BRINGING CARE Home

North Simcoe Muskoka CCAC

2014-2015 ANNUAL REPORT

North Simcoe Muskoka
CCAC Community Care Access Centre
CASC Centre d'accès aux soins communautaires du Simcoe Nord Muskoka

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.

Board of Directors

The North Simcoe Muskoka Community Care Access Centre (NSM CCAC) is governed by a volunteer Board of Directors. Their time and passion is dedicated to delivering the highest quality care for the best value, and growing in home and community care to its full potential.

Back Left: Blair Johnston (Vice Chair), Jean Trimnell, Robert Pozzobon (Treasurer), Kim Westfall-Connor.

Front Left: Dr. Al Scarth, Andrea Butcher-Milne, Michael Provan, Colleen Geiger (Chair).

Greetings from the Board Chair and CEO

Colleen Geiger,
Board Chair

Megan Allen-Lamb,
Chief Executive Officer

The North Simcoe Muskoka Community Care Access Centre (NSM CCAC) is pleased to present our Annual Report demonstrating our commitment to delivering outstanding care with the resources entrusted to our organization. In 2014/15, we connected more patients to the health services they needed than ever before to stay well at home or transition to a new care setting. We experienced significant demand for our services and continuously sought new opportunities to expand, improve our services, and develop new partnerships to meet the needs of an aging population.

We are proud of the many significant outcomes achieved over the past year, including improved wait times for personal support and nursing services. Ninety-five percent of all patients requiring nursing care received their first visit within 5 days or less; over eighty percent of complex patients requiring personal support received their first visit within 5 days or less. Reducing wait times for patients has led to increased patient satisfaction and improvements in the delivery of care.

Through direct engagement with patients and caregivers, we redesigned our service delivery model to be better integrated with primary care. Over ninety-five percent of primary care physicians in North Simcoe Muskoka are now connected with a single CCAC Care Coordinator. Ensuring patients receive care from an integrated care team connected with primary care improves clinical outcomes and the overall patient experience.

With our community and hospital partners we implemented new innovative programs and services such as, telehomecare, residential hospice care, and community paramedicine. As a result, we were we able to serve 10% more patients with complex care needs in community, bringing care into the homes of nearly 25,000 patients. Further to this, our Care Coordinators helped close to 10,000 patients in making safe transitions from hospital to home with collaborative care plans.

As we reflect on this past year, and also look forward, we are encouraged that community care continues to be a top priority for the Ontario Government as they look to better integrate all parts of the system and deliver quality care, closer to home. We are grateful to the North Simcoe Muskoka Local Health Integration Network for the investments made in our CCAC to improve, innovate, and expand the care we provide to the thousands of patients and caregivers we serve each day. As an accountable steward of resources, we ensured the most efficient and effective use of all funding in the best interests of patients, caregivers, and the public.

In closing, we invite you to read through our Annual Report that highlights our commitment to patient centered care told through the stories of our patients and caregivers, accompanied by key facts and figures that demonstrate our unwavering commitment to quality and accountability at all levels.

CARE EXPERIENCES SHARED

It is our pleasure to highlight some of the many voices and experiences of patients and volunteer caregivers across North Simcoe Muskoka, that are shaping how we bring care into homes and communities for more people every year.

We are deeply committed to being patient and family-centered, as we aspire to provide an outstanding care experience with every patient, every day.

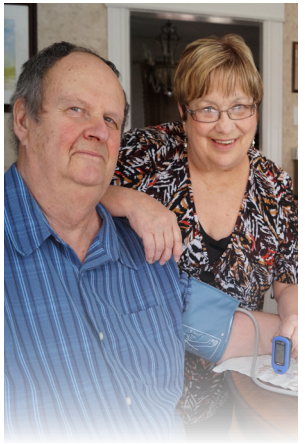
Let us introduce you to...

“I don’t say it enough but it’s in my heart- he’s got me spoiled I think. We have a good life together, 63 years you know, there’s not too many of that today.”

“If you don’t plan, what happens if you fall sick?”

“I recommend people be smart about their retirement and senior years. My mom is the world to me. She’s the only one I have. I want her to live a long, healthy senior life.”

“I know it’s cliché but things really do get better. For it to really click with me, I had to figure it out for myself. I had to get better myself to be able to see it.”



“I would speak to Joanne about Harold’s condition. I just think it’s wonderful, because you can call every day if you want, and they’re so good.”

Our sincere thank-you to Mr. and Mrs. Smith, Stella, Alison, Barbara, Lauren, Harold and Judy, for sharing their care experiences with us.

NSM CCAC at a Glance

In 2014-15, the North Simcoe Muskoka CCAC brought more care into homes across our communities than ever before. Nearly 25,000 people got the care they needed by the CCAC care team, and of these people, 14,500 were seniors 65 years of age and older. CCAC care experienced in the home touched 2,400 people on an average day. These were people of all ages, across the region, who received care coordination, nursing, personal support, physiotherapy, occupational therapy, respiratory therapy, speech and language therapy, and social work from our dedicated team of health professionals.

Everyday, we help people understand care options, get the information they need to make informed choices and coordinate care delivery for one's needs or the needs of a loved one. Every person's situation is unique, and plans of care are co-created with each individual, and members of their care team to reflect their care needs, values and safety. Decisions are made with them and care goals support getting the care needed to stay well, heal at home, and stay safe in their home longer.

As the single point of access to supportive care settings, like convalescent care, assisted living and long-term care, the CCAC also helps transition loved ones to new care settings when they are needed. When asked about their CCAC care experience, 96% of patients and caregivers shared that they would recommend the North Simcoe Muskoka CCAC to family and friends.

Care *for the* Caregiver

The North Simcoe Muskoka CCAC values the role of voluntary caregivers. Through charitable donations received, we have been able to support caregivers through the ***Care for the Caregiver*** program since 2008. This program recognizes caregivers who provide personal care and support to a family member, neighbour or friend getting care from the CCAC.

Of the 24 years Mr. and Mrs. Gyory (shown left) have been married, Shemiza has been caregiving for her husband Paul since he was diagnosed with Parkinson's 8 years ago.

As Paul's caregiver, Shemiza shares, "So far everything is okay. You have to make sure he's comfortable. Sometimes I help to feed him, dress him. For him, to put on his shirt is very difficult. Sometimes people cannot understand, but I understand. I try to tell them what it is he says."

In 2014-15, Shemiza was one of the caregivers who received support through the Care for the Caregiver program to use towards caregiving relief.

Advice *from* Caregivers *Shared*

"Feel good about what you do."

"Stay positive. Stay strong."

"Love the person you are caring for as they truly do not wish to be a burden on you."

Care in the Home for the Smiths

KEY facts

1] **1,120,000 hours of personal support** service were provided in 2014-15.

2] **85%** of personal support hours supported seniors to remain at home.

When Mr. Smith of 86 years is asked to share his experience caregiving for his wife, he reflected on her battle with cancer. "I have been doing it ever since she came out of hospital," he says. "It has been going on over 4 years. As far as we know the cancer is cured but she has a stoma and hernias that make it hard for her to get up and down."

Mrs. Smith also has arthritis and is managing her diabetes. Both are thankful for their Care Coordinator who connected them with a personal support worker (PSW) to provide care for Mrs. Smith at home. "The PSW is really good. She does her shower and I am no good to help with the stoma," says Mr. Smith, who wants the best care and support for his wife. She shares, "I appreciate what he's doing and then the PSW comes in. When I get sick he's right there. I don't say it enough but it's in my heart – he's got me spoiled I think. We have a good life together, 63 years you know, there's not too many of that today."

Mr. Smith shares, "There's nothing I can't handle after 63 years. To me, in my heart, I like to do things for my wife in our own home. The way it is right now, the PSW is in 3 times a week and the rest I manage fine. We get around good that way." When asked what advice he had for other caregivers he simply stated, "Do your best for your spouse."

Stella Starts the Conversation

For Stella and Albert Quesnelle, having an advance care plan supported their readiness to make decisions when health and support needs changed. They had a close relationship to a Care Coordinator over 6 years that Albert received more care at home as his needs increased for nursing, medication management, equipment, physiotherapy and personal support.

"Al needed 24-hour care, so what do you do when the kids have to be called in for 24 hours?" remarks Stella. "I wasn't feeling good so we decided between Al and I that we would sell our home." Stella and Al moved from their family farm of 60 years to an apartment. Sharing their advanced care plan with their children and Albert's Care Coordinator supported taking next steps in their care journey that were both timely and important to them. Part of planning their move considered access to care facilities within their community. A community of Stella's Métis heritage.

Soon after moving, Al's care needs required the support of a long-term care home, and in benefit to their planning, Al experienced access to care he needed, when he needed it.

Stella believes in the importance of advanced care planning and asking friends about their care wishes. For Stella, the conversation starts with, "If you don't plan, what happens if you fall sick?"

KEY facts

1] **4,450 individuals** were assisted in making a transition to a new care setting (e.g., convalescent care, assisted living, long-term care).

2] **80% of patients** who transitioned to long-term care had complex or very complex needs.

Barbara's Safe Transition Home

KEY facts

1] Over **3,600 patients** with complex needs received care in their home; **10% more patients** than the previous year.

2] **88% of patients** referred for personal support from hospital received care within **5 days or less**.

After a fall that kept Barbara in hospital, returning home wasn't thought to be possible at first if she didn't have 24 hour supervision. Her daughter Alison recalls, "There were safety concerns, but our family knows mom is fairly independent and would get better with supports to live at home." Kathryn, Barbara's Care Coordinator, understood the complexities of her care needs and created a care plan with Barbara, her daughters, Alison, Lee-Anne and Lynda, and all members of the care team. The care plan supported her safe transition home with a visit from a CCAC Rapid Reponse Nurse, and wrap around care coordinated to bring care into Barbara's home and connect her with community support programs.

Today, Barbara is managing well at home with personal support, is closely connected to her Care Coordinator, accesses community resources and has a lifeline in case of a fall. "Mom is still a little weak," says Alison. "She builds her strength up by going to a seniors exercise program Wednesdays, and Thursdays she goes to the VON adult day program. Mom wasn't on the right medications. Now she's stabilized, doing great and connected to a mental health specialist. Sometimes the medications make her groggy, but she's responsible in taking her medications. The blister packs help."

When asked about the value of care coordinated for her mom, Alison shares, "I really appreciate Kathryn's help in getting mom back on her feet and allowing her to be independent in her own home. Supports can teach mom how to be independent. How to be safe. It was such a relief to our family when mom got home from hospital and had CCAC care in the morning to get her dressed and ready for the day, along with dinner and nightly supports with medication checks. I think she will do well over time. Mom will need supports throughout her senior years. I hope when I am mom's age, similar supports will be there for my sisters and I, as we grow older together."

Harold Monitors His Health at Home

Sitting with his wife of 45 years on a park bench with a view of Lake Simcoe, Harold started to have difficulty breathing. Oxygen from the tank he brought didn't help, so Judy called 911. "We could hear the ambulance coming," recalls Harold. "I got on the stretcher and I don't remember anything after that. I was in the ICU for a couple of days on life support."

Harold has experienced triple bypass surgery and at 72 years of age, is living with diabetes, congestive heart failure and has difficulty breathing. Harold shares, "My diaphragm is paralyzed. Only one of my lungs is working so I am short of breath all the time. I sit down for 2 minutes and then I am okay."

Referred to the CCAC telehomecare program by his doctor after coming home from hospital, Harold was connected to Joanne, a CCAC nurse. Over 6 months, Harold had weekly health coaching calls with Joanne and monitored his vital signs and symptoms daily. "It was the first thing I did every morning when I got up," says Harold. "I'd check my weight, blood pressure and my oxygen level every day, just to see how everything was going." Harold would then use a tablet to input his health information, which was then transmitted to Joanne. "Joanne would call once a week, and if there was a problem she'd call right away. She encouraged me to ask questions," states Harold.

Working with Joanne, Harold met all of his care goals and reflected on the experience. "The main thing is that you're doing it every day and you are aware of how things are going," he explains. "I still take readings once a week. Definitely a positive experience."

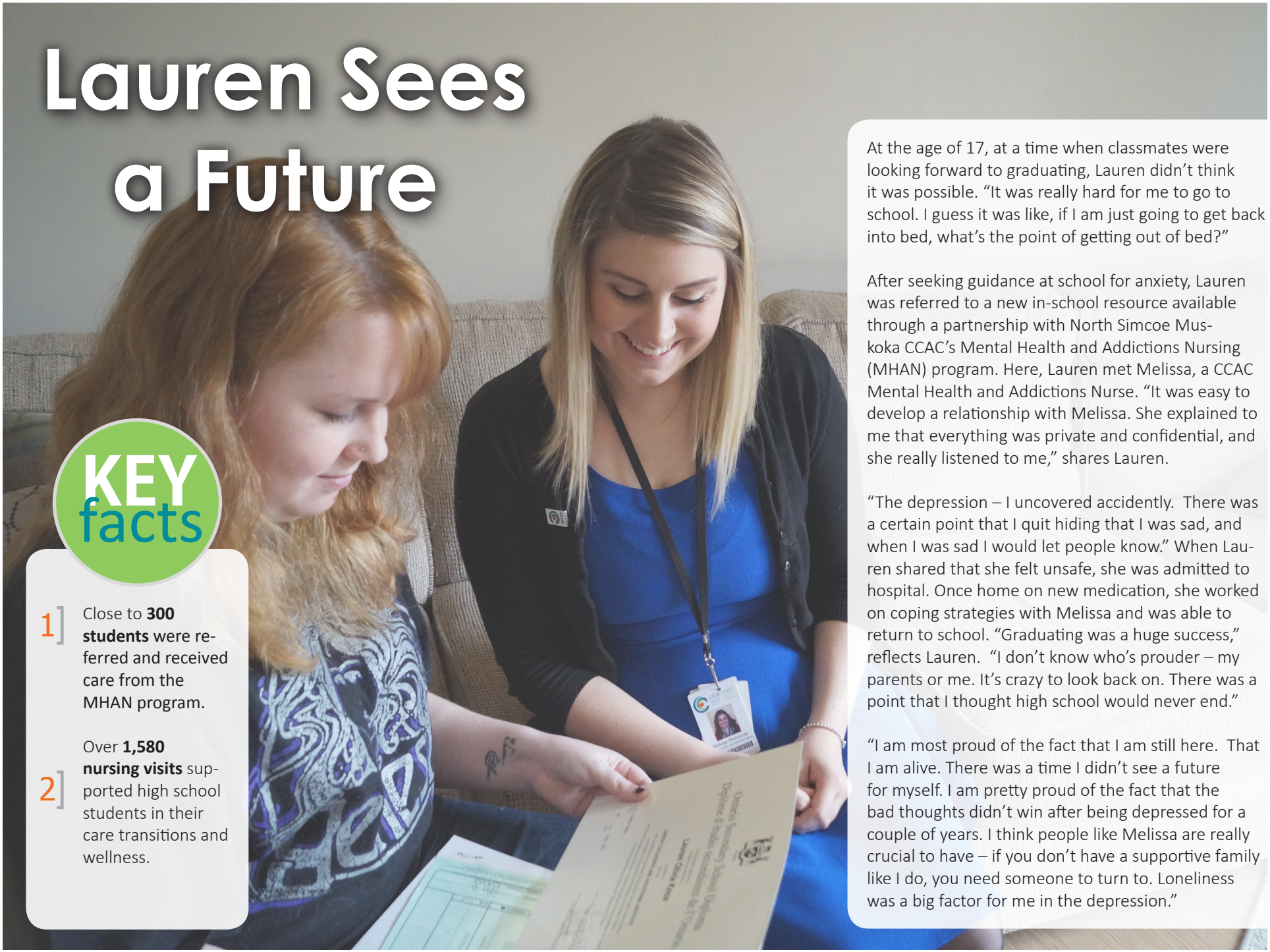
KEY facts

In 2014-15, people living with congestive heart failure (CHF) and chronic obstructive pulmonary disease (COPD) were enrolled in the CCAC's new Telehomecare Program.

1] Since June, **over 2,670 health coaching and alert management calls** with patients and their families were completed.

2] Of the patients enrolled, **36%** live with CHF and **64%** live with COPD.

Lauren Sees a Future



KEY facts

1] Close to **300 students** were referred and received care from the MHAN program.

2] Over **1,580 nursing visits** supported high school students in their care transitions and wellness.

At the age of 17, at a time when classmates were looking forward to graduating, Lauren didn't think it was possible. "It was really hard for me to go to school. I guess it was like, if I am just going to get back into bed, what's the point of getting out of bed?"

After seeking guidance at school for anxiety, Lauren was referred to a new in-school resource available through a partnership with North Simcoe Muskoka CCAC's Mental Health and Addictions Nursing (MHAN) program. Here, Lauren met Melissa, a CCAC Mental Health and Addictions Nurse. "It was easy to develop a relationship with Melissa. She explained to me that everything was private and confidential, and she really listened to me," shares Lauren.

"The depression – I uncovered accidently. There was a certain point that I quit hiding that I was sad, and when I was sad I would let people know." When Lauren shared that she felt unsafe, she was admitted to hospital. Once home on new medication, she worked on coping strategies with Melissa and was able to return to school. "Graduating was a huge success," reflects Lauren. "I don't know who's prouder – my parents or me. It's crazy to look back on. There was a point that I thought high school would never end."

"I am most proud of the fact that I am still here. That I am alive. There was a time I didn't see a future for myself. I am pretty proud of the fact that the bad thoughts didn't win after being depressed for a couple of years. I think people like Melissa are really crucial to have – if you don't have a supportive family like I do, you need someone to turn to. Loneliness was a big factor for me in the depression."

2014-2015 by the Numbers

92%
Patients and Caregivers reported being very satisfied or satisfied with their care

33%
Increase in patients transitioning from hospital to home

63%
Decrease in patients waiting for long-term care from hospital

1,770
Patients received quality palliative care

273,420
In-home nursing care visits/hours provided to patients

32,500
In-home therapy visits provided to patients

1,400
Individuals supported in their transition to a long-term care home

1,800
Children and youth received care in their school

227 SCHOOL PARTNERS

36,730
Amount of nursing care visits/hours provided in schools

10,500
Therapy visits to assist children in optimizing their abilities at school

33,900
Patients connected to a primary care provider to date

67%
Patients connected within 10km of their home

29,300
Calls handled by CCAC Information & Referral Specialists, connecting people to community services

9,890
Referrals from hospitals to support patients going home

Our Strategic Directions

Challenges Known, Opportunities Ahead

We know there will be increased demand for care in homes and in communities in the future years as residents in this region age, and are managing multiple chronic conditions. North Simcoe Muskoka CCAC has shown our ability to provide safe, quality care for the most complex patients in their homes, where they want to be.

As we journey forward, our CCAC will continue to rise to the challenge of bringing care to more patients in their homes. We will do this by ensuring the best coordinated access to services through partnerships, and by holding to the highest standards of accountability.

Better patient care and better value for money will continue to drive our resolve in making significant system changes for those we care for. Through ongoing diligence in how precious health care resources are allocated, and managing lean administrative costs, we will hold the focus on the provision of care to more seniors, adults and children across North Simcoe Muskoka.

Through the strength and commitment of the Board of Directors and the CCAC care team, we will strive, every day, to meet the needs of residents. With an unwavering focus on our Strategic Directions, the CCAC will grow in-home and community care with patients, our team and partners, to its full capacity as the cornerstone of our health system.

Focusing Forward -
Our Commitments to Strengthening In-Home and Community Care

1] We will engage patients and their caregivers as part of our organization's quest to provide the best quality of care possible.

2] We will innovate new ways of delivering home and community care to enhance the patient and caregiver experience.

3] We will advance the quality of care through performance-based accountability with the adoption and implementation of leading practices.

4] We will further our capacity by leveraging the value of care coordination to ensure patients get the care they need to stay well, heal at home, and stay safe in their homes longer.

5] We will strengthen our partnerships with other providers to help ensure all parts of the health system are working together to foster collaborative care plans.

Financial Statement

Statement of Operations
(12 months ending March 31, 2015)

Revenue	March 2015	March 2014
MOHLTC/LHIN Funding	99.3M	95.0M
Other	1.7M	1.7M
	101.0M	**96.7M**

Net Expenses	March 2015	March 2014
Patient Care	92.1M	88.1M
Administration/ Education/ Marketed Services	8.9M	8.6M
	101.0M	**96.7M**

Balance Sheet
(As of March 31, 2015)

Assets	March 2015	March 2014
Current Assets	11.8M	10.9M
Capital Assets	0.3M	0.4M
	12.1M	**11.3M**

Liabilities	March 2015	March 2014
Current Liabilities	11.2M	10.3M
Deferred Contributions	0.3M	0.4M
Fund Balance (Unrestricted)	0.6M	0.6M
	12.1M	**11.3M**

This is a condensed financial report. The Statement of Financial Position and Statement of Operations have been extracted from the audited financial statements for the year ended March 31, 2015 as reported by our auditors BDO Canada LLP, Chartered Professional Accountants, Licensed Public Accountants. Complete audited financial statements are available on the NSM CCAC website.

KEY facts

In Fiscal 2014-2015:

1] Patient care accounted for over **92%** of our spending.

2] Spending on general administration was **4.5%** of our budget.

3] **3.6%** in new funding from the NSM LHIN enabled the CCAC to reduce the number of patients with high-needs waiting for service by **85%** and increase access to service for **10%**, more patients per week.

BRINGING CARE Home

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North Simcoe Muskoka
Community Care Access Centre

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ACCREDITATION AGRÉMENT CANADA