



50 Years of Caring for Toronto

Toronto Central CCAC
Annual Report
2013/2014

Letter from the Board Chair and CEO

50 Years of Caring

Around the corner from our offices at Toronto Central CCAC, there's a research corridor that's made headlines around the world. It is where insulin was created, where stem cells were discovered and where the genetic origins of many diseases have been found, leading to new cures and therapies.

In home care, we have our own breakthroughs. We're at the other end of that continuum — innovating to serve a population demographic that is living longer, and who want to live as well as possible. That's why, as modern medicine advances, so, too, must home care. The big difference is that our 'lab' is your home. That's where most people want to be as they live longer lives, live with very serious chronic health conditions or recover from a stay in hospital. So, at Toronto Central CCAC, we continually push the limits of health care to make going home, or staying at home, possible. Our success stories are often earned one person at a time, one family at a time.

As you will read in this report, we improve our services by talking with and listening to our clients. We reach more clients and serve them better by partnering with family doctors, hospitals, other health care providers and community organizations.

And because much of our innovation comes through team work, we invest in our people.

Over the years, we've been selected as one of the GTA's Top Employers, we've been recognized for the diversity of our staff, and in 2013 we were accredited with exemplary status by Accreditation Canada. Last year, we were also recognized with several awards specifically stemming from our partnership philosophy, highlighting our belief and desire to collaborate and work with others to deliver care.

At Toronto Central CCAC, we'll keep pushing the limits of health care. Our clients — and the province — are counting on it. Care at home costs much less than care in an institution, which helps sustain our health care system for all.

Much has changed in home care over the past 50 years. It began as a simple effort to help people in need and reduce pressures on hospitals. It's become an essential avenue of health care delivery — one we'll all continue to need in the future. We hope this Annual Report will help inform the conversation about how we can, together, build the home care system we all want, for today and for the next 50 years.

Bill Yetman, Chair, Board of Directors
Stacey Daub, CEO





Watch as you read

This Report can be read...
and it can also be *experienced*

Many pages in this Annual Report contain links to online videos. This allows our clients and partners to pick up where our printed words leave off.

Just look for the following icon throughout the Report:



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Evolution

Where publicly funded home care originated

It was known simply as “the Toronto experiment.”

There never seemed to be enough beds in hospitals. Some seniors were isolated, without family nearby to look out for them. Could more patients recuperate at home, which is where they want to be, and still receive quality care? Would that relieve some pressure on hospitals and make health dollars go further?

They’re important questions, and they were first asked—and answered—50 years ago in Toronto.

City agencies, the Victorian Order of Nurses and local hospitals partnered with private homemaking agencies to tackle the problem. Together, they delivered a pilot, community-based home care program in two of Toronto’s then eight health districts.

Over five years, 400 seniors received health services in the home. The federal government’s 1964 Royal Commission on Health Services noted its success, observing that “home care programmes... have successfully passed beyond the experimental stage.”

In April of that same year, “the Toronto experiment” transformed into the Home Care Program for Metropolitan Toronto. Today, Toronto Central CCAC carries on this legacy—piloting, experimenting, innovating, collaborating and delivering the home care services our community needs now, and that all Ontario communities will need over the next 50 years.

Innovation without end

“The Toronto experiment” never really ended. It grew.

Toronto Central CCAC now helps 73,000 clients per year. They are:

- › Older persons who want to live independently at home
- › Acute care patients recovering at home, instead of in the hospital
- › People who are transitioning out of Toronto hospitals to receive care in other parts of the province
- › Adults rehabilitating from injury so they can get back to work
- › People with chronic conditions who want to live as full a life as possible
- › Children who need health care in order to go to school
- › Those who are dying and want to be comfortable at home in their last days
- › People who are waiting to move to long-term care

In 1964, there were only three or four services offered in home care. Today, there are literally dozens, from in-home chemotherapy to advanced wound care. By listening and responding to our clients, Toronto Central CCAC continues pushing the boundaries of health care in the community, one client and one home at a time.

**WE HELP
73,000 CLIENTS
PER YEAR**



A Look Back at Our History and the World Around Us

1964

The Home Care Program for Metropolitan Toronto is launched with a focus on acute care patients.

1967

Field placements are offered to students in health programs.

1977

Dedicated coordinators assess clients discharged from CAMH, resulting in a 56% increase in the number of clients treated for mental health conditions.

1984

The first health-related services are provided for children with physical disabilities or developmental delays, allowing them to attend school.

1993

A new partnership with Princess Margaret Hospital allows for in-home chemotherapy.

1997

Home care and placement services for long-term care are merged to form the new CCACs.

1998

Outreach programs to help the homeless are initiated through partnerships with local churches, hostels, and health centres.

1985

The first AIDS patient is accepted for home care.

1994

Our Acquired Brain Injury Program is introduced.

2007

42 CCACs across Ontario are replaced with 14 new organizations.

2001

Satellite offices with docking stations and other technologies are set up across the city allowing coordinators to work in the community.

2004

A new, standardized assessment tool is launched for long-stay and placement clients.

2006

The Community Ethics Network is launched, and new partnerships with St. Michael's Hospital and Seaton House allow homeless palliative clients to receive care.

2008

A new Client Service Delivery Model aligns care teams with key client service groups, allowing staff to develop in-depth expertise for these populations.

2010

An integrated Client Care Model for seniors is launched.

2011

Integrated care for clients with chronic and complex needs evolves to improve the quality of care for children and terminally ill clients.

2012

102 neighbourhood care teams are created in order to better respond to client needs.

2014

The Toronto Central CCAC celebrates 50 years of caring for Toronto, joins Facebook and introduces its first Heroes in the Home Awards.

Mission, Vision, Values and Strategic Directions

Our Vision

Outstanding care – every person, every day.

Our Mission

To deliver a seamless experience through the health system for people in our diverse communities, providing equitable access, individualized care coordination and quality health care.

Our Values

Caring and Empathy –

Understanding our clients' experience through their eyes.

Leadership – Being passionate, proactive and creative leaders who are committed to transforming health care delivery for our clients.

Excellence – Committing to the highest standards of professionalism and performance that produce outstanding results of lasting value.

Social Responsibility – Promoting integrity, community development and just use of resources entrusted to us for the enhancement of human life and dignity.

Human Dignity – Valuing each person as a unique individual with a right to be accepted and respected.

Our Strategic Directions

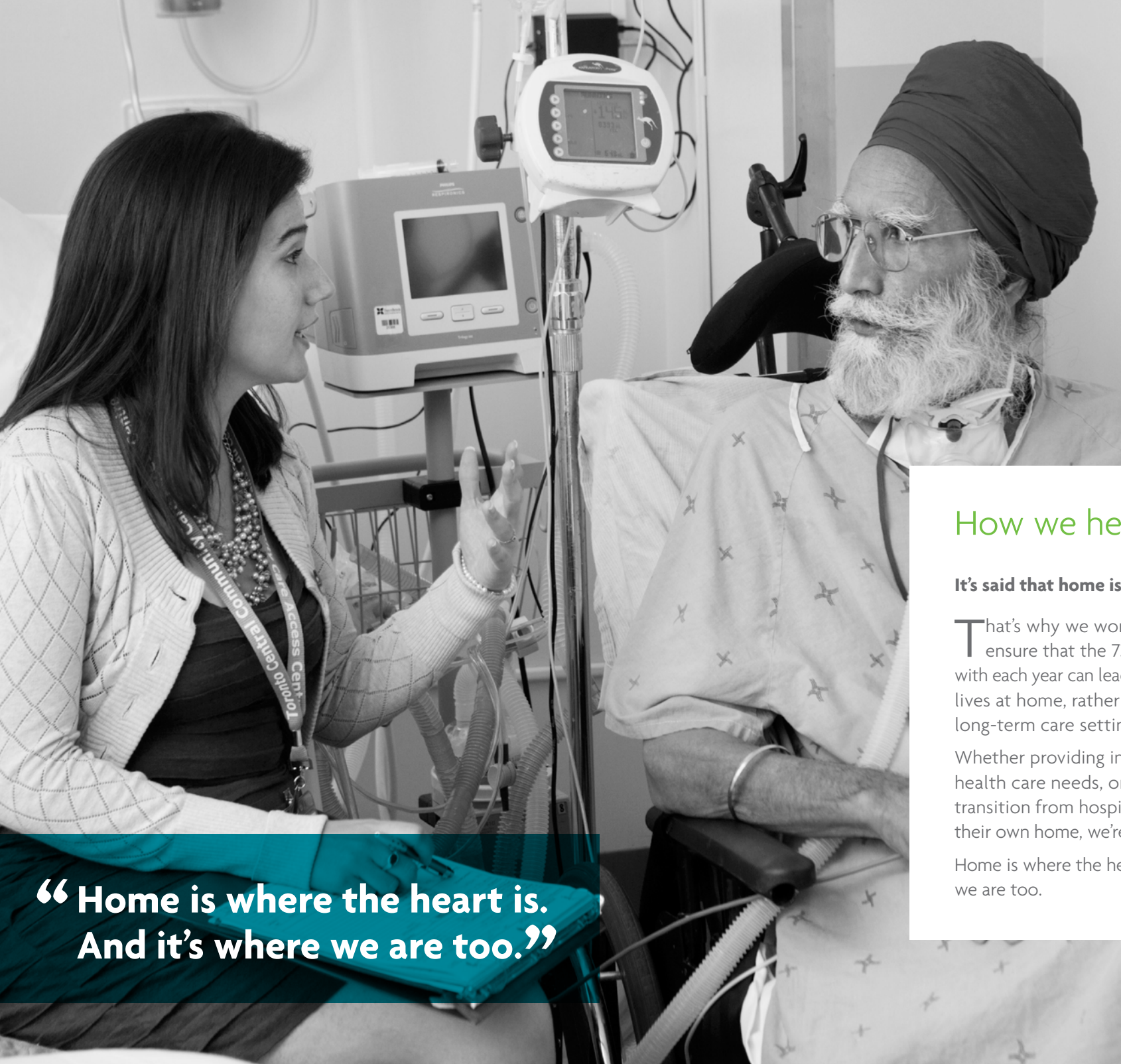
We will relentlessly pursue every option to deliver what is most important to every client.

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

We will unleash the potential of our people.

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





**“Home is where the heart is.
And it’s where we are too.”**

How we help

It’s said that home is where the heart is.

That’s why we work hard, every day, to ensure that the 73,000 clients we work with each year can lead comfortable, fulfilling lives at home, rather than in a hospital or long-term care setting.

Whether providing in-home support with health care needs, or helping people to transition from hospital to the comfort of their own home, we’re there.

Home is where the heart is. And it’s where we are too.

Client-Centred care

Talk first, task second: Changing the Conversation with clients

Profound change can have modest beginnings. Over the last few years, the conversations that began taking place in Toronto homes did not seem like a dramatic departure from the past. But they were.

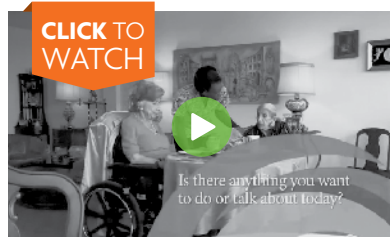
The personal support worker might ask the client: “I’m leaving soon. Is there anything else I can help you with before I go?”

“Could you make me a cup of tea?”

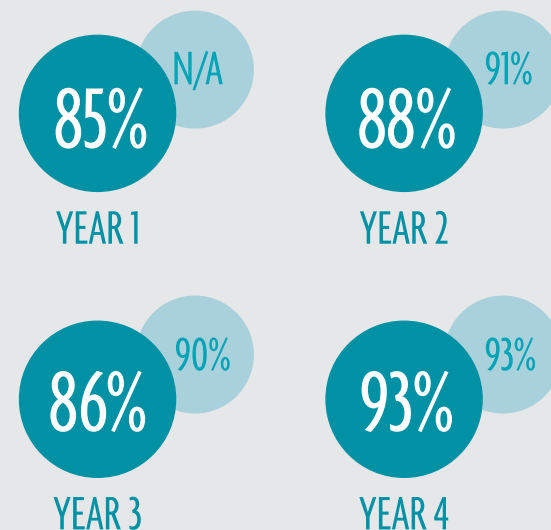
This is not how home care services have traditionally been delivered. Like others in the health system, we tended to focus more on the health care tasks we need to do for our clients. Toronto Central CCAC and our service provider partners have pioneered a program called Changing the Conversation. It is designed to help us better meet the needs and wishes of our clients by making sure we have ongoing

conversations with them about what’s most important to them.

Analysis of feedback shows that clients and family satisfaction are driven by three key factors: listening to and understanding what’s most important to clients and families, explaining things in a way that patients and families can understand and being informed and up-to-date on care needs. Changing the Conversation addresses all three, and client satisfaction is greatly improved as a result.



IMPROVING CLIENT EXPERIENCE



● Client Experience at Toronto Central CCAC
● Provincial Average of Client Experience Among All CCACs

“WHAT’S THE **MOST IMPORTANT** THING I CAN **HELP YOU WITH** WHILE I’M HERE?”

“DO YOU HAVE ANY CONCERNS **TODAY** THAT WE HAVEN’T **TALKED ABOUT?**”

“IS THERE ANYTHING **I’VE SAID** THAT YOU’D LIKE ME TO GO OVER **AGAIN?**”

“IS THERE ANYTHING **YOU HOPED FOR** FROM MY **VISIT TODAY,** THAT DIDN’T HAPPEN?”

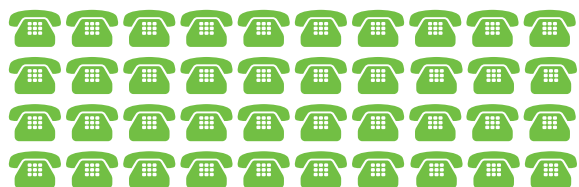
Caring for people

As we see more and more people with complex and chronic health conditions living in the community, we know we need to find innovative ways to help them stay as healthy as possible. That's why Toronto Central CCAC offers Telehomecare — a service offering weekly health coaching and remote monitoring of vital signs to people with chronic heart failure and chronic obstructive pulmonary disease.

We also offered Information and Referral services to 173,000 callers last year. Our client service centre staff helps callers manage health problems and find the right health care supports in their community.



173,000 CALLERS
RECEIVED INFORMATION
AND REFERRAL SERVICES





Integrated care

Wrap-around care teams

You might not have heard of integrated care, but you may understand the need for it. A lack of integrated care might result in a person having to go to an emergency department for conditions that are not life-threatening. It might cause an elderly neighbour to call 911 frequently because of deteriorating health. It may also mean that a patient with a chronic illness can't leave the hospital because there is nowhere else to go. In fact, five per cent of Ontarians with the most complex health conditions result in 60 per cent of provincial health system costs.

Toronto Central CCAC designed Integrated Care Teams to tackle this challenge. The team includes Care Coordinators, service providers, primary care physicians and other health professionals. Everyone involved has an equal voice: from the personal support worker to the doctor. Clients experience one team caring for them.

The hard data tells us that the need for hospitalization and emergency services is going down for clients who are part of an Integrated Care Team. Feedback from patients and families indicate that satisfaction and peace of mind are improved. Everyone is





The Toronto Central CCAC works with many community partners including hospitals, Long-Term Care Homes, Community Health Centres, Family Health Teams, Community Support Services, as well as home care providers who deliver care on behalf of the CCAC.

CLICK HERE to see a list of our contracted home care providers.

focused on the most important task: better health, safety and experiences for our home care clients. Early research shows an Alternate Level of Care reduction of 50%, a reduction in hospital-to-Long-Term Care demand of 20%, and an increase in the number of clients with high and very high medical needs being cared for in the community versus the hospital. It has also resulted in fewer unnecessary 911 calls and Emergency Department visits.

Primary care integration

For most of us, family doctors are the face of our health care system. That's why, as more care shifts to the community, CCAC Care Coordinators can be found working alongside primary care providers, connecting clients to the home care services they need. Toronto Central CCAC works with over 1,200 primary care physicians. As we support an increasing number of clients with complex and chronic

health conditions, it is even more critical that we partner together so that clients have 'one team' working for them in the community. To date, we have Care Coordinators working in teams with 540 primary care physicians, with a goal of working in teams with all 1,200 of our primary care physicians and nurse-practitioner led clinics over the next few years.

These Care Coordinators act as the family doctors' eyes and ears in the home environment. They help connect the doctors' patients to a wide range of community services. Doctors are able to spend more time with patients, and less time on the phone finding services. When patients undergo surgery, doctors can monitor their recovery at home with the support of the CCAC.

We trust our family doctor to do what's best for us. And family doctors trust Toronto Central CCAC Care Coordinators to connect their patients with safe and high-quality home care.

“As a physician who has provided in-home palliative care in Toronto for the past 18 years, I can attest to the valuable role played by the Care Coordinator... This collaborative approach to care ensured that the patient stayed out of the emergency department and out of the hospital. This outcome was consistent with his wishes and certainly was a desirable outcome from a health care system perspective.”

– Dr. Russell Goldman, Director of the Temmy Latner Centre for Palliative Care



Partnerships

We're part of the Toronto health care community, and have been for 50 years. We are in every Toronto hospital, working in 24 hospital sites and 7 emergency departments, as well as with family doctors, paramedics and medical clinics across the city. For our clients, we are their connection to a whole network of care providers.

Since the Fall of 2012, the Ontario Ministry of Health and Long-Term Care (MOHLTC) has been championing the creation of Health Links within each Local Health Integration Network (LHIN) in Ontario with a goal of improving the delivery and coordination of care for patients. While ultimately, each Health Link will improve coordination of care for the entire population it serves, the initial focus is on the 1% – 5% of patients with the most complex and extensive

health needs. In the Toronto Central LHIN there are nine Health Links and the Toronto Central CCAC is a full partner in all of them. In addition, the Toronto Central CCAC is the coordinating lead for one of the Health Links – the West Toronto Health Link. As coordinating lead, the CCAC has an additional role to develop a shared vision and strategy and oversee the development of the Health Link on behalf of the partners.

**24 HOSPITAL
SITES**
H H H H H
**7 EMERGENCY
DEPARTMENTS**

**CLICK TO
WATCH**

Working Hand-in-Hand
with Primary Care





Enablement

Innovation inspired by courage

There's some fear in leaving a hospital or institution before you're fully recovered, or with a chronic condition that may never go away. But the desire for independence and the simple joy of home and family are even stronger emotions. Toronto Central CCAC is continually inspired by the courage of our clients and the patience and generosity of family caregivers. Enablement is about harnessing the strong will of our clients to take the leading role in managing their own health and wellbeing.

Physiotherapy

In recovery, getting better means being able to get around. In aging, mobility makes independent living more enjoyable. In chronic care, maximizing movement contributes to a fuller life.

Between August and September of 2013, 2,000 people who had been receiving care through private providers billing OHIP had their care switched to Toronto Central CCAC. Toronto Central CCAC is now the single point of access to in-home physiotherapy services in our region.

Neighbourhood care teams

Torontonians love their neighbourhoods. We have history and relationships here. There's a sense of belonging. During the early days of home care, staff typically worked in a neighbourhood supporting a range of clients

who lived there. They got to know the area, its people and the different services that were available there.

As demand for home care grows and as clients' needs become more complex, neighbourhoods are once again where we are focusing our care. Today, Toronto Central CCAC has over 100 Neighbourhood Care Teams, made up of Care Coordinators, personal support workers, nurses, physiotherapists and other service providers. They serve areas such as Cabbagetown, Greektown, St. James Town, Thorncliffe Park, High Park, Roncesvalles, Rosedale and all neighbourhoods in between.

Clients tell us they like the consistent care they get from their local neighbourhood care team. Service providers report higher job satisfaction. Last year, 6,636 clients were supported in their communities through our neighbourhood care teams.

Continual connection: In 1984, home care in Toronto began partnering with schools. The first services were provided to children with physical disabilities or developmental delays so they could attend public schools. Today, we also have Mental Health and Addiction Nurses working in schools across Toronto, providing support to students facing issues of mental illness or addictions.

6,636 CLIENTS SUPPORTED
IN THEIR COMMUNITIES
THROUGH OUR
NEIGHBOURHOOD CARE TEAMS





Innovation

Serving people who are homeless and vulnerable.

The hospital is a place where people can go for care. But Toronto Central CCAC's mission is different. We take care to our clients, wherever they may be.

We care for any Toronto resident, regardless of income, age, address, or location. We go to where our clients need us: be it a shelter or a park bench. We work in every language of our diverse city. We are proud to represent the diversity of the city we serve.



Future of home care

Values that never change

No longer a niche: we're all home care clients now.

Home care is one of the fastest growing sectors of the health care system. And in the decades to come, there will be many more people who rely on it.

Home care clients may be supporting your family, friends, colleagues and neighbours. At some point, you may be a client or a caregiver, with the CCAC in your home to help care for you or someone you love. Home care is part of the solution in planning for the aging of our society.

The next 50 years will bring the greatest growth and challenges we've ever seen in home care.

“The next 50 years will bring the greatest growth and challenges we've ever seen in home care.”



Toronto's changing care needs

These are some of the things that Toronto Central CCAC is thinking about as we help shape the future of home care:



- › Opening our minds, pushing boundaries and being creative in helping clients and caregivers come up with options and make well-informed choices.
- › Partnering with clients and caregivers to make CCAC services better.
- › Delivering more flexible and customized care experiences and providing clients with more control and choice over their care.
- › Making sure our clients have the best information and resources to stay healthy.
- › Helping build neighbourhoods and communities of care, and improving access for underserved communities.
- › Helping people make sense of the health care system and all it has to offer.
- › Making sure we have a strong and stable home care workforce.
- › Making sure that unpaid caregivers, family, friends and neighbours feel well-supported in caring for loved ones.
- › Making sure that people understand and know that the home care system provides good value for the funds that are entrusted to us by taxpayers.

Performance Data

93% OF CLIENTS SURVEYED REPORTED HAVING A **POSITIVE EXPERIENCE** OF THEIR CARE FROM TORONTO CENTRAL CCAC



4,957 PATIENTS WERE HELPED BY THE THE TORONTO CENTRAL CCAC TO FIND A **PRIMARY CARE DOCTOR** THROUGH THE **MINISTRY OF HEALTH** AND **LONG-TERM CARE** HEALTH CARE CONNECT PROGRAM (A 50% INCREASE IN THE LAST TWO YEARS)



REDUCTION IN ALTERNATE LEVEL OF CARE* PATIENTS



 # OF PATIENTS RETURNING HOME WITH SUPPORT

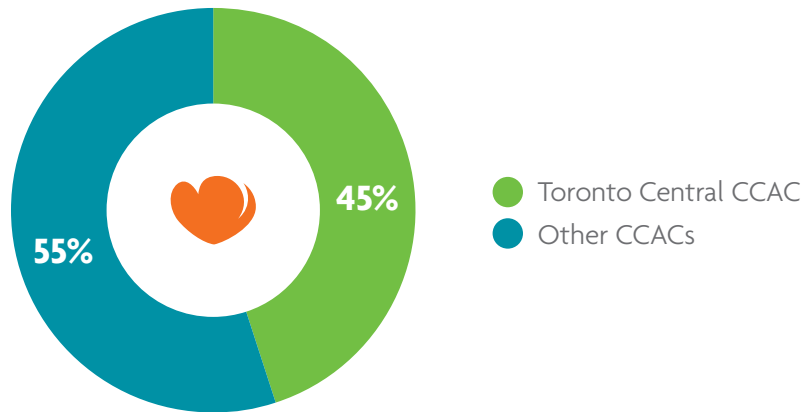
 # OF CLIENTS WAITING FOR LONG-TERM CARE

* Alternate level of care refers to clients in a hospital who are waiting to go elsewhere for care.

Financial Information

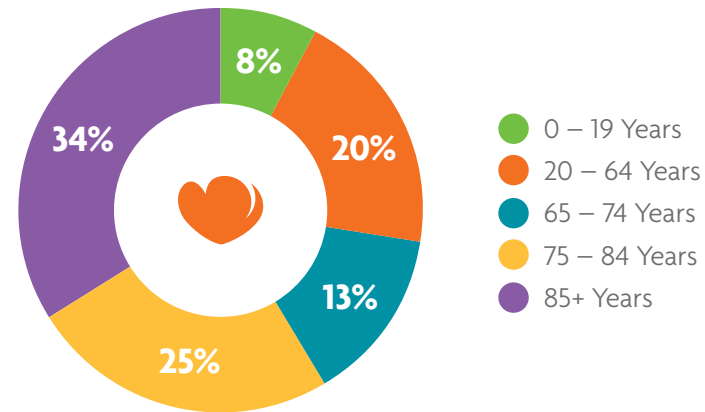
People discharged from hospitals

Toronto is a health care destination for many Ontarians. Of the clients discharged from Toronto hospitals with the help of Toronto Central CCAC, more than half return to the care of other CCACs throughout the province.



Expenditures by age group

Toronto Central CCAC is serving a growing population of older persons. 73% of our funding is used to support the care of clients over 65 years of age.

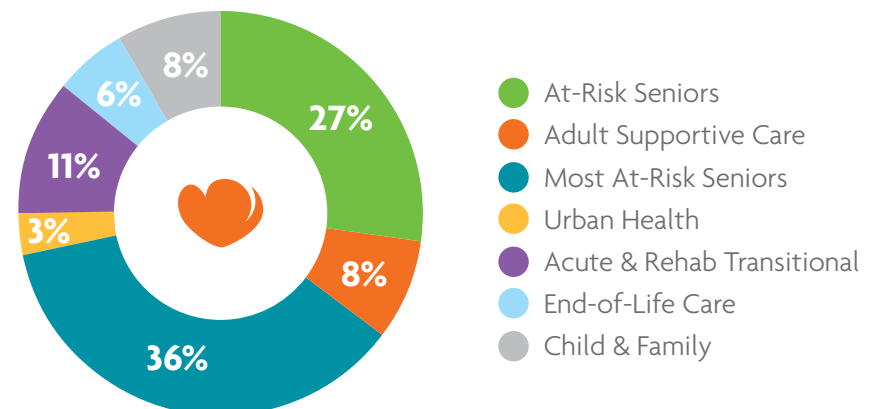


WE HELPED
68,000
PEOPLE TO GO HOME FROM
THE HOSPITAL WITH
CCAC SUPPORT



Expenditures by client population

The services of Toronto Central CCAC are not just for older generations. We help a vastly diverse group of people, at all ages and stages of their lives.



Financials

In the fiscal year 2013 – 2014, for the sixth 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.

The following table summarizes Toronto Central CCAC's financial position for the year ended March 31, 2014 compared with the previous year.

Statement of Operations

Year ended March 31, 2014

	2013/14	2012/13
	\$'000	\$'000
Revenue		
MOHLTC/LHIN Funding	230,987	211,830
Other revenue	3,496	2,303
	234,483	214,133
Expenses		
Client Care related expenses	215,144	196,473
Administration	19,302	17,862
	234,446	214,335
Excess of revenue over expenses	37	(202)

Balance Sheet

Year ended March 31, 2014

	2013/14	2012/13
	\$'000	\$'000
Assets		
Current Assets	27,596	24,800
Pandemic supplies	346	353
Capital Assets	6,088	8,337
	34,030	33,490
Liabilities		
Current liabilities	27,080	24,328
Deferred Capital contributions	6,088	8,337
Fund balance	862	825
	34,030	33,490

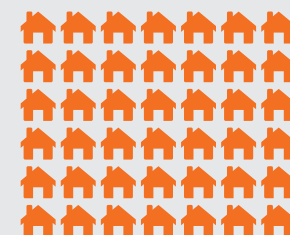
We also welcome you to access our full financial statements on our website:

healthcareathome.ca/torontocentral

5.7%
INCREASE
IN NUMBER
OF **CLIENTS**
SERVED



12%
INCREASE
IN **PEOPLE**
WITH HIGH NEEDS
STAYING HOME
AND SUPPORTED
IN THEIR
COMMUNITIES



Board of Directors 2013 – 2014

William Yetman
Board Chair

Gina DeVeaux
Member, Governance Committee

Nancy Dudgeon
*Member, Audit & Finance
Committees*

Robert Foldes
Member, Governance Committee

Laurie Hicks
*Member, Client Service & Quality
Committee*

Myra Libenson
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Committee*

Shannon MacDonald
*Chair, Corporate Governance
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Paul Sudarsan
*Member, Audit & Finance
Committees*

Natasha vandenHoven
*Member, Audit & Finance
Committees*

Senior Management Team
Stacey Daub
Chief Executive Officer

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

Dipti Purbhoo
Senior Director, Client Services

William Tottle
*Senior Director, Corporate
Services*

Anne Wojtak
*Senior Director, Performance
Management & Accountability*



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

healthcareathome.ca/
torontocentralhealthline.ca



Toronto Central CCAC is fully funded by the
Toronto Central Local Health Integration Network.