# Annual Report

April 1, 2008 – March 31, 2009

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Judith Hayward, Chair, Board of Directors
Camille Orridge, Executive Director

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## Message from Board Chair and Executive Director

New opportunities, major challenges, continuing growth, and a renewed sense of commitment were all part of the Toronto Central CCAC experience over the past year. As an organization, we have matured in our role within the Toronto Central LHIN and played a key role in the care continuum of the communities we serve. We provided care coordination and in-home services to a total of 54,171 clients during the past year, placed a total of 1,835 clients in long-term care homes and handled 296,558 calls for information and referral services through our Client Services Centre.

Early in the year, the Minister of Health and Long-Term Care announced new funding for CCACs to raise the maximum levels of service for clients meeting specified criteria to support more people at home and assist in reducing length of stay in hospitals. The new service maximums, which came into effect May 30, 2008, provide more flexibility in helping high risk, high needs clients and their caregivers.

The Toronto Central CCAC was awarded $1 million dollars by the Toronto Central LHIN for a seniors' independence program, as part of the Aging at Home Strategy. This allows us to work with multiple community resource organizations in providing services to at-risk or isolated seniors who can live independently and to move ALC clients home for care.

We had much to celebrate over the past year. The opening celebration for the West Office had Matt Anderson, CEO of Toronto Central LHIN, in attendance, along with CCAC staff, Board members, services providers and community partner organizations. We used the occasion to promote use of our space by other community-based organizations as a way to provide support to the community.

We opened a CCAC FAST (Fast Access to Supportive Treatment) Centre at the site of the Canadian National Institute for the Blind (CNIB) in October 2008. This is the fourth such centre operated by our CCAC, providing a centralized site for clients to receive I.V. therapy, wound care, ostomy care and generalized nursing and teaching.

In the first few months of the year, we recognized that with the many activities we were undertaking to help keep people at home, get people home from hospital sooner and have patients referred to us directly out of hospital emergency departments, that we could anticipate a huge growth in our number of clients. Knowing that with the impact of the global economic crisis that we would have to be even more responsible with our resources, we launched a 'Make Every Dollar Count for Client Care' Campaign with our staff and service providers. We solicited ideas from all our staff and service providers about how we could operate more efficiently and make better use of our budget for client care. We were impressed with the creativity and resourcefulness of the ideas we received. Through the many efforts of our staff and service providers we were able to see more clients this year and still come in on budget at year end.

Our Executive Team applied for and was accepted into the Leadership for Performance Excellence program offered by the Centre for Healthcare Quality Improvement. The objective of the program is to help participants develop a deeper understanding of the practices necessary to lead and inspire change in the way health care is delivered to patients. Many applied: we are pleased to be one of the few chosen.

The Toronto Central CCAC participated in the Provincial Employee Engagement Survey, coordinated by the OACCAC. Results were reviewed with managers and staff, with the help of the consulting team at Watson Wyatt. Feedback from the healthy lifestyle component

of the Employee Engagement Survey identified organizational wellness as an important issue. In an effort to build a workforce committed to wellness and work/life balance, we created a Committee to develop and evaluate strategies that will drive the promotion of health and wellness in the organization and improve the work environment by creating and supporting initiatives aligned with work/life balance.

The Toronto Central CCAC continues to refine our new Client Service Delivery Model focusing on the development and alignment of teams to key client service groups and communities. This population-based model enables staff to develop in-depth client service expertise for the particular client group they support.

Staff throughout the organization continues their participation in professional conferences and health care meetings across the province, along with their active involvement in outreach and partnership activities throughout the health care sector and our communities.

This is just a very brief overview of some of the key activities carried out during 2008/2009. Many more are described in other sections of this annual report. That we were able to successfully meet the challenges presented, take hold of new and exciting opportunities to further support our clients and our community, and continue to move forward on so many key issues, is due to the unwavering support, of our Board of Directors and the ongoing dedication, commitment and hard work of staff at all levels.

Judith Hayward, Board Chair

Camille Orridge, Executive Director

## Awards and Recognition

At the June 2008 Annual Dinner of the Ontario Association of Community Care Access Centres (OACCAC) Judith Hayward, Toronto Central CCAC Board Chair, was presented with the Volunteer Award. Judith was also announced as the new Board Chair of the OACCAC.

## CCAC Vision and Mission

In March 2009, the 14 CCACs in Ontario launched a new Vision and Mission Statement.

### 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.

## Order in Council Appointment Dates*

| | Appointment | Term Expires |
|---|---|---|
| Executive Director | | |
| Camille Orridge | September 27, 2006 | March 31, 2009 |
| Board Chair | | |
| Judith Hayward | June 20, 2007 | March 31, 2009 |
| Directors | | |
| Florence Cleary | December 6, 2006 | March 31, 2009 |
| Sandra McCulloch | December 13, 2006 | March 31, 2009 |
| Wendy Nailer | January 12, 2008 | March 31, 2009 |
| Adam Plackett | November 11, 2007 | March 31, 2009 |
| Thomas E. Reber | February 7, 2007 | March 31, 2009 |
| Victoria Santiago | February 15, 2008 | March 31, 2009 |
| Carole Tangney | May 2, 2007 | June 2, 2008 |
| Harold Wu | October 11, 2006 | March 31, 2009 |
| William Yetman | June 27, 2008 | March 31, 2009 |

* On April 1, 2009, the CCAC Boards changed from Order in Council Appointments to community-based boards.

## Community Partnerships

### Community Partnerships and Outreach Activities

The Toronto Central CCAC focuses on partnership and collaboration as important areas of community engagement and we continue to develop new partnerships with other health care organizations and services to provide a collaborative approach to serving our community. We have a number of activities and partnerships in place to support the priorities of the Toronto Central LHIN and Ministry of Health and Long-Term Care (MOHLTC) for our local health system. Priorities and supporting activities include:

**Activities to Support Seniors**

Seniors constitute the largest proportion of the CCAC's clients. A number of partnerships with other community agencies support integrated services for seniors including transportation services, home support services, respite care, and homemaking.

Our Aging at Home Strategy is designed to provide a more supportive environment for seniors to age comfortably and safely at home and avoid unnecessary institutionalization. The CCAC directly supports the Toronto Central LHIN's Aging at Home strategy with our own set of priorities including:

1. **Connecting people to care,** across the Toronto Central LHIN
2. Providing **wraparound care coordination** for high risk and high needs populations
3. Increasing ***equity of service delivery*** for extremely marginalized populations
4. Building **shared capacity** with community partners-in-care
5. Championing research to support **evidence-based system change.**

Our Aging at Home activities included completing of our 'Balance of Care' project with the University of Toronto and Ryerson University researchers and community support agencies to link individuals on long-term care waiting lists to a variety of community-based services that will enable them to stay at home longer. Through this project, we found we could keep about 37% of seniors on the long-term care waitlist in their homes with targeted and integrated services. We are using the findings from this study to build a program for high-risk seniors in the community.

We partnered with three alternative housing/ shelter sites in Toronto (Fred Victor, Homes First, and Women's Residence) and the Inner City Health Associates physician group to plan and implement a team-based model of care for under-housed, homeless and marginalized individuals. The Inner City Access Program, implemented in April 2009, provides a dedicated team that includes a care coordinator, nurse, personal support worker, housing staff and physicians from the Inner City Health Associates to provide health and support services to residents at these shelters. This will improve access to services for homeless, under-housed and marginalized individuals; improve health outcomes for clients; and test a new service delivery approach for these clients that could be rolled out to other shelters and alternative housing sites in Toronto.

The Emergency Department Notification Project continues our partnership with acute care hospitals to link clients over the age of 75 to community services more quickly, providing them with the support they need to age at home.

The Community Referrals to Emergency Medical Services (CREMS) program, focused on seniors who frequently call 911 for support, has been expanded across the entire CCAC catchment area. A number of other activities in the Aging at Home Plan target at risk and homeless seniors, in partnership with area shelters and hostels, as well as frail seniors with medication management issues.

Our program to support seniors waiting for Long-Term Care (LTC) in alternate level of care beds in hospitals to wait at home with enhanced case management and services continues to prove successful. The goals of the program are to: offer seniors the option of waiting in the comfort of their own home for LTC instead of in hospital; and to support capacity in hospitals by freeing up beds for those requiring acute care services, thus relieving pressures on the emergency rooms.

The Toronto Central CCAC Community Care Resources public website (www.communitycareresources.ca), supported by the Toronto Central LHIN, is well used by those caring for seniors as a way to access a wealth of information about community resources and education materials available to them.

As part our activities to better support caregivers, we partnered with Caregiver Omnimedia Inc. to sponsor Home Health Care Expo 2008 on April 8, 2008, at the Metro Toronto Convention Centre and produced two regional issues of Family Caregiver Newsmagazine. Both of these activities are designed to provide access to community-based resources, information and education about supports available to family and friends who provide care to clients.

**Activities to Support Mental Health and Addictions**

The Toronto area has high rates of mental illness. The Toronto Central CCAC serves a significant number of individuals with primary and secondary mental health diagnoses combined with physical health issues. Services offered by the CCAC are integrated with other partner organizations including homeless shelters, St. Michael's Hospital psychiatric services, drop-in centres, and Assertive Community Treatment (ACT) teams. Since centralizing our mental health services into a single program with a dedicated manager, we have been able to provide more focused support to this population. Our Community Care Resources website, in partnership with Connex, a provincial database of mental health and addictions resources will greatly improve public access to community resources to this population and their caregivers.

**Activities to Support Rehabilitation**

Toronto Central LHIN contains about half of all rehabilitation beds in the Greater Toronto Area (GTA). We actively participate in GTA Rehab Network planning activities and have a priority partnership with several acute and rehab hospitals to serve post-hip and knee surgery clients in support of the provincial agenda to reduce surgical waitlists.

**Strengthening links between hospitals and community**

In 2004, the Toronto CCAC and University Health Network (UHN) joined information management and technology (IM/IT) services, building on a long standing patient/client referral relationship. Since then, 14 additional facilities have joined the Shared Information Management Services (SIMS) partnership, including Bridgepoint Health, Central CCAC, COTA Health, North York General Hospital, Providence Healthcare, St. John's Rehab Hospital, St. Joseph's Health Centre, St. Michael's Hospital, Sunnybrook Health Sciences Centre, Toronto East General Hospital, Toronto Rehabilitation Institute, West Park Healthcare Centre and Women's College Hospital. Sunnybrook Health Sciences Centre and St. Michael's Hospital are the newest members to join the partnership.

The participation of Sunnybrook is a step forward for patients who live in both the Central and Toronto Central LHINs, further strengthening inter-LHIN collaboration. It also strengthens linkages among acute care and rehabilitation hospitals and community care, thus enhancing the sharing of patient/client information among healthcare providers. St. Michael's Hospital is actively involved with the SIMS partnership on a number of projects, including the Emergency Department Notification System.

**Supporting Toronto Central LHIN**

One way we demonstrate our commitment to supporting better integration of the health care system is by having Toronto Central CCAC staff representation on all the priority committees for the LHIN: seniors, rehabilitation, mental health and addictions, health human resources, education and research, e-health, energy and environment management, and back office integration. These committees have been a critical component supporting the LHIN's ability to deliver its Integrated Health Services Plan.

**Activities to support Ministry Priorities**

The Toronto Central CCAC also has a number of activities and partnerships in place to support the Ontario Ministry of Health and Long-Term Care (MOHLTC) priorities for the health system, including the following:

***Increase integration and improve patient navigation across the care continuum***
This MOHLTC priority is supported by our activities related to the implementation of our two 'Flo' projects with Toronto East General Hospital and St. Joseph's Health Centre (an initiative looking at improving the patient experience and transition from hospital to other care settings), linkages with primary care through care coordination integration with physician group practices, support for physician e-referral, and support for the development of Family Health Teams.

***Decrease wait times for cardiac care, cancer care, hip and knee replacements, cataracts, and diagnostic services***
This MOHLTC priority is supported by our activities related to Acute Care Substitution and support for Reduced Wait Times including: increased admissions directly from emergency departments (EDs); Flo activities; increased staffing in emergency departments; intensive winter capacity activities designed to move as many patients as possible who require alternative levels of care (i.e. those who no longer require acute care services, but are waiting for another type of care in the system) during the winter months and flu season; and, our hospital-to-home program which provides escorts from emergency department to frail individuals returning home.

***Better access to comprehensive, round-the-clock health care to people in their own communities***
This MOHLTC priority is supported by our activities related to Linkages with Primary Care (care coordination integration with physician group practices, palliative program model, support for provincial E-Physician project, and outreach activities to support family physicians) and Support for Chronic Care Populations (medication management program, regional CCAC and community wound care initiative, diabetes management and education, client education packages, support for Regional Cancer Care Strategy, and provincial CCAC lead for Children's total parenteral nutrition services). Through our new client services delivery model, the CCAC launched plans to create community office sites across the city providing CCAC staff and service providers with bases from which to provide services to local communities.

The CCAC has numerous partnerships designed to provide support to homeless persons at sites convenient to them, including hostels, shelters and out-of-the-cold programs. Our services to the homeless include a partnership with St. Michael's Hospital and Seaton House to serve homeless palliative patients.

***Expanded access to home care and long-term care to free up hospitals and treat people more quickly***
This MOHLTC priority is supported by our activities related to Acute Care Substitution, including Flo collaboratives and Chronic Care Populations. These activities include: the regional CCAC and community wound care initiative; partnership with SIMS to develop a patient portal and continuum of diabetes care and education across the partner organizations; client education packages; support for the Regional Cancer Care Strategy; and, our Hospital to Home program).

## Significant Committees in the Community

The Executive Director, Directors, Managers and Staff of the Toronto Central CCAC serve as members on boards or participate in a wide range of committees and activities in the community on an ongoing basis.

Key outreach activities involving **management** include:

- Negative Pressure Wound Care Study Advisory Committee
- City of Toronto Social Research and Data Consortium
- Solutions
- West End Urban Health Alliance
- Primary Care Pilot at Lawrence Heights
- Child Health Network
- Balance of Care for medically and technologically complex children
- Pay for Results ED Wait Time
- Sick Kids Dietician project
- Rapid Rehydration Study- Sick Kids
- St. Michael's Hospital Community Connection Program
- St. Michael's Hospital Homeless and Under-housed Advisory Panel
- Seniors Mental Health and Addictions Services Committee
- Seniors Mental Health and Addictions Services Executive Committee
- Society of Graduates in Health Policy, Management and Evaluation (University of Toronto)
- GTA Health Information Access Layer (HIAL) Committee
- Committee Network Agencies
- Toronto Dementia Network Steering Committee
- CCAC e-Health Assessment Steering Committee
- Regional Geriatric Program (RGP) Outreach Committee
- Diabetes Strategy Steering Committee
- Ontario Community Support Association (OCSA)
- Toronto Western Hospital Community Advisory Committee
- LTCH Mobile Emergency Program
- ER Pay-for-Results Working Group
- Patient Flow Steering Committee
- Careful Transitions (Palliative)
- Trac-PG palliative research group
- Pharmacy Resident Educational Rotation – potential for pilot of Community-based Anticoagulation Partnership (CAP) project with Toronto Central CCAC and Toronto-based Family Health Teams (FHTs
- Feasibility project for private sector pharmacy integration into continuum of care for frail elderly (home visits and medication management) and Chroic Disease Management (CDM) education
- Home Care Chronic Disease Management partnership between Toronto Central CCAC and a community pharmacy chain
- FreshCare with Sunnybrook, SPRINT and other organizations
- Dementia LINC
- Stroke Study with McMaster University
- St. Michael's Mental Health Community Advisory Panel
- Acquired Brain Injury (ABI) Network Advisory Committee
- Mental Health Interagency Ethics Group
- ABI Network Waiting at Home Sub-Committee
- Toronto Rehab Institute ABI Community Advisory Group
- Toronto Interagency Hoarding Coalition
- COTA Health/Toronto Central CCAC Mental Health Joint Working Group
- Partnership (Mental Health and Central) with Fred Victor: Innovative Integrated Care Models

- Valuing Health-care team members: Working with Unregulated Health Professionals. Roundtable participation. Sponsored by the Canadian Nurses Association.
- ER/ALC Expert Panel
- Toronto Central LHIN Resource Matching & Referral Advisory Committee
- Toronto Central LHIN Seniors Council
- Continuing Care E-Health Council
- Emergency Department Expert Panel
- E-Referrals and Access Tracking Steering Committee
- Regional Geriatric Program
- GTA Rehab Network

Outreach activities involving **staff** include:

- Elder Needs Interest Group: Networking opportunity with community partners and service providers focusing on the needs and care of seniors. It is also an educational forum with periodic guest speakers and planned tours of retirement and long-term care homes in the area.
- The Joseph Brown, a seniors' building at Yonge and Lawrence: a social worker from SPRINT, a North District Care Coordinator and a nurse from Anne Johnston Health Station are in the building once a month for two hours to provide services to clients.
- West Toronto Task Group: a group created initially in response to the challenges faced by Toronto Central CCAC and Toronto Housing in dealing with the issue of bedbug/cockroach infestation at 2025 West Lodge.
- Ongoing meetings with west end community agencies and Toronto Housing help identify issues, particularly those relating to seniors that affect the provision of services in the building.
- West end Health Fair, organized last fall, included presentations by Public Health, Toronto Central CCAC (Pharmacist) and a community theatre group
- West End Diabetes project at Bailey House.
- West End Heat Registry
- Integrated Partnership Network (IPN) at CAMH
- Monitoring of Health Bus Sites that provide mobile services for the marginalized and homeless populations
- Monitoring of Sites that service the Homeless population
- "Out of the Cold" program management
- Referral management for the Tamil population in conjunction with St. Michael's Hospital Family Practice Unit
- Referral and consultation at the Toronto Western Hospital Family Practice Unit
- Participation in the Elder Abuse team
- Casey House initiatives
- Toronto Planning Initiatives for HIV & AIDS Committee
- Senior Pride network
- Women's Shelters for homeless women who are drug users
- Research group on Stroke and Health for Marginalized Women

# Statistical Overview of Client Services

**Individual Clients Served** Source: MIS 2008/2009 Q4 Submission

| | No. of Discrete Individuals | | No. Males | | No. Females | |
|---|---|---|---|---|---|---|
| | **2008/09** | 2007/08 | **2008/09** | 2007/08 | **2008/09** | 2007/08 |
| 0–19 | 7,158 | 6,784 | 4,736 | 4,465 | 2,419 | 2,319 |
| 20–64 | 16,472 | 15,871 | 8,036 | 7,706 | 8,436 | 8,165 |
| 65–74 | 7,597 | 7,136 | 3,529 | 3,337 | 4,068 | 3,799 |
| 75–84 | 11,906 | 11,274 | 4,506 | 4,229 | 7,400 | 7,045 |
| 85+ | 10,425 | 9,481 | 3,142 | 2,768 | 7,283 | 6,713 |
| Not Known | 4 | | | | | |
| **Total** | **53,558** | 50,546 | | | | |

**Client Services** Source: MIS 2008/2009 Q4 Submission (In-Home and School)

| | No. Clients | | % of Total | | Units of Service (hrs/visits) | |
|---|---|---|---|---|---|---|
| | **2008/09** | 2007/08 | **2008/09** | 2007/08 | **2008/09** | 2007/08 |
| Nursing | 19,742 | 20,105 | 31.09 | 32.89 | 733,308 | 692,977 |
| Personal Support | 18,942 | 17,898 | 29.83 | 29.28 | 1,966,661 | 1,767,364 |
| Therapies | | | | | | |
| Physiotherapy | 6,645 | 6,333 | 10.50 | 10.36 | 26,755 | 28,741 |
| Occupational | 12,535 | 11,606 | 19.74 | 18.99 | 47,492 | 48,779 |
| Speech/Language | 2,725 | 2,546 | 4.29 | 4.17 | 14,830 | 15,631 |
| Social Work | 1,675 | 1,516 | 2.64 | 2.48 | 5,891 | 7,344 |
| Nutrition | 1,185 | 1,100 | 1.87 | 1.80 | 4,741 | 4,207 |
| Psychology and Behaviour Therapy | 37 | 22 | 0.06 | 0.04 | 636 | 794 |

(Note: individual clients can receive more than one service)

**Referrals**

| | **2008/09** | 2007/08 | % Change |
|---|---|---|---|
| Short and Long Stay Programs | 25,580 | 22,799 | 12 |
| Child and Family Program | 2,965 | 2,391 | 24 |
| Acquired Brain Injury Program | 75 | 28 | 168 |
| **Total Admissions** | **28,620** | 25,218 | 13 |
| Non Admissions | 5,512 | 5,163 | 7 |
| Reactivations | 17,328 | 12,786 | 36 |
| **Total Requesting Service** | **51,460** | 43,167 | 19 |

**Hospital Referrals**

| | **2008/09** | % of Total | 2007/08 | % of Total |
|---|---|---|---|---|
| Admissions | 16,185 | 44 | 15,881 | 48 |
| Reactivations | 17,328 | 47 | 12,786 | 39 |
| Non Admissions | 3,219 | 9 | 4,447 | 13 |
| **Total** | **36,732** | | 33,114 | |

## Source of Admissions of Clients

| | 2008/09 | % of Total | 2007/08 | % of Total |
|---|---|---|---|---|
| Community | 12,435 | 43 | 8,488 | 34 |
| Hospital | 16,185 | 57 | 15,881 | 63 |
| Not Classified | – | | 849 | 3 |
| **Total** | **28,620** | | 25,218 | |

## Admissions by Age Group

| | 2008/09 | % of Total | 2007/08 | % of Total |
|---|---|---|---|---|
| Child | 2,965 | 10 | 2,670 | 11 |
| Adult | 11,206 | 39 | 10,180 | 40 |
| Senior | 14,449 | 51 | 12,367 | 49 |
| **Total** | **28,620** | | 25,218 | |

## Client Care Expenses

| | 2008/09 | 2007/08 |
|---|---|---|
| Nursing | $ 40,333,061 | $ 35,691,657 |
| Personal Support | 56,343,304 | 49,285,829 |
| Therapies | | |
| Physiotherapy | 2,857,116 | 3,101, 593 |
| Occupational | 4,838,653 | 4,931,151 |
| Speech/Language | 1,757,417 | 1,688,921 |
| Social Work | 838,801 | 850,824 |
| **Total** | **$106,968,352** | $ 95,549,975 |

## Auxiliary Services Expenses

| | 2008/09 | 2007/08 |
|---|---|---|
| Laboratory, Transport and Translation | $ 562,575 | $ 546,999 |
| Medical Supplies and Equipment | 11,139,916 | 10,925,276 |
| **Total** | **$ 11,702,491** | $ 11,472,275 |

**Top 10 Clinical Conditions Leading to Admission**

| | | 2008/09 | % of Total | | | 2007/08 | % of Total |
|---|---|---|---|---|---|---|---|
| 1 | Mental Disorders | 4,389 | 15.3 | 1 | Mental Disorders | 3,583 | 14.2 |
| 2 | Injury & Poisoning | 3,363 | 11.8 | 2 | Injury & Poisoning | 3,058 | 12.1 |
| 3 | Neoplasms | 3,143 | 11.0 | 3 | Neoplasms | 3,045 | 12.1 |
| 4 | Diseases of Circulatory System | 2,963 | 10.4 | 4 | Diseases of Circulatory System | 2,747 | 10.9 |
| 5 | Ill-Defined Conditions | 2,810 | 9.8 | 5 | Musculoskeletal System | 2,486 | 9.9 |
| 6 | Musculoskeletal System | 2,330 | 8.1 | 6 | Diseases of the Skin | 2,451 | 9.7 |
| 7 | Diseases of the Skin | 2,275 | 7.9 | 7 | Ill-Defined Conditions | 1,888 | 7.5 |
| 8 | Diseases of Nervous System | 1,352 | 4.7 | 8 | Diseases of Nervous System | 1,182 | 4.7 |
| 9 | Metabolic & Immunity Disorders | 1,060 | 3.7 | 9 | Metabolic & Immunity Disorders | 991 | 3.9 |
| 10 | Diseases of Digestive System | 1,029 | 3.6 | 10 | Diseases of Digestive System | 859 | 3.4 |
| | Other | 3,906 | 13.7 | | Other | 2,928 | 11.6 |
| | **Total** | **28,620** | | | Total | 25,218 | |

**Top 10 Treatment Goals on Admission**

| | | 2008/09 | % of Total | | | 2007/08 | % of Total |
|---|---|---|---|---|---|---|---|
| 1 | Adjust to Altered Functional Status | 6,364 | 22.2 | 1 | Healing of Wound | 4,469 | 15.6 |
| 2 | Delay or Prevent Deterioration | 5,035 | 17.6 | 2 | Delay or Prevent Deterioration | 4,321 | 15.1 |
| 3 | Healing of Wound | 4,565 | 16.0 | 3 | Adjust to Altered Functional Status | 4,298 | 15.0 |
| 4 | Teach Treatment Protocol | 3,800 | 13.3 | 4 | Teach Treatment Protocol | 3,385 | 11.8 |
| 5 | Return to Former Functional Level | 2,842 | 9.9 | 5 | Return to Former Functional Level | 2,735 | 9.6 |
| 6 | Return to Self-Care Function | 2,157 | 7.5 | 6 | Return to Self-Care Function | 2,713 | 9.5 |
| 7 | Assess Level of Care Required | 1,992 | 7.0 | 7 | Assess Level of Care Required | 1,478 | 5.2 |
| 8 | Re-Integration into Community | 934 | 3.3 | 8 | Re-Integration into Community | 800 | 2.8 |
| 9 | Return to Total Self-Care | 549 | 1.9 | 9 | Return to Total Self-Care | 504 | 1.8 |
| 10 | Return to Total Care by Parents | 371 | 1.3 | 10 | Return to Total Care by Parents | 491 | 1.7 |
| | Not Specified | 11 | 0.0 | | Not Specified | 24 | 0.1 |
| | **Total** | **28,620** | | | Total | 15,545 | |

**Top 10 Hospital Sources of Admission**

| | | 2008/09 | % of Total | | | 2007/08 | % of Total |
|---|---|---|---|---|---|---|---|
| 1 | University Health Network | 3,639 | 22.5 | 1 | University Health Network | 3,582 | 22.1 |
| 2 | The Toronto East General Hospital | 2,135 | 13.2 | 2 | The Toronto East General Hospital | 1,964 | 12.1 |
| 3 | St. Michael's Hospital | 1,805 | 11.2 | 3 | St. Michael's Hospital | 1,891 | 11.7 |
| 4 | St. Joseph's Health Centre | 1,764 | 10.9 | 4 | St. Joseph's Health Centre | 1,704 | 10.5 |
| 5 | Mount Sinai Hospital | 1,460 | 9.0 | 5 | Mount Sinai Hospital | 1,312 | 8.1 |
| 6 | Sunnybrook Health Sciences | 1,378 | 8.5 | 6 | Sunnybrook Health Sciences | 1,291 | 8.0 |
| 7 | Toronto Rehabilitation Institute | 500 | 3.1 | 7 | Toronto Rehabilitation Institute | 417 | 2.6 |
| 8 | Providence Healthcare | 482 | 3.0 | 8 | Bridgepoint Hospital | 381 | 2.4 |
| 9 | Bridgepoint Hospital | 467 | 2.9 | 9 | Women's College Hospital | 361 | 2.2 |
| 10 | Women's College Hospital | 382 | 2.4 | 10 | Hospital For Sick Children | 319 | 2.0 |
| | Other | 2,173 | 13.4 | | Other | 2,323 | 14.4 |
| | **Total** | **16,185** | | | Total | 15,545 | |

# Performance Information Highlighting Key Successes

## Service Delivery

From April 1, 2008 to March 31, 2009, the Toronto Central CCAC provided services to 54,171 unique individuals and a total of 1,835 clients were placed in long-term care homes. In addition, 296,558 calls for information and referral services were handled through our Client Services Centre.

Of clients receiving in-home services:
- 27,590 were discharged; 98% achieved their goals on discharge

As of March 31, 2008 there were:
- 281 individuals waiting in hospitals for a bed in a long-term care home
- 1,400 individuals waiting in the community for a bed in a long-term care home
- 803 individuals waiting in a long-term care home for admission to the home of their first choice

In addition, over the past year:
- 323 clients were placed in long-term care homes as a result of a crisis situation (this number includes clients from other CCACs placed in Toronto LTC homes; 389 of these were clients of the Toronto Central CCAC).
- 1,835 clients were placed in long-term care homes for permanent, interim or short stay (600 were for permanent placement)
- 45% of total placements went to the long-term care home of their first choice; 25% were placed in the home of their second choice and 23% in their third choice.

## Performance Monitoring

The most important way that the Toronto Central CCAC measures the performance of services we provide is from the feedback we get directly from clients. In 2009 we will be launching a new Client and Caregiver Experience Survey. We already encourage clients and their families to tell us about their experiences with our services and we track this information through our quality and risk tracking system, documenting events, and tracking complaints to our Ombudsperson

## Events

As part of our on-going quality improvement and risk management initiatives we actively encourage staff and service providers to report all events. These reports are reviewed and followed up by the management team and Quality, Risk and Evaluation Department. Event reporting includes the ability for us to track events, complaints and compliments regarding the care and services provided to our clients. This year there were a total of 1,674 events reported. Nursing services reported 40% of all events and Personal Support Worker services reported 16%. Another 20% reported involved therapy areas, including Occupational Therapy, Physiotherapy and Social Work, and 5% involved equipment and supplies. Non-contracted services providers accounted for 10% of the total. The Toronto Central CCAC issues accounted for 225 reported events (13%).

## Ombudsperson

Ontario legislation requires each CCAC to have in place a complaints process. The Toronto Central CCAC has an ombudsperson. Mr. Jim Boyles has filled this role since 2007. He is an independent contractor whose role is to receive complaints from clients or family members, review the issues with CCAC staff, and work at resolving the concerns. At times this involves mediation with families and the CCAC. Complaints cover a wide variety of concerns: requests for increased service levels; admissions to long-term care homes and issues concerning waiting lists; quality of care; and communication issues.

In 2008/09,132 complaints were received and approximately 60% were resolved satisfactorily. These numbers are higher than the previous year. Another 25% were requests that fell outside the CCAC mandate and could not be met, 5% were ongoing at year's end, and 10% were not resolved to the client's satisfaction.

Clients can also register complaints with the provincial Long-Term Care Action Line, and if they are dissatisfied with the results of the CCAC's complaints processes they may also appeal to the Ontario Health Services Appeal and Review Board.

## Privacy

The Toronto Central CCAC is committed to protecting the privacy of all client information and the safe transfer of their personal health records. Client information on privacy is included in our client admission kits and on our website. A Privacy Officer is available to speak with clients about their privacy questions.

# Continuous Quality Improvement Highlights

The Toronto Central Community CCAC has implemented a number of quality improvement activities to enhance the quality of services provided to client and the organization's overall operations. Highlights of the continuous quality improvement activities include:

## Quality Management

We use a broad array of Quality Management tools to ensure we continue to provide the best possible client care. These tools include: regular quality improvement/occurrence reports, case reviews, chart audits, accreditation certification, and the services of an independent Ombudsperson. We are looking at the best practices from each of the predecessor CCACs and have completed a Quality Framework for the new organization. Client satisfaction surveys are another tool we will use in the months to come.

## Information on Service Providers

The following is a list of the service providers that the CCAC worked with in 2008/09 to deliver home care services to our clients:

*Equipment and Medical Supplies*
Bayshore Specialty Rx Ltd.
Calea Ltd.
KCI Medical Canada Inc.
Medigas, a Division of Praxair Canada Inc.
Shoppers Home Health Care (Ontario) Inc.
Shoppers Drug Mart Specialty Health Network
Starkman Surgical Supply Inc.

*Nursing*
Casey House
Comcare Health Services
ParaMed Home Health Care
S.R.T. MedStaff International
Saint Elizabeth Health Care
Spectrum Health Care
VHA Home HealthCare
VON Canada Ontario Branch - Toronto -York Region Site

*Nutrition*
VON Canada Ontario Branch - Toronto -York Region Site
Hospital for Sick Children

*Personal Support Services*
Bayshore HealthCare Ltd.
Canadian Red Cross Community Health Services
CanCare Health Services Inc.
Circle of Home Care Services
Comcare Health Services
Nightingale Health Care
ParaMed Home Health Care
ProHome Health Services Inc.
Revera Health Services Inc.
S.R.T. MedStaff International
Saint Elizabeth Health Care
Spectrum Health Care
Storefront Humber
Toronto Homemaking Service
VHA Home HealthCare

*Joint Partnership Providers*
VHA Home Health Care+Carefirst+ St. Christopher House+SPRINT+West Toronto Support Services+St. Clair Services to Seniors+Scarborough Support Services+Better Living Health and Community Services
Toronto Homemaking Service=Senior Link+ Woodgreen Community Centre+Central Neighbourhood House

*Physiotherapy/Occupational Therapy/ Speech Language Therapy/Social Work*
1 to 1 Rehab
COTA Health
Comcare Health Services
Rehab Express Inc.
Respiron Care-Plus Inc.

*Other Providers*
Access Alliance Multicultural
Arrow Taxi
Gamma-Dynacare Medical Laboratories
LifeLabs Medical Laboratory Services
Metro Ambulance
Multi Lingual Community Interpreters
Pryor, Linder & Associates
Toronto Ride

# Organizational Development Work

We recognize that a compassionate, qualified and skilled staff is our most valuable resource. The Toronto Central CCAC supports all employees in continually building their skills and knowledge to ensure they can meet the unique needs of our community. In the rapidly changing environment in which we work, a major focus is on providing managers and staff with the tools and skills to respond and adapt to these changes. We support continuous learning to stimulate professional development, we recognize staff achievement, and we actively foster job satisfaction. We work with partner organizations to develop an effective, coordinated community-based delivery system for health and social support services. We also work closely with academic centres and other organizations in research initiatives and providing learning opportunities for students to further develop health and social support services in the community.

## Orientation

- In 2008/09, we had 516 employees (486 full-time equivalent positions). We welcomed 88 new employees to the organization providing a comprehensive orientation program for 52 new care coordinators, 23 new team assistants and 13 new management and administrative support staff.
- In addition, we provided employment to 19 students participating in our *Summer Student Program* which included work experience and learning for targeted at-risk students in our LHIN.
- Work continued on revising the orientation program to reflect our strategic directions and new models of service delivery within client services and throughout the organization.

## Training and Staff Education

- A major focus of training for 2008-09 was the continued introduction of technology tools to support client care. This included:
  - Upgrades to our Care Coordination Portal (our version of an electronic health record) to incorporate: the new provincial Consent Form, added functionality to make accessing and completing information more intuitive, and the new Client Quality Survey..
  - Preparation of our Hospital Care Coordinators for increased use of technology to support Emergency Department referrals and electronic completion of Placement applications. This included introduction of wireless technology for this team.
  - Launch of a public version of the Community Care Resources website in April 2008. The Community Care Resources website (www.communitycareresources.ca) includes over 13,000 records for community health and social services.

We also provided training to assist with process and work-redesign within Placement Services and the Client Service Centre.

- The Moving to the Future Committee, formed to assist with monitoring how organizational changes were impacting staff, concluded its work in June and was instrumental in assisting with managing the impact of the Client Services Caseload Redistribution Project and helping plan our One Year Anniversary celebration
- In-house we offered 43 different educational programs including such topics as:
  - Community Workplace Safety
  - Consent and Capacity
  - Ethical Decision Making
  - Medical Equipment
  - Cultural Competence
- We also introduced two web-based e-Learning modules to address mandatory education requirements for Workplace Hazardous

Materials Information System (WHMIS) and Privacy.
- Support was provided for staff to attend 98 external workshops, seminars or conferences including:
  - The Ontario Association of Community Care Access Centres (OACCAC) Annual Conference
  - Canadian Home Care Association Annual Conference
  - When Hoarding Causes Suffering
  - Safe Talk: Suicide Prevention
  - National RAI Conference
  - Provincial Conference on Palliative and Hospice Care
  - 7th International Conference on Urban Health.
- 92% of staff participated in at least one educational activity over the year with an average time of 19 hours per person (who participated) spent in these activities.
- Tuition assistance was provided to 22 staff enrolled in Certificate, Undergraduate or Postgraduate Degree programs and three staff were supported in pursuing the Certificate in Case Management through McMaster University.

## Student Placements

- Our commitment to student education continued with experiences provided for:
  - 108 first year medical students in the Determinants of Community Health Program at the University of Toronto, providing a half-day of home visiting with a care coordinator as well as an independent visit to one of our clients.
  - A student from the Social Service Worker program at Seneca College who worked in our Client Service Centre.
  - A student from the Bachelor in Health Studies program and one from the Master in Health Sciences program at University of Toronto worked on ethics-based research activities.
  - We hosted 4 students for a half day from the Master in Health Informatics course at University of Toronto
  - Two nursing students from the Post-RN Degree Program at Ryerson University and five nursing students from the Undergraduate Nursing Program at the University of Toronto were here for 12-week placements. During that time they worked alongside community and hospital care coordinators and assisted with some of our project work.
  - Two students from the Masters in Health Policy, Management and Evaluation Program from the University of Toronto completed work placements with our Senior Management Team
- A draft Academic Plan was developed in conjunction with the Research Advisory Committee to look at our student support in a more strategic way in the future.

## Leadership Development

- Our development focus this year was on the Senior Management and Leadership Teams. This work focused on how the teams interact and the development of a common language and decision-making guide to enhance communication and decision-making efficiency and effectiveness.
- An enhanced Performance Management process was developed and implemented for the Management team including the adoption of updated leadership and organizational competencies.

## Research Activities

In 2008-2009, Toronto Central CCAC actively participated in several research projects with various health care partners including hospitals, universities, other CCACs, and service provider organizations.

We continued to participate in three major research projects. The first is a Stroke Rehabilitation Study (Markle-Reid et al.), with McMaster University and four of our service providers: Saint Elizabeth Health Care, VHA Home Health Care, Bridgepoint, and Victorian Order of Nurses (VON). This interdisciplinary stroke rehabilitation project aims to examine the prevalence, correlates, and costs of rehabilitation for survivors of stroke receiving home care services; and to evaluate the acceptability, safety, effects and costs of a specialized and interdisciplinary team approach to community-based stroke rehabilitation. The main goal of the study is to lower the number of stroke survivors in acute care hospitals or other institutions by preventing recurrent stroke and promoting successful community re-engagement.

The second major research Study is titled CIHR Team in Community Care and Health Human Resources - Project 1.2: Children with Long-Term Care Needs (Spalding, et al.). This study is one of three separate but inter-related projects involving application of a Balance of Care (BoC) model. Researchers plan to apply the Balance of Care (BoC) methodology for the first time to children with long-term care needs. Working with the University of Toronto, Ryerson University and several community-based agencies, Project 1.2 aims at documenting and assessing child and youth community/home care services initially in Ontario and then expand to include the rest of Canada.

The final study is titled Negative Pressure Wound Therapy (NPWT) for the Treatment of Chronic Pressure Wounds (Goeree, et al.) This study is designed to provide evidence regarding negative pressure wound therapy (NPWT) as compared to standard dressing regimes in the treatment of chronic pressure ulcers in the pelvic region. This study is being conducted under the recommendation of the Ontario Health Technology Advisory Committee (OHTAC) to establish more Canadian evidence about the use of NPWT to help direct health policy decision making.

The following is a sample of some of the many other research projects we were involved in over the last year:

- Internet-based Support Services for Family Caregivers of Individuals with Alzheimer Disease and Related Dementias (Chiu et al.) Research Partners: Alzheimer's Society, University of Toronto, COTA Health
- Toward Quality of Care and Quality of Work: A Study of CCAC Contracted Personal Support Services in the Greater Toronto Area (Cranford et al.)
- Emergency Department Rapid Intravenous Rehydration for Paediatric Gastroenteritis: A Randomized Control Trial (Freedman et al.) *Research Partner: Hospital for Sick Children*
- The impact of the Toronto LHIN on the Toronto Central CCAC to deliver in-home physiotherapy and occupational therapy rehabilitation services to its service recipients. (Ampong, C.)
- Evaluation of the efficacy of a community-based medication management support service in preventing medication-related adverse events and hospital admission (Umali et al.) *Research Partners: West Park Healthcare Centre, Institute for Safe Medication Practices, COTA Health, Saint Elizabeth Health Care*

- An Investigation into Mobility and its Effects on the Use of Winter Footwear: An Interview Study (Fernie et al.) *Research Partner: Toronto Rehab Institute*
- How do Home Care organizations learn from and transfer knowledge about adverse events -2007-2008 (Baker et al.) *Research Partner: University of Toronto*

## Research Infrastructure

In early April 2008, Phase II of establishing a research infrastructure commenced with the creation of the Research Advisory Council. The Council has the task of identifying research opportunities based on research priorities, as well as promoting and supporting research activities, including planning and dissemination.

Phase II also saw the creation of the research Intranet web page, ongoing support of the research application process, and the development of more CCAC-initiated research studies.

## Health Care Ethics

With patients being discharged from hospitals much sooner and with more complex health issues than in the past, ethical dilemmas are frequently encountered by community health and support workers, including care coordinators, nurses, personal support workers, therapists, and others. Responding appropriately to ethical dilemmas in the community sector requires tools that support staff and clients in making difficult and challenging decisions.

The Toronto Central CCAC is actively involved in sponsoring the Community Ethics Network (CEN). Our staff ethicist co-chairs the Network, which now has 36 local, provincial, and national members and affiliates, and works closely with the University of Toronto Joint Centre for Bioethics. Our ethicist regularly presents to groups across the country on the topic of ethical decision-making in the community health and support sector.

The shared goal of the Toronto Central CCAC and the CEN is to advance the practice of ethics in the community health and support sector and to focus on building capacity. The Network provides resources, coordination and support for both clinical and operational ethics at the local level and at the Local Health Integration Network (LHIN) level.

During the past year, and the Toronto Central CCAC, with the support of the Joint Centre of Bioethics at the University of Toronto, undertook a major quality improvement project to ensure that the CEN continued to meet the needs of its members and remain relevant to the community health and support service sector. The results of the project were tabled at the fall strategic planning conference and new strategic priorities for the CEN were identified for 2009 and 2010. In addition, over 120 front line staff from member agencies, many of them personal support workers, participated in a very successful role-playing ethics training session. Several special workshops, as well as academic presentations, are now being planned as a result of the success of the quality improvement initiative and the Fall Conference

The Toronto Central CCAC remains actively involved in the development of ethics core competencies in support of the University of Toronto Office for Interprofessional Education, due to be launched in September 2009.