



Toronto Central CCAC

Annual Report 2012/13





“I didn’t even have a computer in my home before. But it’s so simple. It takes less than five minutes each day!”

Jenny, TC CCAC Telehomecare client

At Toronto Central CCAC, we're constantly evolving to meet the needs of our clients and partners, and to empower our staff. We've had great success in advancing our new strategic plan in its first year – it has been rewarding and instrumental to the development of our strengths as an organization.

We take innovation seriously. As we evolve and make changes, we ensure they are evidence-based, and draw from proven strategies and programs which we adapt and test in our own organization before committing to adopting these solutions more widely.

As our community ages, we need to provide greater support to our clients and their caregivers. At Toronto Central CCAC, creating an integrated client experience through team-based support and empowering self-management methods is a top priority. Our Diabetic Self-Management Efficacy study is contributing to finding a new way to slow the progress of the disease and improve the quality of life for our clients with diabetes.

This year, we've created 102 Neighbourhood Care Teams which are tailored to the needs of Toronto's unique population landscape, helping Toronto Central CCAC to reorganize our care to serve a particular geographic area. Our clients feel comfortable interacting with a dedicated care team and this gives us more flexibility to meet their needs.

Toronto Central CCAC's leadership in quality and innovation has been recognized this year through a number of high-profile awards. We received the OHA Quality Workplace Silver Award, the Inter-RAI Award for Innovation, a Healthy Workplace Certificate of Recognition, and the OACCAC Sector Strategy Team Award. Congratulations to everyone involved – and that's almost everyone. Together, we're successfully developing a new organizational culture centred on employee empowerment, client respect and caregiver value.

Nancy Dudgeon

Chair, Board of Directors
Toronto Central CCAC



Every day I feel we're in a position of honour and privilege. We work with people on the most intimate level – in their homes, helping them with their most important needs, at a time when they are most vulnerable. And we're making a positive difference.

This year has been about taking this relationship with people to heart and pushing ourselves to do better. We've spent the past five years really listening to our clients, and I'll be honest, it wasn't always easy. While we heard that we've touched many lives in remarkable ways, we also heard some hard truths. Some of our best intentions didn't always match up with our clients' experience.

We formed a new strategic plan to build on our strengths and to set a new course for us over the next four years. 2012-2013 was the first full year of that plan and this is a status report on our progress.

Forming partnerships has been key to our success, whether we're talking about integrated care teams, working with hospitals, emergency services, primary physicians or our service providers. I'm consistently impressed by the solutions and outcomes we achieve when we work together.

Our success as an organization lies not in programs or numbers, but in people – the fantastic people working for Toronto Central CCAC, and the citizens of Toronto allowing us into their homes to work with them, trusting us to provide the right care for them, when and where they need it.

Stacey Daub

CEO
Toronto Central CCAC





Quick Facts



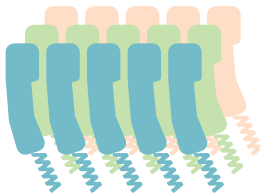
46,039 people received care in 2012/13 (up 3% from 2011/12)



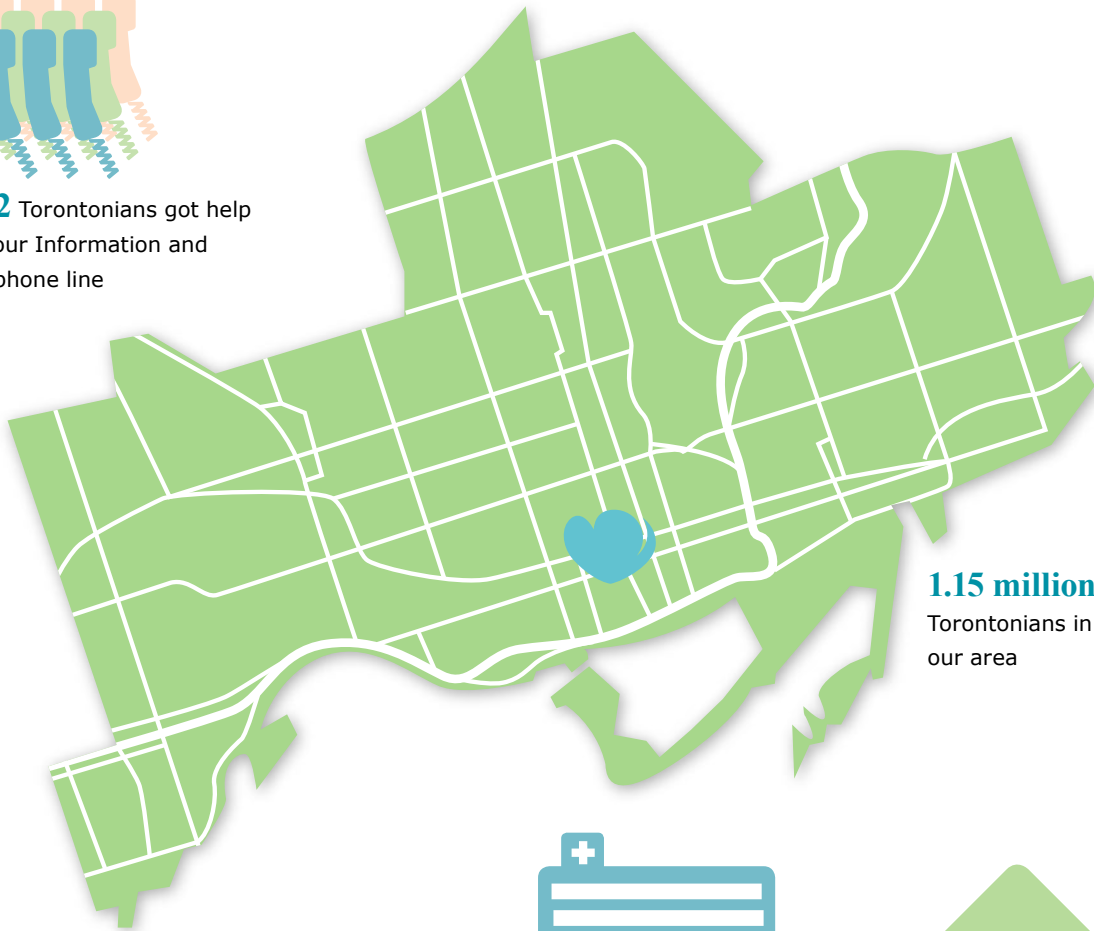
4,000 patients are discharged home each month from Toronto hospitals and need home care from our CCAC



87% of TC CCAC clients reported overall satisfaction with their care



283,392 Torontonians got help through our Information and Referral phone line



1.15 million Torontonians in our area



0 students in schools are waiting for our services, as our wait lists were eliminated this year



589 fewer people transferred to long-term care from hospital, meaning more people went home instead with CCAC support



5,825 people found a new family health practitioner through our Health Care Connect program in 2012/2013



28 people left long-term care to live independently at home with TC CCAC support



*"I can't just give up on myself.
I try to do whatever it is I can."*

*Alma, TC CCAC client,
Diabetes Self-Management Efficacy
study participant*

We will relentlessly pursue every option to deliver what is most important to every client

Strategic Direction #1

Our first strategic direction acknowledges that our clients are in the best position to **determine and drive their own healthcare**. It's our job to **listen**. **Only then can we deliver a better care experience.**

What's most important to our clients begins with waiting less for our services. This year, we're especially proud to announce the **elimination of wait times for services in schools**.

An extraordinary **organizational cultural change** is underway aimed at putting our **clients at the centre** of their care and allowing staff greater flexibility. **CHANGING THE CONVERSATION** is understanding what is most important to each client in every conversation.

Already our staff and service providers are reporting that these conversations are helping them build more meaningful relationships with clients, allowing them to better serve their needs, and have **more satisfaction** in

doing their jobs. And it's the best way to use the **same resources** to get better satisfaction for our clients.

This year, **100% of our care teams** and service providers were introduced to the philosophy and are engaging their own teams in it. Each team customizes it to fit their clients' needs.

One personal support worker began using the Changing the Conversation model with a client, and after a few visits, her client exclaimed, "You really care for me!" That's exactly the feeling we want all our clients to have. Every day.

Looking ahead: This year, all teams will begin finding ways to get at what is most important to our clients. Our nursing and therapy partners will also be testing this approach.

1 DAY

- Clients leaving hospital generally receive care within 1-2 days



3 DAYS

- Palliative or end-of-life clients receive CCAC in home support within 3 days





Heather's story

One moment Heather is a bright, dancing three-year-old. The next, she's collapsed, not breathing, and needs to be resuscitated. This happens every 21-28 days. Every 'episode' requires Heather's mom, Darcy, to bring her own child back to life while calling 911. The terrifying episodes have required fifty-nine hospital admissions since Heather was 3 months old.

Yet Heather's parents were determined for their developmentally advanced child to have as normal a childhood as possible. Toronto Central CCAC has been the family's partner in making this happen.

To meet the family's priorities, Heather's care coordinator arranged an innovative solution: Heather's parents and a small team of nurses received special resuscitation training so that Heather could go home.

No technology can monitor Heather's 'episodes' – she must be watched 24 hours a day. Toronto Central CCAC provides nursing support, allowing Darcy to get some sleep two nights a week, then have some "real family time" in the evening. Darcy calls the nurses her "sanity in scrubs."

Currently, Toronto Central CCAC care coordinator Sheena is working with the local school to ensure that Heather can begin Junior Kindergarten in the fall, with on-site nursing care to make it possible. It's one more support for which Darcy is grateful. "The support we have been given through Toronto Central CCAC has been nothing short of life-altering. We truly would not have made it through the past three years without it."

BY THE NUMBERS:

- **89%** of clients said their personal support worker listens carefully, a 7% increase over the previous year (Changing the Conversation is the only change made in the last year to this metric.)
- **5,682** children received TC CCAC care in their schools this year

We will support
our clients to live the
fullest and healthiest
lives possible

Strategic Direction #2

We're committed to looking at our clients as 'whole persons', caring for them holistically, and understanding the milestones in their lives.

We know that falls are one of the most significant risks to our older clients. A major fall can often lead to hospitalization. Worse, one major fall greatly increases an individual's chances of having a second major fall. Preventing falls is the **single most important change** we can make for our older clients. Our staff have the right tools and **ask the right questions** to help clients prevent falls.

Technology is also improving quality of life for some of our vulnerable clients. Toronto is one of three locations that launched **Telehomecare** this year. The program follows people with chronic heart failure and chronic obstructive pulmonary disease, tracking their vital signs

daily using technology that is monitored by nurses, who also provide weekly health self-management coaching sessions.

Supporting a very different client population, our new **mental health nurses** in schools are focussing on quickly getting children and youth the help they need. This province-wide initiative is an exciting one to identify early signs of **mental health and addiction** struggles and address them early, providing better opportunities for children and youth to take charge of their future.

Looking ahead: We will expand and track results for our falls prevention strategy. This year we are working with caregivers and clients to offer more flexibility and choice around how their care is delivered.

Telehomecare pilots showed the program resulted in:



65%

reduction
in hospital
admissions



73%

reduction in
emergency
department visits



Adil's story

When Adil* ended up in hospital after a fall, Toronto Central CCAC care coordinator Alisha was introduced to a **family struggling to cope** with his needs. Unable to walk safely, and with mental health problems made worse by dementia, Adil, in his late 60s, could no longer be left alone.

The situation seemed dire and the family doubted they could care for Adil at home, but they were **impressed with the services** Alisha quickly put in place.

To deliver care and prevent future falls, an occupational therapist assessed the couple's apartment and arranged for necessary equipment. Nurses visited to teach the caregiver how to administer Adil's medications. A personal support worker came several times a week to help with bathing and dressing. His medications were reassessed, and Alisha spoke with his wife about eating better.

Adil's health has improved remarkably. He's stronger, able to walk once again, and has **not suffered another fall**. "He's walking very slowly but...we can go for coffee and I can take him out to the mall," says Dawoud, Adil's brother.

This is a success story: a crisis placement to long-term care was averted and Adil was able to stay home with his family.

* Names of the family members have been changed to protect their privacy.

“ Medication can often be an issue in patient falls. Older people metabolize medications differently. And it's quite easy for patients to forget whether or not they took their second pill, and end up taking a double dose. ”

James Mastin, TC CCAC Nurse Practitioner

We will unleash
the potential
of our people

Strategic Direction #3

Toronto Central CCAC is committed to creating an environment in which every employee can grow personally and professionally.

When our staff feel **connected and passionate** about their work and they have the opportunity to make changes at the front lines of care, they're more effective at making a difference for their clients. We're **empowering employees** and service providers to be creative and resourceful in designing care plans to meet the **individual needs** of clients and families.

We are asking our staff to contribute ideas about how to improve how we work. We know they are in the best position to tell us what could make our work place better.

To ensure we're listening to our staff on an ongoing basis, we launched an internal social media platform for staff to contribute their ideas.

We have seen impressive creativity across all teams and with our provider partners. One result has been our teams' success with **Alternate Level of Care patients (ALC)**. These are high-needs patients who are in hospital, but have completed the acute care phase of care, and are **waiting for a placement elsewhere**. They can usually be better served in the community with the right support and resources around them. It's not always easy, but Toronto Central CCAC care coordinators are succeeding. This year we hit a record low number of ALC patients in hospitals.

Looking ahead: We will continue to listen to our employees and act on their suggestions, allowing them to drive change. Our **Releasing Time to Care** program will free up more employee time to focus on client care by reducing time spent on reporting and paperwork.



266 long-term ALC patients living in hospital successfully moved out to long-term care or independent living supported by TC CCAC

67 ALC patients were in acute care hospitals at the end of the 2012/13 year, an all-time low





Debora's story

When Linda, a Toronto Central CCAC care coordinator, met her client Debora, she found a 53-year-old woman who was bed-bound and completely dependent on others due to morbid obesity, arthritis and diabetes. But Debora's remarkable goals were not consistent with life in long-term care: she wanted to gain her independence and get a law degree.

Linda and her manager, Sally, thought creatively and designed an individualized care plan with an extraordinary team. They contracted a unique psychotherapist, who is also a nutritionist, to work with Debora in her home three times a week to help her lose weight, a key to regaining independence. An occupational therapist and physiotherapist also worked with her three times a week.

Remarkably, Debora has lost 200 pounds. She is now able to roll over in her bed, raise herself to a sitting position, dress independently and is even beginning to stand briefly. Her diabetes is now completely diet-controlled. And Debora, who at one time visited the emergency department frequently, has only gone four times in the

past two years. "Linda and Sally deserve a medal. Without their help, I probably wouldn't be here."

Reversing Debora's dependence is an incredible achievement shared by Debora, Linda and Sally and the team they created. To have an innovative plan work and see a client come closer to her goal of independence, Linda says, "is very rewarding." Debora's self-confidence has increased, and she tries to keep her focus on her ultimate goals: independence and a law degree.

“ Linda and Sally deserve a medal.
Without their help, I probably wouldn't be here. ”

Debora, TC CCAC client

We will drive the highest possible care integration for our client populations who need it most.

Strategic Direction #4

While our healthcare system can often seem disconnected and confusing to those who need it, we are making changes so that our clients **see and experience a single healthcare team**, helping them at each step of their journey.

For our most complex and vulnerable clients, **the gap** they experience between their primary care, hospital and community care teams can often be **dangerous** – it **can mean a rocky transition and poorer health outcomes**. For our system, it often means frequent emergency department visits and **hospitalizations that are avoidable** and unsustainable.

For these clients, we bring together a **care team** to understand what is most important to each client and to develop a plan that ensures everyone is working together to **reduce that gap**. A client's team is led by their care coordinator and may include nurses, nurse practitioners, pharmacists, occupational therapists and physiotherapists. Team members come to the client's home when needed,

and work with the client's family doctor. Our previous experience developing the ICCP (Integrated Client Care Program) has given us ample evidence that when we work together with primary care physicians, our clients experience better care and require hospitalization and emergency services significantly less often.

A new nursing program further supports these goals. **Rapid Response Nurses** visit our highest need clients within **24 hours** of their discharge from hospital, confirm they are taking the right medications, and ensure that they have a visit to their family doctor booked within a week.

Looking ahead: We will work with our local partners to implement **Health Links**, a government priority for better integrating primary healthcare with other parts of the health system, and create an integrated circle of care for clients. In cooperation with primary care, we will develop new ways of working and communicating with one another so that our clients experience us as one team.

Our care coordinators are embedded in primary care settings across Toronto and work on-site in:

- 22** acute and rehab hospitals
- 7** Family Health Teams
- 2** Solo practice physician clinics
- 1** Community Health Centre



4,610 clients with complex care needs supported at home
(32% over target, and 41% of TC CCAC clients)



Jim has multiple health problems, including chronic obstructive pulmonary disease (COPD) and other respiratory and cardiac difficulties. He is also visually impaired due to macular degeneration. As a result, the 84-year-old is homebound, using a walker or wheelchair inside the house he shares with his wife, Josie.

Recently, Cheryl, Jim's Toronto Central CCAC care coordinator, who works directly with the South East Toronto Family Health Team, was called in when Jim's falls increased. Nurse Practitioner Mary Ann from the Family Health Team visited, diagnosing cellulitis in his legs. When antibiotics in pill form didn't improve the situation, Dr. Thuy-Nga (Tia) Pham, Physician Lead of the Family Health Team, visited and decided that antibiotics administered by IV were necessary.

But Jim didn't want to go to hospital for IV treatment. With this in mind, Cheryl acted quickly to assemble his care team to provide the IV treatment in his home and to ensure ongoing monitoring and assessment. Dr. Pham was impressed. "Cheryl helped me get the first dose of

IV antibiotics started within 12 hours and increased his Personal Support Worker (PSW) support ... that way we avoided emergency department visits and a prolonged admission during flu season."

Jim recovered and he and Josie are "more than happy" with the extended care team supporting them, allowing them to remain together at home.

" I have just been so tremendously impressed how well the system works when we work hand in hand as such a smooth, integrated team... diverting avoidable emergency room visits and admissions. "

*Jim's doctor, Dr. Thuy-Nga (Tia) Pham,
Physician Lead South East Family Health Team*

Making sure that every dollar we spend adds value to clients and the health system

In the fiscal year 2012/13, for the fifth 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 2012/13 was \$214 million, 92% of which was directed to client services.

The following table summarizes Toronto Central CCAC's financial position for the year which ended March 31, 2013 compared with the previous year.

Toronto Central Community Care Access Centre

Statement of Operations

Year ended March 31, 2013

	2012/13 \$000	2011/12 \$000
Revenue		
MOHLTC/LHIN Funding	211,830	206,350
Other revenue	2,303	3,379
	214,133	209,729
Expenses		
Direct services to clients	196,473	190,726
Administration	17,862	18,508
	214,335	209,234
Excess of revenue over expenses	(202)	495

Balance Sheet

Year ended March 31, 2013

Assets		
Current assets	24,800	21,857
Pandemic supplies	353	368
Capital Assets	8,337	8,956
	33,490	31,181
Liabilities		
Current liabilities	24,328	21,198
Deferred capital contributions	8,337	8,956
Fund balance – unrestricted	825	1,027
	33,490	31,181



“I feel blessed to have Nichole working with our family. She’s on top of everything, and is very informed. She knows all the options for care.”

Lianna, daughter and granddaughter of two TC CCAC clients

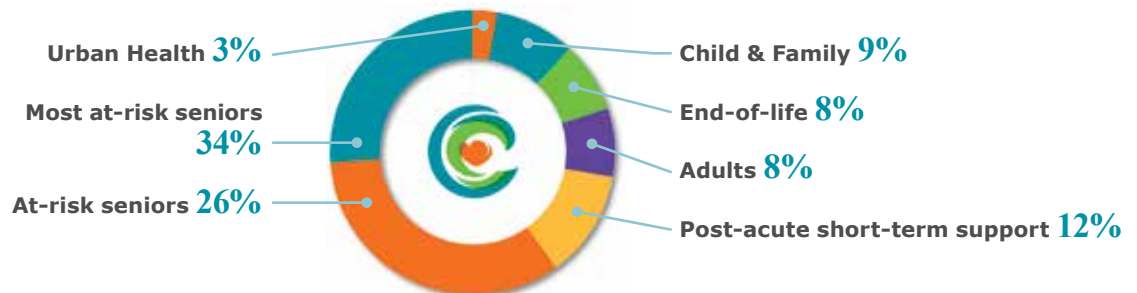
Highlights



Effective use of resources: Toronto Central CCAC continues to strive to use its funding effectively, ensuring the best value for our clients. This year, administrative spending was reduced from 9% last year.



Hospital transitions: People from all over Ontario benefit from Toronto's excellent hospitals. Toronto Central CCAC hospital care coordinators worked with 67,912 patients on their discharge this year, often working with care coordinators, long-term care homes and family members all over our province.



Expenditures by client population: Each year, Toronto Central CCAC serves more clients with complex needs as well as those with multiple chronic conditions. We are finding ways to support these individuals and their caregivers to stay in their homes longer. The proportion of our services to frail seniors climbs slightly but steadily each year.



Care expenditures by age group: With one of the fastest growing populations of older adults in Ontario, Toronto Central CCAC directs 70% of our funding to the care of clients over 65 years of age.



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*Ce rapport est disponible en français.
(This report is available in French)*

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