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

Partnerships:

A 2014-2015 Report to our Community

The Value of Partnerships

2014-2015 was an eventful, inspiring year marked by strengthened partnerships and bold innovations.

As demand for home and community care continues to rise, the Central West CCAC is once again serving more people than ever before, many of whom have increasingly complex needs that require significant collaboration with partners across and beyond the health care system. To best meet these needs, over the past year we have forged dynamic new partnerships that have enabled us to provide more coordinated, seamless care while supporting health system sustainability for future generations.

This report highlights just some of the many ways we work with hundreds of partners each day, including hospitals, family doctors and nurse practitioners, community support agencies, service providers, school boards, long-term care homes, the Central West Local Health Integration Network (LHIN) and, most importantly, the patients, caregivers and families we serve.

Over the past year, we chartered a bold new course through our ground-breaking integration of non-clinical support service functions with Headwaters Health Care Centre and William Osler Health System; this created the first cross-sectorial partnership of its kind in the province (page 4). We dramatically expanded our collaboration with family doctors and nurse practitioners to enable more integrated, comprehensive support for patients and families across our region (page 7); partnered with local school boards to provide specialized care for young people with special needs (pages 11 and 18); and forged new partnerships across our community, such as the one with Peel Cheshire Homes profiled on page 12.

We also further developed our patient experience expertise, leveraged the knowledge and skills of our people, and built on existing programs to support patients across the continuum of care, all the while advancing our three strategic directions: *patient engagement, fabulous people, and developing a culture of innovation*.

Over the months ahead we will continue to work with our strategic partners to provide the best experiences, treatments, and outcomes for patients and families across the Central West region. Together, we envision a bold new future in which patients are truly at the centre of their care, supported by strong system partnerships and wrapped in the services and supports they need to live the fullest, most rewarding and independent lives possible.

Carmine Domanico
Board Chair
Central West CCAC

Cathy Hecimovich
Chief Executive Officer
Central West CCAC

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 patients come first.

Respect is critical to all good relationships.

Learning environments are empowering.

Diversity is an asset.

We are accountable.

Table of Contents

Board of Directors

Carmine Domanico
Board Chair

Elizabeth Hull
Board Member

Dr. Bhupinder Sharma
Board Member

Wanda Yorke
Board Member

David Robertson
Vice Chair

David Lehtovaara
Board Member

Moyra Vande Vooren
Board Member

Carolyn Young
Board Member

Kevin Campbell
Treasurer

Anna Paluzzi
Board Member

Matthew Vella
Board Member

Providing Better Care, Together

In 2014-2015 we took our partnership with Headwaters Health Care Centre (Headwaters) and William Osler Health System (Osler) to bold new heights by integrating our non-clinical support functions across all three organizations. This dynamic new cross-sector partnership is the first of its kind in Ontario and will enable us to put patients and families first by finding new and better ways of working together to create an integrated, patient-centric health care system that is easier for people to access, understand, and navigate.

We've already taken steps to change our approach to regional planning. For the first time, all three organizations worked together to create our Quality Improvement Plans (QIPs) and Annual Business Plans (ABPs). This collaborative approach helps us to define more in-depth and systematic ways for setting improvement targets and developing change initiatives that will benefit patients in the communities we serve.

Supporting Integrated Care with Integrated Leadership

As part of our cross-sector integration, we created a new joint leadership structure that oversees finance, human resources, information technology, facilities, communications and strategy operations. This highly-skilled team ensures that our collective operational priorities are aligned and supports collaborative planning and joint investment.

Learn about our Joint Leadership Structure.

Hear from Mary-Ellen.

Our collective commitment to regional planning places patients and families at the heart of everything we do. With our strategic partners, we are working together to provide the best experiences, treatments, and outcomes for patients and families across the Central West region.

Beyond Borders

The cross-sector partnership between the Central West CCAC, Headwaters and Olser is breaking down barriers to care. Through collaboration, we are identifying opportunities to create efficiencies that will streamline the patient journey from acute to community care.

As one example of our joint efforts, each organization has taken steps to blend the roles of hospital discharge planners and CCAC care coordinators into a single function. Through this work, patients will have one point of contact to support them through their discharge from hospital and return home, streamlining their experience and smoothing transition points.

Transforming the Patient Experience

As part of our bold new partnership with Headwaters and Osler, in 2014-2015 we created a new cross-appointed Chief Patient Experience Officer role to ensure the patient is at the heart of everything we do. This role will support our collective focus as leaders and innovators and inform new strategies that will transform the patient experience across hospital and community settings.

While historically each partner organization had sought patient and caregiver feedback independently, Headwaters, Osler and the CCAC are now collecting data that is allowing us to develop a regional perspective on the patient experience. As a first step, Osler has expanded its existing call centre to contact not only Osler patients, but also inpatients from Headwaters and a segment of Central West CCAC patients following their discharge home from hospital.

Through this work, we are now able to measure satisfaction across the continuum of care to better understand how patients move between our organizations during their journey. By listening to patients, we understand that their satisfaction is largely based on their experience of how service is delivered, rather than the technical aspects of their medical care – and we are committed to working together to transform and improve the way they experience care across our region.

We are committed to an exemplary patient experience.

9/10* patients and caregivers told us they've had a positive experience with our CCAC.

97% said they would recommend us to family or friends if they needed help.*

* Responses collected over the past 12 months via independent third-party survey.

Partnering with Family Doctors & Nurse Practitioners

Hear from John.

Family doctors and nurse practitioners are tremendously important in a person's care journey. When faced with a health question, troubling symptom, or life-changing diagnoses, more often than not people first turn to these primary care providers for information, treatment, and support.

The Central West CCAC is working more closely with our primary care partners than ever before to support the delivery of holistic, integrated and patient-centred care. Fostering and strengthening partnerships with these professionals continued to be an area of focus over the past year – and by the spring of 2015, our care coordinators were embedded in the practices of all Family Health Teams and Community Health Centres in the Central West region, working directly with over 100 primary care providers on a regular basis. We also conducted a highly successful pilot project to align care coordinators more closely with primary care providers – and exciting work is underway to spread this innovative new model throughout our community, supporting a more streamlined, collaborative approach to working with these key partners.

The Central West CCAC continues to participate in all five local Health Links to support the health, safety and independence of some of the most vulnerable patients in our community. To support these efforts, many CCAC care coordinators spend time each week working directly within primary care practices, consulting with physicians about the services and supports available to help their most complex patients.

Most importantly, through working in close collaboration with our primary care providers we will improve patients' experience and strengthen the quality of care they receive. As the "eyes as ears in the home," CCAC care coordinators work with primary care providers to build comprehensive patient care plans that reflect the context of their patients' lives – the home environment, family dynamics, priorities, social reality, and personal goals that contribute greatly to each individual's health and well-being.

> "As a caregiver, it is really important for me to know that the doctor is getting reports from someone other than myself. What we owe CCAC for helping to keep [my parents] alive for the past 10 years is beyond valuation."
>
> John Birks, caregiver

Tara, Josephine & Michael Bolden

Josephine's Story

"It's a really devastating time when a family member becomes ill and you don't know where to go for help," says Tara Bolden. "I thought I knew how to navigate the health care system, but I didn't really know what hidden treasures there were embedded within it."

For the Bolden family, the need for help came suddenly when Tara's mother Josephine developed a rapidly progressive dementia. Her family physician, Dr. Thind, explains Josephine's diagnosis as a "rare degenerative brain disorder" that dramatically affected her memory, speech and mobility in only a few short months.

Recognizing the support Josephine and her family would need as she continued to decline, Dr. Thind asked CCAC Care Coordinator Sandra Hastings to connect with the Boldens. Sandra responded by meeting with the family to understand how she could best support their needs and wishes.

"Josephine faces numerous challenges that impact her health, well-being and safety," Sandra notes. "As her care coordinator, I want to make sure that both she and her family are well supported so they can stay at home for as long as possible, which is their ultimate goal." Sandra connects with the family on a regular basis to connect them to resources, ensure the supports in place are making a difference, and plan for Josephine's future care.

To Tara and her father, the support is much appreciated.

> "Before this, I certainly did not appreciate what was available or how helpful your care coordinator can be. Sandra has become a part of our family- she knows everything about our dynamics and this has been done in a very non-intrusive manner that is very respectful and informative."
>
> Tara Bolden, daughter

Hear Josephine's Story.

"We go to Sandra for help and guidance and information… the different services and information that she has provided have been instrumental in helping my mom maintain a good quality of life," says Tara. "Sandra has also been amazing in supporting my Dad and I, and works very closely with my mom's family doctor. She is the central, key person in all of this."

Dr. Thind agrees. "The CCAC has been pivotal in providing the supports this family needs," says Dr. Thind, explaining that he meets with Sandra to discuss not just Josephine, but all of his patients who receive or would benefit from CCAC support. "It has been great working with the CCAC," he says, "to tap into that network of supports as a patient's health improves, declines or changes."

By all accounts, the partnership is working. "My mom has a great sense of humour and it has been very comforting for my Dad and I to see it still come through – despite a lot of our sadness, we also have a lot of laughter," Tara notes.

Josephine's husband Michael sums up their experience in a simple, heartfelt statement: "being able to support Jo at home means everything."

> "Sandra and Dr. Thind have a very good relationship, and when we go to meet with him he already knows everything before we talk to him," Tara says. "A lot of communication has happened."

Sandra & Dr. Thind

Partnering to Meet Unique Needs

At the Central West CCAC, we believe that each patient is unique, with individual needs, circumstances, goals, and preferences. As we strive toward our vision of outstanding care – every person, every day, we create care plans that are customized to each patient's needs, respectful of their beliefs, and flexible to their circumstances.

We're leading the way with transformative programs, initiatives and partnerships – and when such opportunities don't exist, we create them.

One such example is the innovative partnership between the Central West CCAC, Supportive Housing in Peel (SHIP) and the Canadian Mental Health Association of Peel (CMHA). In 2014, we recognized that a more purposeful integration of roles between these organizations would better support adults living with both chronic health conditions and mental health challenges. With the support of the Central West Local Health Integration Network (LHIN), we developed the first such partnership of its kind in Ontario. Through this initiative, five integrated mental health consultants jointly employed by SHIP and CMHA consult with Central West CCAC care coordinators to support the creation of collaborative, interprofessional care plans for patients with chronic conditions and mental health needs, particularly the complex patients identified through our region's five Health Links.

Through joint home visits and monthly mental health educational rounds, this purposeful integration is also building capacity among CCAC care coordinators, allowing them to better respond to mental health issues that commonly accompany the clinical needs of their most complex patients.

Partnering for Change

Five percent of all children are affected by developmental coordination disorder (DCD), a specific motor delay that can affect their success in school. Early intervention is critical to prevent secondary academic, mental and physical health issues; however, in recent years long occupational therapy waitlists have meant that many students were not receiving the timely support they needed to succeed.

Fortunately, a partnership between the CCAC, educators, health professionals, policy-makers and families is helping these special children, their schools and their families access this much-needed care.

Funded by the Ministry of Health and Long-Term Care, the *Partnering for Change* (P4C) program is identifying special needs earlier and preventing future issues while building the capacity of educators and families to better manage the challenges these children face.

"P4C is truly transforming the way we provide health services to children with special needs in school," says Kimberley Floyd, Director of Patient Care Services at the Central West CCAC. "While traditionally these children have been supported on an individual basis, through the P4C model occupational therapists are more engaged at the school level: they support students with a broad range of needs, provide resources and education to classroom teachers, and help create environments that encourage the children's health, wellbeing and success. It's a far more collaborative and holistic approach."

> "As teachers, we feel at a loss when we encounter occupational therapy issues with children because we are not quite sure how to guide them and teach them to be successful … empowering us with the tools to intervene has changed the outlook for these children."
>
> Teacher supported by P4C

376% Since September 2013, the number of students benefitting from P4C has increased by and **waitlists for this care have been eliminated**.

Wesley Coupland and Clinton Baretto

Supporting Independence at Home: Peel Cheshire Homes

When CCAC care coordinator Eric Lee began working with Peel Cheshire Homes, a supportive housing facility for individuals with physical disabilities, he quickly realized there was an opportunity to partner for better patient care.

"I began working with the home's residents, as well as on their community outreach program," Eric recalls, "and it just struck me how much better we could collectively support these individuals. Residents were frustrated, for example, by the many challenges they faced simply travelling to their medical appointments; it was often taking half a day or more. I knew that by pooling our resources with our primary care and community partners, we could work smarter, provide better care and help more people, especially those who might otherwise fall through the cracks of the health care system."

Eric began by reaching out to Clinton Baretto, a nurse practitioner with the North Peel Family Health Team. Clinton and the North Peel team readily agreed to provide in-home primary care at Peel Cheshire, eliminating the need to arrange for specialized transportation and staff to accompany residents to and from appointments. In turn, Clinton's support allowed Eric to devote more time to supporting Peel Cheshire's outreach program in the community.

> "The goal of the partnership is to try and encourage patient care at home and for very complex patients."

Eric Lee

Dianne Austin

Learn how the CCAC is Supporting Independence at Home.

"Within this partnership, we each play a different role," Eric explains. "Clinton addresses residents' medical concerns, Peel Cheshire provides personal care and support, and I coordinate in-home therapeutic services, provide assessments and consultation as needed, and link people to other community resources that can help."

The goal of the partnership, says Clinton, is "to try and encourage patient care at home and for very complex patients. Eric is our eyes and ears in the community. We have a really good working relationship and we have learned to trust each other's clinical skills."

As a result, "we have prevented many unnecessary health crises and hospital visits," Eric notes. "By wrapping the right care around the individuals we support, we have caught many vulnerable patients before their situations escalate."

Dianne Austin, executive director at Peel Cheshire Homes, also sees a significant difference in the way her residents are supported. "We have individuals here who are non-verbal, and it takes some time to work though the issues they might have… [now] they are more interactive and happy. I feel more secure that their health is being managed in a way that is to their benefit."

And while in the past connecting people with community resources was a challenge, "now it's a cinch- we just pick up the phone and call Eric."

Bessie Swailes

Creating a Better Experience for Palliative Patients

There is a strong need for coordinated, individualized and respectful palliative care in the Central West region. Together with Headwaters, Osler and the Central West Local Health Integration Network (LHIN), the Central West CCAC has committed to dramatically transforming and improving the patient experience for those living with life-limiting illnesses through a Joint Palliative Pledge.

As partners, we're committed to providing leadership for a high quality, comprehensive, integrated and well-coordinated hospice palliative and end-of-life care system in the Central West LHIN. Together, we are founding participants for a joint palliative and end-of-life care "pledge" which, when complete, will strive to improve the patient experience for those living with life-limiting illness in our region.

The Central West CCAC palliative care team includes care coordinators, advance practice nurses, nurse practitioners, and physician medical leads. In 2014-2015, we cared for 1,055 people on their end-of-life journey.

Hear from Dianne.

By taking action together, we can change the way we collectively support patients and families – and enhance the quality of living and dying – by emphasizing respect, dignity and compassion as we support them through this journey. A great need for coordinated, individualized and respectful palliative and end-of-life care has been identified and, through enhanced service delivery, work has already begun to close the gap.

As we collaborate with palliative care partners across the region, we will determine a shared course of action that will amplify our collective impact.

"With the help I was getting, everyone was telling me things that I needed to know and making it the most comfortable for my mom. I will never thank CCAC enough, for making sure mom was with us until the end."

Dianne Keough, Bessie's daughter

Mr. & Mrs. Deepoo’s Story

With help from the Central West CCAC, this Health Links patient and her spouse of 64 years are able to remain safe and independent in their own home.

In the summer of 2014 Mrs. Deepoo’s family doctor referred her to the Central West CCAC, citing concerns with her uncontrolled blood pressure, unmanaged diabetes, medication challenges, and overall decline in physical functioning. Mrs. Deepoo had also begun going to the hospital with abnormally high blood sugar, and her husband of 64 years – who had health concerns of his own – grew worried about her fluctuating health conditions.

While Mrs. Deepoo had been referred to professionals who could help, however, she found travelling difficult and often missed appointments due to miscommunication or forgetfulness. When she met CCAC Care Coordinator Linna Tran, Mrs. Deepoo was overwhelmed, uncertain, frustrated with the health care system, and had no clear sense of how to navigate it to address her complex needs. As Mrs. Deepoo explains: “When you don’t know things, what are you going to do?”

Linna began by developing a care plan designed to meet the couple’s requirements and circumstances. To help address their immediate needs first, Linna arranged for a visiting nurse and in-home pharmacist to work closely with Mrs. Deepoo’s doctor and endocrinologist to adjust her insulin levels and stabilize her critically high blood sugar. Over the coming months, the team closely monitored and supported Mrs. Deepoo while her medical needs continued to change; additional services included physiotherapy treatments to support Mrs. Deepoo’s functional goals, as well as a nurse to teach Mr. Deepoo to help manage and monitor her diabetic care. And when Mr. Deepoo ended up in the hospital with his own health issues, Linna followed up to ensure he accessed specialist care and joined him on an appointment with his family doctor, providing essential background information to support the physician’s assessment. As a result, Mr. Deepoo was referred to a pain clinic, is on new mediations and awaits his next specialist appointment.

“Wrapping care around Mr. and Mrs. Deepoo has been a true team effort,” Linna says of the collaboration. “Throughout this journey, there has been constant communication between their doctors, specialists, nurse, pharmacist and myself – and the positive outcome is very evident. Mrs. Deepoo has had no emergency room visits, is now attending all medical appointments, has remained medically stable, and is more independent overall, while Mr. Deepoo is also getting the care and support he needs.”

Remarkably, the couple who once struggled to attend a doctor’s appointment recently travelled to Guyana to visit their children – a dream two years in the making. With their newfound knowledge and improved health, they successfully managed their needs independently during the month-long visit.

Asked what she would tell others about her CCAC experience, Mrs. Deepoo’s answer is simple. “You can get help, and it helps you help yourself,” she says.

“Thank you very much for everything.”

> “Wrapping care around Mr. and Mrs. Deepoo has been a true team effort.”
>
> Linna Tran, CCAC Care Coordinator

Partnering to Better Support Students: Mental Health & Addictions Nurses

Recognizing the significant impact of mental health on an individual's overall wellbeing and quality of life, CCAC mental health and addictions nurses (MHANs) are helping students who struggle with these challenges not only to attend, but to thrive in school.

"As a CCAC, we are committed to providing individualized care," notes Donna Sherman, Manager of Patient Care Services. "That's incredibly important with our students, whose mental health needs cannot be viewed in isolation from the context of their lives. If their challenges are impacting their success at school, we can work with their school and community to support them."

Students supported through the MHAN program face a variety of mental health challenges, ranging from anxiety and self-harming behaviours to substance use, bipolar disorder and depression. For many, even the thought of attending school is more than they can bear.

> "[Our mental health and addictions nurse] has created a miracle. My son has taken charge of his illness, is taking his pills, seeing his doctor, going to school, and attending clinic. Her caring and guidance we could not do without."
>
> Parent

Learn how the CCAC is Partnering to Support Students with Mental Health & Addictions.

"We work closely with students, families, school boards, physicians, local hospitals, mental health agencies and other partners to support not only the student's return to school, but also the development of a coordinated care plan that will help keep them there," Donna says. For some students, the team considers options outside of traditional school day, such as specialized programs; in others, MHANs meet with teachers to answer questions about diagnoses or explain how the medications a student is taking might impact their behaviour in class. And when school breaks for the summer, the MHAN team continues to support these vulnerable young people through the warmer months.

"Ultimately," Donna notes, "the program is about helping the system adapt to students as much as it's about helping students adapt to the system."

> "This program is very kinetic, very flexible and resilient to emerging needs in our Board."
>
> Glenn Carley, Chief Social Worker, Dufferin Peel Catholic District School Board

> "Partnership with the MHAN program has helped us formalize a process to respond to and support the safe transition of our students from hospital to school."
>
> Archie Kwan, Senior Psychologist, Peel District School Board

Honouring Excellence in Innovation

To promote collaboration, cooperation, and improve the seamless delivery of health care services across our region, the Central West CCAC, Headwaters and Osler created a joint Strategic Partnership Committee. Our new model for multi-organizational governance is unique to our three organizations and a natural extension of our existing collaborative relationship.

Consisting of representatives from all three partner organizations, the Committee provides a platform for the exchange of ideas to collectively improve access to health care services, promote continued efficiency of administrative functions, and align performance accountabilities.

By exploring voluntary partnerships and integration opportunities together, we're leading the way forward with innovative approaches to regional health care. As a testament to the integration's significance, this ground-breaking work was recognized with the *2014 Award in Leading Governance Excellence* through the Ontario Hospital Association's Governance Centre of Excellence.

For the second consecutive year, the Central West CCAC has also been recognized with a ***Gold Quality Healthcare Workplace Award*** through the Ontario Hospital Association and the Ministry of Health and Long-Term Care for its efforts to create a supportive culture in which health care professionals can learn, work and thrive.

In 2014-2015, we expanded our exercise and falls prevention program to almost **120 classes**, with **over 2,000** seniors registered from across our community.

Care in our Community, By the Numbers

In 2014-2015, the Central West CCAC:

Helped 10,207 patients safely transition home from the hospital

Provided nursing clinic care to 94% more patients than in the previous year

Supported patients through more than 1.2 million hours of personal support services

Provided over 77,000 visits from physiotherapists, occupational therapists, and speech language pathologists

Helped 1,168 people transition to long-term care

Supported 7,364 long-term care residents, staff and families impacted by dementia and other neurological conditions through the *Behavioural Supports Ontario* program

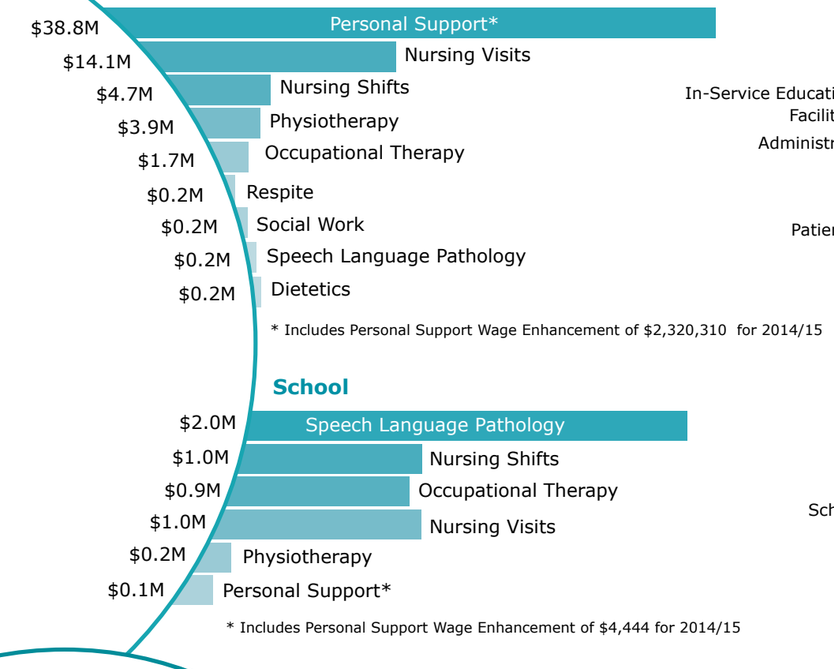
Ensured residents could access up-to-date information about local health services and supports on www.centralwesthealthline.ca, an online database with over 134,000 unique visitors

Learn about Central West's Physiotherapy Program for Seniors.

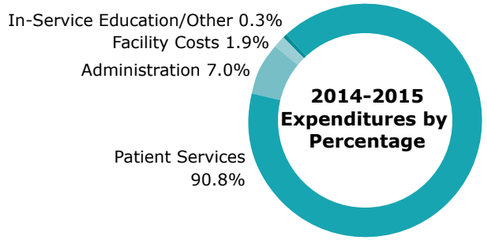
Fiscal Accountability & Statistics

2013-2014 Expenditures by Service Type

In-Home

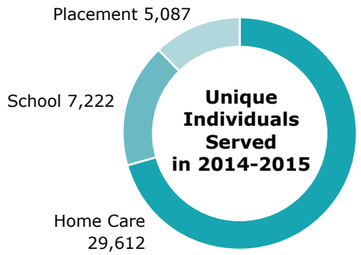


* Includes Personal Support Wage Enhancement of $2,320,310 for 2014/15

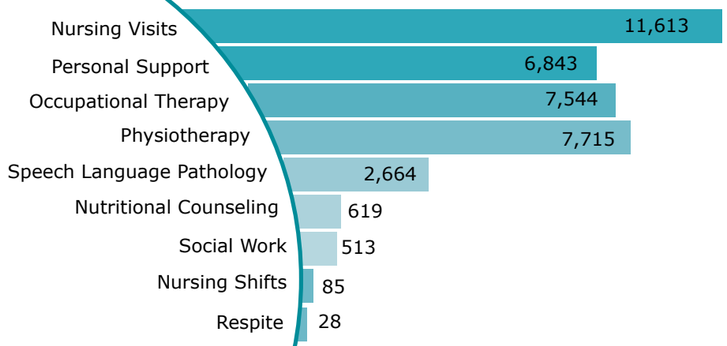


School

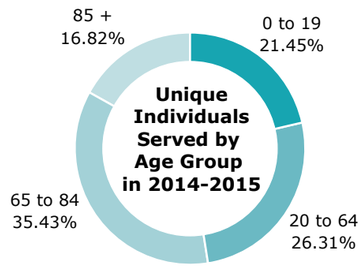
* Includes Personal Support Wage Enhancement of $4,444 for 2014/15



Individuals Served by Service Type*



* Individuals may receive more than one service



About the Central West CCAC

The Central West Region

The Central West region covers approximately **2,590** square kilometres and includes all of Dufferin County, the northern portion of Peel Region, parts of north-western Toronto, and south-west York Region. We are proud to serve the almost **840,000** people (7.0% of Ontario's population) who live in the Central West community.

2014-2015 Annual Revenue:

$113 M

Patients Served: 38,640

Staff members: 293

(*full-time equivalent*)

CCAC offices in Brampton and Orangeville

Staff located onsite at local hospitals:

Headwaters Health Care Centre

William Osler Health System

The Value of Care Coordination

CCAC care coordinators are regulated health professionals – nurses, physiotherapists, occupational therapists, social workers, and others – with additional, specialized training in coordinating care across the health care system. They use their clinical skills to assess patient needs and develop comprehensive care plans, then monitor outcomes and adjust plans, as appropriate, to ensure that the care and supports in place are making a difference. Care coordinators help their patients get:

the right care: health care from nurses and physiotherapists, for example; services such as personal support; and other supports, including medical equipment and referrals to other organizations that can help

at the right time: when care is required and as a patient's needs change, their CCAC care plan will change too

in the right place: in-home care, care in the community, long-term care, care at school, hospice care, and care in other settings. Care coordinators have specialized knowledge about their patients' challenges, and work in partnership with them to improve their quality of life.

Central West CCAC
Community Care Access Centre

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

The Central West CCAC is here for you.

If you have a question, concern, or need information, help is only a call or click away.

Find resources and help close to home:

www.centralwesthealthline.ca

Contact us:

199 County Court Blvd.
Brampton, Ontario
L6W 4P3

To learn more or make a referral, call:

905-796-0040
1-888-733-1177

Visit us Online:

www.healthcareathome.ca/centralwest

Connect on Twitter:

@CWCCAC

Join us:

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

ACCREDITATION CANADA • AGRÉMENT CANADA
ACCREDITED • AGRÉÉ

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). CCAC advice and services are covered by the Ontario Health Insurance Plan (OHIP). A physician's referral is not required; anyone can refer to the CCAC.