is also the most economical way for us to deliver health care. It is by far and away the more rational option for the health care system to pay for care at home than to keep people in very expensive acute or long-term care beds."

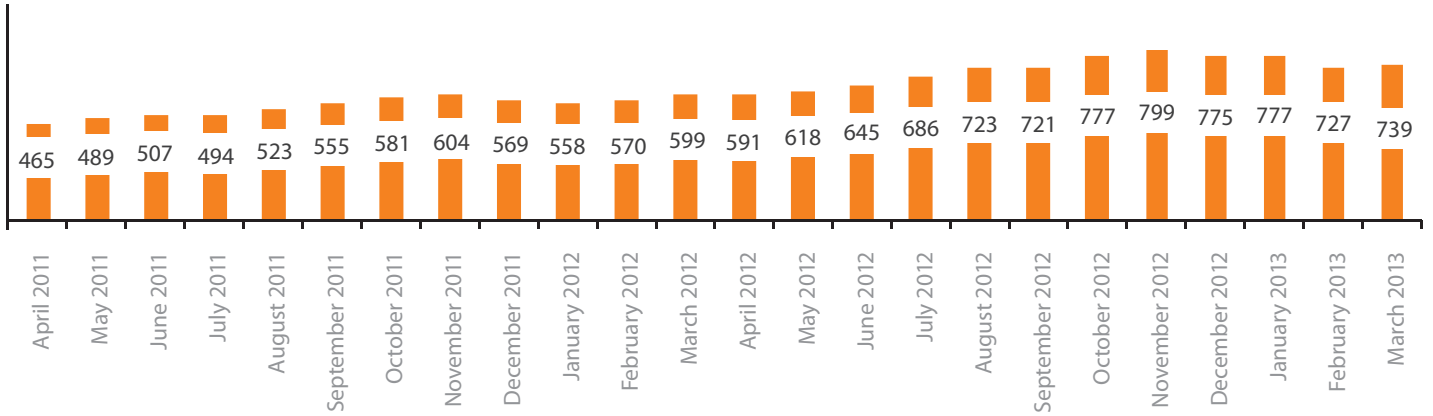
(left to right): CEO Sandra Coleman, Care Coordinator Heather McCallum, Premier Kathleen Wynne, Peggy Patterson (Norman's wife), Personal Support Worker Moe and Minister of Health and Long-Term Care Deb Matthews with Home First patient Norman Patterson (seated) during the Premier's visit on May 24, 2013.

The power of the Home First approach was recognized by the South West with a 2013 Quality Award.

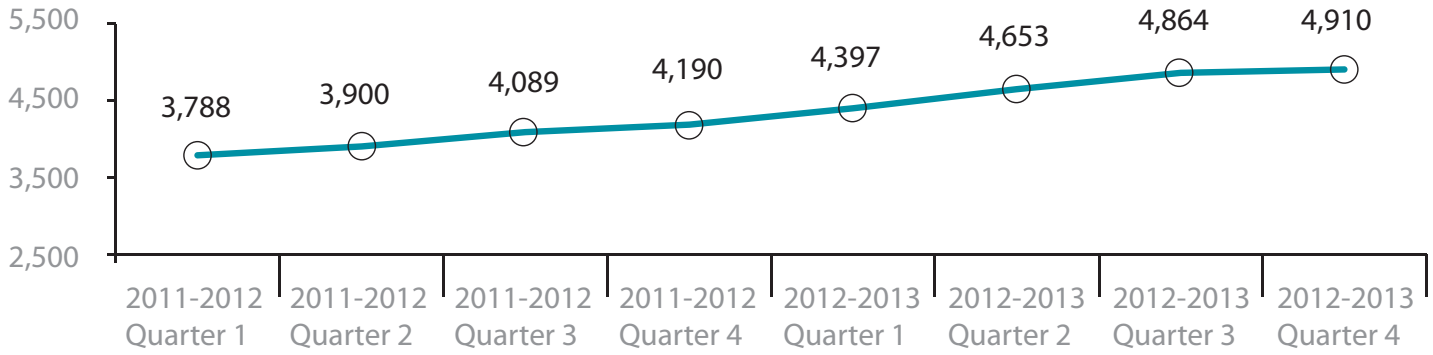
The charts that follow capture the success of the approach.

Home First Charts

We are seeing a rise in the number of individuals being supported with robust service plans in the community.

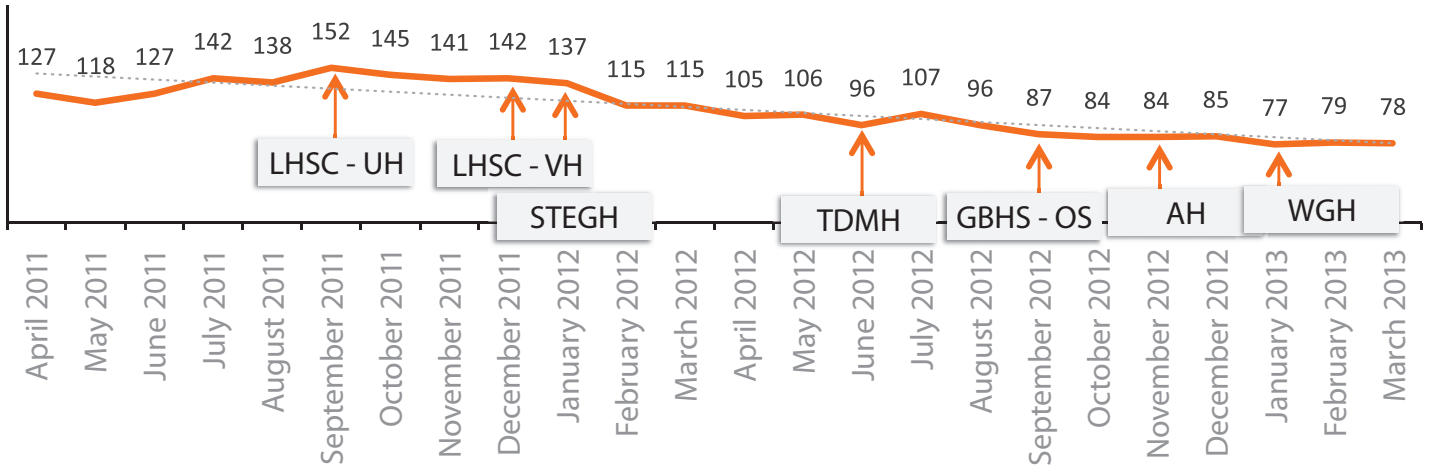


We are seeing a rise in the complexity of care needed by those receiving care through the South West CCAC. This represents the number of patients supported by the CCAC in the community with a MAPLe score of High or Very High.

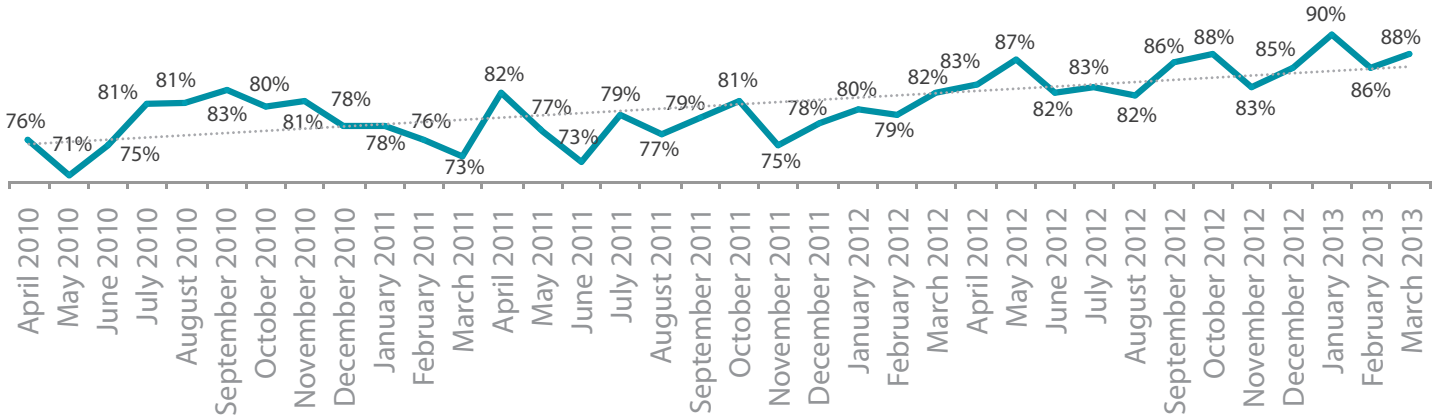


Home First Charts

The number of patients designated ALC-LTC in hospitals that have implemented Home First is decreasing.



We are seeing a rise in complexity of those admitted to LTC with High or Very High MAPLe scores, indicating an increase in complexity and acuity.



Statement of Financial Position Year ended March 31, 2013

Revenue

Ontario Ministry of Health and Long-Term Care grant	186,272,389
Other revenue	2,063,619
Donation revenue	15,385
Total revenue	188,351,393

Expenditures

Patient Care		175,640,729
Purchased patient services	109,821,365	
Salaries and benefits	53,679,286	
Medical supplies	10,455,385	
Medical equipment rental	1,684,693	
Supplies and sundry		8,317,466
Building and ground		2,174,494
Depreciation		1,680,320
Equipment		515,117
Total expenditures		188,328,126

Excess of revenue over expenditures for the year (see supplementary information below)	23,267
Due to Ontario Ministry of Health and Long-Term Care	(23,267)

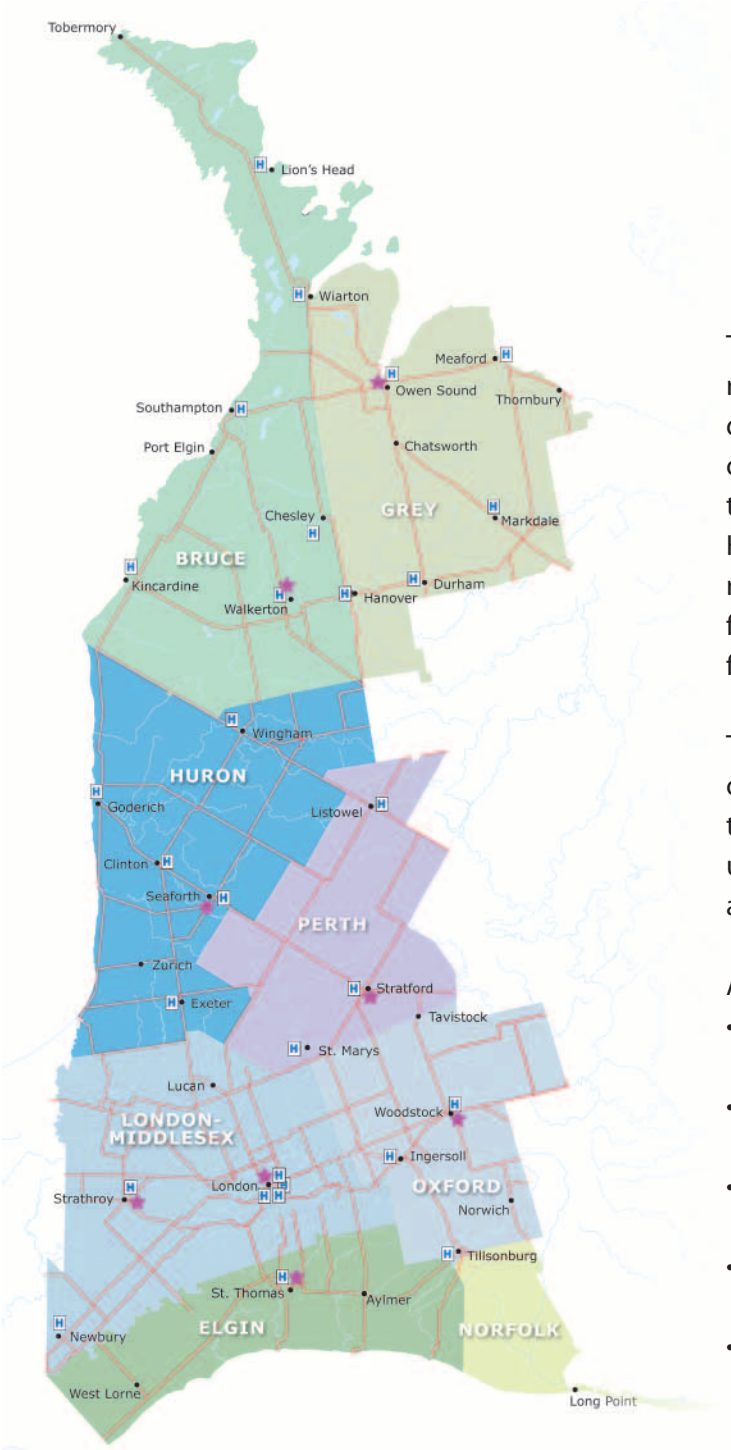
Statement of Operations Year ended March 31, 2013

Current assets

Cash	17,937,209
Restricted cash	–
Accounts receivable	1,947,545
Prepaid expenses	632,864
	20,517,618
Rental, security and benefit deposits	130,548
Capital assets	7,178,970
Total assets	27,827,136

Current liabilities

Accounts payable and accrued liabilities	18,327,138
Non vesting sick pay obligation	531,748
Due to Ontario Ministry of Health and Long-Term Care	2,101,407
Current portion of capital lease obligations	510,160
Current portion of deferred contributions for capital expenditures	1,050,741
	22,521,194
Commitments and contingencies	
Long-term capital lease obligations	183,087
Long-term deferred contributions for capital expenditures	5,654,603
Total	28,358,884
Accumulated non vesting sick pay	531,748
Total liabilities	27,827,136



Looking Ahead

There is an old story that a king once had a huge rock rolled into the middle of a main road in his domain. Most people simply walked around it, often complaining about the inconvenience. Eventually, a peasant approached and saw the rock. He pushed and shoved until he was able to roll the rock to the side of the road. Where it had been he found a purse full of gold coins – the king's reward for the person who faced the challenge head on.

This is a time of great challenge and great opportunity for home and community care. We at the South West CCAC are ready to embrace both, united by our commitment to quality, compassion and innovation.

Among the challenges in our environment:

- Our population is aging, so the demand for health and home care services is increasing.
- Like all organizations in health care, we are challenged by shortages in health human resources.
- There is uncertainty in the political and policy environment.
- With their limited resources, hospitals will be counting on us to do more.
- In general, the patients we support in the community are sicker and have more care needs than in the past.

The opportunities are many. They include:

- The potential for more funding.
- Deeper and broader integration with primary care.
- New electronic tools to make care more efficient and effective.
- Expansion of the Home First philosophy.
- More collaboration with community support services.
- Closer partnerships with care providers.
- Support from the South West Local Health Integration Network (LHIN) and the Ministry of Health and Long-Term Care.

We go forward with confidence, knowing that the people of the South West CCAC share a passion for the principles of Client-Driven Care and a commitment to making care better. Working with our patients and caregivers, we will find innovative ways to help people stay well, get better, live safely in the community and die with dignity. We will push aside the challenges and find the treasure – outstanding care, every person, every day.

The Year in Review

Highlights of a *very* successful year

The Diamond Jubilee Medal

Connecting you with care
Votre lien aux soins

South West
CCAC Community Care Access Centre
CASC Centre d'accès aux soins communautaires
du Sud-Ouest

HOW TO CONTACT US

Call 1-800-811-5146.

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