Central East
CCAC CASC
Community Care Access Centre
Centre d'accès aux soins communautaires du Centre-Est

2012-2013

Our report to the community

Central East Community Care Access Centre

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

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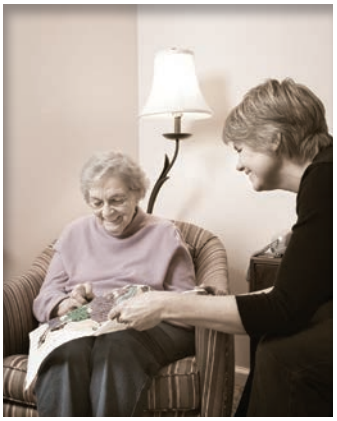

Central East
CCAC Community Care Access Centre
CASC Centre d'accès aux soins communautaires du Centre-Est

What the Central East Community Care Access Centre (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, patients, 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.

Central East Community Care Access Centre (CCAC) Board Members:

- Beverley Dew-Tezak, *Chair*
- Jamie Marcellus, *Vice-Chair*
- William (Bill) Botshka, *Treasurer*
- Helen Briggs
- Susan Donaldson
- Graham A. Lowman
- Liz McCreight
- Rick Morphew
- Dr. Barry Neil
- Glenn Rogers
- Joseline Sikorski

2012-2013 Facts & Stats

$242 million budget

$664 thousand was spent each day

- 91% contracted clinical service and care coordination
- 5% general administration
- 2% Information Technology
- 2% facilities costs

77,697 patients were served

60,525 in-home patients were served

38,994 visits were made to our outpatient care settings (Alternate Care Settings)

11,567 children were provided with School Health Support Services

6,883 people were initially assessed for long-term care placement

2,521 people were placed into their first long-term care home

Message from the Board Chair and CEO

A diabetic struggles to manage his own care. A student suffering from depression needs support and guidance. A daughter who is the primary caregiver for her dying mother needs support to help her mother stay at home. A 72-year-old man with Alzheimer-type dementia needs specialized behavioural services to stabilize his violent behaviour in a long-term care home.

These are some of the stories that represent the more than 30,000 patients the Central East Community Care Access Centre (CCAC) cares for each day. Some are the frail elderly living in our community, patients with complex chronic diseases, seniors transitioning to long-term care and children who are medically fragile or technologically dependent or who have mental health and addiction challenges.

Health care is undergoing a transformation. Increasingly, patients and caregivers are taking a more active role by helping to direct and participate in providing the care and services needed. We are committed to working with our patients and caregivers so that together we can meet their expressed needs and achieve excellent health care. We are providing more service, in more locations, applying different and innovative ways of providing service, and are meeting more needs, all while living within our budget.

Our mandate and accountabilities are complex and in the ever changing world of health care, we can only accomplish our goals if we work collaboratively with our health care and community partners. The commitment of our partners: caregivers, physicians, health care colleagues, community support agencies and the Central East CCAC staff, allows us to provide care to our patients each and every day.

Our Report to the Community highlights the new initiatives we have implemented over the past year and celebrates the many successes our commitment to excellence in care for our patients has provided.

Beverley Dew-Tezak
CHAIR, BOARD OF DIRECTORS

Donald M. Ford
CHIEF EXECUTIVE OFFICER

Year in review

It has been a significantly busy year for the entire CCAC sector across the province and in Central East, our commitment to integration and partnerships with our acute care and community partners continued to strengthen. During 2012–2013 fiscal year, we have led or participated in several cross-sector integration initiatives whose goals have been to ensure better coordinated care, better health outcomes, better care experiences for our patients, and best value for money.

Working collaboratively with our health care and community partners, we have identified sustainable ways in which to support the philosophy of patient-centred care. Through the many initiatives we have participated in with our partners we have achieved the continuation of sustained growth in our relationships, improved transitions for our patients, continuing implementation of best practices, as well as an ongoing emphasis on the importance of a quality patient-based experience.

We continue to serve the highest number of high needs patients of any region in Ontario, serving over 77,000 patients annually requiring an expenditure of $664,000 a day.

Home First

As the lead agency for the implementation of the Home First philosophy which began across the Central East region in 2010, the Central East CCAC continues to work collaboratively with our hospital partners and community support service agencies to ensure patients are provided with the right supports, at the right time to return home safely and recover successfully. During the last fiscal year, we completed the final roll out of the Home First philosophy to all Central East hospitals with the implementation to the Ontario Shores Centre for Mental Health Sciences. Over the past year, 9,789 patients were safely and effectively transitioned from hospital to home.

Northumberland PATH

In partnership with The Change Foundation and led by Northumberland Hills Hospital (NHH), the Central East CCAC has joined with several other community-based organizations to support the Partners Advancing Transitions in Healthcare (PATH) project.

Year in review

The only one of its kind in Ontario, the Change Foundation is providing the funding to deliver on PATH's main goal: to improve people's health care experience as they move in, out of, and across Ontario's health care system over time.

As one of 12 cross-sector community-based providers along with patients/caregivers, the Central East CCAC has representatives who participate on various committees to understand and co-design how care is delivered with the goal to design and improve health care transition problems that patients identify.

Peterborough Health Link

In December 2012, the Minister of Health and Long-Term Care (MOHLTC) announced the creation of community Health Links designed to improve co-ordination of care for high-needs patients such as seniors and people with complex conditions. In the Central East region, the Peterborough Health Link is one of 19 early adopter Health Links across the province that is mandated to develop a new way of doing business that place patients at the centre of care.

The Peterborough Health Link is committed to embedding the patient experience in their work and has used patient stories to guide the process. The shared vision for the Peterborough Health Link is to improve the health outcome and experience for all patients in our region. With the Central East CCAC as the lead administrative agency, there are 12 partners around the table working toward the goal of achieving greater collaboration and co-ordination between a patient's different health care providers as well as the development of personalized care plans. Two identified cohorts have been the focus of the early work: seniors age 65 and over with advanced congestive heart failure and, patients with serious mental illness and addiction issues.

Assisted Living for High Risk Seniors

Working with our community support service partners – Community Care Durham, Victorian Order of Nurses (VON), Carefirst Seniors & Community Services Association and Yee Hong Centre, Assisted Living for High Risk Seniors hubs aim to help people maintain their independence and remain in their homes for as long as possible. Assisted Living provides personal support, homemaking and security check and assurance services on a 24/7 basis. The Central East CCAC Care Coordinator determines the eligibility for admission to the program.

Each hub generally serves an area of five kilometer radius, and they have been rolled out across the Central East region in Scarborough, Ajax, Whitby, Oshawa, Cannington, Beaverton, Sunderland, Lakefield and Peterborough. Two hubs in Scarborough were added earlier in 2013 bringing the total of Assisted Living hubs to 11.

Centre for Complex Diabetes Care (CCDC)

As part of the ongoing effort to improve the health and health care of Ontarians, the Ontario Diabetes Strategy was launched in 2008, to help people with diabetes and those who are at high risk of developing it. In 2012, the MOHLTC provided funding for a new regional Centre for Complex Diabetes Care (CCDC) in the Central East designed to manage people with diabetes who have complex needs.

Including Central East CCDC, there are currently six sites across the province. The Central East CCDC is made up of three care delivery sites located at Peterborough Regional Health Centre, Lakeridge Health, Whitby and The Scarborough Hospital, General Campus.

The Central East CCDC exceeded new patient targets in its first year of operation by about 70 patients and we have received many positive patient stories and testimonials, some of which are shared later in this report.

Nursing Initiatives

As part of the MOHLTC's Action Plan for Health and the 9,000 nurses commitment, three direct nursing programs were introduced in the CCAC sector to help address the increasingly complex health care needs of specific patient groups.

Mental Health and Addiction Nurses

The Mental Health and Addiction Nurses (MHAN) at the Central East CCAC work in collaboration with four regional District School Boards to help support, recognize and respond to student mental health and addiction issues. Memorandums of Understanding were signed with Kawartha Pine Ridge District School Board; Peterborough, Victoria, Northumberland, Clarington Catholic District School Board; Durham District School Board; and Durham Catholic District School Board.

The goal of the MHAN staff is to become an integral part of an interdisciplinary District School Board-based team who work together to provide early identification and intervention services and support students who have mental health and addiction issues, and follow up with students who are released from hospitals and Emergency Departments. Along with a Manager, the six Registered Nurses and two Registered Practical Nurses support the program which was officially launched in January 2013.

Rapid Response Nurses

The Rapid Response Nursing (RRN) program is a dedicated team of Registered Nurses providing a variety of intensive in-home services to patients and their families within 24-48 hours of discharge from hospital. This allows patients with complex care needs and their families to be professionally assisted to support smooth and safe transitions from hospital to home. Working closely with the staff in the inpatient units and Emergency Departments at the three early adopter Central East region hospitals – Northumberland Hills, Ross Memorial and Rouge Valley Centenary and later at Lakeridge Health, Port Perry, 12 Rapid Response Nurses are collaborating with patients, families, and care coordinators to ensure successful transitions.

Community Palliative Nurse Practitioner Program

The third nursing initiative, Community Palliative Nurse Practitioner (CPNP) Program in the Central East region was blended with the already existing program introduced previously by the Central East LHIN.

Year in review

Only 10 percent of people die suddenly, while the remaining 90 percent will require assistance and support at some point in their life, and studies have shown that 70 to 80 per cent of people would prefer to die at home if supports are available.

The Central East CCAC CPNP Program is a dedicated team of Nurse Practitioners providing direct clinical care to patients with complex palliative needs, including pain and symptom management. Inter-professional care is identified as the gold standard for hospice palliative care. Working within a network of palliative care providers, including Central East CCAC Care Coordinators and community-based physicians, the CPNPs enhance the continuity of clinical care across primary care, community supports, acute and specialty care sectors to support patients in living and dying and in their place of choice.

Long-Term Care Homes (LTCH) waitlist report

To help families and individuals make informed decisions about long-term care, the Central East CCAC launched a report on our public website designed to help anyone seeking information about long-term care home waitlists. The report includes the number of individuals on the waitlist for each level of accommodation within a home and the average number of beds that become available in each home.

During the 2012–2013 fiscal year, the Central East CCAC assisted 2,521 people to access a long-term care home. The report can be viewed at www.ce.ccac-ont.ca.

Balanced budget

The Central East CCAC ended the 2012-2013 fiscal year in a balanced budget position.

Accreditation

In January, the Central East CCAC was awarded a three-year accreditation from the Commission on Accreditation of Rehabilitation Facilities (CARF) International. The CARF survey team was on site for four days and reviewed in excess of 1,800 standards and noted our successful compliance with 98.5 per cent of the standards.

"We are writing to express our most heartfelt thanks to a compassionate and competent Care Coordinator. With your care and support, our father was able to go through his health challenges and his final days peacefully."
FAMILY MEMBER OF CENTRAL EAST CCAC PATIENT

"I wanted to take the time to thank and compliment everyone for the care that they give. I can't say enough about them and the efficient and caring service that I have received."
CENTRAL EAST CCAC PATIENT

"Thank you for the support and empathy during a difficult time."
DAUGHTER OF CENTRAL EAST CCAC PATIENT

Caring for our patients

Centres for Complex Diabetes Care (CCDC)
A new approach to managing complex diabetes

For every 100 adults in the Central East LHIN, approximately 11 adults are living with diabetes. This ratio is higher than the Ontario average. The highest rates of diabetes in the Central East LHIN occur in Scarborough and the Durham Region, both of which have higher-than-average rates.

The Central East CCDC manage complex diabetes and is a program to augment the continuum of care already provided by Diabetes Education Programs, primary care providers, diabetes specialists and other diabetes programs. The CCDC helps to ensure that patient–centred care and specialized supports are available to address the unique needs of people with diabetes with complex needs. Patients receive comprehensive care by the CCDC inter-professional team which is made up of a Nurse Practitioner, Registered Nurse, Registered Dietitian, Social Worker, and a Pharmacist.

In the Central East region, admission to the CCDC is facilitated by the Central East CCAC. Established during the second quarter of the 2012-2013 fiscal year, by March 31, 2013, a total of 326 patients had been referred to the three Central East CCDC care sites at The Scarborough Hospital, General Campus; Lakeridge Health, Whitby; and Peterborough Regional Health Centre.

The following success stories are a few examples of how the CCDC care sites and their inter-professional teams have benefitted those patients who have attended.

Mrs. S is an elderly woman, who attended the clinic with her daughter. She lives with her 90-year-old husband, and although frail, they are fiercely independent and determined to remain in their own home.

The patient's daughter stated that although her mother had been diagnosed with Type 2 diabetes for some time, this is the first time that a comprehensive assessment had been carried out, that did not necessitate her having to take multiple periods of time off work.

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Mr. C is a 45-year-old man who came to CCDC for assistance in managing his Type 2 diabetes. His co-morbidities include: congestive heart failure, hypertension, hyperlipidemia and morbid obesity. He was seen and assessed by the entire inter-professional team at the CCDC. Mr. C built a very positive rapport with the entire team and has had numerous follow up appointments to address his health and psychosocial issues.

The Nurse Practitioner was able to link him with the CCDC consulting endocrinologist and the Registered Dietician has been providing ongoing diet counselling and support including telephone and email consults in between follow-up appointments. The Social Worker has been able to assist him with completing a Trillium Drug Program application for additional drug benefits and helped the patient manage a family crisis. Mr. C is one of the first patients seen by the new Central East CCDC and he stated that he looks forward to continued involvement with the team as he works towards improving his health outcomes.

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Mr. D was referred for assessment to the CCDC from the Diabetes Education Program he was attending. The Nurse Practitioner at the CCDC conducted an initial assessment and identified that he was non-compliant with his self-care in terms of adequately managing his blood sugars.

He was further assessed by the CCDC Social Worker who supported him by setting up family home visiting through a community-based agency; financial supports; medication support during the home visit; and, as agreed to by the patient, referral to the hospital's spiritual care department for trauma counselling and future support to deal with past issues.

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Mr. G is a 41-year-old patient diagnosed with Type 1 diabetes who is on an insulin pump and had been experiencing financial issues and having difficulty being motivated to take the necessary steps to get financial support and gain more control of his diabetes. After six appointments with a combination of goal setting and diabetes education support, he reported that he has his financial situation in order and he has also begun to test his blood glucose four times per day, helping him to re-qualify for the Assistant Devices Program.

Mr. G identified that regular follow-up appointments every two weeks were very encouraging and made him feel proud that he was on the right track. He commented on how great it felt to come in and talk and receive the time and support that he was provided through the CCDC.

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Mr. T is a 69-year-old male with Type 2 diabetes and other chronic diseases, who has attended appointments at the CCDC clinic since his referral in early February. The main issue is poor control of blood sugars and nerve pain. He is taking both insulin and oral medication. At his last appointment Mr. T stated that he feels he has learned more about his diabetes in this setting because of the time spent in each appointment. With

"I can't say enough about the care I received..I felt like I had an entire team behind me working to get me better again."
CENTRAL EAST CCDC PATIENT

"I am glad I can see the whole team at the same time so I can tell them what I need only once."
CENTRAL EAST CCDC PATIENT

Caring for our patients

a greater understanding of his condition he is being motivated to do self-management through more regular testing. Mr. T is now testing before each meal and he is becoming more confident about managing his diabetes and is starting to use a correction factor as part of his management routine. He was very adamant that we, "tell other people about how the CCDC can help you understand how your diabetes works."

Nurse Practitioners go beyond clinical to help a patient remain at home

Nurse Practitioners (NPs) in Long-Term Care Homes (LTCH) play an integral role in supporting the quality of resident care and work closely and collaboratively with LTCHs health care professionals to help divert a number of avoidable Emergency Department (ED) transfers of those LTCH residents. They also help to facilitate the discharge of residents from hospitals back to their LTCHs.

The Central East CCAC is funded by the Central East Local Health Integration Network (LHIN) to implement the Nurse Practitioners Supporting Teams Averting Transfers (NPSTAT) program to develop and address the health risks of transferring frail seniors to Emergency Departments for visits which could be avoided if treated in the LTCH.

There are currently 10 NPs on the Central East CCAC's NPSTAT team who work in both a full time and part-time capacity.

The NPSTAT program had 5,680 encounters with residents in LTCHs over the past fiscal year. During these encounters NPs have provided direct clinical care

or consulted LTCH staff about a resident. But there are also times when helping a patient means going beyond the clinical care.

Mrs. A was a LTCH resident who had lung cancer that had metastasized. Fluid was accumulating in her lungs and it needed to be drained on a regular basis. The LTCH was not set up with the right equipment to drain the fluid and Mrs. A had to be frequently transferred to the ED to have the fluid removed.

"Recognizing that Mrs. A was having recurrent fluid accumulation in the lung space, my colleague Sandra and I worked together with her, the LTCH, the physicians, and the thoracic team at Lakeridge Health to devise a solution that would enable Mrs. A to remain in the LTCH, while still receiving the best possible care, maintaining dignity, improving quality of life and relieving symptoms related to this chronic condition," says Nancy, a Central East CCAC Nurse Practitioner with the NPSTAT program.

Nancy advocated on behalf of Mrs. A for resource allocation so the LTCH could provide her with the equipment needed to drain the fluid as the supplies required were very expensive and not financially feasible for the LTCH initially. Nancy spoke extensively with surrounding hospitals and suppliers ultimately acquiring initial supplies for Mrs. A at no cost for a trial period.

This involved contacting numerous suppliers and manufacturers across the United States and Canada. A supplier in Canada agreed to provide the initial set up for the patient and to help the LTCH with education. They donated the initial thoracic drainage units.

The team at Lakeridge Health implanted the thoracic drain in Mrs. A's left lung space where it drains fluid from the lung three times a week. They also worked with the LTCH to educate about troubleshooting and maintaining the drain.

By advocating for Mrs. A's care, Nancy and the rest of the team have enabled her to live comfortably at the LTCH with improved quality of life, decreased respiratory distress and the ability to carry on with normal daily activities. The trial will be evaluated to assess its success and determine how to proceed for other similar patients.

Caring for our patients

Soaring above mental illness with the help of the MHAN program

Seventeen-year-old Priscilla describes her life over the past few years as a roller coaster ride with good times and then a lot of rough patches.

"This past year, there was a death of a close friend which led me into a downward spiral and I became very depressed. Some days I wouldn't want to get out of bed and a lot of the time I was absent from school. I couldn't be in class because I was so anxious. Even with my friends I stopped being so outgoing. I closed myself off from everyone," Priscilla recalls.

In February, she broke down at school, no longer able to cope with her anxiety and depression and was taken to the Emergency Department at a local hospital. When Priscilla returned to school, the Vice Principal realized that her academics were slipping and there were risks involved if she did not get further help. The Central East Community Care Access Centre (CCAC) was contacted to see if the Mental Health and Addictions (MHAN) program would be a good fit for her.

The MHAN Program is a dedicated team of mental health nurses providing a variety of services to students and their families in collaboration with the district school board team. This program is a joint initiative funded by the Ministry of Health and Long-Term Care, Ministry of Education, and Ministry of Child and Youth Services, and supported by the School Boards and the Central East CCAC. Across the Central East region the MHAN program is partnered with Durham District School Board (DSB), Durham Catholic DSB, Kawartha Pine Ridge DSB, and Peterborough Victoria Northumberland Clarington Catholic DSB. The MHAN program supports students who are discharged from hospital with their successful transition back into school and their community. Referral to the program is completed by the district school board and available services are determined according to eligibility.

"I was unsure of what to expect with the MHAN program but once I found out there was one-on-one therapy and privacy involved, it was a lot easier to talk about my feelings," says Priscilla.

Tina, the MHAN Nurse who was assigned to work with Priscilla, began meeting with her at her school two times a week using techniques such as Cognitive Behavioural Therapy (CBT) and Inter-personal Psychotherapy (IPT).

Thoughts, feelings and behaviours were examined as part of CBT. There was a great focus on examining negative thought patterns and replacing them with more balanced thoughts.

“I couldn’t figure out why I was getting so anxious… why I was so distraught with my friends. I found out that my anxiety was due to over-analyzing situations and the people around me. By tapping into my feelings, it showed me what was happening,” Priscilla explained.

Tina showed her how tools such as an anxiety booklet helped pinpoint reasons why she was so uncomfortable and uneasy with her surroundings.

“By gauging her mood out of 10 we could identify her anxiety level,” Tina explained. “She kept a log of how she was feeling and we worked together to develop strategies to help her cope with her anxiety. We looked at different techniques she could do in school, like a distraction app on her phone, staring at a spot on the wall, talking to someone next to her – all ways to divert her attention off her anxiety, which helped her stay in class.”

IPT focused on identifying Priscilla’s values and how those values related to her relationships with people.

“I have family issues, and I was trying to find hope in my situation. My issues were looming and I dreaded facing the issues that I knew I had to deal with. I don’t live with my mom or dad or any of my family so the feeling of being alone is a big deal,” said Priscilla.

Through IPT, she was able to explore what each relationship meant to her by comparing that to a list of her top values – what brings meaning to her life. Through this work, she was able to recognize which relationships she was willing to work on and set goals each week about reconnecting with her family and friends, setting healthy boundaries and journaling how she was feeling about those interactions.

“Tina and I talked a lot about values. She made me look at my values and find out what was most important to me in life. If I was unhappy, it was because I wasn’t satisfying my values. She was a constant support for my problems and issues and she shed light on some of the areas I needed to work on,” said Priscilla.

She recalled a situation when she needed to make a phone call to someone about her living arrangements. She was paralyzed with fear of making the phone call for weeks, but Tina encouraged her to make the call. Tina worked with Priscilla to write out what she would say when the call was placed. After the call was made, Priscilla’s anxiety levels dropped dramatically and she was grateful she took the risk.

“I have good days and then not so good days. Now I would say I am a 9 on a scale from 1 to 10,” she said with a smile. “Working with Tina has definitely alleviated my discomfort and sadness.”

Tina and Priscilla will continue to meet once a week over the summer and will work on a transition plan for September when Priscilla enters her last year of high school.

With the support of Tina and the MHAN program, Priscilla said she has found her potential – she plans to enroll in college to pursue a career in human resources.

Caring for our patients

Caring for our patients, supporting their caregivers - Central East CCAC health professionals provide "wrap-around" care

Family caregivers provide care to parents, spouses, children, or extended family members who are in need of support due to age, chronic conditions, injury, long-term illness or disability.

The Canadian Caregiver Coalition estimates that four to five million Canadians are providing care for a family member with long-term health problems, and these caregivers save the public system more than $5 billion dollars in unpaid labour every year.

Family caregivers play an important role as part of the health care team that patients rely on.

Laura Borden is one of these caregivers who has had first-hand experience caring for her mother, Devina Borden, for the past five years.

As a mother of nine, Devina had always been healthy and spent her life caring for others. She was involved in community outreach programs, a breakfast club for children, and worked with the Toronto District School Board before retiring to become a nanny. She eventually returned to school as a lunch room supervisor for kindergarten classes.

"Mommy never stopped caring for children – she absolutely adored them and loved them. She worked right up until six months before she passed away," said Laura.

When Devina fell ill, the Borden family thought it may be the stomach flu or an ulcer. After a visit to the doctor, tests confirmed she had colon cancer. Laura describes how shocked they were to hear her mother's diagnosis.

"Mommy was so invincible and healthy – she had never been in hospital or had any health problems… it was very difficult to receive the information."

During this time, Devina's grandson was getting married in Venezuela. The doctor wanted to book the surgery to have the cancer removed, but Devina told the doctor she would be away for her grandson's wedding and he could schedule it when she returned.

"I was panicked because I was worried something would happen in a third-world country and about the care they could provide. She was so sick down there but we came back without incident," said Laura.

Devina had an amazing recovery after the surgery and the Borden family celebrated her health and continued to live on as normal until two years later when routine checkups identified that Devina now had cancer in her liver.

Devina began 12 sessions of chemotherapy to combat the liver cancer and Laura became her primary caregiver, taking her to the hospital for treatments, providing personal care, and taking her to the Central East CCAC's Alternate Care Setting (ACS) to have her PICC line flushed.

With Devina and Laura, the Central East CCAC Care Coordinator reached out to them to tailor care that respected their wishes and provided the support they were looking for.

Devina was reluctant to meet with the Central East CCAC Care Coordinator assigned to her because of her illness.

"When I couldn't reach her by phone, I stopped by her house and knocked on her door," recalled the Central East Care Coordinator, Odessa. "Even though I had coordinated nursing service for her, the home visit was an opportunity to conduct a full health assessment. She told me upfront that she didn't want additional services, yet I met with her anyway. It didn't feel as though it was an assessment, it was more like having a conversation. It was from her recounting her story that I was able to complete the health care assessment."

Devina's concerns about travelling to the ACS when she was not feeling well were alleviated by Odessa who reassured her that a nurse could visit her in her home on those days she wasn't well enough to travel. Odessa also referred her to community services such as WheelTrans and Meals on Wheels to assist with transportation to appointments and fresh hot meals as she didn't want to bother her daughters, who were caring for her.

Odessa had a lot of interaction with Laura as she investigated the services the Central East CCAC provided. Odessa spoke with Laura about her mom's needs and suggested she look towards palliative care.

"Every health care person my mother came in contact with was amazing. It was an absolutely frightening time – they took away the fear and allowed me and my family to focus on just mommy and not having to worry about the medical side or what happens next, or how to take care of her so we were able to just love her and be with her," said Laura.

The cancer in Devina's liver metastasized into her lung and after a couple more treatments of chemotherapy, she told her family that she would do no more.

"Mommy and I were very close and it was very hard for me to accept that she didn't want to continue the treatment because I believed it would keep her alive, but then I realized I didn't want her to suffer that way," said Laura.

The night before Devina passed away, Central East CCAC Palliative Nurse Practitioner, Dean Walters met with the Borden family to help them through their difficult time.

"When I visited, there was a group of people on the ground floor – pouring out their feelings of grief and praying. I met with the patient and Laura was sitting at her bed holding her hand. As soon as I saw Devina I could tell that she was on her way home. I did a very gentle health assessment, reassuring the daughter that I wasn't going to hurt her or make her uncomfortable," recalled Dean.

Caring for our patients

Dean helped the family come to terms with the imminent passing of their mother and reviewed the expected death package with them – who they should call, what they need to have in place. He also explained how they could care for her after she died – physical care, such as how to wash the body, position her, and dress her.

Devina passed away on March 22, 2013 at the age of 77 in her home with her family surrounding her.

"When I visited, Laura's focus was to be at her mother's bedside. She reached out to me afterwards asking for my expertise and help about grief as she was having difficulties getting back to work. Laura's connection to her mom was so strong that she was having difficulties understanding that her mom was really dead," said Dean.

Laura recalls that even though it was the most difficult moment of her life, the "care was so overwhelming that I never felt alone; there was someone there all the time. It eased the pain and fear by having a nurse practitioner, nurse and PSW.

"My mommy is so blessed to have had the help from the CCAC – your agency is out of this world. I hope you never stop providing care for those who need it."

"I wanted you to know how pleased my family was with the health care provided to my wife during her courageous battle with cancer. My wife passed away peacefully at home thanks to the excellent care received from the Central East CCAC. One call for necessary supplies or equipment was all it took for immediate action and delivery. Thank you from all my family."
HUSBAND OF CENTRAL EAST CCAC PATIENT

"A special thanks to the Care Coordinator at CCAC for all the support and compassion during a difficult time for all involved. We appreciate all your efforts to make my mom as comfortable as possible in her time of need. Thanks so much."
DAUGHTERS OF CENTRAL EAST CCAC PATIENT

Self-Management program developing strong partnerships

The Central East LHIN Self-Management Program completed its third year as a fully operational program operating out of the Central East CCAC. The program has continued to build on its successful partnerships with community and health care organizations, that has resulted in more workshops reaching priority populations in the Central East LHIN.

During 2012-2013, a total of 86 "*Living a Healthy Life*" Self-Management workshops were delivered to 1,060 participants. Self-Management Coordinators in the program worked to connect with a wide variety of community partners, resulting in workshops delivered to the francophone community, members of the Afghan Women's Organization and clients at Ontario Works among others. Workshops were conducted in a total of five different languages: Cantonese, Mandarin, Tamil, French and English.

The *Choices & Changes* workshops geared to physicians and other health care professionals, continue to be well received, with 31 workshops conducted overall. This resulted in the training of 347 clinicians to enhance communication skills in order to support behaviour change. The Self-Management clinician education program successfully expanded its partnership with The Scarborough Hospital and Northumberland Hills Hospital.

The Ministry of Health and Long-Term Care, through the Ontario Diabetes Strategy (ODS), expressed strong confidence in the Central East LHIN Self-Management Program by awarding the responsibility to coordinate Self-Management training for the province of Ontario. This special project was twofold; the Central East LHIN Self-Management program would coordinate three Master Trainings for the Stanford Chronic Disease Self-Management Program, in which 47 Master Trainers were trained. It also allowed for the training of 48 health care providers from across the province to become *Choices & Changes* workshop facilitators.

The Central East LHIN Self-Management Program continues to focus on collaboration and enhancing both clinician and client education and skills to improve the health of the population.

Caring for our patients

Behavioural Supports Ontario (BSO)

*For **Mr. R**, a resident in a Central East long-term care home (LTCH) lashing out physically and swearing at fellow residents had become a frequent occurrence. His behavior caused other residents to continually avoid him and as a consequence he found himself alone most of the time, especially during meals.*

Behavioural Supports Ontario (BSO) exists to enhance services for older people with responsive behaviours linked to cognitive impairments, people at risk of the same, and their caregivers; providing them with the right care, at the right time and in the right place (at home, in long-term care or elsewhere).

Through the development and implementation of new models designed to focus on quality of care and quality of life for this population, a $4 million provincial BSO investment in the Central East Local Health Integration Network (LHIN) has provided for local health service providers to hire new staff including nurses, personal support workers and other health care providers, and to train them in the specialized skills necessary to provide quality care to these residents in long-term care and clients in the community. The Central East LHIN provides funding to the Central East CCAC for staffing resources to support the BSO project. The project is rooted in client-centered and caregiver-directed care where:

- Everyone is treated with respect and accepted "as one is"
- Person and caregiver/family/social supports are the driving partners in care decisions
- Respect and trust characterize relationships between staff and clients and care providers.

Completing its first full year of operation in 2012-13, the initiative has seen 50 new front-line staff hired in LTCHs, and almost all 68 long-term care homes in Central East have increased their in-house behavioural supports. An estimated 1,500 front-line staff received specialized training in techniques and approaches applicable to behavioural supports.

Mr. R, now after several months of interacting with BSO trained staff, who slowly and carefully gained rapport with him, introduced him to puzzles and games, allowed him to talk about his stroke, illiteracy and homelessness, and in general built a relationship with him, can now be seen having coffee with other residents, and his previous "bad guy" label is disappearing.

Rapid Response Nurses work to support patients returning home from hospital

Mr. M is a Pickering resident who suffers from congestive heart failure (CHF), diabetes, high blood pressure and high cholesterol. He had been admitted to the Rouge Valley Centenary hospital for CHF exacerbation and was discharged home from hospital where his wife is his main caregiver.

Mr. M was assessed to receive in-home nursing services for wound care, personal support for bathing and dressing and a Rapid Response Nurse (RRN) visit for teaching about CHF, medication reconciliation, and help with booking follow-up appointments.

There are 12 RRNs hired for the Central East CCAC under the provincial Rapid Response Nursing initiative to provide enhanced front-line care to some of the most complex and vulnerable patients: frail seniors and adults and children with complex, serious illnesses, within the first 24-48 hours after they are discharged home from hospital. Evidence shows that a visit from a nurse within 24-48 hours of discharge from hospital helps to avoid re-visits to the Emergency Department.

In consultation with CCAC Care Coordinators and other community health providers, the RRNs are responsible for ensuring the patient is connected to a primary care provider and has an appointment within five to seven days after discharge from hospital. They will also help patients: understand their illness and symptoms; understand their hospital discharge plan; understand how to take prescribed medications; arrange for follow-up medical appointments or tests; connect with their primary care providers; ensuring everyone has necessary information about each step of the patients' journey and, receive appropriate home supports as quickly as possible so that they have everything they need to stay at home safely.

In Mr. M's case his legs and feet were quite swollen due to the CHF and he had been prescribed three types of water pills to help flush out the extra fluid but he and his wife were having difficulty following and understanding the medication regime. Central East CCAC RRN, Stephanie visited Mr. M within the first 24 hours of his discharge in order to support him with a range of transitional care needs and to ensure he had a successful return home and avoid a return to hospital.

Stephanie visited Mr. M three times over the next week to teach how to take the medications as directed. At the end of the week, Mr. M's wife was confident and able to prefill his dosette which led to Mr. M taking the right dose of medication at the right time.

Mr. M was also prescribed a new blood thinner from the hospital and was to discontinue the one he had been taking previously. However, once discharged home from the hospital, Mr. M forgot to stop taking the old blood thinner medication and was now taking two types which put him at high risk of making his blood too thin. Stephanie spoke with Mr. M's family doctor to confirm that he should only be taking one blood thinner and then, with Mr. M's consent, removed the extra medication and returned it to his pharmacy to be discarded.

Caring for our patients

In the case of Mr. M, Stephanie realized that he had not been taking his medication as prescribed and that Mr. M had no idea that he was taking two types of blood thinners as both pills had different names and each were filled at a different pharmacy. Stephanie worked with the family to teach them why and how to take the medication in a consistent way as well as preventing duplication of medication.

Within five days of her intervention, Mr. M lost eight pounds of fluid, his swelling had decreased and he was able to walk and get downstairs and the skin colour in his legs improved significantly.

"Although my interaction with Mr. M and his family was short and intense," Stephanie observed, "problem-solving to help get him on the proper path of taking care of his health and working with the family, his doctor, pharmacist and Care Coordinator was both a challenge and a reward."

"The Care Coordinator does a wonderful job at ensuring that everything that can be done is done to maintain our patient care and health in home."
EMERGENCY ROOM NURSES
AT NORTHUMBERLAND HILLS HOSPITAL

"Staff at ACS is very compassionate and connects with their clients. The staff cares and goes out of their way to make things better."
CENTRAL EAST CCAC PATIENT

New website helps connect residents in the Central East region to thousands of health care resources

Centraleasthealthline.ca

To help people navigate a sometimes complex health system, the Central East CCAC launched a new information and referral (I&R) website in February 2013.

By the summer, each of the 14 CCACs will have a region-specific healthline website, creating a common provincial portal that will include a database of more than 50,000 health and social service providers across Ontario.

The **CentralEasthealthline.ca** is a robust and easy-to-use website with enhanced search capabilities designed to provide accurate and up-to-date information about health services to citizens and health care providers across the Central East region of Ontario.

"The Central East CCAC believes this website is an important initiative in the evolution of making information and referral readily accessible," said Central East CCAC Chief Executive Officer, Don Ford. "The CentralEasthealthline.ca enhances our responsibility as leaders in health system navigation; ensuring people are connected with the health and community services information they require."

In addition to helping the public navigate the system, the CentralEasthealthline.ca provides benefits to the health system. With over 1,500 listings of community organizations across the Central East region, health care providers can profile their services, publish career opportunities and event listings for free within a centralized provincial website and family physicians and other health care professionals have a reliable source of information about health resources in their communities.

"Accessing information about health care is important, but we know that it can be an intimidating process for many people. Community Care City of Kawartha Lakes appreciates being able to direct clients to the CentralEasthealthline.ca site as so many health care providers are listed on it. Staff at the agency use it themselves to obtain information and to help in referring clients to different services," said Mike Puffer, Director of Marketing & Development, Community Care City of Kawartha Lakes Health and Support Services.

The Healthline.ca is one of several provincial eHealth enablers used by Ontario's CCACs to deliver outstanding care efficiently. It complements the CCAC electronic health record, CHRIS, and the Health Provider Gateway (HPG), to support electronic referral to health and community system partners. We are committed to ongoing collaboration across the system to develop the best possible information resource for Ontarians.

Our story in numbers

Our story in numbers

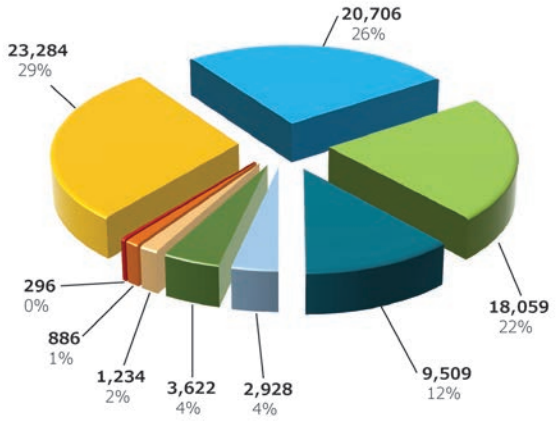
"The support and services provided by the staff of the CCAC is nothing short of incredible. They have just assisted our family in the placement of our parents. Everyone involved has made the transition possible with such good care and understanding. We could not have asked for more and are so appreciative."
CHILDREN OF CENTRAL EAST CCAC PATIENT

"I am writing with gratitude for such exceptional care from your staff at the Community Care Access Centre. We are blessed in Ontario to have such a phenomenal health care system. Although I lost my best friend and lifetime partner, your supportive staff touched my husband in a very special way. The entire experience made us both stronger and more appreciative."
WIFE OF CENTRAL EAST CCAC PATIENT

Client Services Individuals Served and Percentage Distribution

APRIL 01, 2012 - MARCH 31, 2013

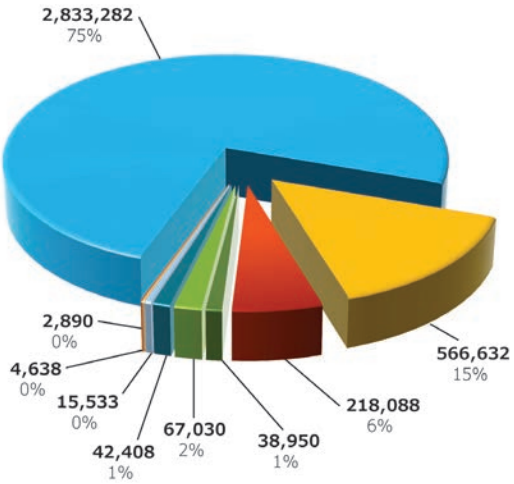
SERVICE	2012-2013	2011-2012
Visiting Nursing	23,284	24,549
Personal Support	20,706	19,540
Occupational Therapy	18,059	17,012
Physiotherapy	9,509	9,636
Speech	2,928	3,190
Nursing Clinic	3,622	1,607
Social Work	1,234	1,222
Nutrition	886	1,001
Shift Nursing	296	271



Client Services Units Provided and Percentage Distribution

APRIL 01, 2012 - MARCH 31, 2013

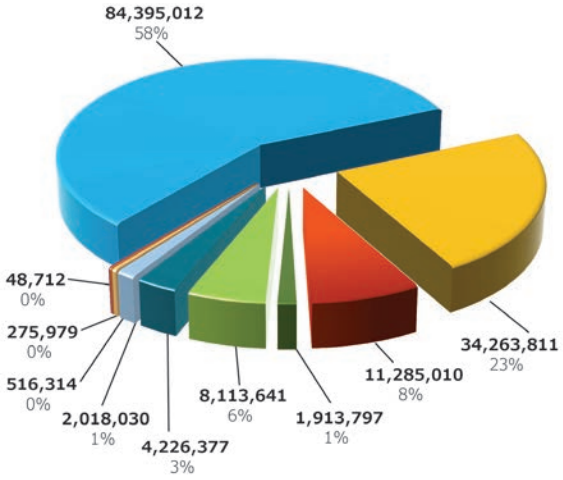
SERVICE	2012-2013	2011-2012
Personal Support	2,833,282	2,622,293
Visiting Nursing	566,632	596,226
Shift Nursing	218,088	202,262
Nursing Clinic	38,950	19,816
Occupational Therapy	67,030	62,733
Physiotherapy	42,408	43,018
Speech	15,533	16,245
Social Work	4,638	5,153
Nutrition	2,890	3,199



Client Services Total Expenditures ($) and Percentage Breakdown

APRIL 01, 2012 - MARCH 31, 2013

SERVICE	2012-2013	2011-2012
Personal Support	84,395,012	78,634,545
Visiting Nursing	34,263,811	36,367,445
Shift Nursing	11,285,010	10,472,247
Nursing Clinic	1,913,797	825,294
Occupational Therapy	8,113,641	7,608,538
Physiotherapy	4,226,377	4,218,785
Speech	2,018,030	2,042,166
Social Work	516,314	582,369
Nutrition	275,979	289,294
Psychology	48,712	46,699



Our story in numbers

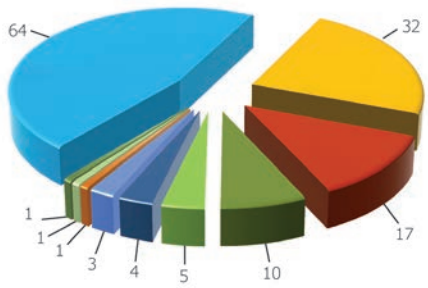
Recognizing Evaluations for Future Leads in Excellence and Care in Treatment (REFLECT)

Current or past patients who share their experiences while on service with the Central East CCAC help the organization provide better care for you and your family.

Continually striving to improve the care we provide to our patients, the Central East CCAC welcomes compliments, comments, and questions. We hear about patient and caregiver experience through a number of ways including letters, emails and surveys.

Through the patient and caregiver experience evaluation survey, the Central East CCAC has received valuable feedback from individuals about the care they receive. The evaluation survey has improved our accountability to our patients and the health care system as a whole; a fundamental goal that is embedded in the Ministry of Health and Long-Term Care's *Excellent Care for All Act*. The data received from this survey gives us insight into the patient experience and establishes a benchmark of performance in comparison to the other 13 CCACs - creating the opportunity to share strategies for improvement.

NUMBER OF COMPLIMENTS BY SOURCE OF FEEDBACK
APRIL 01, 2012 - MARCH 31, 2013



- Family/Caregiver
- Client
- Other Third Party
- Employee
- Service Provider
- Community Partner
- Hospital Staff
- LTCH
- Retirement Home
- Client/Caregiver survey

The Central East CCAC evaluates our effectiveness on a daily basis through our Quality, Compliance and Risk Management portfolio which records and tracks our risk events, complaints, compliments and inquiries in a robust monitoring system.

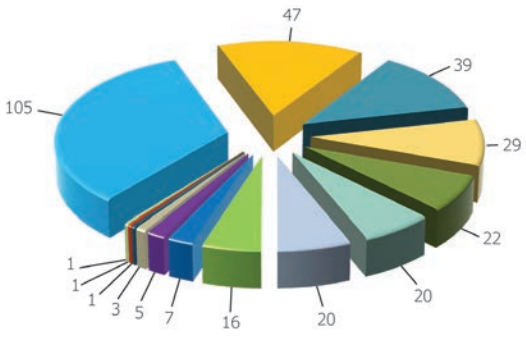
For the 2012-2013 fiscal year there was an increase in the number of complaints, compliments and inquiries when compared to the previous fiscal year: complaints increased by 9 per cent, compliments increased by 26 per cent and inquiries increased by 66 per cent.

Complaints trended similar to last year with Service Quality and Service as the main categories identified. The themes or issues contributing to Service Quality relate to the care or treatment, attitude, courtesy and coordination of care of service providers and/or the Central East CCAC employees. Service complaints were primarily about the quantity of service received by patients.

In the 2012-2013 fiscal year, complaints from Elected Official Offices decreased by 22 per cent in comparison to last fiscal year. The majority of complaints from political offices was related to quantity of service; readiness for service discharge or eligibility for service.

Inquiries from Elected Officials, including questions regarding the placement process and wait times accounted for 40 per cent of the total number of inquiries received by the Central East CCAC.

NUMBER OF COMPLAINTS BY SOURCE OF FEEDBACK
APRIL 01, 2012 - MARCH 31, 2013



- Family/Caregiver
- Client
- Political Office
- Client/Caregiver Survey
- Employee
- Action Line Ticket
- Independent Complaint Facilitator
- Service Provider
- Physician
- LHIN
- Client Advocate
- Community Partner
- Other Third Party
- Retirement Home

Our story in numbers

Family/caregivers and patients complimented the Central East CCAC for our service quality - specifically the attitude, courtesy, coordination of the care and treatment received by our patients from our service providers and employees. The total number of compliments received this fiscal year increased 26 per cent when compared to the 2011-2012 fiscal year.

By accurately capturing risk events, patient complaints, compliments and inquiries in our monitoring system, the Central East CCAC is able to review and analyze the data for trends, which in turn, allows for the planning and implementation of quality improvement initiatives.

During the 2012-2013 fiscal year, risk event trends were shared with Central East CCAC service providers and each service provider was responsible to analyze the information and provide updates on improvement initiatives implemented at their organization. The process of reporting complaints was modified to capture new feedback and root cause complaint categories which allows us to better analyze the data and assess more opportunities for improvement.

"I want to compliment the receptionist who directed my call. The only information I had was a first name. I described the service and the receptionist didn't flinch as I tried to explain who I wanted to speak to. She was patient and very, very good with me."
CENTRAL EAST CCAC PATIENT

"I don't think you will ever know just how much we appreciate the support we were given for my father by your agency. My father had some very serious medical issues and over the past five years, you have supported us with caring for him at home with tending loving hands. You are fantastic support workers and were always available for changes with great flexibility and warm hearts."
FAMILY OF CENTRAL EAST CCAC PATIENT

Our community

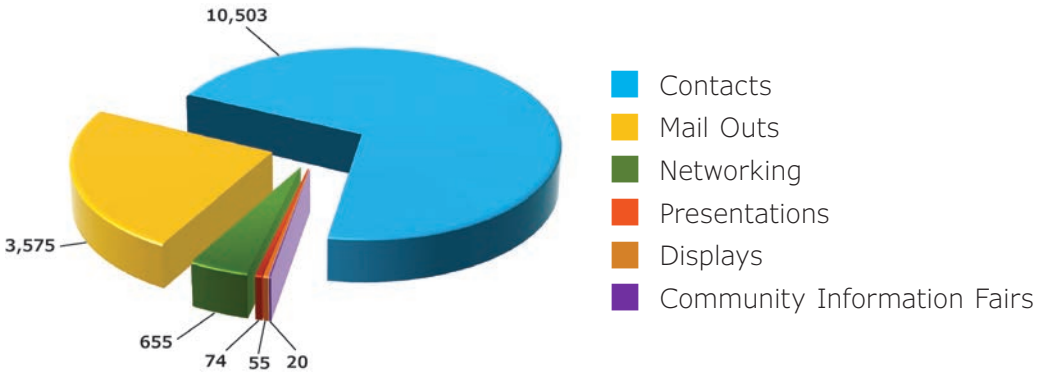
Integration in the community

Community education and outreach support engagement of community partners. The 2012-2013 fiscal year presented many opportunities for integration, community engagement, outreach events, information fairs and knowledge exchange between the Central East CCAC, our community partners and the general public.

The Central East CCAC Community Education and Outreach Representatives participated in a total of 784 events during the past fiscal year including networking, displays, presentations and phone and email communications. These outreach events reached more than 10,000 people in the community who had the opportunity to learn about the services and programs provided by the Central East CCAC.

The outreach team continues to establish relationships with various local community partner networks in the Campbellford, Haliburton, Lindsay, Peterborough, Port Hope, Durham Region and Scarborough areas of the Central East region and the networks meet on a regular basis throughout the year. These contacts are essential in ensuring that an avenue for consistent exchange of information is available on a regular basis and provides the opportunity to address specific community concerns in the various geographical areas across our region.

NUMBER OF OUTREACH ACTIVITIES
APRIL 01, 2012 - MARCH 31, 2013



Our community

Our outreach representatives participated on a number of committees including assisting with the planning of the Durham Elder Abuse Network's Conference – *Past, Present and Future, Pathways to Preventing Elder Abuse*. The conference took place in October 2012 with 120 health care professionals, private care providers, police officers, emergency management services (EMS) staff, outreach workers and others from the community attending. Following the success of this conference the Durham Deaf Society repeated the conference for those in the community who were hearing impaired.

In the Haliburton region, our outreach representatives also participated with the Haliburton County Service Providers Network on the Respite and Education Series Subcommittees and assisted with the planning of an education series for the community and volunteers of agencies involved with the Network. The series is scheduled to be offered from September to November 2013 and April to June 2014 and each education session will focus on a health or social service topic.

The Central East CCAC outreach representatives also facilitated the sharing of community partner information with our internal staff through a series of Community Information Fairs that provided Central East CCAC employees an opportunity to gather information and ask questions about the services provided by these agencies, which in turn, creates more effective information and referral to the appropriate community support agencies and other services patients may need in their community.

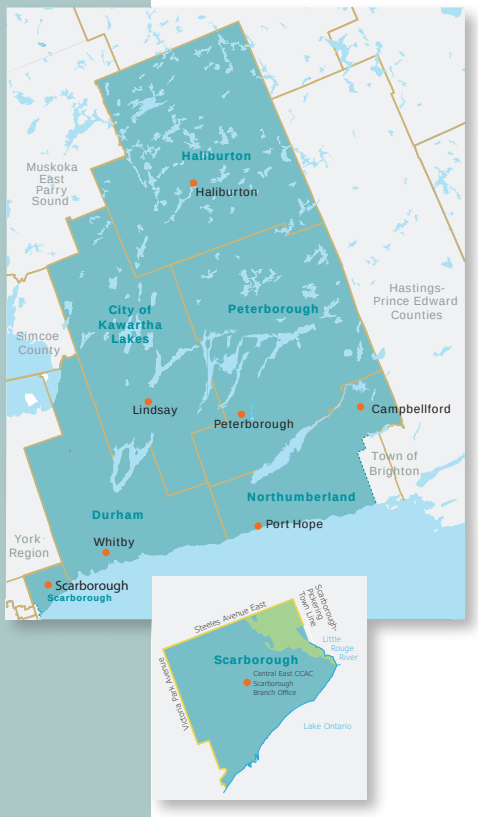
Statement of Operations

	2012-2013 $	2011-2012 $
REVENUES		
Funding from Central East Local Health Integration Network (LHIN)/ Ministry of Health and Long-Term Care (MOHLTC)	240,194,112	226,007,365
Service revenue - LHIN programs	824,400	824,400
Interest	98,051	144,555
Other income	487,295	747,657
Amortization of deferred capital contributions	574,718	477,826
Amortization of deferred lease inducements	228,740	228,740
Amortization of deferred donations	11,113	11,112
Total Revenue	**242,418,429**	**228,441,655**
EXPENDITURES		
Salaries, wages and benefits	66,309,482	61,250,193
Contracted out services		
Personal Support/Homemaking	84,395,012	78,634,545
Nursing	45,548,821	46,839,692
Nursing Clinic	1,913,797	825,294
Occupational Therapy	8,113,641	7,608,538
Physiotherapy	4,226,377	4,218,785
Speech-language Pathology	2,018,030	2,042,166
Social Work	516,314	582,369
Psychology	48,712	46,699
Nutrition	275,979	289,294
Medical Supplies	13,486,863	11,340,707
Medical Equipment	3,233,890	3,302,343
Administrative costs	7,245,419	7,088,861
Occupancy costs	4,006,224	3,654,491
Amortization of capital assets	814,568	717,678
Total Expenditures	**242,153,129**	**228,441,655**
Excess / (deficiency) of revenue over expenditures	**265,300**	**-**

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, 2013.

Contact us

"Calling to thank you for all the help you gave us. I felt better after talking to you."
DAUGHTER-IN-LAW OF CENTRAL EAST CCAC PATIENT



Central East CCAC BRANCH Offices

- **Campbellford** 705-653-1005
  119 Isabella Street, Unit 7, Campbellford ON K0L 1L0
- **Haliburton** 705-457-1600
  PO Box 793, 13321 Highway 118, Haliburton ON K0M 1S0
- **Lindsay** 705-324-9165
  370 Kent Street West, Lindsay ON K9V 6G8
- **Peterborough** 705-743-2212
  700 Clonsilla Avenue, Suite 202, Peterborough ON K9J 5Y3
- **Port Hope** 905-885-6600
  151A Rose Glen Road, Port Hope ON L1A 3V6
- **Scarborough** 416-750-2444
  100 Consilium Place, Suite 801, Scarborough ON M1H 3E3
  Chinese Line 416-701-4806
- **Whitby** 905-430-3308
  920 Champlain Court, Whitby ON L1N 6K9
- **Toll free**: 1-800-263-3877
- **TTY Line**: 1-877-743-7939
- **Website**: www.ce.ccac-ont.ca

- **Central East Healthline**
  Wherever you live in Ontario, to find health care and community-based services, call 310-CCAC (310-2222) or visit www.centraleasthealthline.ca.

ASPIRE to Excellence® carf CANADA ACCREDITED

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

Central East
CCAC CASC
Community Care Access Centre
Centre d'accès aux soins communautaires du Centre-Est

Right care, right time, right place.

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