



2010-2011

Report to the Community



Connecting you with care

Table of Contents



- What the Central East CCAC Stands For ... 1
- Message from the Board Chair and CEO ... 2
 - Central East CCAC Board Members ... 2

Year In Review

- Achievements and highlights ... 3

Caring for our Clients

- Home First ... 6
- Wound Care: finalist for Health Care Innovations Award ... 6
 - Speech clinics - childrens' therapy clinics ... 7
 - Evan May - a child's story ... 8
 - Cluster Care ... 9
- Integrating the Self-Management Program ... 9
 - NPSTAT Outreach Program ... 10

Home First ... 13

Our Story in Numbers ... 21

Our Community

- Community Engagement ... 25

Statement of Operations ... 27

Contact Us ... 29



What the Central East CCAC Stands For:

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

We relate to each other, to those we serve and to those with whom we work with compassion, respect, integrity and fairness and value the contribution of everyone.

Excellence

We base our decisions on ethical principles and best available information and our actions on best practice.

Client-Centred

We encourage and promote personal responsibility and informed and participative decision-making.

Collaboration

We co-ordinate our efforts, working in partnership with colleagues, clients, families, caregivers, providers and the community.

Accountable

We manage resources responsibly, share performance related information freely, and foster a culture of open communication.

Continuous Improvement

As a learning organization, we foster a spirit of inquiry, committed to improving understanding and encouraging innovation.

The **Central East Community Care Access Centre** (CECCAC) is one of 14 CCACs that work in communities across Ontario to connect people with quality in-home and community-based health care. CCACs strive to make sure clients receive the care they need, when they need it, provided by qualified care providers, at a responsible cost, to help people come home from the hospital sooner or live independently at home longer. CCACs also provide information and referral services to assist people with finding support from community based resources.

CCACs 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 (LTCH), an adult day program, or a supportive housing program.

Our caring and knowledgeable staff work hand-in-hand with clients and their families. We seek to understand each person's situation so that by working together we can develop an individualized care plan.

The CCACs' expertise, in-depth assessment process, and strong community partnerships ensure clients receive specific care tailored to personal requirements and feel supported through their entire care journey. ●●●



Message from the Board Chair and CEO



DR. BARRY NEIL
*Chair
of the Board*



DONALD M.
FORD
*Chief Executive
Officer*

The 2010 - 2011 fiscal year saw the Central East CCAC continue to build and strengthen the valuable partnerships we have between ourselves and our acute care partners, our Service Provider agencies, community partners and the Central East LHIN (CE LHIN). Our commitment to over 31,500 clients served each day can only be achieved by working successfully with these partners to employ best practice and an evidenced-based approach to delivering quality care. Initiatives such as Wound Care and Cluster Care in combination with a focused attention to Service Allocation Guidelines and the Outcome Based Resource Allocation Model (OBRAM) tools, are among the contributing factors to our success.

A predominant focus for the Central East CCAC this past year was the development and roll-out of Home First. We successfully implemented Home First in eight acute care

corporations at 14 hospital sites and have contributed to increased Emergency Department (ED) diversions and reduced Alternate Level of Care days (ALC). Since the first hospital implementation in September 2010, we have seen approximately 33 per cent increase in clients being referred back to the community from hospital, successfully avoiding unnecessary hospital admission and ALC designation. Going forward, the challenge will be to sustain this unprecedented growth within our allocated budget.

We continued to work with our primary care partners on a number of initiatives including the Health Care Connect Program. During the year our three Care Connectors successfully connected 6,872 patients to family health care providers in their communities, an increase of 107 per cent over the year before.

Other successful initiatives include: the CE LHIN Self Management team who trained over 240 clinicians as part of the Self-Management Program's work to assist in advancing Ontario's Chronic Disease Prevention and Management framework; and the Nurse Practitioners Supporting Teams Averting Transfers (NPSTAT) Outreach program that works with Long-Term Care Homes (LTCH) to help reduce avoidable visits to hospital and help to improve the health care experience of long-term care home residents. By the end of the year, the NPSTAT team had clinically assessed almost 3,700 LTCH residents and had contributed to averting transfers to an emergency department for 97.4 per cent of those residents.

Health care is a complex and constantly demanding system. With the magnitude of health care expenditures and increased scrutiny of health care dollars, there is an increasing awareness of accountability. Following two previously challenging fiscal years and through the dedicated effort of our staff, we were able to retire a cumulative deficit and achieve a balanced budget by March 31, 2011.

None of our successes could have been achievable if not for the hard work and diligence of our staff, in particular those who interact most directly with our clients, or the commitment of our health care partners across the spectrum of the health care continuum. We are grateful and proud of the achievements we have made and of the partnerships we continue to forge that will provide a solid foundation as we move forward. ●●●

Central East CCAC Board Members

- Dr. Barry Neil - *Board Chair*
- Elizabeth McCreight - *Board Vice Chair*
- Mary Bazeley - *Chair, Performance Quality and Effectiveness Committee*
- Bill Botshka - *Chair, Audit Committee*
- Susan Donaldson
- Michael Irwin
- Graham Lowman
- David McDonald
- Glenn Rogers - *Chair, Governance Committee*
- Susan Rowley
- Beverley Tezak
- Peggy Vokins - *Chair, Finance Committee*



Year in Review



- Achievements and highlights



Year in Review



A focus on quality, accountability and collaboration with our health care partners defined the work that was achieved during the 2010 - 2011 fiscal year.

During the year a number of provincial reports that were focused on or had an impact on the CCAC sector were released.

The Auditor General of Ontario's Report on Home Care Services was released in December 2010 and the recommendations focused on continuous quality improvement for the CCACs.

The first Home Care Report by the Ontario Health Quality Council followed in January and reported on 24 indicators divided under the themes: Effective; Keeping People Safe and Healthy at Home; and Accessible Access to Care and Services. In February the OACCAC released the sector's first Provincial Quality Report showcasing CCACs' delivery of quality care and examples of innovative programs, partnerships and system integration across the province.

In the Central East region, in an ongoing effort to address the challenges of Emergency Department and Alternate Level of Care, we worked with the Central East Local Health Integration Network (CE LHIN), our hospital partners and community support service organizations on several initiatives and projects including the implementation of Home First, GAIN Clinics and the Nurse Practitioner Outreach Program. These initiatives highlight the benefits of strong

partnerships between all health care providers in our region.

Internally, the Central East CCAC entered the 2010-2011 fiscal year with a significant challenge of recovering a cumulative deficit to achieve a balanced budget by March 31, 2011. Due in large part to the hard work, dedication and determination of our staff who diligently utilized new tools such as the Outcome Based Resource Allocation Model (OBRAM) that tracks and maintains an active, consistent and equitable client caseload across Central East CCAC, by the end of the fiscal year we were successful in balancing our budget.

In July, the Ministry of Health and Long-Term Care (MOHLTC) introduced new Long-Term Care regulations that had significant impact on the CCACs. As a result, reassessments of all clients on a waitlist for a LTC Home had to be undertaken as well as all related Central East CCAC documents were updated.

We issued our first three Requests for Proposal (RFP) for the provision of Medical Supplies, Medical Equipment and Equipment-Related Supplies and Infusion, and Infusion Supplies in August using the Ministry of Health and Long-Term Care's new standardized RFP contract templates. Following a six month evaluation process, contracts were awarded to three successful vendors. The contracts commenced on April 1, 2011.

After careful organizational reviews and based on a goal of continuous improvement

and the adoption of best practice principles, changes to some of our business processes and practices including the closure of our Pulmonary Rehab Program and our Medical Supplies Depots took place.

We continued the work toward building an organizational culture of a healthy work environment that supports the goal of increased staff engagement and organizational effectiveness where all employees feel valued. Activities to support and encourage this goal were held throughout the year as well as the introduction of the Methods of Management educational program intended to provide the infrastructure and support necessary for organizational success. ●●●

Facts & Stats

In 2010-2011 fiscal year the Central East CCAC:

- Had a budget of \$217 million, making it the second largest CCAC based on budget
- Spent approximately \$600,000 per day
 - 91% contracted clinical service and case management
 - 5% general administration
 - 2% Information Systems (IS) and
 - 2% plant operations
- Served 70,000 unique clients
- Assessed 14,000 clients for LTC
- Placed 2,700 clients into LTC ■■■

Caring for our Clients



CLIENT SERVICES INITIATIVES

- Home First
- Wound Care: finalist for Health Care Innovations Award
 - Speech clinics - childrens' therapy clinics
 - Evan May - a child's story
 - Cluster Care
- Integrating the Self-Management Program
 - NPSTAT Outreach Program



Caring for our Clients

Working collaboratively with our hospitals, community partners and the CE LHIN strengthens our system partnerships and supports improvement to our client care, provision of quality services as well as helps to provide more extensive understanding of the value that CCACs bring to health care. Several joint opportunities and initiatives during the past year have served to strengthen the relationships with our health care partners as we collectively worked toward helping to find solutions to the Alternate Level of Care (ALC) and Emergency Department (ED) Challenges.

“CCAC is the only organization who has given us the information about our health care needs and health care services available to us in the whole health care system; otherwise, we wouldn’t know what services are available and where to go get the services we need. CCAC is our guidance to access health care.”

WIFE OF CENTRAL EAST CCAC CLIENT



HOME FIRST

The provincial definition of Alternate Level of Care (ALC) is, “when a patient is occupying a bed in a hospital and does not require the intensity of resources/services provided in this care setting, the patient must be designated Alternate Level of Care (ALC) at that time by the physician or her/his designate.” As ALC rates continued to grow in the Central East region along with other areas across the province, the Local Health Integration Networks (LHIN), in partnership with the local CCACs and Community Support Service agencies, worked together to implement Home First, an effective model of care that is being delivered in many hospitals across Ontario.

ALC rates, by definition, indicate that patients who have completed their acute care course of treatment and no longer need to be in hospital are now not receiving care in the right place at the right time. Studies have shown that extended periods of time in hospital can have significant negative consequences on patients and thus there is a need to have them return to their home or community as soon as possible.

The primary objective, therefore, for the successful implementation of the Home First philosophy is to create conditions which allow patients to be returned to their community to the most appropriate setting (e.g. home, retirement home, Convalescent Care, transitional care, etc.) with supports

in place to help them with this transition after their acute care stay has ended.

Working closely with our hospital and community support agencies and the LHIN, the Central East CCAC-led Home First implementation was rolled out in an impressive nine month period in all eight acute care hospital corporations at 14 sites in the Central East region. Following full implementation in all hospitals we have seen approximately 33 per cent increase in the number of clients being referred from Central East hospitals back to the community, therefore avoiding unnecessary hospital admission and ALC designation. To date, more than 4,000 clients have been referred home with enhanced services.

On page 13 a special in-depth look at how our clients have benefited from the introduction of Home First is featured. Clients and their families share their own story about their care journey. ●●●

WOUND CARE

The Advanced Wound Care Program was implemented across all seven branches of the Central East CCAC in spring 2010 to address the growing challenge of caring for clients with wounds



in the community in an evidence-based, safe, effective and efficient manner.

The program was implemented following a pilot project that was conducted the previous year to evaluate and measure the impact of new wound care protocols and products on client outcomes, cost and productivity. The results of the pilot were significant indicating wound healing in 13 weeks versus 50 weeks prior to the pilot.

A Quality of Life survey was also conducted to determine the level of change in clients' perception of wound care. The survey showed clients felt there was better management of pain, improvement in mobility, less interference with sleep, improved social interactions, more positive feelings about themselves, greater satisfaction with health and overall better health.

The primary goals of the Central East CCAC Advanced Wound Care Program are to improve client care and quality of life, have improved wound outcomes and realize efficiencies through best practice guidelines and evidence-based clinical protocols utilizing advanced wound care products.

To further support the Advanced Wound Care Program and strive for continual improvement, a Central East CCAC Wound Care Committee was formed. The Committee builds leadership, fosters networking to deliver quality care for clients and provides continuing education to Central East CCAC Case Managers and health care providers. A collaborative approach between the Central East CCAC and hospital partners and community physicians assists in aligning wound care management practices, which supports system-wide improvement.

The success of the pilot and the significant improvement in the quality of client care resulted in the Central East CCAC Advanced Wound Care Program being nominated for the Minister's Award of Excellence at the 2010 Health Care Innovations Expo. ●●●



SCHOOL HEALTH SUPPORT SERVICES - SPEECH THERAPY ASSESSMENT CLINIC

A Speech Therapy Assessment Clinic pilot project was introduced in November 2010 to help address the growing number of children on the waitlist in the School Health Support Services (SHSS) program for Speech Language Pathologist (SLP) services. Children waiting for speech therapy services at school were offered an opportunity to have a scheduled assessment with a SLP therapist at the Central East CCAC Whitby Branch.

The clinic ran on a Saturday from 9 a.m. to 4 p.m. and was facilitated by two SHSS Case Managers. The assessments were done by SLP therapists who assessed 15 clients currently on the SHSS waitlist for speech therapy. The therapists conducted 30-minute assessments and spent 15 minutes establishing programs with the client and their parents.

The pilot clinic was designed to fulfill the following goals:

- Complete assessments of children currently on the waitlist for speech therapy service at school, to ensure appropriateness for the waitlist, adjust priority as needed, or recommend discharge
- Develop partnership with parents/care-givers and provide strategies and home programming recommendations that can be implemented with the child while waiting for intervention at school

- Opportunity for parent/caregiver to share home program/strategies with school staff to facilitate improvement in the child's speech production.

Based on the success of the pilot in achieving the program goals and the positive comments received from parents who attended the clinic with their child, three other SHSS Speech Therapy Assessment Clinics took place in February and March with anticipated expansion to other branches in the next fiscal year. ●●●

STANDING ON MIRACLES- EVAN'S STORY

Seven-year-old Evan May lives with his mom, Lorilee, sister Kimberley and a chocolate labrador retriever named Tasha, in rural Peterborough.

Watching Evan bounce up and down and raise his voice in excitement to his mother's singing, it is hard to comprehend that Evan

was born with a life-threatening chromosome disorder called Edwards syndrome. With a ventricular septum defect in his heart, Evan has now developed pulmonary hypertension and takes medication for this on a regular basis.

His mom says that since he was a baby, Evan has received nursing care coordinated through the Central East CCAC. Overnight shift nurses provide respite care for Lorilee and administer Evan's feeding by a tube through the nasal passage and into the stomach.

"There are a lot of situations people find themselves in and if you don't know about the CCAC it makes it very difficult for people because they are asking themselves: Where do I go? Who do I call? What services are out there?" says Lorilee. "It's nice to have a coordinating agency that provides you with a lot of information, offers a lot of different services and can direct you to the appropriate services that are available."

In addition to coordinating nursing care for Evan in-home, the Central East CCAC also coordinates care for Evan while in school. During school trips the Central East CCAC arranges for nurses to accompany Evan to assist with feeding and during regular classroom days, the Central East CCAC Case Manager coordinates a physiotherapist to assist with movement, exercises, review his progress and set up the next steps for challenging his mobility. An occupational therapist ensures that the school environment is safe and accessible for Evan and provides a program for developing fine

and gross motor skills such as grasping items with his hands and fine-tuning his balance.

As part of our system navigator role, the Central East CCAC has also linked the May family with community partners such as: Community Living for respite funding and horseback riding, Easter Seals for family camp and Five Counties for ongoing support with physiotherapy, occupational therapy and augmented communication.

Working with the Physiotherapist in school, and Community Living who offer 10-week sessions of horseback riding, Evan has shown much improvement in his range of motion.

"For a long time he did not have a lot of strength in his limbs or upper body or was even able to hold his head up and he couldn't sit up on his own. He gradually started to sit up on his own and as his abilities progressed, we tried to look for little things that will help him with his movement and balance. When he started horseback riding that really helped with his upper body strength, his core strength and balance. During the last year he has progressed leaps and bounds."

Today, Evan is an excitable, bubbly boy who is able to stand on his own by holding on to objects. He has come a long way since birth when doctors said he would not live past one month. With the help of the Central East CCAC Case Managers, service providers and community partners, along with his loving family, Evan has defied the odds and is standing on his own... he is standing on miracles. ●●●



PERSONAL SUPPORT CLUSTER CARE

Cluster Care for Personal Support or a "Multiple Client Visit" means a face-to-face visit with a client or caregiver in a circumstance where the Service Provider is visiting three or more clients during the same trip to the Service Delivery Location.

The Central East CCAC launched this initiative in the Fall 2010 after the Personal Support Allocation Committee comprised of Senior Managers, Case Managers, Contracts & Relationships and Project Planning representatives developed an innovative approach to Cluster Care.

A period of one month from Go-Live (October 18, 2010 to November 18, 2010) was provided to complete the transfer of identified clients to their new designated Service Provider.

The Central East CCAC Contracts Team collaborated with the contracted Service Providers to establish each cluster address. Each designated cluster address was based on the majority of hours currently being

provided as well as maintaining the volume of hours currently assigned to the Service Provider in that branch. A retirement home, apartment, seniors building, or any address where three or more clients are receiving personal support services, were assigned one Service Provider for Cluster Care.

Cluster Care will enable more clients to get to know their Personal Support Worker, will strengthen relationships, and ensure a consistent provider is assisting with health care needs. The Central East CCAC is committed to improving efficiencies, and implementing innovative services to better serve our clients.



INTEGRATING THE SELF- MANAGEMENT PROGRAM

During the 2010-11 fiscal year, one of the goals of the Central East LHIN Self-Management Program was to become more integrated into the Central East CCAC core business.

Following the best practice guidelines for supporting self-management, published by the Registered Nurses' Association of Ontario (RNAO), education sessions for Case Managers in all seven Central East CCAC branches were designed to emphasize the importance of using self-management approaches with clients and referring individuals to community self-management programs, such as the "Living a Healthy Life with Chronic Conditions" workshop.

The CE LHIN Self-Management Program expanded its activities to help advance Ontario's Chronic Disease Prevention and Management framework in the Central East region. Some of the activities included achieving the framework's goal of "informed and activated patients," through the delivery of 81 six-week volunteer-led "Living a Healthy Life" self-management workshops to 1,053 participants across the Central East region.

The chronic disease framework also calls for "prepared and proactive practice teams," and to that effect, the Self-Management Program was successful in training over 240 clinicians, across a range of organizations including hospitals, community health centres, community support service agencies, home care service providers, and family health teams using an accredited half-day training course in self-management support.

Called "Choices & Changes," the train-the-trainer program was adopted from the Institute for Healthcare Communication beginning in 2010; our evaluation shows that over 95 per cent of training graduates are confident applying techniques in clinical settings to influence change in self-management behaviours.

Also in 2010-2011, the Ministry of Health and Long-Term Care, through the Ontario Diabetes Strategy, implemented new funding and targets to all LHIN regions in Ontario, resulting in a new consistency and alignment for self-management activities across Ontario. ●●●

NPSTAT OUTREACH PROGRAM

Thousands of our most frail and elderly residents in the Central East region live in Long-Term Care Homes (LTCHs). Many of these residents experience acute episodic illnesses and injuries which frequently result in stressful and lengthy visits to Emergency Departments (ED). These avoidable ED visits put these residents at high risk for severe de-conditioning, nosocomial infections, pressure ulcers, and increased confusion and agitation.

The Nurse Practitioners Supporting Teams Averting Transfers (NPSTAT) program was developed to address the health risks of transferring frail seniors to EDs for visits which could be avoided if treated in the LTCH. Reducing avoidable hospital visits and admissions will improve the health profile and health care experience of LTCH residents, while maintaining or reducing the cost of providing care.

NPSTAT can also help facilitate earlier discharges back to the LTCHs which can decrease hospital length of stay (LOS), enhance continuity of care and communication between acute and LTC sectors, and provide support and resources to LTCH staff to help manage repatriated LTCH residents.

Nurse Practitioners in LTCHs play an integral role in improving the quality and continuity of resident care. The Central East CCAC is one of three health care service providers who were appointed by the Central East LHIN in 2009-10 to implement the NPSTAT program. Eight Nurse Practitioners work on the NPSTAT team. Teams are located at The Scarborough Hospital, The Village of Taunton Mills in Whitby and in Central East CCAC offices in east Durham and the northeast and support LTCHs in the Scarborough, Durham, Peterborough and Northumberland clusters of the Central East LHIN region.

The primary focus of the NPSTAT program is to assess acute changes in a resident's physical, neurological or behavioural conditions, and to work closely and collaboratively with the LTCH's health care professionals to help divert the number of avoidable ED transfers of those LTCH residents. Besides providing acute, episodic health care services and preventing avoidable ED transfers, one of NPSTAT's goals is to help reduce Alternate Level of Care days.

By March 31, 2011, the NPSTAT team had successfully diverted ED transfers by 97.4 per cent based on the 3,675 LTCH residents who were clinically assessed.

The top three most common interventions that helped to avert ED visits were:

- Post-Fall Assessments which include suturing lacerations and treating injuries
- Replacing dislodged Percutaneous Endoscopic Gastrostomy Tubes (G-Tubes) and troubleshooting them when blocked and,
- Treating infections; e.g. Pneumonia, Acute Exacerbations of COPD, Urinary Tract Infections, cellulitis, wounds and pressure ulcers ●●●



“On Monday July 5, 2010 Pickering Fire Service Station 6 responded to an alarm at a Nursing Home in Pickering for the report of a male [with] difficulty breathing. Very shortly after our arrival and patient assessment we were greeted by a Nurse Practitioner and her co-worker. Immediately she gave us the patient information, nature of the emergency, event history, past medical history, assessment findings, vitals and patient care that they had been providing. Upon the arrival of the EMS crew her information she provided to them expanded, she was now talking to an Advance Care Paramedic.

“The level of knowledge and information that was shared between the Fire and EMS crews was as if we walked into an ER. In previous experiences with alarm calls at that location the information received by Fire and EMS was not always as in-depth and forthcoming. During the time EMS was attending to the patient I spoke to the NP and thanked her for what she had provided. She spoke of the Team she and her co-worker are a part of.

“The CE LHIN NPSTAT team provided great assistance to both Fire and EMS, being greeted with the knowledge and in-depth patient information at this call allowed us to be able to provide a valuable service to that member of our community. I would like to thank the NP for her work and look forward to seeing more members of her Team in the future.”

MIKE PALACHIK, ACTING CAPTAIN, B2 PLATOON
OPERATIONS AND EMERGENCY SERVICES DEPARTMENT FIRE SERVICES
DIVISION CITY OF PICKERING



What our clients tell us...

"With your unique gifts of sensitivity and compassion, you came alongside my family with practical help and support for my mother, as well as a listening ear for me!"

DAUGHTER OF CENTRAL EAST CCAC CLIENT

"Thank you for your beautiful heart. You did your job with so much humanity; it never felt like you were doing a job. You gave your best to us, you did make a difference and we will never forget you. Your support during these 20 years represents a tangible thing, like an immense rock we can hold onto. Our gratitude is as big as that rock. My son and I will miss you and forever thank you."

MOTHER OF CENTRAL EAST CCAC CLIENT

"CCAC made us grateful to have kept our father at home where he passed peacefully in the arms of his family. Thank you very much."

DAUGHTERS OF CENTRAL EAST CCAC CLIENT



"There were so many individuals who were a part of Fred's care. Their work was carried out with great diligence and tenderness. We will always remember you with great appreciation."

FAMILY OF CENTRAL EAST CCAC CLIENT

"Dear Premier: I am especially impressed with the expertise with which the Province has 'passed the baton' from my parents surgical care, to CCAC home health care, and now to a first-class nursing home. My parents grew to embrace our CCAC-coordinated caregivers as family. They have lightened my load dealing with this crisis as an only child. And they have confirmed in me my mother's conviction of how fortunate we are to live in this great province"

SON OF CENTRAL EAST CCAC CLIENT

"Your words about 'it's not a one-way door' really resonated with us and allowed us to bring my mom home where we knew she wanted to be in the end. You provide both care and comfort in a difficult time. Your kindness will be remembered."

SONS AND DAUGHTERS OF CENTRAL EAST CCAC CLIENT

"I would like to thank all the CECCAC and VON for their time. All of these folks were there to work and make my husband comfortable and better. We will always be very thankful."

WIFE OF CENTRAL EAST CCAC CLIENT



Home First



- Shirley Holliday
- Harold and Barbara Willis
 - Mr. & Mrs. H
- A Case Manager's perspective
 - Meeting cultural needs
- Client needs focus of inter-professional team



Home First

Home First is a major step toward aligning health care partner respective services around a common system goal: the safe discharge of all patients at the right time and to the right place. A critical success factor is the importance of the inter-professional team working together to develop a safe and effective transition from hospital to home.

Success stories play an important part in helping to demonstrate how Home First has changed the way in which health care partners work together to provide a better client experience and support an individual's decision to return home after their hospital stay.



“Central East CCAC teams have worked closely with our LHIN, hospital partners and community support agencies to improve our collaboration and integration. Through the enhancement of these relationships we have positively influenced our collective client-centred care visions.

“Home First has also had an impact on the health care system at large in the Central East area. We have made improvements in some of our hospitals’ emergency departments wait times by the presence of a Central East CCAC Case Manager and by reducing the number of Alternate Level of Care (ALC) clients in many of our Central East hospitals.

“By employing the Home First philosophy we believe that hospitalized clients and their associated families/caregivers receive early engagement of the Central East CCAC Case Manager which enables clients to transition home as soon as their acute hospital stay is completed. Through the effective utilization of their system navigation skills our Case Managers successfully assess and develop individual client care plans that allow clients to return home in a timely manner and receive the services required to support their transition to the community.”

SALLY DAVIS
SENIOR DIRECTOR, CLIENT SERVICES
CENTRAL EAST CCAC

SHIRLEY HOLLIDAY

As Alternate Level of Care (ALC) rates continued to grow in the hospitals in the Central East Local Health Integrated Network (CE LHIN) region, a partnership with the Central East Community Care Access Centre (CECCAC), Lakeridge Health and Community Care Durham was formed to help address the issue and introduce a new philosophy called Home First. Lakeridge Health became the first hospital in the Central East region to introduce Home First to all of their sites in September 2010.

A proven and effective model of care, Home First is designed to ensure patients receive the right care in the right place at the right time. Improving the lives of all patients, in particular seniors, is one of the goals of Home First. Keeping them safe and providing the care that will avoid the unnecessary loss of independence and dignity that can come with extended stay in hospitals or other institutions is among its highest priorities. Home First is designed to promote safe and timely care with the services and supports to allow patients to return to their homes following a hospital stay.

One woman who benefitted from the adoption of this philosophy at Lakeridge Health was 72-year-old Shirley Holliday.

A long-stay client with the Central East CCAC who had been receiving CCAC services to assist her in living a healthy life while managing Leukemia and 90 per cent vision loss, Shirley was admitted to Lakeridge Health Oshawa with a fractured pelvis following a fall in July 2010. She became the first Home First patient and benefitted from the engagement of an inter-professional team approach to her care. Comprised of doctors, nurses, physiotherapists, the Central East CCAC Hospital Case Manager and community support from Community Care Durham, team members worked together to transition Shirley back into her home on the Labour Day weekend.

In an interview conducted after she was discharged home, Shirley recalled the first time she heard about Home First while she was recovering in hospital. "The Home Care nurse (Central East CCAC Case Manager) came in one day and said the government is starting a new program made just for me."

The Central East CCAC Case Manager told her they had a new approach called Home First and that Shirley would be able to go home with added personal support worker (PSW) hours to help her cope at home .

"I said, 'well its one way of getting out of here!'"

Home First provides clients transitioning home with enhanced PSW hours so that the

transition from hospital to home is safe and clients are receiving the right care at the right time and in the right place.

"Home First gives patients confidence that they will be successful in safely transitioning home following their hospital stay," says Dr. Lauren Linett of Lakeridge Health Oshawa.

Home First assessments are first administered in the hospital by the Central East CCAC Case Manager in collaboration with the inter-professional team. Some clients may qualify for enhanced services initially and all clients are then reassessed every two weeks following discharge from hospital to monitor the client's progress and ensure the health care service plan is meeting the client's needs.

"It's great to have these people come and help you," Shirley said. The PSW supported Shirley in her home by serving her breakfast, lunch and supper. "Sometimes, and I have been through it before, you get to the point where you are too tired to get anything to eat. It was a good way to make sure I was going to eat."

The PSW also assisted her with bathing, mobility around her apartment and the heavy laundry and vacuuming.

After two weeks of enhanced support, Shirley's Central East CCAC Community Case Manager, Hana Rudolf, reassessed her health care needs and together they were able to adjust her care plan by gradually reducing the number of her PSW hours.

"I would recommend Home First... if people need that much help, they should take the help," Shirley advised.

Shirley was able to wait at home safely and in the comfort of her own surroundings until she was placed in a Long-Term Care Home of her choice in January. She passed away in March 2011.

Home First has allowed over 2,300 people to transition home across the Central East region and has been implemented in Lakeridge Health, Peterborough Regional Health Centre, Rouge Valley Health System (Ajax Pickering and Centenary sites), The Scarborough General, Northumberland Hills Hospital, Ross Memorial Hospital, Campbellford Memorial Hospital and the Haliburton Highlands Health Services. ●●●



HAROLD AND BARBARA WILLIS

While vacationing in Mexico earlier this year, 83-year-old Harold (Hank) Willis experienced a severe pain and swelling in his calf. He was taken to the local hospital where he was diagnosed with deep tissue hematoma and consequently underwent surgery. Harold spent two weeks in hospital before he was able to fly home to Canada via Los Angeles.

The couple's son met them at the airport in Toronto and immediately drove the two-hour journey directly to the Northumberland Hills Hospital (NHH) in Cobourg. The dressing on the wound on Harold's leg had been there for a day-and-a-half by the time they arrived at NHH and they were concerned about infection and wanted to have the dressings changed and have the wound checked.

On arrival at the hospital, what happened next could only be described as "terrific" Barbara Willis said. "They took us in and immediately found a bed for Hank."

Following an x-ray, ultrasound and blood work, he was seen by a physiotherapist and a doctor.

In recounting the experience at the hospital, Barbara praised the

attention they were given, "It was really great, because the physiotherapist worked with Hank and showed him how to walk while a special wound nurse also attended to him and gave instructions how to care for his wound. We were there the better part of the day and they were very busy in the Emergency Department (ED) but we knew he was well taken care of.

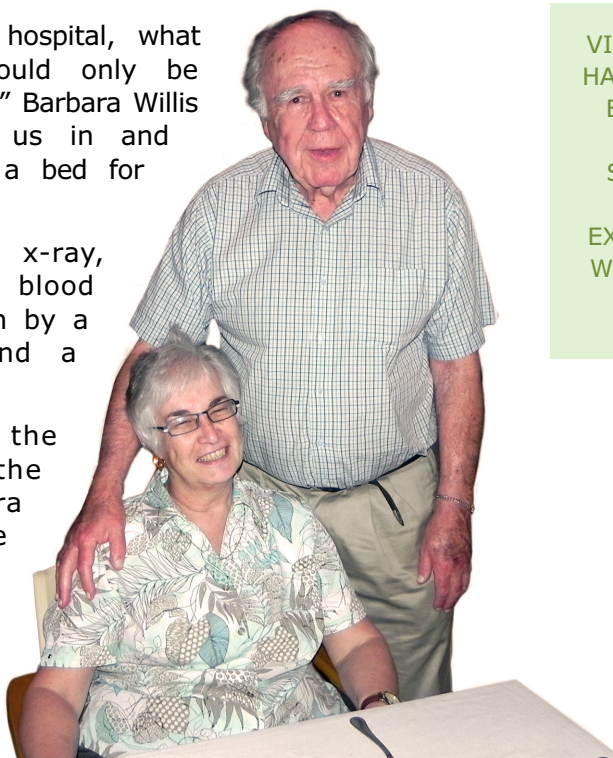
"When the Case Manager from the Central East CCAC came in and talked to us about Home First and arranged to have a nurse come to our home to care for his wound, we were so pleased and reassured."

While the Willis' had dealt with the Central East CCAC previously when Barbara's mother was ill, this was their first encounter with receiving direct care for either one of them.

"It's (Home First) so much more economical for the whole system and is one of the smarter moves on the part of the health system. When most people talk about health care, they don't think about receiving services in the home so that you don't have to stay in the hospital occupying a bed."

What began as a harrowing experience in Mexico was completely turned around once they arrived back in Canada and Harold was treated in the hospital. Reflecting on his experience, Harold said, "We know it could have come out so differently if I hadn't received such good care. Especially with the fact that I arrived at the hospital in a wheelchair and a few hours later I was able to walk out with a cane." ●●●

VIDEO WITH
HAROLD AND
BARBARA
WILLIS
SHARING
THEIR
EXPERIENCE
WITH HOME
FIRST



“Home First has improved patient care by having the professional team working together to create a smooth transition from hospital to home safely, with patient satisfaction of returning home.”

Home First has empowered patients to allow them to return home with family and community support while they wait for appropriate destination if needed.

Patients may spend more time in the privacy and comfort of home to finalize their future plans.”

MARY-ANN POTTER, REGISTERED NURSE
LAKERIDGE HEALTH OSHAWA

“Home First gives me the peace of mind that my patients will have the supports they need to safely transition home from hospital.”

DR. LAUREN LINETT, HOSPITALIST AT
LAKERIDGE HEALTH OSHAWA

MR. & MRS. H

Long-stay clients of the Central East Community Care Access Centre (Central East CCAC), Mr. and Mrs. H's health care needs were high. Mrs. H suffered from severe dementia and was at risk for falls and while Mr. H's condition was frail, he provided caregiver support to his wife.

Each client of the Central East CCAC is reassessed every six months by a Central East CCAC Community Case Manager. With their most recent health care assessment, Mr. and Mrs. H were receiving six hours per week (combined) of a personal support worker (PSW) service in their home. The PSW assisted with their personal care as well as laundry, vacuuming, meals and cleaning.

Due to their high care needs, Mr. and Mrs. H with the support of their family, had filled out applications for Long-Term Care Homes of their choice and were waiting for beds to become available.

In August 2010, Mr. and Mrs. H had a fall in their home and were admitted to Lakeridge Health Oshawa.

While in hospital, Mr. and Mrs. H and their family were told about Home First. The philosophy is dependent on a true collaboration between an inter-professional team made up of doctors, nurses, social workers, Central East CCAC Hospital Case Managers and local community agencies. Due to Mr. and Mrs. H's high care needs,

many discussions took place amongst the inter-professional team to determine whether or not the couple could return home safely to await long-term care placement.

Home First provides clients transitioning home with enhanced PSW and/or Nursing hours so that the transition from hospital to home is safe and clients are receiving the right care at the right time and in the right place. ●●●

“Because of my mom's condition and the fact that she could no longer walk, I didn't think that bringing her home from hospital was going to work. After discussing and reviewing her care plan and the amount of hours she would receive with Home First, I thought it was workable to bring her home - I didn't want her to go into a nursing home; I wanted her home with me.

My mom benefitted from the high level of PSW service as she was bathed and changed. It was helpful for me to have a break and to be stress-free knowing she was in good hands.”

DAUGHTER OF HOME FIRST CLIENT

A CASE MANAGER'S PERSPECTIVE ON HOME FIRST

Irene James, Central East CCAC Hospital Case Manager at Peterborough Regional Health Centre (PRHC) works on the acute medical floor. The floor has 36 acute care beds including specialized care for patients who have suffered strokes.

"The majority of clients treated on this floor go home with Central East CCAC services," says Irene. "We see a range of clients from those who have suffered a stroke, clients with dementia or Alzheimer's disease and patients with acute medical problems. We also see clients from retirement homes who have deteriorated or de-conditioned. With Home First we are able to send these clients home with enhanced in-home services or back to the retirement home with increased service if needed. Before Home First, clients from retirement homes would often have ended up in Long-Term Care Homes if they needed added service."

The goal of Home First is to discharge all patients at the right time and to the right place directly from the ED or after their acute care hospital stay. This gives patients and families the time they need to make important life-changing decisions, such as whether to reside in LTCH, retirement home or remain in their own home with services. Home First allows patients transitioning home to receive enhanced Central East CCAC and other Community Support Services where required.

Central East CCAC Hospital Case Managers work very closely with other members of the inter-professional team to develop a safe and effective transition plan to meet the individualized needs of patients.

"I work very closely with two occupational therapists, two physiotherapists and a Charge Nurse on the acute medical floor of PRHC, as well as social work, nutrition and the Speech Language Pathologist. We have bullet rounds to discuss each patient's health care needs and post-round huddles for more specific one-on-one information to be discussed such as equipment needs or level of function. We have a really good team approach to patient care."

Upon first contact with a client in hospital, Central East CCAC Hospital Case Managers meet with the client to determine how they were managing at home, what services they were receiving at home, and what therapies may benefit them while in hospital.

The inter-professional team works together to make requests for assessments, such as cognitive or physiotherapy assessments earlier on in the patient's hospital stay to assist patients in moving through the system faster. Through this collaboration, the inter-professional team determines the right care for the patient in hospital and the Central East CCAC connects the client with in-home services and community supports upon discharge from hospital to home.

Several dementia and Alzheimer's clients transition home with more than 22 hours per

week of PSW service. "The Home First enhanced hours offer care that a client needs to recover and stay healthy, while providing their primary caregiver with the break that they need," says Irene.

Irene provides a story of how Home First helped a family at PHRC:

The daughter of a patient had taken a leave of absence from work to take care of her mom full-time. One day she brought her mom into the ED as she couldn't handle the stress of providing care for her mom who had dementia. She was unaware of services and with Home First the inter-professional team was able to send the mom home with respite and PSW services, giving the daughter much needed relief from the stress of being the primary caregiver.

"Home First is a great initiative that has allowed us to help more families get their loved one home with services that they need." ●●●



MEETING CULTURAL NEEDS

Thanabathy Sellathurai is very happy with Home First because it meant her husband, Sivalingam could come home to be with family rather than go into a Long-Term Care Home. As residents of the Tamil community in Scarborough, being able to stay with family is very important as is the freedom to communicate in their native tongue. "I appreciate having a Case Manager who can speak my language - she's my language lady," says Thanabathy.

Thanabathy is speaking about Damy Maheswaran, a Tamil-speaking Case Manager with the Central East CCAC who works directly with Tamil clients and their families. In an effort to reach our diverse communities, the Central East CCAC has three dedicated Tamil-

speaking Case Managers and a team of Chinese-speaking Case Managers working out of the Scarborough Branch.

Thanabathy recalls how being able to communicate in her own language helped alleviate stress during her husband's hospital stay:

"My husband was quarantined by infection control as another patient tested positive for an infectious bug. I was not allowed to see my husband for 15 days, but I didn't understand why I couldn't see my husband. The Hospital Staff just kept telling me I couldn't see him for 15 days but gave me no reason, so I called Damy. She followed up with Hospital and then provided me with the explanation of why he was quarantined

for 15 days. My anxiety decreased after I understood why."

"There is a very high need for every health care organization to have Tamil-speaking health care workers to be able to relate and relay information to the Tamil community."



"From a hospital case manager perspective, the Home First program has been received very well by clients and their families. The majority of my clients are 'very elderly' with elderly caregivers and historically when they came to hospital, they remained there. In other situations, family members have to work and cannot participate in clients' care. Home First offers these clients an opportunity to return safely to their own homes, with extensive supports and care in place, where research has shown they feel more comfortable, become less depressed and de-conditioned and above all, maintain a sense of control over their lives."

JACQUELINE MCGUIRK, CASE MANAGER, CENTRAL EAST CCAC

"Home First is a great gift for me. It is very helpful because I am not able to even dress my husband because he is resistant to care and even the care workers are finding it very difficult to care for him. I benefit from Home First - it's a great gift."

THANABATHY SELLATHURAI,
WIFE OF CENTRAL EAST CCAC CLIENT

CLIENT NEEDS FOCUS OF INTER-PROFESSIONAL TEAM

Shortly after his wife was admitted to a Long-Term-Care Home (LTCH) in Scarborough, Mr. R presented himself to The Scarborough Hospital (TSH) and was admitted due to hypoglycemia and failure to cope.

Following his assessment, an important collaboration was established between Mr. R, his daughter and the members of the inter-professional team responsible for his care while in hospital including the Central East CCAC, TSH staff and TransCare Community Support Services. As part of the process implemented with the Home First philosophy, members of the inter-professional team were made aware of the history of this client refusing services as a potential barrier to discharge. Working along with his daughter, the team paid special attention to how they would present an attractive basket of services that would motivate Mr. R to accept the services being offered once he was able to return home from hospital.

Exploring all options for Mr. R to consider attending a more active program meant for more ambulatory and cognitively intact seniors, the TransCare Home First Enhanced Care Coordinator invited him to try the Community Dining Program, free of charge. He agreed. Since then Mr. R has said he enjoys the program and he has made some friends and had a few laughs. Without this flexibility of offering enhanced hours to get him back on his feet, Mr. R would not have regained enough strength to carry out the activities he likes to do.

His renewed interest and confidence sparked a motivation in him to join a group and be around other people. He is now a regular client of the Community Dining Program, and now reports that he is able to drive himself to visit his wife in the LTCH. Gurprit Matharu, TransCare Manager, Integrated Care explains the value of Home First, "Mr. R transitioned from enhanced hours, to paid services, but now is able to enjoy a program he knew nothing about and would never have tried if it were not for the flexibility of Home First."



"Community Care Peterborough is very pleased with the collaboration between the Central East Community Care Access Centre and Community Care Peterborough through Home First at PRHC. There has been a positive increase in referrals, communication and service provision as a result of this new working relationship. We see continued reduction in ED wait times and ALC rates as we strengthen the partnership between CE home health care services and CCP community support services, as our clients receive services at the right time and in the comfort of their own home."

DANIELLE BELAIR, EXECUTIVE DIRECTOR
COMMUNITY CARE PETERBOROUGH

"Home First has been very good to us. They provided our brother with meals on wheels, transportation to his appointments, PSWs for help in the home and telephone reassurance.

We are very grateful for their tender loving care and thoughtfulness."

THE GARROD FAMILY



Our Story in Numbers



- Statistical charts
- Monitoring our effectiveness



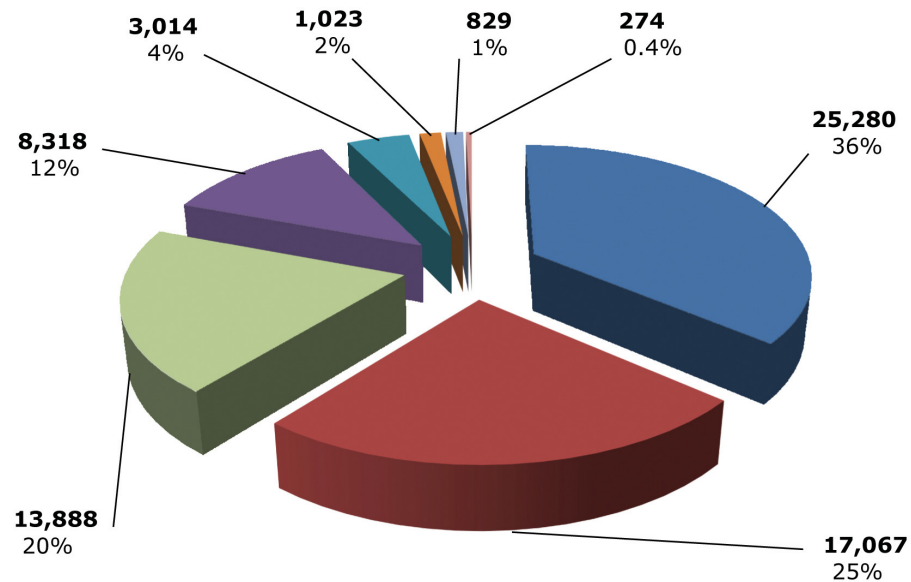
Our Story in Numbers



CLIENT SERVICES INDIVIDUALS SERVED AND PERCENTAGE DISTRIBUTION

APRIL 01, 2010 - MARCH 31, 2011

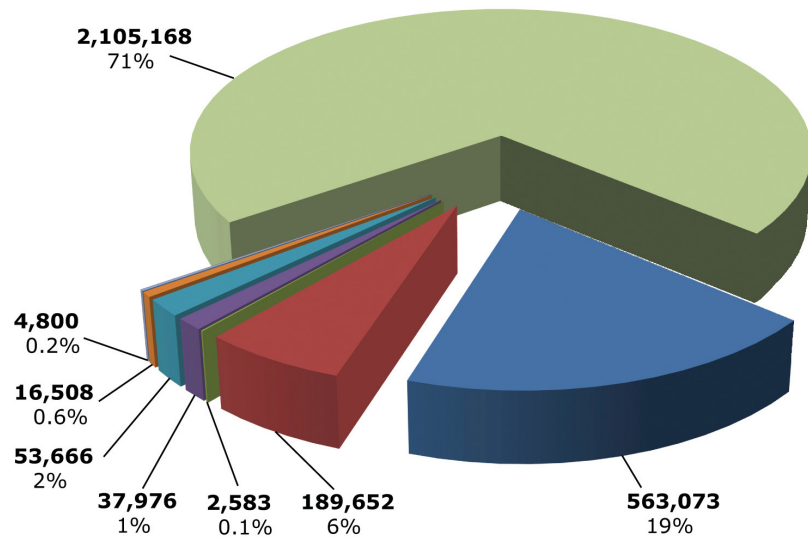
SERVICE	2010-2011	2009-2010
Visiting Nursing	25,280	27,149
Personal Support	17,067	17,233
Occupational Therapy	13,888	15,309
Physiotherapy	8,318	10,102
Speech	3,014	3,463
Social Work	1,023	2,093
Nutrition	829	1,360
Shift Nursing	274	316



CLIENT SERVICES UNITS PROVIDED AND PERCENTAGE DISTRIBUTION

APRIL 01, 2010 - MARCH 31, 2011

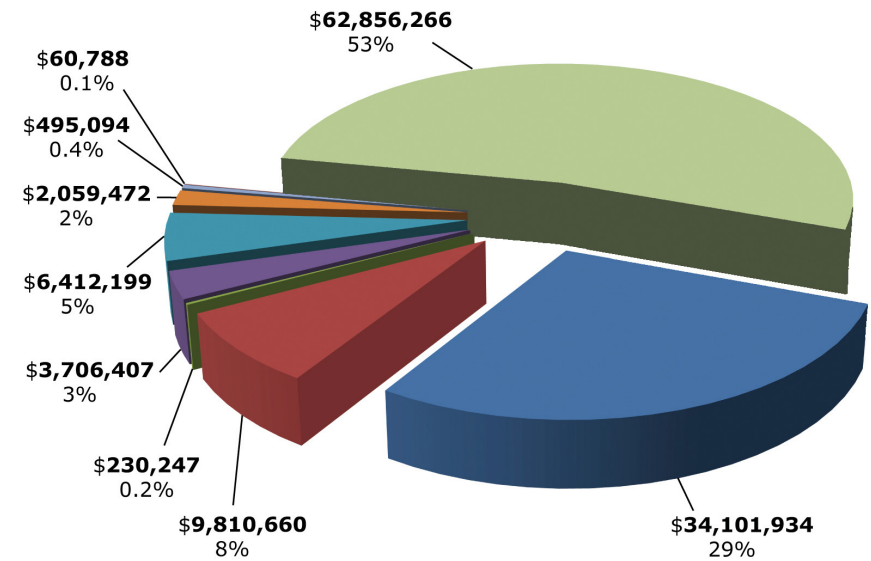
SERVICE	2010-2011	2009-2010
Personal Support	2,105,168	2,303,789
Visiting Nursing	563,073	712,175
Shift Nursing	189,652	192,165
Occupational Therapy	53,666	67,531
Physiotherapy	37,976	52,457
Speech	16,508	18,583
Social Work	4,800	12,623
Nutrition	2,583	4,620



CLIENT SERVICES EXPENDITURES (\$) AND PERCENTAGE BREAKDOWN

APRIL 01, 2010 - MARCH 31, 2011

SERVICE	2010-2011 (\$)	2009-2010 (\$)
Personal Support	62,856,266	66,596,357
Visiting Nursing	34,101,934	42,158,020
Shift Nursing	9,810,660	9,604,572
Occupational Therapy	6,412,199	7,592,048
Physiotherapy	3,706,407	4,900,077
Speech	2,059,472	2,288,503
Social Work	495,094	1,438,871
Nutrition	230,247	422,709
Psychology	60,788	40,100



MONITORING OUR EFFECTIVENESS

To live our Vision, "Outstanding care - every client, every day," the Central East Community Care Access Centre (Central East CCAC) evaluates our effectiveness in serving our community on an ongoing basis. Our Quality and Risk Management portfolio records and tracks our risk events, complaints and compliments.

Consistent with the last fiscal year, the main area of complaints continues to be in the category "service quality." The total number of complaints over the 2010-2011 fiscal year has increased by 11.8 per cent due in part to the impact of the budget recovery initiatives the Central East CCAC has implemented.

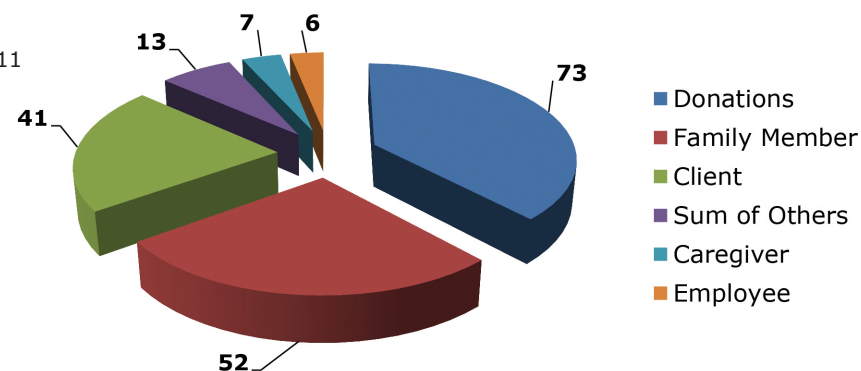
"Service quality" trended high in feedback of compliments, accounting for 98 per cent of the total number of compliments. Family members and clients were the prominent sources of compliments, primarily acknowledging the great care and service they felt they received from either the Service Provider and/or Central East CCAC Case Manager.

With the results of our monitoring system indicating a high importance on "service quality," the Central East CCAC has taken several forward strides over the past fiscal year to create programs that focus on quality initiatives, such as the creation of Performance Excellence Teams and participating in the Provincial CCAC Quality Report and the Client and Caregiver Experience Evaluation.

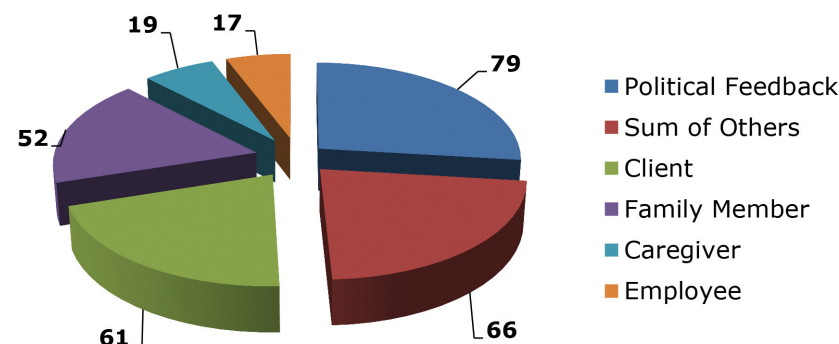
Generally, from the Client and Caregiver Experience Evaluation Report which is conducted on a quarterly basis by Ipsos Reid, indications are that the Central East CCAC is on par with the other CCACs in the province in terms of overall satisfaction. Clients report that the primary strengths for the Central East CCAC are that Case Manager's help clients, they look after their care and the Case Manager listens carefully.

The Quality and Risk Management portfolio have also been reviewing new systems to better enhance the performance of auditing, monitoring and trending risk events. On the horizon, with a new system in place, case reviews will continue to be reviewed and trended to determine root causes for the complaints and to identify improvement opportunities. ●●●

SOURCE OF COMPLIMENTS
APRIL 01, 2010 - MARCH 31, 2011



SOURCE OF COMPLAINTS
APRIL 01, 2010 - MARCH 31, 2011



Our Community



- Community engagement



Our Community

REACHING OUR DIVERSE COMMUNITIES

COMMUNITY ENGAGEMENT RESULTS 2010/11

The Central East CCAC Community Education and Outreach Representatives (CEORs) work in their designated areas across the Central East region to provide education and disseminate information to the geographic and culturally diverse communities we serve. In addition to our representatives who conduct presentations, host information sessions and provide booths at community health fairs and other related events, subject matter experts from Client Services also participate in presentations on specific topics as required.

From April 1, 2010 to March 31, 2011 the Central East CCAC Community Education and Outreach Representatives participated in a total of 153 events, 217 networking opportunities and activities, made 15,000 contacts and sent out 1,636 mailouts.



As part of the community education and outreach strategic plan, the CEORs target groups are typically seniors to help support the provincial initiative of Aging At Home, as well as culturally diverse community

organizations. Fact sheets, presentations and other documents are produced in Tamil and Chinese to effectively serve those clients whose first language is not English or French.

Outreach to the aboriginal community has been focused in those communities in the northeast area of our region and in November 2010, a connection was made with the Lovesick Lake Aboriginal Women's Support Group for future collaboration.

The CEORs participate on several community partner networks or initiatives and their representation of the Central East CCAC on each of these groups help to deliver clarity of our process as well as organizational updates. These forums offer a conduit for the exchange of information and issues community organizations may bring forward on behalf of their clients who are also served by the Central East CCAC. In the area of client services concerns, representation on these networks have proved particularly effective in helping to resolve misunderstandings or head off potential problems.

The following is a list of community partner networks on which our CEORs participate:

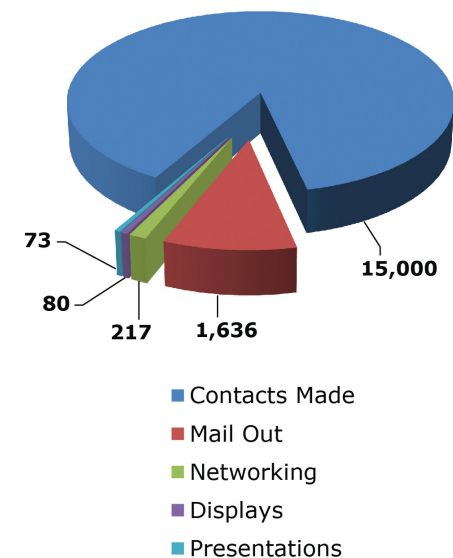
- Durham Advisory Committee for Community Services
- Scarborough Advisory Committee for Community Services
- Peterborough Community Service Provider Network
- Haliburton Kawartha Lakes Elder Abuse Prevention Network
- Haliburton Community Service Provider Network

- Age Well Network (Campbellford)
- Partners in Aging Network (Peterborough)

PLANNED ACTIVITIES

Future activities will continue to support the community engagement goals and focus on the senior population across our region. To support increased collaboration and networking, a Community Information Fair is planned for the spring in response to the need identified by Central East CCAC Client Services staff as well as community support services to create a forum in which new information can be exchanged and discussed. ●●●

COMMUNITY EDUCATION AND OUTREACH ACTIVITIES
APRIL 01, 2010 - MARCH 31, 2011



Statement of Operations



Statement of Operations

	2011 \$	2010 \$
■ REVENUES		
Funding from Central East Local Health Integration Network (CE LHIN)/Ministry of Health and Long-Term Care (MOHLTC)	217,769,211	209,795,206
Interest	107,879	6,546
Other income	658,181	1,121,112
Amortization of deferred capital contributions	573,517	1,114,302
Amortization of deferred lease inducements	228,740	34,094
Amortization of deferred donations	11,112	11,112
	219,348,640	212,082,372
■ EXPENDITURES		
Salaries, wages and benefits	58,290,586	54,304,437
Contracted out Services		
Personal support/homemaking	62,856,266	66,596,357
Nursing	43,405,339	51,304,440
Nursing Clinic	507,254	458,152
Occupational Therapy	6,412,199	7,592,048
Physiotherapy	3,706,407	4,900,077
Therapy Clinic	49,419	52,106
Speech-language pathology	2,059,472	2,288,503
Social work	495,094	1,438,871
Psychology	60,788	40,100
Nutrition	230,247	422,709
Medical supplies	11,295,530	10,973,382
Medical equipment	3,618,152	4,618,660
Client transportation	-	27,536
Administrative costs	7,418,214	7,404,386
Occupancy costs	3,322,861	2,857,540
Amortization of capital assets	813,369	1,182,332
	204,541,197	216,461,636
Excess/(deficiency) of revenue over expenditures	14,807,443	(4,379,264)

The Statement of Operations presented above has been extracted from the complete audited financial statements of Central East Community Care Access Centre for the year ended March 31, 2011. ●●●

Where we are located:

■ CENTRAL EAST COMMUNITY CARE ACCESS CENTRE OFFICES

Campbellford Branch

119 Isabella Street, Unit 7, Campbellford ON K0L 1L0
705 653 1005 or 800 368 8053

Haliburton Branch

PO Box 793, 13321 Highway 118, Haliburton ON K0M 1S0
705 457 1600 or 800 368 8027

Lindsay Branch

370 Kent Street West, Lindsay ON K9V 6G8
705 324 9165 or 800 347 0285

Peterborough Branch

700 Clonsilla Avenue, Suite 202, Peterborough ON K9J 5Y3
705 743 2212 or 888 235 7222

Port Hope Branch

151A Rose Glen Road, Port Hope ON L1A 3V6
905 885 6600 or 800 347 0299

Scarborough Branch

100 Consilium Place, Suite 801, Scarborough ON M1H 3E3
416 750 2444 or 866 779 1931
416 701 4806 Chinese Line

Whitby Branch

920 Champlain Court, Whitby ON L1N 6K9
905 430 3308 or 800 263 3877

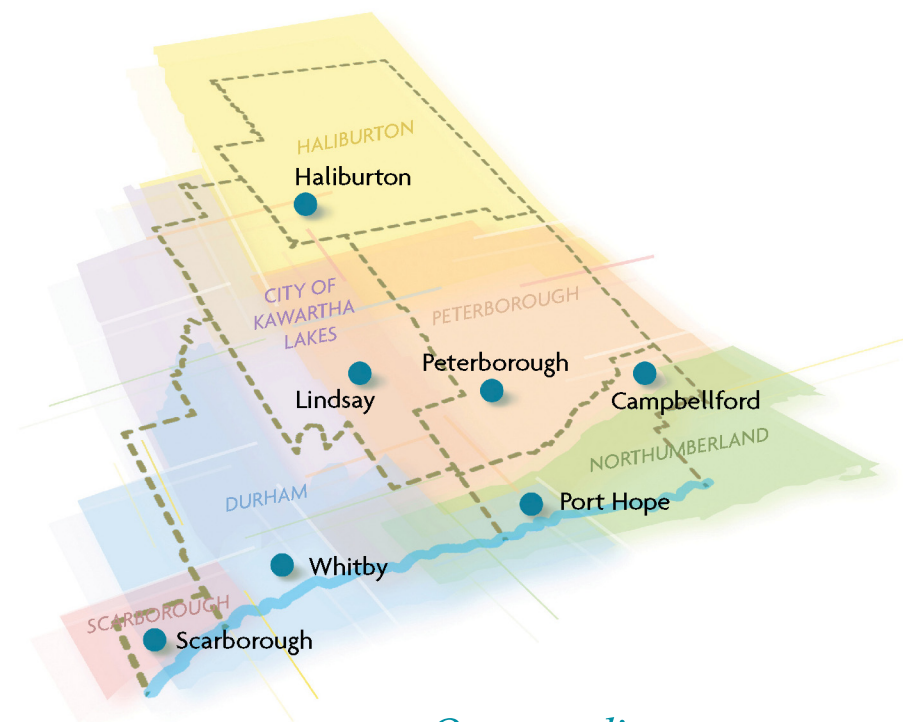
TTY Line: 877 743 7939

French Line: 416 701 4646 or 877 701 4646

Website: www.ce.ccac-ont.ca

310-CCAC

Wherever you live in Ontario, to find health care and community-based services, search www.310CCAC.ca or call 310-CCAC (310 2222).



*Outstanding care -
every person,
every day.*





www.ce.ccac-ont.ca