


South East
CCAC CASC
Community Care Access Centre
Centre d'accès aux soins communautaires

# 2013-2014

# ANNUAL REPORT

# *Connecting You With Care*

ACCREDITATION CANADA
AGRÉMENT CANADA
*Driving Quality Health Services*
*Force motrice de la qualité des services de santé*

Ontario
South East Local Health Integration Network
Réseau local d'intégration des services de santé du Sud-Est

## 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

We value our patients, ourselves and each other through open communication, respect, and customer focus, while promoting continuous learning and accountability in a supportive, healthy environment.

## Our Story

Community Care Access Centres (CCACs) work in communities across Ontario to connect people with quality in-home and community-based health care. We make sure our patients receive the care they need when they need it. We provide information, direct access to qualified care providers and many comprehensive services to help people come home from the hospital sooner or live independently at home longer.

Finding and accessing care can sometimes be confusing and complicated. CCACs are here to help people find their way through Ontario's health care system, understand their options and get the highest quality care possible. We help people across their life spans from school children who have special health needs to seniors who need health services at home or access to a long-term care home.

Our caring and knowledgeable staff work hand-in-hand with patients and their families. We seek to understand each person's situation so that working together we can develop an individualized plan. The CCACs expertise, in-depth assessment process, and strong partnerships ensure patients receive specific care tailored to them and feel supported through their entire care journey.

## Message from the Board Chair and Chief Executive Officer

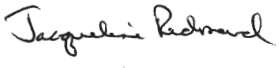
Over the next two decades the number of Ontarians over the age of 65 is expected to double, and the number of adults over age 85 will quadruple. As the population ages our health system will have to transform along with it to meet the needs of our population.

Home and community care is an essential part of meeting those increasing needs.

Ontario's 14 Community Care Access Centres (CCAC) get people the care they need in their homes and communities. CCACs provide a single point of access to a wide range of home and community services, enabling people to get the specialized blend of the health-care services they need, when they need it.

In 2013/2014, South East CCAC provided care to more than 35,000 people across the South East Region, including supporting 15,550 seniors who were able to stay in their homes independently, 3,700 children receiving health services at school and we helped 13,000 patients return home from hospital.

Our 2013/2014 annual report demonstrates how we are delivering better care, better access to care, and better value to provide people the care they need in their community.



**Jacqueline Redmond,**
*CEO*

**David Vigar,**
*Board Chair*

**In 2013/2014, South East CCAC provided care to more than 35,000 people across the South East Region, including:**

- 22,000 patients receiving care at home
- 15,500 seniors who were supported to stay in their homes independently
- 3,500 children receiving health services at school

## Board of Directors

**David Vigar (Chair)**
**Wendy Cuthbert (Vice-Chair)**
**Stan Collins (Treasurer)**
**Deanna Dulmage (Secretary)**
**Marion Hughes**
**Emily Leslie**
**Francyne St Pierre-Givogue**
**Carole Weir**
**Ray Marshall**

**Other:**

- Average number of clients served per/day 3,500
- 9,000 Patients came from community referrals, 13,000 patients came from hospital referrals

## Highlights and success stories:

The South East Community Care Access Centre (CCAC) is mandated to provide community-based health services, Long-Term Care Home Placement Coordination and Information & Referral services to the almost 500,000 residents of the South East.

With offices in Belleville, Bancroft, Kingston, Northbrook, Selby, Brockville and Smiths Falls, a presence in 14 sites of seven local hospitals and three Family Health Teams, the South East CCAC provides services to more than 13,000 clients on any given day.

As Ontario's population ages and care needs are more diverse, our health care system is evolving to better address the burden of chronic disease, the reality of age related health challenges, and help people maintain their independence.

Increased investment in home and community care by the Ministry of Health and Long-Term Care ensures people can remain in their homes and communities – and out of hospital and long-term care homes, for as long as possible.

This annual report to the community highlights how the South East Community Care Access Centre is working with our partners including hospitals, community support services, primary care, community health centres, service provider organizations and long-term care homes to build a better health care system by providing better access, better care and better value.

**We provide better access to care** for people in homes and communities, providing support for people with the highest care needs.

The demand for home and community services is growing and CCACs are caring for more and more people with multiple chronic and complex health issues. As we build capacity in home care, we are learning that people with more complex conditions can be cared for safely in their own home. That means even more people can benefit from home care, and that the care delivered at home must be more advanced than ever before.

Over the past three years the average weekly number of patients served by the South East CCAC has gone up by 22 per cent whereas those identified as 'high intensity' has risen by 77 per cent. Patients with high care needs include the frail elderly, children who are medically fragile and people who are living with complex health conditions. Providing specialized care and intensive care coordination helps them live in their homes longer.

CCAC's core business is care coordination – an essential component of a modern, high functioning health care system. Our care coordinators are all health care professionals – nurses, social workers, occupational therapist and others. They work directly with our patients, their families and other health care providers to identify each person's individual needs, develop care plans and ensure that people get the right care in the right place to meet their needs.

**We provide better care** by working as a team to innovate and improve care and participating in new approaches to care including Health Links to ensure connections between primary care and care coordination to support a smooth and integrated patient journey through the health system. The South East CCAC is an active participant is seven Health Links.

Announced in December 2012 by the Ministry of Health and Long-Term Care, the Health Links initiative is viewed as a "Major Transformational Milestone" focusing on improving care for seniors and others with complex health conditions. This innovative approach brings together health care providers in a community to better and more quickly coordinate care while maximizing patient access to health services.

The aim of Health Links is to bring together this group of providers through a voluntary partnership to develop and provide coordinated and comprehensive care plans for patients. More importantly, patients will know they have a coordinated care plan, will have access to it, and will be able to provide input into its creation.

We provide better value by creating efficiencies to improve the patient experience and facilitating successful transitions to deliver the care that people need, now and in the future.

The home and community care sector is demonstrating its value, both to patients and to the health care system. It is keeping patients out of hospital and long-term care by supporting people at home and in their community. Home is where people are healthiest, happiest, and where they want to be. And it's where care can be delivered at a lower cost than in institutions. Our care coordinators work with hospitals every day to increase hospital capacity, reduce emergency department wait times and reduce hospital readmissions.

**In homes, schools and communities across the South East, the CCAC provided:**

- 372,000 nursing visits (home and clinic) and 34,000 hours of shift nursing
- 1,445,000 hours of personal support services
- 78,000 visits from rehabilitation professionals (physiotherapists, occupational therapists and speech language pathologists)
- 4,500 social work visits and 2,000 visits from clinical nutritionists/dietitians

CCACs help reduce people's length of stay in hospitals by supporting people who have had surgery or a serious illness to come home with care. Increasingly, CCACs are helping people with enhanced care needs to come home rather than waiting in hospital for alternative types of care, including long-term care homes.

At a news conference held at a CCAC patient's retirement residence, Minister of Health and Long Term Care, Deb Matthews announced $12 million to improve home and community care in Southeastern Ontario. This investment supports programs that reduce unnecessary emergency room and hospital readmissions including Home First, which ensures that seniors can be safely discharged from the hospital and cared for in their own homes.

Through collaborative discharge planning based on the Home First philosophy and increased investment in community alternatives, the number of people waiting in acute and post-acute beds for alternate levels of care decreased by 15 per cent between 2009 and 2013. And the number of patients moving directly from hospitals to long-term care homes has decreased by 37 percent. Instead of waiting for months or even years in acute care beds, these patients are now transitioning home or to other community settings where their needs are more appropriately met at significantly lower cost.

The South East CCAC also partnered with local hospitals and community support services to create a pilot of an Integrated Community Assessment Referral Team (ICART) to help patients who trigger in a high risk screening process in the emergency department. It is intended that the team will ensure those at high risk of hospital readmission are identified and assessed for support services and, if appropriate, alert care teams that their patient requires further assessment or a review of current care plans.

We partnered with hospitals and the LHIN to develop an emergency department notification system that will assist emergency department personnel and physicians in making decisions about discharging patients home. Although most CCAC patients are able to stay safely in their homes, sometimes they show up in hospital emergency departments. The notification system will help to quickly identify when an individual receiving CCAC services goes to the emergency department so the patient can get safely back home as quickly as possible.

**Getting people the care they need at home and getting better every day the South East CCAC:**

- Assisted more than 1,000 seniors transition to a long-term care home
- Worked in hospital inpatient and emergency departments across the region to help 13,000 people return home from hospital with CCAC care
- Provided 600 more patients with personal support, and 162,000 more hours of personal support than the previous year




We worked with many partners to create The Hospital @ Home program, a new service offered in the Picton area aimed at avoiding hospital admissions or to return patients home from hospital sooner by providing care in the comfort of home with the help of a team of health care professionals who can respond to needs 24 hours a day, seven days a week. This two-year pilot project is unique to Prince Edward County and is not available anywhere else in Ontario. In partnership with the Centre for Studies in Primary Care at Queen's University, research will help measure effectiveness and identify areas for improvement and determine if this approach should be made available in other areas.

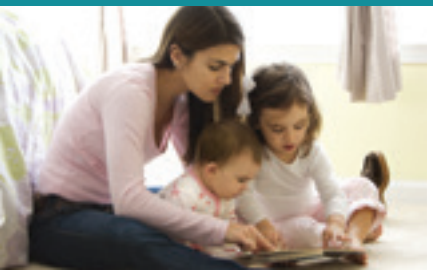
Sometimes people need a little more time to recuperate before they can be discharged home. We are pleased that the South East LHIN approved a regional 22-bed Short Stay Convalescent Care unit located within Lennox & Addington County General Hospital in Napanee. Convalescent care is for individuals from the community or a hospital who do not require acute care, but who cannot yet return home, and require convalescent care after an acute medical episode, after surgery, or as a result of deconditioning as the result of another condition.

We continue to develop a number of nursing initiatives funded through the Ministry of Health and Long-Term Care which include Rapid Response Nurses, Mental Health and Addiction Nurses, and Hospice Palliative Care Nurse Practitioners. The programs are designed to support patients to safely transition home from hospital, to support children and youth with mental health issues, and to expand support to our high-needs end-of-life patients.

Across the South East two Nurse Practitioners work closely with Long Term Care Home teams, responding to calls to reduce avoidable emergency department transfers, support acute care in the home and ensure a safe transfer back to the home after a hospital visit. Our Nurse Practitioners have diverted 315 emergency room visits for long-term care home residents and they have provided education to long term care home staff on 873 of their visits.

In June 2013 the Ministry of Health and Long Term Care announced a significant change in the way the physiotherapy services would be delivered. This change meant that CCACs will now be responsible for all in-home physiotherapy services, including retirement homes and other congregate living settings. After matching identified need with existing provider capacity, the South East established one-year overflow contracts with five (5) providers to support this population. Special rates were negotiated and services implemented in a very short period of time. Work with client services and our service provider partners throughout the transition to these new services ensured minimal disruptions in physiotherapy services to the residents of retirement homes eligible to receive these services.

Under the auspices of Quality and Value in Home Care (QVHC), Ontario's CCACs developed a provincial Client Service Contract Performance Framework incorporating all requirements as outlined in the September, 2012 Contract Management Guidelines For Community Care Access Centres released by the Ministry of Health and Long-Term Care.




Comprised of four components including performance measurement, monitoring, reporting and management, the Framework is centered on the client, and is underpinned by strong, respectful CCAC-Service Provider relationships and a commitment to continuous quality improvement.

With the expiration of the contracts for medical supplies and equipment and equipment-related supplies, Procurement and Service Contracts embarked upon a nine-month Request for Proposals (RFP) process. Beginning with a series of internal and external consultations to help us better understand the changing patient/service requirements associated with this contract, the RFP process is continuing through the new fiscal year. The information gained through the consultation process was used to write the RFP requirements; designed to meet current and anticipated service demands.

Work on a second RFP for Negative Pressure Wound Therapy also began in 2013/2014 for a contract to be awarded in late 2014.

In December 2013 SEIU initiated labour action against Red Cross Care Partners (RCCP) our largest provider of personal support services (PSW) in the South East. We worked with all our other service provider partners to establish temporary contracts which allowed providers to utilize additional worker classifications, use non-PSW Providers to provide PSWs and even facilitate PSWs to come from out of our geography to address significant service pressures. The CCAC established daily calls with our local RCCP office to determine capacity and to identify those patients most in need who would need to be supported by other provider resources. These actions assured services to those patients who needed it most.

In January 2014 a meeting was arranged with Quinte Health Care hospital therapy staff, the CCAC, our equipment and therapy providers for the purpose of reviewing equipment that is available through CCAC rental. As a result of this meeting, the number of patients with non-compendium items and the cost of non-compendiums decreased from a high of 18 patients in April 2013 at a cost of $5,800/month down to 5 patients at a cost of $1,300/month in March 2014. This is an example of collaboration between hospital, CCAC and service provider staff to deliver excellent, cost effective patient care.

Thanks to technology, we have greater ability to share information than ever before. CCACs connect people to the care they need. We provide people with timely and accurate information through a web-based resource, southeasthealthline.ca. Thehealthline.ca, now deployed across Ontario, is a one-stop-shop to help patients navigate the health services they need in their communities, bringing together multiple databases and electronic resources into a single solution. Within the first year of provincial launch it is expected the healthline.ca will attract two million visitors. The South East CCAC has partnered with our LHIN to develop a mobile app to enhance access to southeasthealthline.ca and to translate service records of organizations offering services in French.

The South East CCAC presented our recommendations to strengthen the LHIN Legislation to the Standing Committee on Social Policy in February. We shared some suggestions for improving Local Health System




Integration Act (LHSIA) and the local delivery of health care services. We believe that the Local Health System Integration Act works well overall and sets out a strong framework for local health system planning, funding and accountability. Our suggestions are intended to strengthen the current framework.

We recommend 1) that public health and primary care be brought under LHSIA; 2) LHINs should provide multi-year funding; 3) while modifications to LHSIA can provide more integrated and stable health care, we must ensure that any changes are not disruptive to the communities who we serve by working within existing structures.

Only in this way can we deliver a health system our communities can rely on that is integrated, well-coordinated and easy to navigate.

Twice each year the South East CCAC surveys our partners about the quality of our working relationship. Our partners tell us that we are steadily improving and they provide a lot of positive feedback and encouragement as well as a mix of constructive suggestions for improvement. The South East CCAC values the working relationship we share with health and community partners as we work together to provide care to the residents of the South East area.

Considerable planning and consultation went into redeveloping our strategy to guide and inform our priorities over the next three years. Stakeholder feedback was collected in multiple ways including individual interviews, focus groups, and an online survey. In consultation with a broad group of stakeholders we have chosen to focus on these four strategic priorities for the next three years:

Right Service Focus: we will have a system of care that adds value and adapts to our changing patient profile. We all know that there are more patients being cared for by the CCAC and that patients are sicker when they come onto service.

We can't continue to do business in the same way we have always done business. So, we will be working with the LHIN, hospitals, community services and others to define who are we going to see and how we will care for them given the resources available and the role we play in the health system. This will include really understanding who our patients are and what they need as well as looking at ways to better manage service demand and optimize efficiencies by further introducing innovation and best practices.

System Integration: we are going to improve patient outcomes by better defining and strengthening our integration role. Patients generally state that they receive great service from the various health providers involved in their care—what doesn't always work is the hand-offs between the health care providers and their doctor's knowledge about what is going on with their care. CCACs are the system navigators and the glue that works between and amongst these players. We will be strengthening that role, beginning with complex patients.

Outstanding Patient experience: we will ensure patients and caregivers have confidence and trust in their care. We need to build the opportunities for patients to have input into the planning of their care and CCAC services. All around us is the evidence that giving patients a voice in planning programs and services leads to stronger programs and more fully engaged patients in reaching the outcomes of care.




We are going to figure out how to do this in a more formal way and make sure we use the input we receive. In addition, we will enhance the confidence and trust of our patients by increasing their awareness and knowledge of CCAC and local health services and focusing on creating an organizational culture where quality and safety of care come first.

Organizational Excellence: we will continue to build on our ability as an organization to deliver superior performance. In order for our CCAC to provide the services patients need and the system is expecting, we need to run our business well and be agile in figuring out when things aren't going as they should and make improvements. We also need to make sure we are using the technology available to help us do our work as efficiently as possible.

We look forward to working with patients and their caregivers and our many partners to continue improve on how we care to provide a better patient experience now and in the future.

| *Financial and statistical highlights* | |
|---|---|
| Administrative Expenses | $ 8.4M |
| Care Coordination | $ 24.4M |
| Other Patient Services & Education* | $ 3.1M |
| Purchased Patient Services | $ 84.1M |
| **Total** | **$ 119.9M** |

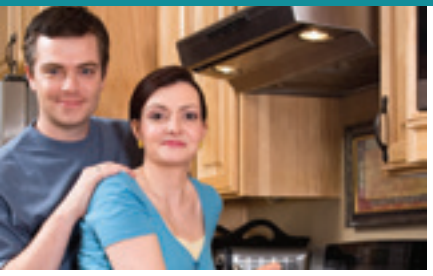
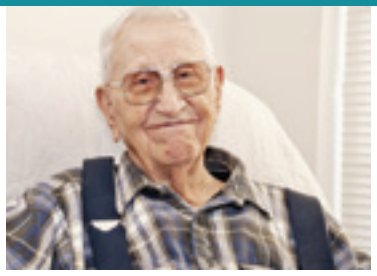
* Includes Mental Health & Addictions, Rapid Response Nurses and LTC Home and Palliative Nurse Practitioners

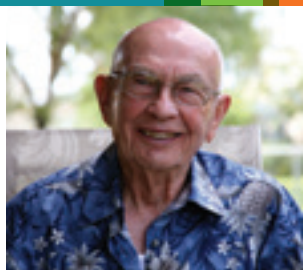
**Service Utilization: Fiscal 2013/2014**

| Service | Utilization |
|---|---|
| Nursing – Shift | 49,000 hours |
| Nursing – Clinic | 34,000 visits |
| Nursing - Regular | 272,000 visits |
| Personal Support Services | 1,444,000 hours |
| Dietetic Therapy | 2,300 visits |
| Occupational Therapy | 36,000 visits |
| Physiotherapy | 31,000 visits |
| Social Work | 4,600 visits |
| Speech Language Pathology | 12,000 visits |

Complete Audited financial statements are available on our website – www.healthcareathome.ca/southeast

If you would like additional information or a speaker for your community group, contact us at 310-CCAC (310-2222).

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