Mississauga Halton CCAC
Community Care Access Centre

CASC
Centre d'accès aux soins communautaires de Mississauga Halton

Health Care At Home

2011/12 Annual Report to the Community

Print edition to accompany video annual report

Ontario
Mississauga Halton Local Health Integration Network

Health Care At Home: Helping more clients at the end of their lives

We cared for more clients at the end of their lives so they could fulfill their wish to die at home - with dignity. Our clients express, most poignantly, what ***Health Care At Home*** means during this most difficult emotional time. Here is a touching tribute we received from Judy Chapman. Her beloved mother was our palliative client. These are her words.

Many Many Thanks

Marlene and Judy Chapman

To Marlene Grzesiak, Certified Hospice and Palliative Nurse (CHPN) registered nurse, Palliative Case Manager

This letter is going to sound like a tribute at The Oscar's, but in the scheme of life, you and your team at the Mississauga Halton CCAC, if awards were available, would win the Oscar.

I want to thank you on behalf of Mother, and my entire family, for the kindness, patience, empathy, service, equipment, support, humour, professionalism, and TLC that you offered, not only to Mother, but to my sister and me, in Mother's care.

Our sincere thanks to the individual and unique contributions of nurses and friends to the care of Mother.

And you, Marlene, who arranged, educated, supported, advised, for the past two years.

Without your management of Mother as a client, Marlene, I know that we would not have had the attention and kindness that we received. Your ever-present humour and optimism made possible the comfortable end of life that we all wanted for Mother.

When I was worried and unsure, you were also cheerily there for me, with the explanations and information that I needed to be strong for Mother.

The Mississauga Halton CCAC and your team were life-lines, angels, and provided the holistic care that not only the client/patient needed, but supported the family. I learned so much about palliative care and what is available in the community. Mississauga Halton CCAC should be proud to have you on their team, and proud of their elder-care services.

Warm Personal Regards,
Judy Chapman

Beloved Mother, Frieda

2011/12 Board of Directors

Left to Right:
Roshan Sapra, *Treasurer*
Dieter Pagani, *Secretary*
Kelly Bottone, *Director*
Don Taylor, *Director*
Jane McCarthy, *Director*
Rob Stansfield, *Director*
Astrid Lakats, *Director*
Bruce McCuaig, *Chair*
Kareen Hall-Clarke, *Director*
Bob Cooke, *Director*

Absent:
Ray Gilbert, *Vice-Chair*
Marcy Saxe-Braithwaite, *Director*

We are privileged to have a Board of Directors comprised of dedicated, skilled individuals who volunteer their time to represent your health interests. Board members lead governance practices and give generously of their time to important committee work. They represent exemplary leadership and commitment to providing ***Health Care At Home***.

Committees:
- Advocacy Committee
- Audit Committee
- CEO Compensation & Performance Evaluation Committee
- Client Services and Quality Committee
- Governance Committee
- Resources Committee

Health Care At Home: More demand, more care

Welcome to our ***2011/12 Annual Report to the Community***, ending on March 31, 2012.

Ray Gilbert
Vice-Chair

Caroline Brereton
Chief Executive Officer

So much is changing in health care today; people need a different kind of health care, now. We know of the baby boomer tsunami, where through sheer force of numbers, 'boomers' will change the face of health care. But we have a fast growing population of citizens who need care, now. With 61 percent growth in citizens 85 years of age and older in the Mississauga Halton region, we are experiencing a tsunami today – our seniors population, by sheer force of need, if not numbers, is changing how health care is being delivered.

Today, we are supporting a very different person; we provide nursing, personal support, rehabilitation and ongoing support and dignified end-of-life care to clients with high needs.

What does this mean for the Mississauga Halton CCAC? Astoundingly, one in two of our clients are citizens aged 75 and older. The traditional way of delivering health care is not sustainable. ***Health care today demands "Health Care At Home."***

Fortunately, people are living longer. With a longer life, they are living with more medical conditions and chronic diseases like dementia, hypertension, arthritis, asthma and diabetes. We are now supporting more frail seniors with high needs than ever before. Our region is also experiencing a 42.9 percent growth in citizens between the ages of 75 and 84.

And 93 percent of Canadians want to remain in their home and not in an institution. We are caring for more clients with high needs at home than ever before.

Canadians also want the vital medical and surgical care available at hospitals, when they need it. The Mississauga Halton CCAC achieved one of the lowest alternate level of care (ALC) rates in Ontario. This means that only 6.5 percent or seven hospital beds out of 100 have patients who could be cared for out of hospital. We are freeing up more hospital beds to enable shorter wait times for patients in urgent need of medical or surgical care.

Despite the tremendous demands for our services, we ended the year with a balanced budget.

We invite you to view our multimedia **2011/12 Annual Report to the Community** at www. healthcareathome.ca to learn more about our clients and view an update on our Strategic Plan; listen to subject matter experts presenting valuable, trusted information to help you plan for your health care needs and the needs of loved ones.

Health Care At Home is demanded today; we are leading the way as responsible stewards for the people of the Mississauga Halton region.

Ray Gilbert
Vice-Chair

Caroline Brereton
Chief Executive Officer

A profile of clients with chronic and complex care needs

We use the terms 'chronic' and 'complex' to talk about our clients' care needs. Here are two clients to help describe these different needs.

A client with chronic care needs

Meet Anita. She is 85 years old and lives with Victor, her husband of 61 years. Victor also has health care conditions, so he is unable to care for Anita alone.

Anita is aware of her surroundings but she is in slow cognitive decline. She still has the judgment to keep herself safe generally; but she has good days when she remembers well, and other days, when she forgets many things.

Anita suffers from arthritis, which makes her dizzy. She can take care of some daily activities; she can get out of bed with help and needs assistance dressing. Anita can manage her bowel movements independently but is incontinent for bladder. Anita needs supervision to avoid risk of falls. With a circle of care that includes family members who visit based on a schedule, Anita can continue to live with Victor at home.

As a client with chronic care needs, Anita's personalized care plan includes:

- Care for her wound until it is healed
- Personal support worker two times a week for bathing - up to 14 hours per week
- Equipment, including a walker, bath bench, raised toilet seat
- Physiotherapy and occupational therapy for a limited time to help manage her arthritis

A client with complex care needs

Meet Sonia. She is 86 years old and like most women, she outlived her beloved husband and now lives alone. Family members live in other cities.

Sonia is in significant cognitive decline. She doesn't remember things and is not aware of her conditions and surroundings; so it is difficult for Sonia to use judgment and make decisions that keep her safe. Sonia is incontinent for bowel and bladder. She is bed bound, which increases risk of bed sores. These pressure sores are caused a by a loss of blood flow and need ongoing nursing care.

Sonia cannot move without help. She needs help transferring from bed to standing to wheelchair. Sonia needs help with dressing and undressing and help with turning in bed. Sonia's needs are intensified by the lack of family members who can become her caregivers.

Sonia receives multiple visits by her Mississauga Halton CCAC case manager, who admits Sonia to our ***Stay at Home*** program.

With our ***Stay at Home*** program, Sonia receives:

- Three hours of personal care per day, seven days a week – up to 21 hours per week
- Ongoing nursing care to manage pressure sores
- Ongoing physiotherapy and occupational therapy
- Safety equipment: toilet seats, bed lifts or two people are required to move Sonia; the more complex needs our client has, the more equipment is needed

A life-line for clients

We enabled more citizens to remain at home in 2011/12. In fact, **98.2 percent** of our clients who are in our ***Stay at Home*** program remained at home and out of long-term care facilities.

Our client Eva is 86 years old with Alzheimer's dementia. She was referred to the Mississauga Halton CCAC from hospital, after she fell at home and fractured her hand.

During the first visit to Eva's home, her Case Manager Natoya Hylton saw that Eva was unable to manage her own personal care or manage daily activities of life. Yet Eva's son and daughter were adamant that their mother not move to a long-term care facility.

Natoya increased Eva's personal support and ordered occupational therapy and physiotherapy to help Eva regain her strength and avoid another fall. Natoya also arranged equipment for her mobility and bathroom safety.

Monitoring Eva closely, Natoya found that Eva was becoming increasingly frail. When the personal support worker prepared breakfast for her, she came back in the evening to find Eva hadn't eaten and was sitting in the dark. When Eva drank from a cup with dish soap, thinking it was juice, her personal support worker notified Natoya and Eva's family and she was taken to the emergency department. That is when Natoya admitted Eva into our ***Stay at Home*** program so she can remain at home safely.

Eva now receives personal support worker assistance three times a day, to help with her personal care and prepare her meals, ensuring Eva's health and nutritional needs are met.

It's been a year since Eva was placed in the ***Stay at Home*** program and she has never returned to hospital. Eva wanted to stay at home and with our services, she can live safely in the comfort of her own home.

About Natoya Hylton

Natoya is a registered nurse who has worked with the Mississauga Halton CCAC as a community Case Manager for the past eight years. It has always been Natoya's desire to positively impact the health care field and to reach out to the vulnerable in our communities. Through case management, information and referral services, placement and other community-based services available, Natoya declares she is *"living her dream of helping clients achieve their health goals through personalized care plans. It gives me great joy to know that what I do through the Mississauga Halton CCAC makes a difference in peoples' lives."*

Collaborations support *Health Care At Home*

Health Care At Home is achieved through collaboration among all health care providers to best support clients and their family members. We are working with valuable community services agencies and hospital partners to eliminate fragmented care, providing citizens in search of answers the support they need, now.

Collaborative Partnerships

Synergy GTA West Collaborative. With the support of the Mississauga Halton and Central West Local Health Integration Networks (LHINs) and in partnership with Metamorphosis – representing community service agencies in our community – and the Central West CCAC, we are focusing on three key priorities.

SYNERGY WEST
better care through community collaboration GTA

1. Quality community collaborative, championed by the Mississauga Halton CCAC
2. Back office integration, championed by the Central West CCAC
3. Leveraging technology, championed by Metamorphosis

Hospital Referrals: Our hospital-based Case Managers work closely with hospital staff to receive referrals for patients, moving from hospital to home. In 2011/12, we received 34,000 referrals from hospitals in our region.

Moving patients from hospital to home: Collaborating with our region's hospitals, we achieved one of the lowest alternate level of care (ALC) rates of 6.5 percent. This means that only seven out of 100 beds were used by patients who could receive more appropriate care in the community.

Short-stay: We helped 15 percent more clients leaving hospital to get the short-term medical care they needed to recover at home through our **Short Stay** program. By moving patients from hospital to home three days earlier to complete their medical care, we saved approximately $1.3-million in hospital days.

Health Care Connect: In 2011/12, we collaborated with local family doctors and helped 1,702 people find a family doctor. With just 770 citizens requesting a family doctor, our region has one of the lowest rates of residents without a primary care physician in Ontario.

Improving care planning

We bring experts to your home – virtually – to provide trusted information and help you plan for care before you face a crisis.

Our second annual ***Your Health, Your Way*** free public information event gives you free, trusted advice from a lawyer, a family doctor and our highly qualified, experienced Case Managers. Visit www.healthcareathome.ca for broadcasts.

Heroes in the Home annual celebration

Honouring Caregivers – our partners in care

Heroes in the Home celebrates the tireless dedication of family and loved ones who make it possible for people to live at home. The Canadian Caregiver Coalition estimates that informal caregivers contribute $5-billion in unpaid services annually.

We honour all caregivers for their kindness, compassion and dedication to caring for loved ones living with illness or disability. Caregivers are critical to the success of our Mississauga Halton CCAC programs to help keep clients living safely – and with dignity – at home. Visit www.heroesinthehomemh.com to learn more about these extraordinary heroes.

This year, we celebrated 22 percent more caregivers than last year. We invite citizens and clients in our region to nominate their special caregivers – family members, loyal friends, volunteers and health professionals. All caregivers nominated are recognized during our annual awards celebration.

This year, we held two events, one in Mississauga on November 29 and one in Oakville on December 1, celebrating caregivers from Mississauga, South Etobicoke, Oakville, Halton Hills, Milton and Georgetown. The celebration events show our appreciation for this special group of people and honour their dedication to caring for others.

Unprecedented media coverage enhanced the celebration and further honoured caregivers.

Alan's story: *Wait at Home Enhanced* program a life-line for Alan and Shelley

Imagine walking into your bathroom at home and blacking out, only to wake up in hospital several days later, partially paralyzed and unable to speak. How do you begin the long road to recovery? Will you ever be able to return home?

This is exactly what happened to Alan. At just 65 years of age, a massive stroke left him completely paralyzed on his left side and unable to speak.

While in hospital Alan met Anne, one of our hospital-based Case Managers. Anne completed a ***Home First*** assessment and organized the care and services required to make it possible for Alan to return home safely. Alan's wife, Shelley, became his primary caregiver, but she is physically much smaller than Alan and required considerable assistance to meet his care needs.

Alan's physical limitations confined him to the first floor of the family home. Before Alan was discharged from hospital, Anne ordered a hospital bed, special turning device, and wheelchair to assist with Alan's care; and a ramp was built up to the front door to improve access to and from their home.

To help with Alan's continuing recovery and ensure he could remain safely at home for as long as possible, Anne brought in Helen, one of our community-based Case Managers.

Helen Bell, a registered nurse with more than 20 years of experience, specializes in managing care for clients with complex* care needs. Helen, like all our Case Managers, is a personal health care advisor and coordinator, supporting clients and their caregivers.

Helen relied on her expert case management skills to determine the type and combination of care Alan needed to remain safely at home. She assembled his personal care team, including personal support workers (PSW), a social worker, an occupational therapist (OT), and a physiotherapist (PT).

Alan's physiotherapist designed an exercise program to maximize his physical recovery and abilities. The occupational therapist worked with Alan to determine his equipment needs to enable mobility and ensure his home was safe. PSWs work with Alan three hours a day, seven days a week, and help with bathing, toileting, dressing, and other activities of daily living.

Initially Alan and his family experienced tremendous difficulty adjusting to Alan's physical limitations. People who experience this type of health crisis often become depressed and Helen recognized the symptoms and their effect on Alan's recovery. Shelley was also under considerable stress and feeling overwhelmed by her new caregiver role. To support Alan's mental health, Helen arranged for a social worker for Alan. Helen also encouraged Alan to attend an Adult Day program, which provides an opportunity for social interaction for Alan and a needed break for Shelley from her caregiving responsibilities.

It is a long, ongoing road to recovery for Alan, but with the personal guidance, support and care arrangements from Helen, he is starting to regain his quality of life. Recently Alan produced a digital slide show of photographs from vacations he and his wife took over the years. This is an amazing accomplishment considering the immense challenges he has faced to regain functionality and independence since the stroke.

Traditionally, someone in Alan's situation would have had only one option – to enter a long-term care facility. However, because of the care and support provided by the Mississauga Halton CCAC, Alan and his family view long-term care as a last resort.

Please see Page 2 for a general description of a client with complex care needs.

For a description of our ***Wait at Home*** program, please read, ***Health Care At Home: Your Essential Guide to Mississauga Halton CCAC Services***, located in the Living Room Library: Resources.

Health Care At Home: When long-term care is the best 'home'

The path to long-term care is unique for each of our clients. Many seniors can live safely and comfortably at home, with the appropriate community-based supports from the Mississauga Halton CCAC, deferring or even avoiding entry to long-term care. For others, advanced illness or disability triggers the difficult decision to apply for long-term care.

Catherine's Story: Caring placement into long-term care

For Catherine, an independent 87-year-old with advancing dementia, her safety and security were a major concern. Placement in a long-term care facility on a secure floor was the correct choice for her, once all other care options had been explored.

Catherine lived with her sister, who was also elderly and experiencing health issues. Three years ago, Catherine was hospitalized due to advancing dementia. She stopped taking her medication, and was not eating properly. Catherine was discharged after a brief stay in hospital, but re-admitted within six months.

Bernice, one of our hospital Case Managers, became Catherine's personal health coordinator. Bernice completed a ***Home First*** assessment for Catherine, enabling Catherine to move into a retirement home with additional support provided by the Mississauga Halton CCAC. Catherine's services included visits from a personal support worker for personal care and bathing assistance, an occupational therapist, a physiotherapist, and nursing care.

Once at the retirement home, Lauren Howard, one of our community Case Managers, took over care for Catherine. While living in the retirement home, Catherine's sister was her Power of Attorney and main caregiver. As Catherine's illness progressed, she became increasingly reclusive. Ultimately, it was the danger to Catherine's safety that resulted in the difficult decision to apply for long-term care.

Sadly, Catherine's sister passed away shortly after the long-term care application was completed. Catherine's niece, Kim Twohig, agreed to assume the responsibility of Power of Attorney. Lauren, serving as Catherine's personal placement coordinator, and Kim worked through the completion of the transition to long-term care.

"Lauren, who managed my Aunt Catherine's long-term care application, was absolutely excellent, caring, knowledgeable, helpful, and understanding. We really appreciated everything she did. I am very pleased with my Aunt's placement at Post Village Inn," declares Kim Twohig, Catherine's niece.

Catherine was moved from her retirement home to a secure floor at Post Village Inn in Oakville where she is receiving the care she needs and is responding well.

Long-term care videos and average wait times: Helping you make the right decisions for care

We believe moving to a long-term care facility is the last option for people. But when it is the best choice for clients, our Case Managers are personal care advisors who assess, and assist our clients and their loved ones to make the best choice for care.

This year, we produced video tours of 27 long-term care facilities in our region to help clients and families select the residence best suited to care needs. We also publish average wait times to help you make informed decisions about care. Visit www.healthcareathome.ca for videos and more.

2011/12 Achievements

HOME FIRST INITIATIVES	2011-12	2010-11
Alternate Level of Care rate	6.50%	5.40%
Number of Clients served through ***Stay at Home***, ***Wait at Home*** and ***Wait at Home Enhanced*** programs	1051	989
Palliative Care	**2011-12**	**2010-11**
Total number of Palliative care clients	1605	1457
Long-Term Care	**2011-12**	**2010-11**
Number of clients admitted to a long-term care home	841	918
Number of clients on wait list for a long-term care home	1034	919
Fast Facts	**2011-12**	**2010-11**
Consecutive months with adult services wait list at zero	12	11

Notes: Previous year's numbers have been restated wherever necessary for comparison with current year's numbers.

Ontario
Mississauga Halton Local Health Integration Network

MH LHIN: Vision and Leadership

The Mississauga Halton CCAC is proud to receive funding for its programs from the Mississauga Halton Local Health Integration Network (MH LHIN).

Through the leadership and commitment of the MH LHIN, citizens in our region benefit from programs, including ***Home First***, ***Wait at Home***, ***Wait at Home Enhanced***, ***Stay and Home***, ***Short Stay***, ***Palliative*** and long-term care ***placement***, as well as many other community-based services provided by the Mississauga Halton CCAC through the support of the MH LHIN.

The Mississauga Halton LHIN plans, funds, and integrates the local health system. It provides appropriate, coordinated, effective, and efficient health services to the more than 1.15 million residents in our region.

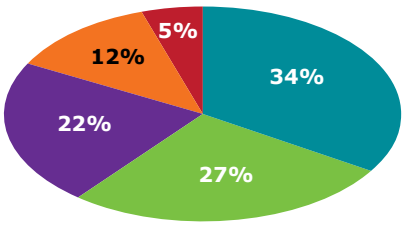
Fiscal Year 2011-2012 Results

Overall Totals	2011-12	2010-11
Average clients served per month	13,569	13,402
Total number of clients served	39,107	39,077
Total number of visits received by clients	2,147,002	2,102,543
Number of children who received health services at school	3,903	3,467
Number of full-time equivalent employees	350	344

PROGRAMS	2011-12	2010-11
Number of visits to care for community clients	1,591,334	1,574,016
Number of visits to care for palliative clients	239,248	236,429
Number of visits to support short stay clients	184,807	155,157

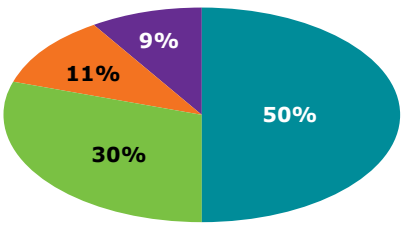
FINANCIAL RESULTS ($ in '000s)	2011-12	2010-11
Revenues	**$ 131,522**	**$ 127,466**
Operating Expenses		
Administration	11,441	10,472
Client Care	120,081	116,994
Total Operating Expenses	**$ 131,522**	**$ 127,466**
Net Surplus/(Deficit)	**-**	**-**

Visits by Age in 2011/12



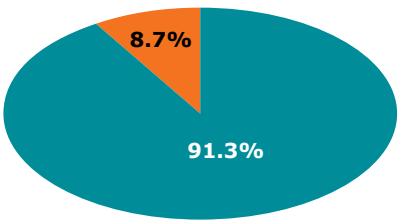
0-18 75-84
19-64 85+
65-74

Contracted Services in 2011/12



Personal Support/Respite
Nursing
Medical Supplies and Equipment
Rehabilitation Services

Operating Expenses in 2011/12



Client Care
Administration

Notes: 1. Current year's numbers are unaudited.
2. Previous year's numbers have been restated wherever necessary for comparison with current year's numbers

Health Care At Home: Trusted resources

From Hospital:

We have Case Managers and team assistants located in all hospitals in our region to help you move from hospital to home. And we have Case Managers located in the Emergency Departments to help avoid hospital admissions and re-admissions. Simply call our contact centre at 310-CCAC (2222) to be transferred to our hospital-based staff, located in:

The Credit Valley Hospital and Trillium Health Centre

- Trillium: West Toronto site
- Trillium: Mississauga site
- Credit Valley Hospital site

Halton Healthcare Services

- Oakville Trafalgar Memorial Hospital
- Georgetown District Hospital
- Milton District Hospital

In the Community

We have Case Managers, team assistants, placement coordinators and palliative care specialists available throughout communities in our region. Call our contact centre from 8:30 am to 9:00 pm, Monday to Sunday, to obtain information and advice or to speak with one of our experienced Case Managers who will be your personal health advisor. Simply call 310-CCAC (2222); no area code is needed.

***Health Care Connect:* Helping you find a family doctor**

Call 310-CCAC (2222) to find a family doctor. **Health Care Connect** helps you find a family doctor in or near your community.

Honouring ***Heroes in the Home***: Visit www.heroesinthehomemh.com. Watch our video and obtain our 2012/13 nomination form, or call 905-855-9090 extension 2070 for a print copy of the nomination form.

From Home:

Visit www.healthcareathome.ca for electronic copies of the following resources or call 905-855-9090, extension 2070 to obtain print copies.

Health Care At Home: Your Essential Guide to Mississauga Halton CCAC Services.

***Health Care At Home* free consumer newsletter**. Visit www.healthcareathome.ca to subscribe or call 905-855-9090 extension 2071.

2010/11 Quality Report Ontario Association of CCACs (OACCAC) report on all 14 provincial CCACs.

Video tours of 27 long-term care facilities in our region, with average wait times to help you make informed decisions about care.

2011/12 Multimedia Annual Report to the Community, complements this summary report and includes additional client case studies and details of exciting new innovations.

2011-2014 Strategic Plan, Year 1 Update. Learn how our strategic plan is working for you.

Second annual ***Your Health, Your Way*** free public information event and presentations from subject matter experts, providing relevant and trusted advice to help you plan for care before you face a crisis.

- Mr. Mark Handelman, Whaley Estate Litigation
- Mr. Rudolph Hyles, family doctor in Mississauga
- Natoya Hylton, Community Case Manager, Mississauga Halton CCAC
- June Rimar, Placement Coordinator, Mississauga Halton CCAC

Mississauga Halton CCAC Community Care Access Centre

CASC Centre d'accès aux soins communautaires de Mississauga Halton

www.healthcareathome.ca

Call 310-CCAC (2222) and no area code is needed.