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

# Toronto Central CCAC Annual Report 2010/11

## *Transforming the Experience of Clients and Caregivers*

Ontario
Toronto Central Local Health Integration Network

Judith Hayward

Stacey Daub

A Message from the Board Chair and CEO

# DEFINING **QUALITY**

*At Toronto Central CCAC, **quality** means coming to work everyday to make things better – better for our clients, better for our partners, better for the health system and better for each other.*

Ontario's health care system is at a critical point in its evolution. The rising prevalence of chronic diseases and costs for prescription drugs, medical technology and other services are putting greater pressure on our resources at a time when almost 50% of the provincial budget is already spent on health care. For those of us working in the system, we know we need to make things better, including redesigning health care delivery to make it more responsive to changing client care needs, more client-focused and user-friendly, more cost-effective and offering a better client experience.

Research shows that delivering better quality and safer care, actually costs less. In our 2010/11 Annual Report, you will see how we are meeting the challenges facing our health care system by advancing quality improvement at every level of our organization. The profile of the clients we serve is shifting rapidly and we are now serving more clients with multiple complex and chronic health conditions than ever before. Until very recently, many of the people we now support at home would have been receiving care in acute care hospitals or long-term care homes.

As you review the report you will see how we have evolved our care coordination services to better serve our different client populations. You will encounter the names, faces and stories of real people whose lives have been transformed by our new approach to care. For example, additional funds from the Toronto Central LHIN helped support a Home First approach that enables us to get people home from hospital sooner and support them at home longer.



## Who We Are

**A dedicated team connecting, supporting and advocating for our clients**

### In the community...

**A first point of contact to connect people to a broad range of community and social support services**

### In homes & neighbourhoods...

**Community-based care coordinators supporting clients in their choices about how they live in their communities**

### In the hospitals...

**Working onsite in 26 hospitals and emergency rooms to help people make the transition home or to long-term care**

We are also working with service providers and health care partners in hospitals and communities to change how we deliver care. These improvements have enabled us to:

- Support more seniors with complex health and social care needs to stay at home with the right support
- Find ways to improve our clients' experience
- Support clients to transition between different health care services and providers
- Create teams of care providers working with families and caregivers to support clients to live safely and comfortably at home
- Help people navigate the multiple and often confusing array of different health services available to them, and
- Find ways to deliver care more safely, cost-effectively and efficiently.

Our work over the past year focused on three goals:

1. transforming the experience of clients and caregivers
2. keeping people home, getting people home
3. investing in our capacity to improve quality

Our three goals were inspired by our clients and caregivers, who continue to tell us how we can do better. This report includes results of our most recent client surveys and an example of how we are using client feedback to improve quality. We have also included performance data showing:

- how we are reducing emergency department visits by clients, and
- supporting more frail seniors to stay in their own homes.

Our CCAC's quality improvement activities were recognized by Accreditation Canada, with an award of full accreditation status in November 2010.

We are proud of what we have achieved and thank the Board of Directors, management, staff, service providers and partners who have supported us throughout the last year. We look forward to the months and year ahead of us as we continue to work together to create opportunities that will advance the quality of home and community-based care in the sector.

Judith Hayward, Board Chair

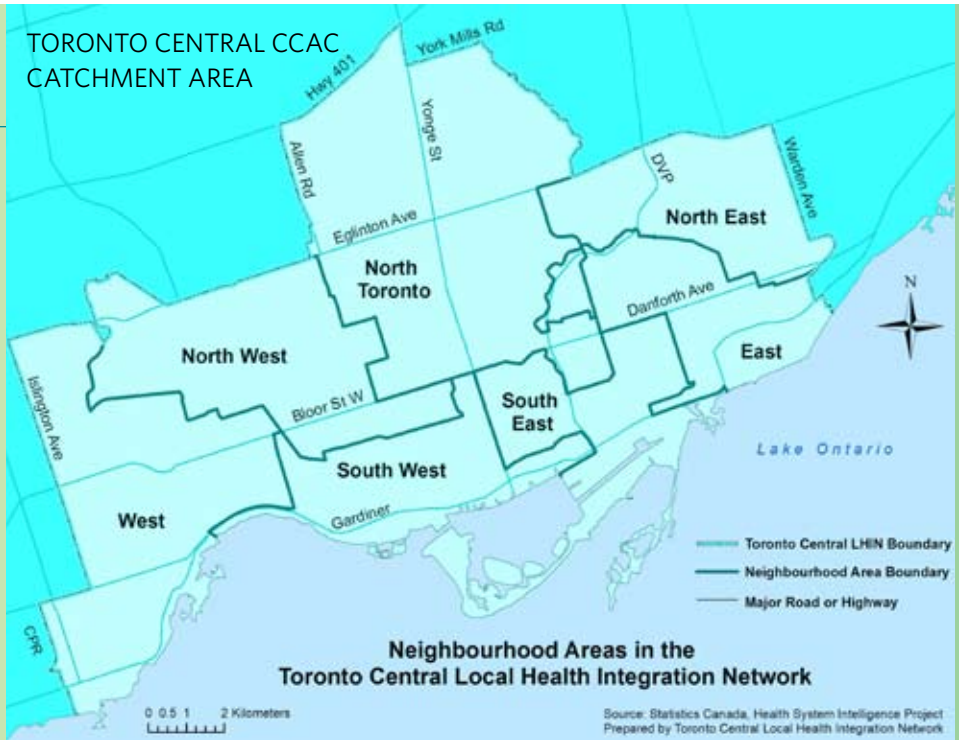
Stacey Daub, Chief Executive Officer



## ...we are partners in care

**Dedicated, specialized teams working together with community and health partners across the care continuum**

TORONTO CENTRAL CCAC CATCHMENT AREA



# HELPING YOU
# COORDINATE YOUR CARE

*Many people find it challenging to find their way through Ontario's health care system to the right place of care or to the right community-based resources to meet their needs.*

### Care Coordination That's All About You

Our Care Coordinators help people find their way through a complex system to get to the right place of care. Our staff has a bird's eye view of the health care system and are connected to every single part of it. Their role is to identify each client's health care needs and goals, coordinate their services and care providers, monitor their progress along the way and make adjustments until they reach their goals.

At Toronto Central CCAC we believe the key to care coordination is getting to know the client as a whole person and involving them in all decisions about their care. "Understanding their life experiences, their family and social supports are all important assets which they bring to the decisions about their care," says Dipti Purbhoo, Senior Director Client Services.

### Advancing Care Coordination to Support Vulnerable Clients

Last year, Toronto Central CCAC reorganized care coordination services around the needs of our diverse client groups. This year, working with our partners, we are focusing even more on our most vulnerable clients. We're creating integrated care teams to improve our clients' and caregivers' quality of care. Early results show measurable improvements, including:

- 65,000 clients were transitioned home from Toronto area hospitals with the help of the CCAC
- 4,600 seniors who were frail and had complex health conditions were supported by the CCAC at home, 6% more than the previous year
- 10% fewer emergency department visits by clients over 80 years old
- 17% fewer patients waiting for a long-term care bed from acute, rehab and complex continuing care hospitals by providing them with support they needed to return home
- 500+ more seniors who might have moved to long-term care but stayed at home with CCAC support
- A 50% reduction in long-stay patients waiting in hospital beds for an alternate level of care

*"The care coordinator's role is critical to the client's health outcomes and the key link between the client and the other providers and teams. I have been impressed by how well they do this at Toronto Central CCAC," says Dr. Irfan Dhalla, General Internist, St. Michael's Hospital and Toronto Central CCAC Medical Advisor.*

*"Throughout my adult life I have been seen by multiple health care providers. None of the services are delivered in a coordinated fashion, and have required me and my wife to make frequent trips to hospital. For the longest time I wanted to receive some of my treatment closer to home; however, our family was not aware of any local resources that could help. It was a weight off our shoulders when a CCAC Care Coordinator started to work with us to coordinate my care. Because my treatment requires a combined medical and behavioural approach, and there is no interdisciplinary team available to provide this care, I have been able to rely on my care coordinator to bring together a team of specialists to support me," says Michael, Client.*

*"I had no idea about all the things that a person needs to consider and plan for before going to long-term care. The support and information that I got from my Care Coordinator made it easier for me to make my decision. She also helped me move to a nursing home in London, Ontario where I could be close to my daughter," says Mary, Client.*



*"Life has been challenging for our two-year old son. He was born with a condition that causes inadequate oxygen delivery to many of his vital organs. As a result he suffers from high blood pressure, has difficulty swallowing food, has low muscle tone and requires oxygen monitoring and a breathing tube. Caring for John is a full time job. I don't know what I would have done without my CCAC Care Coordinator who has been able to support his care needs. She found us a doctor who is familiar with his complex medical history and a school with the necessary supports for him. One of our biggest challenges was his respiratory problems, especially when he gets the flu, but she has been able to get him the right care and supports," says Jasmine, Caregiver.*

# **IMPROVING** QUALITY OF LIFE FOR SENIORS

**The Integrated Client Care model for seniors is a system level change initiative designed to support seniors with complex care needs, who live at home, and are at risk of readmission to hospital. The initiative is focused on linking different parts of the health care system to better respond to this high risk population. A team of care providers now plans and responds rapidly to the clients' and caregivers' needs regardless of where they access the health care system. At the heart of this model are a CCAC Care Coordinator and Primary Care Physician who are actively engaged and connected to the client and their caregiver throughout their care journey.**



*"The program is providing better support for me and keeping me safe at home," says Mike, Integrated Care Client.*

## The Integrated Client Care Model

Mike was admitted to hospital after complications with diabetes. He wasn't looking forward to it. He knew that, once again, he would have to repeat the story about his multiple health issues to different people and have one more conversation about considering a long-term care home. So when he arrived at the hospital, he didn't think much of it when he was told that his health profile made him an ideal candidate for a new seniors-focused program that would provide enhanced support and in emergencies would bring him back to the same hospital.

The 82 year-old was used to being hospitalized due to frequent falls and health complications caused by congestive heart failure. He lives alone in a home with serious structural damage, creating many fall hazards. He's unable to make repairs with nobody to assist with property decisions or help with his care. During several readmissions to hospital he was asked to consider a long-term care home, and chooses to go home to be cared for by his friend Lucy and the support of the CCAC.

## Making a Difference for Clients and Caregivers

It became clear to Mike what they meant when they said he would receive enhanced support when he called 911 after a serious fall. Mike said, "It was incredible. Everything was different from the moment the EMS team arrived. Everyone I spoke to had prepared for my care before I got to the hospital.

Toronto Central CCAC has been collaborating with partners from across the health system. *Over the past year, our efforts to improve the quality of life for vulnerable seniors has resulted in:*

- *25% decrease in clients waiting for long-term care homes in the community because of the CCAC's enhanced support for clients with higher care needs*
- *10% fewer emergency department visits by clients over 80 years-old within the first 30 days of admission to Toronto Central CCAC from an acute care hospital*
- *A 50% reduction in the number of clients waiting for long-term care in acute care hospitals, freeing up hospital beds for people who require acute care*

*"Medication-related issues and falls are the leading cause of hospitalization for seniors with complex care needs. According to the Canadian Institute for Health Information, over 50,000 seniors are admitted to hospital each year due to falls. Falls proofing and medication management are done for every client in this program and they are part of our broader safety program," says Toronto Central CCAC CEO, Stacey Daub.*

### Rapid Response and Smooth Transitions

When EMS arrived, they picked up my portable health information which was posted on my fridge by my care coordinator. It told them which hospital to take me to. They immediately contacted the emergency department, telling them everything about my health and notified my CCAC care coordinator and caregiver. When I arrived at the hospital someone from the program was waiting for me. She had all the information about my condition. We discussed the plans made for me while I was on my way to hospital and she involved me in the decisions around this plan."

### Specialized Care Coordination

The specialized care coordination planning begins as soon as a client is admitted to the program. It involves thinking through the multiple health and social issues with the clients and caregivers and making decisions together with a team of specialists and community partners.

In Mike's case, the CCAC Care Coordinator developed a relationship with a local family health team and began attending rounds with their physicians and clinical staff. She presented his situation to the team and a doctor agreed to visit Mike at home. The doctor made adjustments to Mike's diabetes medications on the first home visit and follow-up visits were arranged. The doctor also made arrangements for a diabetes monitoring device to be installed in his home and for his caregiver and CCAC Care Coordinator to be taught how to use the machine so the family health clinic could check on Mike's oxygen saturation and blood sugars daily.

The CCAC Care Coordinator also made arrangements for the Ontario Public Guardian and Trustees Office to assume financial guardianship and arrange for repairs to make Mike's home safer.

Mike continues to live at home with support from the CCAC, community support agencies, and his friend Lucy. His financial affairs are managed by the trustee. His doctor continues to make home visits and monitors his blood sugar through the monitoring device.

Participating hospital sites include St. Joseph's Health Centre, Mt. Sinai Hospital, St. Michael's Hospital and Toronto East General Hospital. The Toronto Central LHIN-funded Program which started in January 2011 is already showing great promise and will be evaluated in 2012.



*1% of the population accounts for 49% of hospital and home care costs. They are clients with the most complex care needs and most at risk to have adverse events.*

*- From Ideas and Opportunities for Bending the Health Care Cost Curve*

# **DRIVING** CHANGE THROUGH CLIENT EXPERIENCE

*Striving to see care through the clients' eyes and understanding that every action counts to build and keep the confidence of our clients is helping us transform the client and caregiver experience.*

## Delivering on our Promise

At Toronto Central CCAC we're driven by our commitment to transforming the experience of our clients and caregivers. We actively seek feedback from our clients by:

- Directly asking clients about their care experience
- Listening to our clients' stories
- Understanding our clients' concerns
- Getting our clients' input on improvements
- Reviewing external research and reports

But the most important contact with clients and caregivers is through our front line staff. Our care coordinators listen to and strive to understand our clients' experience through their eyes. We also learn from our service providers, who work very closely with our clients. They are the most important business partner we have on delivering on our promise of care.

Last year, clients and caregivers told us through surveys, what's most important to them. This year, we have been acting on what they told us, including wanting more:

- Care Coordination that involves frequent contact with clients
- Courtesy and respect
- Control and choice about their care
- Time and support for caregivers
- Support with understanding and connecting to services they need

Together with our service providers, we are making changes to improve the experience of our clients and caregivers.

## Measuring Client Experience through Client Surveys

Toronto Central CCAC experienced a 3% overall increase in our clients' and caregivers' overall satisfaction with their care experience. The three areas that had the biggest impact on their overall experience were:

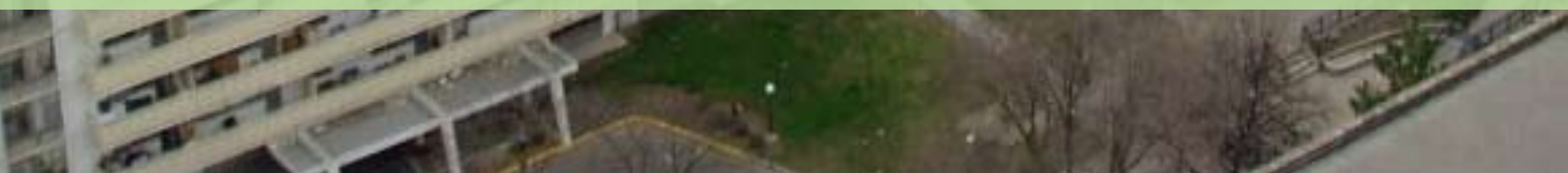
- their satisfaction with service providers
- their satisfaction with how the CCAC handled their care
- how well we met their expectations of quality

| Overall Experience | Year 1 |
|---|---|
| | 85% |

| Key Drivers of Overall Experience | Year 1 |
|---|---|
| Overall Satisfaction with Service Provider | 88% |
| Satisfaction with Handling of Care | 82% |
| Plan was Right for Needs | 85% |

*"Toronto Central is taking collaboration in new and exciting directions through working with all of its contracted service providers to improve the client experience. As co-chair of the Transforming the Client and Caregiver Experience group, I'm thrilled with our progress which is now being reflected in higher client satisfaction scores. This collaborative approach is succeeding in making the lives of those we serve just a little bit better each day," says Rheta Fanizza, Senior Vice President, Saint Elizabeth Health Care.*

*Each client is surrounded by one care team that's able to respond quickly to any changes in their care needs.*



*"It's so reassuring to know that they are here for me. I know my neighbourhood care team and they know me very well."*
*Maria, CCAC Client*

## Improving Care One Neighbourhood at a Time

We have a new model for care in neighbourhoods across the Toronto Central LHIN. Inspired by feedback from our clients, one of the ways we're improving care is by collaborating with our service providers to better organize care in neighbourhoods.

Neighbourhood Care Teams are designed to better support the care needs of people in neighbourhoods where we have many clients. Our clients will be able to count on one consistent care team, which includes one service provider agency, a CCAC care coordinator, personal support workers, nurses and therapists in a single neighbourhood. The focus is on meeting client needs with flexible hours of service. Each client is surrounded by one care team that's able to respond quickly to any changes in their care needs.

## A New Team for a New Reality

The Neighbourhood Care Team Model is already making a big difference for 86 year-old Maria. She has been receiving nursing care through the CCAC for a chronic respiratory disease and diabetes.

Her daughter helped with medication management when she lived at home. When Maria's daughter moved to another country, the CCAC provided medication management education, but Maria consistently forgets to take her medications properly. The nurses, who attend to Maria three times a week, also check on her medication practices. Unfortunately they're not always able to follow-up with her right away because they have other clients in different areas of the city. The new model has changed everything. With a dedicated team in her neighbourhood, the nurses are able to take a few minutes throughout the day and support Maria with her medication management.

Maria says, "It's so reassuring to know the team is here for me. My nurse, Sandra, checks on me frequently throughout the day and when she's not able to make it Mary or Sarah check on me. They know me very well. They know that I don't like to get out of bed before 9:30 in the morning so they are kind enough to come after 10:00."



**Better for Clients:**

- More responsive to client needs
- Improves consistency and continuity in care from direct service provider staff promoting an enhanced sense of safety and security

**Better for Service Providers and the CCAC:**

- Enhances continuity, communication, teamwork and integration
- Reduces travel time between client visits
- Improves staff satisfaction; opportunities to build skills and work in teams

**Better for the Health System:**

- Supports more people to stay at home and reduces emergency department visits
- Enhances the ability of community partners to work together

# **STRENGTHENING PARTNERSHIPS** TO GET PEOPLE TO THE RIGHT PLACE OF CARE

*Many patients get stuck in the gridlock of our health care system, waiting for the right place of care, even though they no longer require the level of care a hospital offers.*

In fall 2010, the number of patients with complex care needs requiring alternate level of care (ALC) peaked to **148** in Toronto Central hospitals. The average length of hospital stay for patients was **1.5 years** with some patients residing in hospital for over **10 years**.

The Toronto Central LHIN and CCAC introduced a project to address this issue. The ALC Project Team has been finding ways to help patients find the right care destinations in the community.



**50%**
reduction in the number of long stay ALC patients

**The project was highly successful in achieving:**

- **a 50% reduction in the number of long stay Alternate Level of Care (ALC) patients in the Toronto Central LHIN**
- **the transition of 70 patients to the right care destination**
- **improved cross-sector knowledge and understanding of the long stay ALC issue and patient care options**

## Carlos' Story

Twenty-four year-old Carlos is one of many clients that a Toronto Central CCAC Care Coordinator has been able to support through this improvement project. In July 2005 at the age of eighteen, Carlos suffered a traumatic injury. For six weeks he clung to life after suffering the loss of parts of both legs and some of his fingers. Carlos was moved to a rehabilitation hospital in 2006 and once his rehab was complete, he no longer required hospital care and was waiting for long-term care - the only destination his care team thought appropriate for him. Carlos said he wanted to be in the community, close to his family, so we worked to make this happen. His situation was one of 148 that were reviewed by the ALC Review Team assembled by the Toronto Central LHIN. The team of health professionals, from across the continuum of care, exhausted all opportunities to help clients find the right place of care. For Carlos, the team wanted to find him a supportive place of care in his community that would support his youth and growing independence.

Tracey Raymore, a Toronto Central CCAC Care Coordinator worked with Carlos for 2 months to transition him to the right place of care – a group home close to his family - that allowed him to be independent with some support. After spending five years in hospital, Carlos is thriving in his community, is close to his family and friends and is planning to go back to school.



*Toronto Central CCAC's partnership with hospitals across the Toronto Central LHIN on a Home First Strategy that helps patients return to the comfort of their home before making any decisions about long-term care, has achieved :*

- *51% reduction in patients waiting in hospital to go to long-term care*
- *Freed-up 75,000 hospital days – allowing hospitals to reinvest $43 million annually back into services for those who need acute care*
- *Delayed premature moves to long-term care (LTC). For every client the CCAC keeps at home to prevent premature LTC admission, the system saves up to $60,000 a year.*

*"Before I became a Virtual Ward client I relied on the emergency department as my safety net. With the support of the virtual ward team I have not had to go back to the hospital," says Rosa, Virtual Ward Client.*

# **CREATING** A SYSTEM OF CARE THAT PUTS THE NEEDS OF CLIENTS FIRST

## Virtual Ward

Toronto Central CCAC transitions about 8,000 clients a month from hospital to home. Almost 50% of these clients go home to other parts of the province. While most transitions work well, 20% of those discharged home are at risk of readmission to hospital within three months. Virtual Ward is an innovative model of care designed to strengthen the bridge between hospitals and home for vulnerable clients at risk of readmission to hospital. It's also focused on building stronger relationships across organizations to improve the client experience and health outcomes.

"Everyone on the team can tell you stories about patients who would likely have fallen through the cracks and ended up back in hospital," says Dr. Irfan Dhalla, General Internist and founder of the Virtual Ward.

The Virtual Ward, based on a UK model, takes the best elements of a hospital ward to the community, 24/7 access, a single point of access and an interdisciplinary team which includes: CCAC care coordinators, physicians, a nurse and a pharmacist to create a ward without walls. What's more, the team gathers daily to hold rounds, just like a hospital, to review each client's care plan, coordinate regular visits with family doctors and identify potential problems to avert hospital readmissions.

"What is truly remarkable about this model of care is the collaboration between different organizations and different professionals across the system," says Stacey Daub, CEO, Toronto Central CCAC.

This pioneering model of care is a research collaboration between Toronto Central CCAC, St. Michael's Hospital and Women's College with funding from the Toronto Central LHIN and the Ministry of Health and Long Term Care. The goal is to test a scalable model of care that can be implemented anywhere in the province.



# MAKING SURE THAT EVERY $ WE SPEND ADDS **VALUE** TO CLIENTS AND THE HEALTH SYSTEM

In the fiscal year 2010/11, for the third consecutive year, Toronto Central Community Care Access Centre balanced our budget and did our best to make sure that every dollar we spent added value to clients and the health system.

Toronto Central CCAC funding for 2010/11 was $ 200 million, 91 % of which was directed to client services.

The following table summarizes Toronto Central CCAC's financial position for the year which ended March 31, 2011 compared with previous year.

## Toronto Central Community Care Access Centre

### Statement of operations

Year ended March 31, 2011

| | 2010/11 $000 | 2009/10 $000 |
|---|---|---|
| **Revenue** | | |
| MOHLTC / LHIN Funding | 202,488 | 178,194 |
| Other revenue | 4,372 | 4,491 |
| | 206,860 | 182,684 |
| **Expenses** | | |
| Direct services to clients | 188,976 | 165,758 |
| Administration | 17,777 | 16,633 |
| | 206,753 | 182,392 |
| **Excess of revenue over expenses** | 108 | 293 |

### Balance Sheet

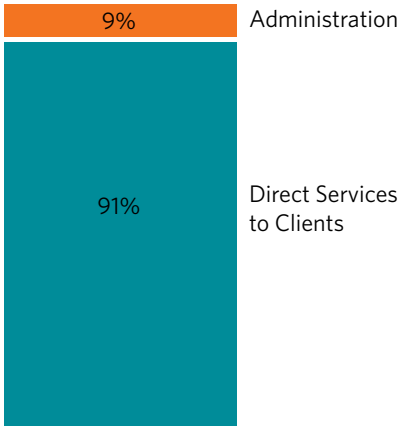
Year ended March 31, 2011

| | | |
|---|---|---|
| **Assets** | | |
| Current assets | 19,024 | 15,600 |
| Pandemic supplies | 538 | 465 |
| Capital assets | 9,768 | 10,840 |
| | 29,331 | 26,904 |
| **Liabilities** | | |
| Current liabilities | 19,031 | 15,640 |
| Deferred capital contributions | 9,768 | 10,840 |
| **Fund balance -** unrestricted | 532 | 424 |
| | 29,331 | 26,904 |

If you would like a full copy of our audited financial statements contact our Executive Office at 416-217-3820 ext. 2604.

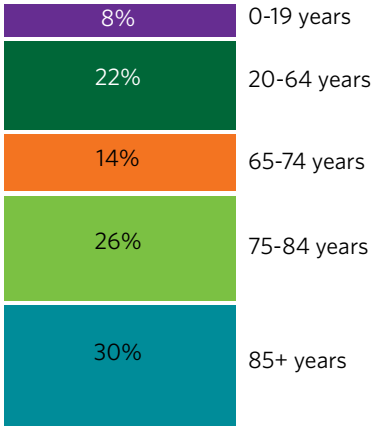
## Effective Use of Resources

In an increasingly challenging financial environment, stronger financial management is more important than ever to ensure that funds are directed where they have the most value for the clients and the health care system. At Toronto Central CCAC we are making sure that every dollar counts for client care. For every dollar the CCAC receives, 91 cents is spent on direct services to clients.



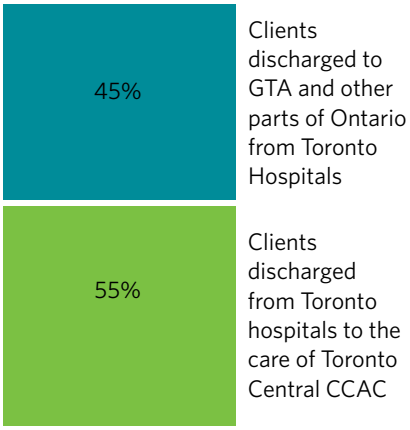

## Care Expenditures by Age Group

Our community has one of the fastest growing populations of older adults in Ontario. About 70% of our funding is directed to supporting the care needs of seniors over 65 years of age. It is clear the need for seniors focused care – today and tomorrow has never been greater. Eight per cent of funding supports children and 22% for adults.



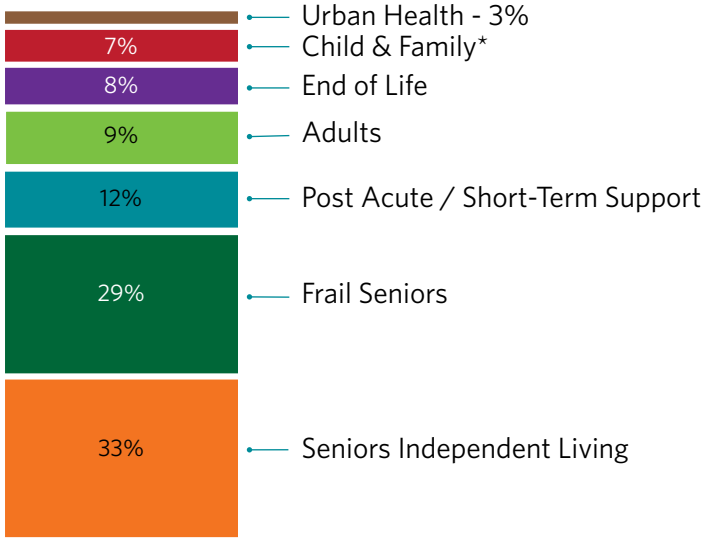

## Hospital Transitions

Many people come to Toronto to receive specialized care in Toronto area hospitals and our CCAC supports almost half of them to go home to other parts of the province. Only 55% of people who receive care in a Toronto Central hospital actually live here. We arrange for their care and services to be in place when they go home regardless of where they live.




## Expenditures by Program

Our population is aging, more people are living with chronic diseases and health care delivery is shifting from hospital to community. We are now serving more clients with multiple complex and chronic conditions than ever before. The changing profile of our clients is reflected in the expenditures on our programs.




* Program Descriptions on Page 19

# **PLANNING** FOR 2011/12

*The following Strategic Directions and Major Aims bring focus to our Quality Improvement Plans for 2011/12.*

| | | | |
|---|---|---|---|
| **Major Aims** | **Transforming the experience for our clients and caregivers** | **Keeping people home, getting people home** | **Investing in our capacity to improve quality** |
| **What it means for clients** | We strive to see our care through the clients' eyes and understand that every action counts to build and keep the confidence of our clients | We are proactive in preventing unnecessary hospital visits and supporting a positive transition experience | We continuously improve and evolve our programs and services, with a goal to increase value to clients, partners, and our staff |
| **Sub-Aims**<br><br>**Where will we focus our improvement activities** | • **Advancing the value of case management and system navigation** to enhance the experience for our clients, our staff and our system partners<br>• **Increasing integration across organizations** to foster stronger relationships that will support clients who are most at risk<br>• **Evaluating and evolving our population-based** model to improve our ability to meet the needs of our diverse client populations<br>• **Changing the conversations we have with our clients** so they know we are listening and we care and that we are doing everything to meet their needs<br>• **Enhancing team work and collaboration** across CCAC teams and with service providers to support a positive client and caregiver experience | • **Ensuring smooth transitions between care settings within our LHIN and beyond** by working with other CCACs and external partners<br>• **Building knowledge of our hospital teams to improve** their ability to make connections back to the community<br>• **Helping individuals and families to manage their care independently**, through more proactive education and support, and better integration with primary care and community based services<br>• **Introducing neighbourhood care teams** focused on meeting the care needs of many clients in a single neighbourhood<br>• **Supporting clients to stay in the community** by proactively providing case management to avoid unnecessary emergency department visits | • **Visibly leading on the quality agenda**, and building capacity of our management team to lead and support quality improvement activities<br>• **Improving value and maximizing the use of our resources**, making sure that all our resources add the most value to clients and the health care system<br>• **Building a culture of customer service across the organization** by equipping all staff with the education, tools and information they need to make things better for our clients, our service providers, our partners and for each other<br>• **Streamlining business processes** and new information systems to become more efficient, add more value and improve communication across our care teams and other CCACs |

*In any given year Toronto Central CCAC supports different client populations:*

**Urban Health – 1,200** clients who are homeless, poorly housed, have mental health or cognitive impairment issues to access services and be supported to live in the community.

**Children – 5,000** children to get the right support in schools; **400** children who have complex medical needs and **1,000** children with short term support needs.

**End of Life – 1,600** clients to die at home with dignity.

**Adults – 1,200** adults and their caregivers to manage long-term conditions.

**Post Acute / Short-Term Support – 13,000** clients who have short-term medical and rehabilitation needs.

**Frail Seniors – 6,400** seniors and caregivers are provided intensive seniors-focused care support so that they can remain at home with dignity.

**Helping Seniors be Independent – 12,000** seniors are connected to care and supported to remain independent in the community.

## BOARD OF DIRECTORS 2010/11

**Judith Hayward**
Board Chair

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Chair of Governance Committee

**Nancy Dudgeon**
Vice Chair and Member of Governance Committee

**Myra Libenson**
Member of Audit & Finance Committees

**Marsha Lindsay**
Member of Client Service & Quality Committee

**Dr. Puneet Luthra**
Member of Client Service & Quality Committee

**Shannon MacDonald**
Member of Governance Committee

**Wendy Nailer**
Chair of Client Service & Quality Committee

**Christopher Neuman**
Member of Governance Committee

**Manuel Pedrosa**
Member of Audit & Finance Committees

**Natasha vandenHoven**
Member of Audit & Finance Committees

**William Yetman**
Chair of Audit & Finance Committees

**Senior Management Team**

**Stacey Daub**
Chief Executive Officer

**Dipti Purbhoo**
Senior Director, Client Services

**Dennis Fong**
Senior Director, Human Resources and Organizational Development

**William Tottle**
Senior Director, Corporate Services

**Anne Wojtak**
Senior Director, Performance Management and Accountability

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

Greater Toronto's Top Employers 2011

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