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

2011-2012 Report to the Community

31,000 stories...

We Serve Thousands of People Every Year.
Each one has a story.

Ontario
Central West Local Health Integration Network

We serve Thousands of People Every Year.

Each one has a story.

Message from the Board Chair and CEO

Our clients. To us, they are our reason for being. To you, they are mothers, fathers, grandparents, siblings, children, neighbours, friends.

In 2011-2012, the Central West CCAC served 31,552 people. Each of them came to us with a story: a life history, a medical history, individual care needs, challenges to achieving independence, personal preferences, and goals. As a CCAC, we customize care plans for each and every one of our clients to ensure that their health outcomes are achieved and individual goals are met.

Simply put, we are key in ensuring people get the right care, in the right place, at the right time. We accomplish this by:

- providing timely clinical assessment and arranging for the individual care people need
- transitioning people across the system to support their care needs being met in the most appropriate setting (hospitals, long-term care homes, supportive housing, etc.)
- referring people to services in their communities that support healthy, independent living
- connecting people with various primary care options, including family doctors and nurse practitioners
- working with health system partners such as hospitals, primary care providers, and community service agencies to help ensure that acute care beds and emergency services are utilized efficiently and effectively by those who need these services most
- coordinating and providing palliative care services that help people die with dignity in the setting of their choice

This Report includes the experiences of just a few of the over 31,000 clients we served last year. On behalf of the Central West CCAC, we would like to thank these clients and their families for generously sharing their stories as a way of helping us tell ours.

To learn more about the Central West CCAC, please contact us at #1-888-733-1177 or visit us online at www.cw.ccac-ont.ca.

David Lehtovaara
Board Chair
Central West CCAC

Cathy Hecimovich
Chief Executive Officer
Central West CCAC

Board of Directors

The Central West CCAC Board of Directors develops our strategic directions and provides monitoring and oversight of program quality, effectiveness and financial viability.

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Chair

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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.

Our Values

Our clients come first. We demonstrate this commitment through active listening, showing compassion, encouraging independence, acting as advocates, and facilitating access to quality care.

Respect is critical to all good relationships. It underscores all our interactions with clients, staff and community partners.

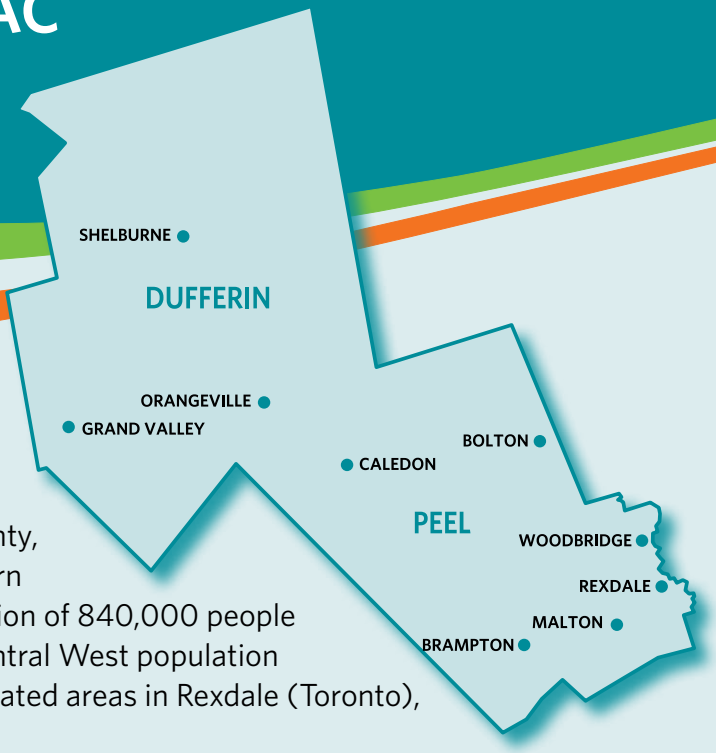
Learning environments are empowering. We explore and adopt new ideas to improve our practice.

Diversity is an asset. It creates a richness of experience and an appreciation of other possibilities.

We are accountable. We strive for consistency, fairness, and optimal outcomes through the wise use of resources and the measurement of results.

Inside

About the Central West CCAC



The Central West Region

The Central West CCAC territory covers approximately 2,590 square kilometers and includes all of Dufferin County, the northern portion of Peel Region, parts of north-western Toronto and south-west York Region. We serve a population of 840,000 people (6.3% of Ontario's population). More than half of the Central West population resides in the City of Brampton, with other densely-populated areas in Rexdale (Toronto), Malton (Mississauga), Orangeville and Woodbridge.

Central West CCAC by the numbers

- 2011-2012 Budget: $89,732,703
- Clients served: 31,552
- Staff members: 247 (full-time equivalent)
- CCAC offices in Brampton and Orangeville
- Staff located onsite at:
  - Etobicoke General Hospital
  - Brampton Civic Hospital
  - Headwaters Health Care Centre
- Satellite offices in Bolton and Shelburne

ROLE OF THE CASE MANAGER

CCAC case managers are regulated health care professionals – nurses, physiotherapists, occupational therapists, social workers – who bring to their role a distinct knowledge base and clinical expertise. These highly skilled professionals develop holistic, comprehensive care plans and share them, securely and electronically, with care providers to ensure that our clients' needs and preferences are clearly understood and that they receive the high-quality support they need, when and where they need it.

Holistic Support for Primary Care Patients: Charles' Story


Charles

When his wife of 50 years unexpectedly passed away, 82-year-old Charles began experiencing leg and back pain. His physician, Dr. Merker, assessed Charles and despite using all the treatment options available, found that his symptoms weren't improving. After several visits and no progress, Dr. Merker consulted Aline, a Central West CCAC Case Manager who supports the holistic care of his patients.


Aline

At Dr. Merker's request, Aline visited Charles at home to assess the impact of his environment, lifestyle and social wellbeing on his health. Through the course of her assessment, she came to understand the impact of his wife's death on his wellbeing and learned that his trips to his doctor were related to loneliness and a lack of social stimulation.

"While in many respects Charles was coping as well as could be expected, throughout the course of our conversation it became evident that he was lacking both a social system and the practical support that would help keep him independent in his home," says Aline. To address these concerns, Aline connected Charles with seniors programs in his area, meal delivery and housekeeping services, and a personal support worker to provide assistance with bathing and personal care.

"Unfortunately, as physicians we are often focused on organic, medical science. With Aline and the CCAC, you get that whole social aspect of your patient's care," says Dr. Merker. "With Charles, the majority of his issue was totally social. For months we were focused on the medical, and thanks to Aline and through the CCAC, we actually picked up on the real issue, the social issue, addressed it, and we've actually done quite well."

After Aline's visit, Charles began to benefit from social activities in his community and balanced meals from his local Meals on Wheels program. His pain levels dramatically improved, and he looks forward to visits from his personal support worker and housekeeper every week.


Dr. Merker

"He's been doing fantastic," says Dr. Merker. "I don't hear about his pain anymore. He's still dealing with the loss of his wife, but the pain, which I think was a manifestation of his grief, is no longer there."

"I think all doctors should tap into the resources of CCACs. If all doctors had that ability to tap into the social aspect of their patients' lives, I think we'd make a much bigger difference in their lives."

ROLE OF THE PRIMARY CASE MANAGER

"Fundamental to the quality and the success of primary care in the community is this partnership with the CCAC. We are trying to develop more dedicated case managers … who then can tell [the physicians] how their patients are actually doing at home – sort of their eyes in the patient's home and their home environment.

I think if we're going to build on successes, we need to go down this road – and I'm excited about the prospects and possibilities that exist in this partnership."

Dr. Frank Martino, Primary Care Lead, Central West LHIN


Mr. Lester

Facilitating a transition "home": Mr. Lester's Story

At 100 years of age, Mr. Lester had been living alone in his home when weakness and difficulty breathing landed him in the emergency department of his local hospital. A diagnoses of bronchitis compounded by an infection, as well as a fracture due to a fall, forced Mr. Lester and his family to consider how much longer he could remain truly independent.

Shortly after his arrival in the emergency department Mr. Lester was connected with


Sheryl

Sheryl, a Transitional Case Manager employed by the Central West CCAC. Sheryl is responsible for ensuring that the hospital's patients are supported in the most appropriate departments, units or programs while they are in the hospital, as well as for planning for their discharge home or to another care setting such as long-term care.

Although Mr. Lester appeared to be a good candidate for long-term care, in speaking with him Sheryl learned that he was an avid gardener who wanted to return home to his gardens. While he had no interest in long-term care, however, Sheryl and Mr. Lester's family were concerned about his safety.

Sheryl called a family meeting with Mr. Lester, his daughter, and the hospital's physiotherapist and occupational therapist to discuss Mr. Lester's wishes to go home despite the challenges he faced. To support his goal of living independently, the team agreed to begin physical and occupational therapy with the goal of discharging Mr. Lester from the hospital to a retirement home where he would be independent but have some support.

When he had recovered from his bronchitis, Sheryl transferred Mr. Lester from acute care to a slow-stream rehab bed in the hospital. From his rehab bed, Mr. Lester received therapy to help regain his mobility and the acute care bed he had occupied became available for someone with acute needs.

To help facilitate Mr. Lester's next transition, Sheryl arranged for an afternoon pass that allowed Mr. Lester and his family to visit the home they were considering. She suggested that the family inquire about window boxes and a gardening area to accommodate Mr. Lester's love of gardening.

On Sheryl's advice, Mr. Lester and his family visited the retirement home and found it to be the best solution for his needs. Because he still required some assistance with dressing, Sheryl arranged for a personal support worker to help him get dressed each morning.

"Sheryl was absolutely wonderful," says Mr. Lester's daughter. "She was kind, she was thorough, she listened to all of our silly questions, she gave us her true opinion on what she thought would be the best thing for Dad. He was the primary concern for her, as was his safety, his happiness, and all the things that go with hospital discharge."

"I firmly believe that without the extra care that we are getting from the CCAC, dad would not been able to be here [at the retirement home] because of the mobility and hygiene issues. If it wasn't for getting that extra support, things would be different for all of us. The CCAC is wonderful!"

Marg, Mr. Lester's daughter

ROLE OF THE TRANSITIONAL CASE MANAGER

"Having a CCAC transitional case manager in our Emergency Department makes a big difference. She is an expert in helping our patients smoothly transition within and from the hospital, so they are cared for in the most appropriate setting. For patients like Mr. Lester, this means that the work to support their recovery and discharge begins as soon as they are admitted. For the hospital, it means our beds are readily available for patients who need them."

Mary Wheelwright
Program Director, Medicine, Rehabilitation and Complex Continuing Care at Headwaters Health Care Centre

"Having the CCAC's support means everything to me," Inderjit says. "I'm so comfortable and now I feel that my son is safe at home. I definitely recommend the CCAC."

Jasnoor and his mother, Inderjit

Supporting Children and their Families: Jasnoor's Story

Jasnoor was a 14-year-old boy preparing to enter grade 9 when he noticed a pain in his ribs after playing hockey.

After a month of pain and intermittent fevers he was admitted to Sick Kids, where he was diagnosed with high-risk Philadelphia positive ALL (Acute Lymphoblastic Leukemia). Recognizing the support that Jasnoor and his family would need, the hospital referred him to the Central West CCAC.

Ruth

"After the first treatment when they were planning on sending us home, I was very scared," says Jasnoor's mother, Inderjit. "Then Sick Kids introduced me to the CCAC, and that's when we met [CW CCAC case manager] Ruth. She explained everything – what we needed at home and how the CCAC can help us. After that I became very comfortable."

In the months that followed, Jasnoor began chemotherapy and Ruth arranged for a visiting nurse to administer the daily injections that would help his body produce more white blood cells during chemotherapy. She also had an occupational therapist conduct a safety assessment in Jasnoor's home. Grab bars, a bath chair with a skid-resistant mat and a removable shower head were recommended by the therapist to help ensure safety.

"Our goal was to support this family any way we could," Ruth says. "Unfortunately, Jasnoor's health rapidly deteriorated due to the side effects of his medications, which caused a two-month readmission to Sick Kids. Along with his hair, eyebrows and eyelashes, he lost almost 50 pounds and the ability to bear his own weight."

Ruth arranged for an occupational therapist to visit once again and, based on her recommendations, the CCAC provided a wheelchair and a commode to support Jasnoor at home.

Throughout his chemotherapy, Jasnoor's nutrition also suffered due to significant nausea and vomiting. While the insertion of a G-tube helped alleviate his symptoms, his mother was understandably concerned for his safety and watched over him through the night, to the detriment of her own wellbeing. Recognizing that the situation was taking a toll, Ruth authorized enhanced respite funding to allow Jasnoor's mother to get some rest.

Today, Jasnoor has completed his chemo treatments and is on a medication to treat his cancer. He has gained back much of his lost weight and is cared for primarily by his mother, for whom Ruth arranged the training necessary to manage his care. He has many future aspirations, among them returning to high school for grade 10 and a future career as a police officer. Jasnoor continues to be followed by hospital oncology clinics, and his family knows that, should they need their support again, Ruth and the CW CCAC are only a phone call away.

"This [focus group] is so appreciated," wrote one participant. "So much to tell of our experiences – glad you gave us the opportunity."

Integrating Care for Improved Healing

In 2011, the Central West CCAC began developing and testing an innovative new approach to serving our clients. The Integrated Client Care Project (ICCP) is based on research showing that more integrated care can result in better health outcomes, improved quality of life, and more cost-effective care overall.

"In a nutshell, we are testing different approaches to care to determine which add the most value for both the client and the health care system," CW CCAC CEO Cathy Hecimovich. "Through the ICCP, we are further integrating the delivery of home care services, taking an even stronger leadership role in monitoring our clients' healing and health, and strengthening the ways we help people navigate the health care system. The results will be even higher-quality client care and a more efficient, sustainable system overall."

While ICCP principles will ultimately be applied to a variety of common health conditions, wound care is the first dimension of care to be evaluated. To ensure that the work was continually informed by the client experience, the CW CCAC organized focus groups with clients and their caregivers, asking participants about their experiences and about what mattered to them, then using their feedback to refine the project.

The combination of best-practice research and client-centered decision making is producing remarkable results. Evidence to date shows that the ICCP approach is producing better health outcomes for clients: since the project began, clients whose care is being guided by ICCP principles are seeing their wounds heal more quickly and efficiently, even exceeding the provincial healing targets that align with best practice guidelines.

"The data to date is very promising," Cathy notes, adding that the Central West CCAC is the only organization in the province testing the ICCP approach with both wound and palliative care clients.

"Going forward, we are applying our learning from the wound care dimension to our palliative population as well," she says, "and we will continue to engage our clients. We are learning all the time – from our clients and their caregivers, from the research, from our own work and from our partners– and we want to ensure that as many people as possible benefit."

"The Central West CCAC is the only organization in the province testing the ICCP approach with both wound and palliative care clients."

"Michelle has been good to me above the call of duty. We have a connection ... no matter what was going on, she always responded. She's worth her weight in gold."

Shirley and Ian

Facilitating Access to Long-Term Care: Shirley's Story

Shirley and Ian Ufton have been married for 48 years. They likely know one another as well as two people possibly can.

Yet as they aged, Ian started to notice incremental changes in Shirley. "What you notice is little things," he says, citing a difference in her considerable cooking skills as one example. "She used to make terrific lasagna ... over time, her cooking started to change slowly."

When Ian retired and began to spend more time at home, he started to notice even more marked changes. One of Shirley's friends commented that she would drive through red lights and not even notice. A former colleague, who Shirley had trained in her years as a bookkeeper, confided that Shirley's professional contributions had also declined in the two years prior to her retirement.

After a visit to the emergency department, Shirley was referred to a neurologist who diagnosed her with Alzheimer's disease.

"I immediately started looking for solutions," Ian says. "Initially, I thought we could cure her, reverse it."

He connected with the Alzheimer's Society, joined their support group, and took advantage of the respite program at Nora's House. Additionally, he and Shirley spoke to a number of specialists and Shirley was placed on medication to help manage her condition.

Over time, however, Shirley continued to deteriorate and her medications were adjusted accordingly. Still, Ian notes, "it comes to the point where the pills don't do anything. We had to consider other options."

The Uftons contacted the Central West CCAC, and a personal support worker was sent to their home to help them manage. Ian still recalls with a smile how the support worker would take Shirley to the park, where they would dance to Shirley's favourite Elvis music. Their relationship with the CCAC also gave them access to case managers who understood Shirley's needs and could refer them to additional resources, as well as prepare them for a future transition to long-term care. When a local long-term care home began offering their adult day program on weekends in 2011, both Uftons benefitted – Shirley from the interaction, and Ian from the break he could take from his role as a full-time caregiver.

"That program was such a big support – we couldn't have gone on last year without it," Ian says. "Without that help, it would have been much more difficult for me." Both Uftons also appreciated the home's warm and personal atmosphere.

So when Central West CCAC Case Manager Michelle Warnock called to say a room at the home had become available, Shirley and Ian jumped at the chance.

"Michelle has been good to me above the call of duty," Ian says. "We have a connection – we're both 'type A' personalities. No matter what was going on, she always responded. She's worth her weight in gold."

Both Shirley and Ian are very pleased with the home's care and attention to detail, from the warm welcome they received when Shirley arrived to the quality of the meals. "Even the laundry people are nice!" Ian exclaims. Although he still lives on his own, Ian continues to visit his wife every other day.

"As a case manager, part of my role is to help both client and family to get through this huge transition and change in their life," says Michelle. "It is so important to listen and advocate on their behalf, as the long-term care process can be very overwhelming."

Health Care Connect can be reached at **1-800-445-1822.**

CW CCAC Care Connectors Donna Perry and Christine Torres-Molina

Connecting People with Primary Care: Pete's Story

Pete* hadn't seen a doctor in over 15 years when he decided it was time for a check-up.

"My family doctor closed his practice and my wife and daughter wanted me to get checked out," he recalls. "I picked up a phone book and started to call around in my area. I called a couple of doctors who weren't taking new patients before one suggested I try *Health Care Connect* and gave me the phone number."

The province launched *Health Care Connect* in February 2009 to help connect "unattached patients" – people without primary health care providers – with physicians or nurse practitioners taking on new patients. The program is implemented by Community Care Access Centres (CCACs), including the Central West CCAC, which serves all of Dufferin County, the northern portion of Peel Region, parts of north-western Toronto and south-west York Region.

"Since 2009, we have connected almost 7,000 local people with family doctors and nurse practitioners."

After calling the 1-800 phone number Pete spoke to a Care Connector, a registered nurse from the Central West CCAC.

"She was extremely helpful," he recalls. "I explained my situation. She told me that people are taken in order of urgency, but assured me that they would get me a doctor and try to get me someone close to home."

Shortly thereafter, Pete got a call that his Care Connector had found a local physician who was taking patients. He's one of thousands Central West residents who now have a family doctor or nurse practitioner thanks to the CW CCAC and the *Health Care Connect* program.

"Since 2009, we have connected almost 7,000 local people with family doctors and nurse practitioners," says Cathy Hecimovich, Chief Executive Officer, Central West CCAC. "This service is one of the many ways we help people navigate the health care system and ensure they get the right care, at the right time, in the right place."

Mimi Lowi-Young, Chief Executive Officer of the Central West Local Health Integration Network (LHIN), agrees.

"Improving access to primary care is one of the Central West LHIN's key priorities," she says. "I'm pleased that *Health Care Connect* is providing local residents with better links to family care."

For Pete, finally seeing a physician led to a new lifestyle. After learning that he had high cholesterol, he revamped his diet with the help of a nutritionist and began a "walking kick."

"I was probably a good candidate for a heart attack, based on the path I was on," Pete recalls. "I'm happy that I'm now on a path to getting healthier. I want to live longer, you know what I mean? I want to be there for my ten-year-old daughter."

(* not his real name due to confidentiality)

Helping Clients Maintain Independence

As a CCAC, much of our work is focused on our most "complex" clients, who have the greatest care needs. While this focus is validated by the literature, there is also growing evidence of the need to proactively support people with less complex needs.

In late 2011, the Central West CCAC launched the Home Independence Program (HIP). The program supports older adults who wish to remain independent at home but who are experiencing difficulties performing essential activities such as bathing and dressing.

"HIP is for people who want to be independent but who have lost some of their ability or confidence along the way," says Cathy Hecimovich, CEO of the Central West CCAC. "Perhaps they've been hospitalized for a fall and, as a result, are understandably anxious about getting into the bathtub. Rather than let that anxiety translate into another fall, we can intervene and provide the education, skills and tools that will help them return to, and sustain, their independence."

Developed in collaboration with local service providers, the evidence-based program represents a transformational shift in the way home care services are delivered by shifting from a "do for" service model to a "do with" model of restorative care. To be eligible for the program, clients must be willing to be active in their own care and engaged in the development of their care plans.

It's a win-win for clients and for the system, Cathy notes. "Placing a greater focus on teaching helps maximize clients' functional status, long-term independence, and quality of life while minimizing the need for ongoing support."

The program has been well received and is continuing to expand in the Central West region.

John's Story

John Pollard has six children, fourteen grandchildren, and five great-grandchildren. At 78, he makes good use of his library card and is an avid bird-watcher.

Recently, he was hospitalized with pneumonia and heart failure.

Upon returning home, "I was having trouble walking, was weak in the knees, had poor balance," recalls John. In an effort to improve his independence – and prevent a fall which would return him to the hospital – John's case manager referred him to the CW CCAC's Home Independence Program (HIP).

As part of the program, a physiotherapist worked with John not only to free him of the cane and walker he had used before his hospital stay, but also to educate him about safety at home.

"Now I know to lead with my strong leg going up the stairs and follow with it going down," John notes. "Has my confidence improved? Most certainly."

"It was fabulous to think we had all this help," Barbara notes. "Martha gave us her cell phone number and made herself available to us at any time. I really can't say enough good things about the CCAC. I'm telling everyone I know."

Helping End-of-Life Clients Stay at Home with their Families: Lloyd's Story

In 60 years of marriage, Lloyd and Barbara Magee welcomed a daughter, enjoyed badminton and lawn bowling, and travelled the world.

Over the years, however, Lloyd's health posed some challenges. A diagnoses of cancer, followed by the removal of his prostate, colon and bladder were already taking their toll when a tumor on his hip surfaced.

"We went to Sunnybrook to talk about an operation, and the surgeon asked if we'd talked to anyone in palliative care," Barbara recalls. "That was the day everything hit us."

Lloyd's family doctor referred him to the Central West Community Care Access Centre (CCAC), and his case manager, Jennifer, visited him at home shortly thereafter. Jennifer arranged nursing, personal support and occupational therapy services for Lloyd, as well as medical supplies to help Barbara manage his care at home.

As Lloyd's illness progressed Jennifer began to consult with Martha, one of three advanced practice nurses (APNs) employed by the Central West CCAC. Martha's advanced clinical knowledge of palliative care allowed her to act as a resource to Lloyd's entire care team.

"I arranged for Lloyd's physician to visit him at home and conducted a joint visit with Lloyd's family and doctor regarding his pain and symptom management," she explains. "My goal was to keep Lloyd as comfortable as possible for as long as possible."

As a result of Martha's specific expertise and recommendations, Lloyd's symptoms were effectively managed and he was able to avoid a return to the emergency department.

"Lloyd wanted to die at home," Barbara says, "and through their support, the CCAC allowed him to do that. I think it was easier when he did pass away. Of course it is still very difficult, but his death didn't hit us the same as if he had been in hospital and we received a call to get there right away because the end was near."

At 80 years of age and 22 years into retirement, Lloyd passed away in the setting he had wished -- in his own home, with his wife close by.

"It was fabulous to think we had all this help," Barbara notes. "Martha gave us her cell phone number and made herself available to us at any time. I really can't say enough good things about the CCAC. I'm telling everyone I know."

Dear Jennifer and Martha,

I want to thank both of you ladies for all the care you provided to my husband, Lloyd Alexander Magee, and myself during the last few weeks. I had no idea of the options available to us in such matters. Martha, my husband really enjoyed the time you spent with him. I was also very impressed at the way you handled everything during your time with him.

Together, you both arranged so many different things for him, many of which I had no idea were available options. Setting all of these arrangements in place helped to ease my mind during the course of the last few weeks.

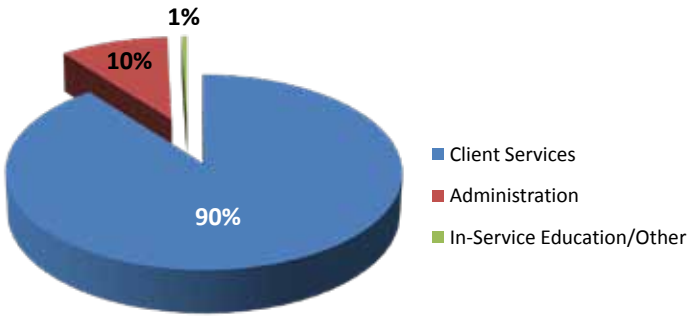
His passing was a blessing in the end, as his pain was ever increasing. Thank you for opening my eyes to the benefits of our medical system, and reminding me how fortunate Lloyd and I are. I hope you both continue with your efforts at the CCAC. Sometimes thanking those that help with care-giving is forgotten. I wanted to make sure you both knew that your efforts were a blessing to us.

Sincerely,

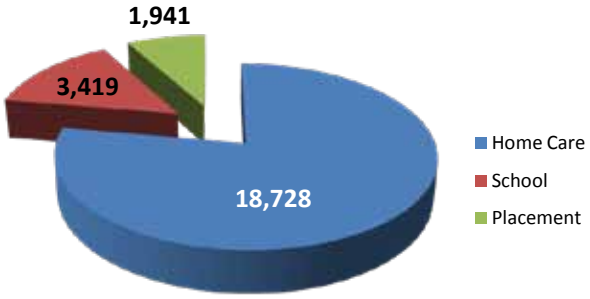
Barbara Magee

Fiscal Accountability & Statistics

2011-2012 Expenditures by Percentage

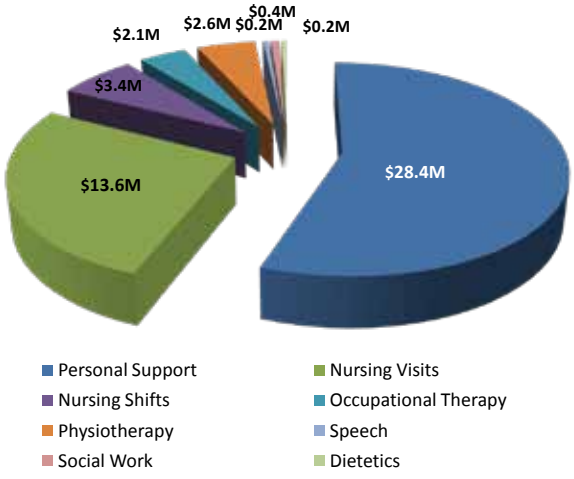


Unique Individuals Served in 2011-2012

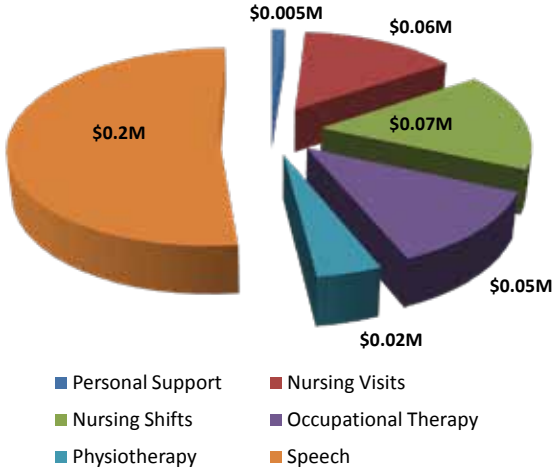


2011-2012 Expenditures by Service Type

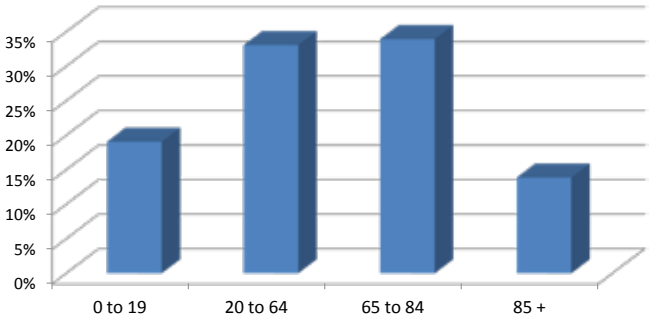
In Home



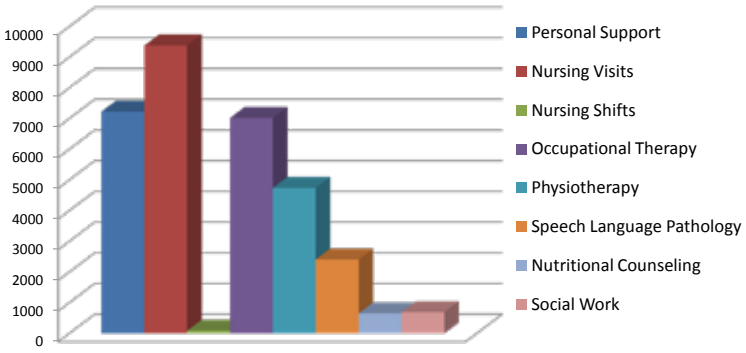
School



Unique Individuals Served by Age Group in 2011-2012 (% by age category)



Unique Individuals Served by Service Type in 2011-2012



** Audited financial statements are available upon request.*

Looking Ahead

We are honoured to play a pivotal role in helping people get the care they need, when and where they need it. Our commitment to our clients is our continued pursuit of our vision: *Outstanding Care – Every person, every day*.

To help reach our vision, the Central West CCAC is dedicated to the continuous improvement of our services. Here are just a few of the many client-centred initiatives the Central West CCAC will pursue in 2012-2013:

Evolving our Model of Care

In June 2012, the Central West CCAC will implement a new approach to serving our clients. Called the Client Care Model, it allows case managers to further specialize their knowledge of client "populations," or groups of clients with distinct care requirements. Based on extensive best-practice research, it will strengthen our ability to consistently match the intensity of CCAC case management, resources and services with our clients' needs.

"While each client is unique, we know that different client populations require different levels of care and case management intensity. For example, someone who has very complex care needs will require greater support than someone who is largely independent but may have some challenges with personal care," says Cathy Hecimovich, CEO, Central West CCAC.

While CCACs currently create custom care plans for clients, the development of the model has provided an opportunity to marry the sector's collective experience with extensive best practice research. And as clients' needs change, "the care standards change right along with them," Cathy explains. "Our specialized case managers will be attuned to the specific needs of each population we serve, allowing for truly customized care."

Providing Mental Health and Addictions Support to Youth

While we currently support children's learning through successful School Health Support Services, in the coming year we will expand our partnerships with our schools to help even more.

In 2012-2013, the Central West CCAC will hire seven specially-trained Mental Health and Addictions Nurses to provide critical early treatment to students who suffer from mental health issues and / or are coping with addictions. The nurses will provide the direct care and support these young people need to successfully manage their health and thrive in school. We look forward to working with our school boards, teachers, and many other system partners to support these special clients.

Helping Seniors Manage their Medications

In 2011, the Central West CCAC began working with key stakeholders to develop a Medication Management Program. The program is designed to support seniors in their homes, optimize the management of their chronic diseases and prevent adverse drug events. It will also help them transition from hospital to home safely.

A CCAC-led steering committee has been formed to help carry this work into 2012-2013, and includes representation from the CCAC, hospitals, long-term care homes, hospices, community service providers

and support services, pharmacists, family health teams, the Ontario College of Pharmacists and the Ontario Medical Association. Going forward, the committee will build on our foundational work to ensure that effective communication occurs amongst providers and across the continuum of health care services. The group will also work to improve safety, optimize medication use and decrease unnecessary hospitalizations for Central West CCAC clients.

Managing Admissions to Adult Day Programs

In October 2011, access to and waitlists for all Adult Day Services in the Central West LHIN were centralized through the Central West CCAC, strengthening our commitment to making access to these services easier and more efficient for those who need them the most.

In 2012-2013, the CW CCAC will pursue further discussions with Adult Day Services providers regarding opportunities for specialized services such as rehab-focused programs for our stroke population.

Partnering for Success: Contract Management Excellence

In 2011-2012, the Central West CCAC and its contracted providers of in-home services began an extensive, collaborative review of current contracts between the providers and the CCAC. The goal of this work is to improve the client experience by ensuring that best practice standards are reflected in our contracts with these key partners.

"Our service providers are critically important to our clients' outcomes and experiences," says Kim Delahunt, Director of Contracts and Procurement, CW CCAC. "They know our clients intimately, and they are often our eyes and ears. We are committed to working in partnership with them. Strengthening our contract management practices is one means of improving our ability to measure and achieve quality and safety for our clients and their caregivers."

Over the course of the next year, the work will include components designed to improve quality, strengthen relationships, manage performance, and create value for money.

Integrating Care for our Palliative Clients

Having experienced early success in improving wound care for clients, the Central West CCAC is applying the same principles to planning care for palliative clients through the Integrated Client Care Project (ICCP). This work will continue into 2012-2013, during which time a fulsome exploration of the palliative client and caregiver experience will be undertaken to determine opportunities for continued quality improvement.

"While all our clients need support, palliative clients are a special group," says project lead Lynn Muir. "They face unique challenges and anything we can do to improve their care and experience is very important to us."

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

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Join us:

For job opportunities, visit www.ccacjobs.ca or email careers@cw.ccac-ont.ca.

Refer to us:

To make a referral to the CCAC or to inquire about services in the community, please call us at 1-888-733-1177.

Ontario
Central West Local Health Integration Network

The Central West CCAC is funded by the Ministry of Health and Long-Term Care through the Central West Local Health Integration Network (LHIN). Services provided by CCACs are covered by the Ontario Health Insurance Plan for those holding a valid health card. A physician's referral is not required; anyone can refer to the CCAC.