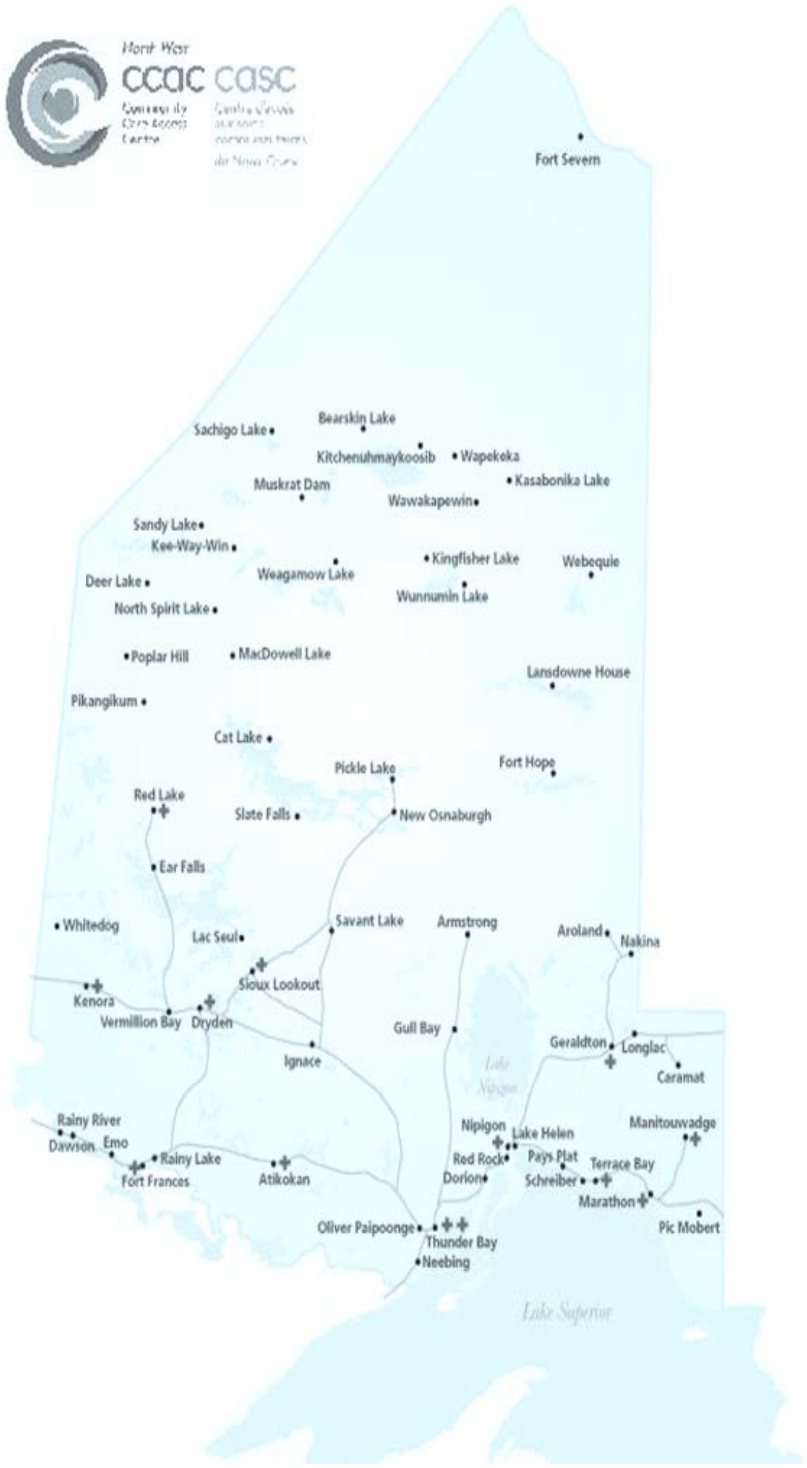
North West
CCAC CASC
Community Care Access Centre
Centre d'accès aux soins communautaires du Nord-Ouest

Connecting you with care

Annual Report to the Community

April 1, 2010 – March 31, 2011

Outstanding care – every person, every day



About Us:

- North West CCAC area covers 458,010 square kilometres.
- Catchment area encompasses a land mass equivalent to 47% of the Province of Ontario and extends from White River in the East to the Manitoba border in the West, to James Bay and Hudson Bay in the North and to the United States border in the South.
- Other than the City of Thunder Bay, the majority of the North West CCAC is rural/remote in nature.

Area Population:	238,245*
*estimated for 2009 based on Ministry of Finance data.	
Funding for 2010/2011:	40,042,937
Number of Clients Served:	12,385
Services delivered:	
Nursing visits:	133,010
Homemaking / Personal Support Hours:..	464,733
Therapy (all) visits:	33,311
Number of long-term care placements:	673

Languages of Individuals Served:

English:	11,052
Italian:	127
Ojibwa:	108
French:	89
Finnish:	70
Other:	64

Our Role:

The North West Community Care Access Centre helps people obtain health care and social services in their homes, their community and in Long-Term Care Homes. We:

- provide the public with information and referrals regarding the CCAC's services, Long- Term Care Homes and other health-related organizations and social services available to them;
- assess people's needs and arrange for health and personal support services in their homes;
- manage all admissions to Long-Term Care Homes and other settings; and
- authorize and arrange health services for children at home or at school.

The North West CCAC is funded by the Government of Ontario through the North West Local Health Integration Network.

Supported by:

Ontario
North West Local Health Integration Network
Réseau local d'intégration des services de santé du Nord-Ouest

Our Programs and Services:

- Care Coordination
- Information and Referral
- Long-Term Care Placement
- School Health Support Services
- In-Home Services:
  - Nursing
  - Personal Support / Homemaking
  - Occupational Therapy
  - Physiotherapy
  - Nutrition
  - Social Work
  - Speech Language Pathology
  - Medical Supplies and Equipment
- Access to Adult Day Programs
- Access to McKellar Supportive Housing in Thunder Bay and Supportive Housing in Kenora, Dryden, Sioux Lookout and Rainy River
- Nurse Practitioners

Specialty Programs:

- Palliative Pain & Symptom Management
- End-of-Life Care Network
- Intensive Case Management Program
- System Navigator
- NICE Fund (Network of Individualized Community Enhancement)
- Health Care Connect
- Chronic Disease Prevention and Management

Mission, Vision, Values and Goals

MISSION STATEMENT

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.

VISION STATEMENT

Outstanding care – every person, every day.

VALUE STATEMENT

Our core values are:

- Treating everyone with respect, empathy, fairness and integrity;
- Fostering initiative, innovation, unity, and continuous improvement in what we do;
- Actively seeking and supporting collaborative care partnerships so that clients experience integrated care;
- Being client focused, open, culturally sensitive and responsive, and accountable in our relationships and all we do;
- Remaining committed to our mission, vision, values and the communities and people we serve.

STRATEGIC GOALS

GOAL 1 Creating an effective presence and strong relationships in our communities.

GOAL 2 Sustaining strong and effective relationships with our system partners.

GOAL 3 Within our means, providing consistent, quality services across the Northwest when and where they are needed through flexible use of resources and exploring alternative ways of providing these services.

GOAL 4 Maintaining a unified, team oriented, learning organization based on best practices.

GOAL 5 Being the best community governance we can be.

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Message from the Board Chair and Chief Executive Officer

Our Organization continued to focus its resources during the 2010-2011 year on the Alternate Level of Care (ALC) and reduction of unnecessary Emergency Department visits, in collaboration with the other system partners such as the hospitals, the North West Local Health Integration Network (NWLHIN) and community support organizations. The Home First initiative proved to be extremely successful in reducing ALC numbers and, more importantly, allowing people to return home from hospital to make important decisions about their care needs in the comfort of their own home. The North West Community Care Access Centre (NWCCAC) Staff and Service Providers were sometimes stretched to the limit in order to respond to the service requests, which resulted in the success of this program.

To help people access the right level of support in their home, CCACs began implementing the Enhanced Role in Placement which was negotiated with the LHINs across the Province. The scope of placement services ranges from Adult Day Programs and Supportive Housing to Long-Term Care Placement. The key principle in this planning is that people end up in the right place, at the right time, depending on their needs. The CCACs' function is as an access point for all the programs.

Several Community Support Organizations worked closely with us in order to coordinate our efforts to provide services in the community and support the caregivers who have often the greatest responsibility for the care plan.

It is important to evaluate what we do. The Employee Engagement Survey showed significant improvement in comparison to the previous one administered two years ago. The client satisfaction surveys showed great satisfaction especially with the System Navigator and Intensive Case Management Programs.

With the emphasis on system integration and collaboration, the Board of Directors spent considerable time in talking to other Boards and community groups, as well as, attending several sessions in system integration and diversity organized by the NWLHIN. In preparation for upcoming vacancies on the Board, the Recruitment Committee sought new members to fill the vacancies to ensure that the Board will provide the best possible leadership during these busy times.

On behalf of the North West Community Care Access Centre, we would like to extend our sincere appreciation to the Board Members, NWCCAC Staff and Management, all Service Providers, System Partners and the NWLHIN for working with us to accomplish our Vision:

Outstanding Care – Every Person, Every Day.

Tuija Puiras, Chief Executive Officer

J. Donald Murrell, Board Chair

Board of Directors

J. Donald Murrell
Board Chair
September 2009 to September 2011

Rob Stinchcombe
Vice-Chair
September 2009 to September 2012

R. Barry McBain
Treasurer
September 2009 to September 2012

Catherine Aubut
Director
September 2009 to September 2011

Bradley Coslett
Director
September 2009 to September 2012

Peter Evans
Director
December 9, 2009 to June 15, 2011

Sam Federico
Director
September 2010 to September 2013

Edgar Morrissette
Director
September 2009 to September 2011

Shelley Peirce
Director
September 2009 to September 2012

Tuija Puiras
Secretary

Leadership Team *at March 31, 2011*

- **Tuija Puiras**, Chief Executive Officer
- **Paula Donylyk**, Senior Director, Client Services
- **Christy McClelland**, Senior Director, Corporate Services
- **Ian Ritchie**, Director, Client Services
- **Mike Davis**, Director, Client Services
- **Chrysta Burns,** Senior Manager, Human Resources
- **Chris Houle,** Senior Manager, Finance

Board Committees

Audit Committee: Barry McBain, Chair; Bradley Coslett; Sam Federico; Edgar Morrissette, Don Murrell, ex-officio; Tuija Puiras, CEO.

Client Services and Quality Committee: Shelley Peirce, Chair; Sam Federico; Barry McBain; Dr. Julija Kelecevic, Bioethicist; Paula Donylyk, Senior Director, Client Services; Ian Ritchie, Director, Client Services; J. Donald Murrell, ex-officio; Tuija Puiras, CEO.

Finance Committee: Barry McBain, Chair; Bradley Coslett; Peter Evans; Sam Federico; Edgar Morrissette; Christy McClelland, Senior Director, Corporate Services; J. Donald Murrell, ex-officio; Tuija Puiras, CEO.

Governance Committee (Committee of the Whole Feb 2011): Peter Evans, Chair; Catherine Aubut; Bradley Coslett; Sam Federico; Barry McBain; Edgar Morrissette; Shelley Peirce; Rob Stinchcombe; J. Donald Murrell, ex-officio; Tuija Puiras, CEO.

Recruitment Committee: Catherine Aubut, Chair; Edgar Morrissette; Barry McBain; Rob Stinchcombe; J. Donald Murrell, ex-officio; Tuija Puiras, CEO; Chrysta Burns, Senior Manager, Human Resources.

Strategic Directions / Key Achievements

Leadership

The North West Community Care Access Centre (NWCCAC) has a twelve member Board of Directors that is composed of community representatives with various backgrounds. All board meetings are open to the public and minutes are posted on the NWCCAC external web site.

There were two themes that dominated the activities of the NWCCAC Board of Directors meetings. They could be described as Integration and Accountability. The Board of Directors spent considerable time contemplating the Integration Framework for the NWCCAC which will guide the integration activity for the organization. The Leadership Team participated in these discussions. The Board received a presentation from the North West Local Health Integration Network (NWLHIN), and various members attended several LHIN engagement sessions across the Region. The NWCCAC Framework includes the following elements:

<u>North West CCAC Integration Framework</u>

- Supported by a business case analysis
- There is a significant benefit to the client/people
- It is voluntary among the organizations
- It may include back office, client service, administrative or Board activity

As a part of the integration agenda, several Board Members and the Chief Executive Officer (CEO) met with members of the hospital boards. While travelling in the communities, Board Members and CEO also arranged information sessions about the CCAC at local seniors' centres.

As the accreditation date is nearing for 2012, the Board of Directors participated in a Quality Performance Roadmap Survey which gave the Board direction for their work plan. Quality care was seen as a priority of the Board as the implementation of Home First created pressures in service volumes and challenges in service allocation.

Collaboration with hospitals, community support organizations and the Local Health Integration Network was the key to the successful implementation of new initiatives, such as Home First, the amended Long-Term Care Legislation and the expanding role in supportive housing. The Board led this activity on the governance level through a number of engagement activities.

Community Relationships

Palliative Pain & Symptom Management

The Palliative Pain & Symptom Consultant will provide consultation to primary health care providers working in the community and long-term care with people who are dying. Additional roles are education, building capacity in palliative care provision, and creating linkages between specialist resources and community providers.

Education & Research:

- Continues to deliver LEAP (Learning Essential Approaches to Palliative Care) in conjunction with the Centre for Education and Research on Aging & Health (CERAH).
- Liaise with CERAH on education and research initiatives in Long-Term Care (LTC) and the First Nations communities.
- Provide education and consultation on palliative/end-of-life care for individuals with intellectual/developmental disabilities for front line workers in the Group Home setting (i.e. Community Living Thunder Bay)
- Participate and support research projects across Northwestern Ontario (QPC-LTC project, Dr. ML Kelley, Lakehead U, Tele-Isaac a CCO (Cancer Care Ontario) project, & Palliative Care in Canada: The Economic Perspective for the Family and the Public Health Care System, Dr. Serge Dumont Laval Université,)

Consultation:

- Monthly consultation rounds in many of the LTC homes, assisting in the development of policies and procedures around end-of-life care in this sector.
- With the Nurse Practitioner Outreach Program to LTC – Thunder Bay Regional Health Sciences Centre.
- Palliative Care Nurse Practitioner consultation to community clients and service providers.

Mentorship & Linkages:

- Collaborate with the End-of-Life Care Network on integration of Palliative/End-of-Life Care across sectors and throughout Northwestern Ontario
- Participate in developing a provincial framework for delivery of Hospice Care in membership with the Quality Hospice Palliative Care Coalition of Ontario
- Membership with the Hospice Palliative Care Association (a new Association).
- Participation in Registered Nurses Association of Ontario (RNAO) Expert Panel to development of Best Practice Guidelines for End-of-Life Care during the last days and hours.

Strategic Directions / Key Achievements

Community Relationships

Participation at Health Fairs/Community Events

- **April 22, 2010**: Health and Wellness Expo at the 55 Plus Centre, Thunder Bay, ON
- **April 23, 2010**: Hosted a meet and greet for the Utilization Coordinators and Social Workers at Thunder Bay Regional Health Sciences Centre, Thunder Bay, ON
- **April 26, 2010**: Presentation to the Alzheimer's Society Family Support Group, Thunder Bay, ON
- **May 8, 2010**: Joint Presentation by North West CCAC, St. Joseph's Care Group and Thunder Bay Regional Health Sciences Centre to North West LHIN Board of Directors
- **May 27, 2010**: North West CCAC Board to Board engagement session with McCausland Hospital Board of Directors
- **May 27, 2010**: Community Information Session in Terrace Bay
- **June 22, 2010**: North West CCAC Board to Board engagement session with Lake of the Woods District Hospital Board of Directors
- **June 22, 2010**: Community Information Session in Kenora
- **June 28, 2010**: Fort William First Nation Health Fair, Thunder Bay, ON
- **August 31, 2010**: Grand Opening of the Red Cross Health Equipment Loan Depot, Thunder Bay, ON
- **September 9-11, 2010**: Participated in the 84th Thunder Bay medical Society Physician Summer School
- **September 13, 2010**: Inter-Governmental Senior's Fair at the Herb Carroll 55 Plus, Thunder Bay, ON
- **September 21, 2010**: 50 Plus Fair, Dryden, ON
- **September 22, 2010**: Inter-Governmental Senior's Fair at the 55 Plus Centre, Thunder Bay, ON
- **September 28, 2010**: Presentation to the Medical Advisory Committee, Thunder Bay, ON
- **October 26, 2010**: Community Engagement Session with the Palliative Volunteers, Kenora, ON
- **October 26, 2010**: Presentation to the Parkinson's Support Group, Thunder Bay, ON
- **November 24, 2010**: Family Health Team Cancer Fair, Atikokan, ON
- **November 24, 2010**: Presentation to the Manor House Adult Day Program, Thunder Bay, ON
- **December 2, 2010**: Home First Philosophy presentation to St. Joseph's Care Group and Thunder Bay Regional Health Sciences Centre, Thunder Bay, ON
- **December 16, 2010**: North West CCAC Board to Board engagement session with Meno Ya Win Health Centre Board of Directors
- **December 16, 2010**: Home First Philosophy presentation to Service Providers
- **February 11, 2011**: Attended Thunder Bay Medical Society Physician Winter School
- **February 23, 2011**: North West CCAC Strategic Plan and Key Priorities Presentation to North West LHIN Board of Directors
- **March 2, 2011**: Transitions to Adulthood Information Fair at George Jeffery Children's Centre, Thunder Bay, ON

Strategic Directions / Key Achievements

Community Relationships

System Navigator

The North West Community Care Access Centre (NWCCAC), in partnership with Thunder Bay District Housing Corporation (TBDHC), is helping seniors stay happy, healthy, and remain in their homes.

The NWCCAC System Navigator (Community Care Coordinator) is available weekly, on a rotating basis, at each of the five TBDHC senior's homes. The role of the System Navigator is to help link seniors to health services suitable to their health condition, and to help them to continue to function actively and safely in their home.

What our Clients are saying about our System Navigator:

100% of those surveyed:

- **Feel their discussion with the System Navigator was helpful.**
- **Feel that they would go to the System Navigator for assistance again, if required.**
- **Would recommend the System Navigator to others in the building who may require her service.**

"And I have told others about her already"

"I feel more comfortable with her here. If I have a question or something is bothering me with my health, I can talk to her rather than trying to find out what else to do"

"She is great, and that's all I can say."

The System Navigator Program was designed to determine and address the needs of individuals living in seniors' housing setting. Here is a "feel good" example of how the System Navigator improves the lives of the residents in the seniors' buildings:

A 60 year old gentleman with several chronic diseases who resides in a seniors' apartment building has benefitted from the assistance of the System Navigator. This spring, he approached the System Navigator about obtaining a scooter. He had spent a week in the hospital last summer and found he was not as mobile as he used to be. He could walk around the apartment building, but could no longer get outside because of his health status. The System Navigator referred him to Occupational Therapy to be assessed for a scooter. Since receiving his scooter, he is able to get outdoors on his own and is feeling much more independent.

There is no doubt that the System Navigator is responding to the needs of people in the apartments, identifying the needs of the individuals, and helping them to remain happy, healthy and at home.

"Outstanding Care – Every Person, Every Day"

Strategic Directions / Key Achievements

Partnerships

Wesway:

The NWCCAC and Wesway have worked collaboratively on several projects: Wait at Home, Home first and the Network of Individualized Community Enhancement (NICE) Fund. Working together with clients and caregivers has enabled many people to stay at home. The following is an example of the excellent partnership:

Mr. D, a 79 year old man with a progressive condition requiring total physical care, was admitted to a long-term care home. His family felt he was not doing well there and decided they would take him home. One of the family members became the primary caregiver and Mr. D was brought home.

His home was renovated and equipment installed to assist with his care needs. Each family member takes their turn caring for their father. Together, this family have developed a great system to provide around the clock care for him. CCAC is involved and Wesway also provides respite every week to enable the primary caregiver to take breaks.

This arrangement worked well until one of the family members experienced their own health problem. Suddenly, there was a gap in the care giving arrangements. Mr. D was at risk for hospitalization.

Wesway applied for “NICE” funding to provide extra respite to help sustain the supports this family already had in place.

An increase in respite hours for a short time enabled the family to continue to care for their father at home.

Alzheimer Society:

The NWCCAC has worked with the Alzheimer Society to provide better access and care to clients with dementia. Once a month, the First Link Coordinator from the Alzheimer Society comes to the NWCCAC to provide consultation about client’s with dementia to enhance the client’s care in their home.

The NWCCAC has also provided data to the Alzheimer Society to help support the programs they offer. By working together, we are helping to avoid hospitalization and keeping people at home where they want to be.

Supportive Housing:

The NWCCAC is working with supportive housing providers in Kenora, Dryden, Rainy River and Sioux Lookout to ensure the right people are getting the right services at the right time. Using a common assessment tool, the NWCCAC will be assessing clients for supportive housing in the West Region. The NWCCAC is also actively involved in the McKellar Supportive Housing Unit in Thunder Bay.

Strategic Directions / Key Achievements

Partnerships

Healthy Change, Chronic Conditions Self-Management:

The NWCCAC in partnership with St. Joseph's Care Group, has been collaborating with many health providers in Northwestern Ontario to provide education and information to people living with Chronic Diseases with a focus on the Self-Management program.

The Stanford University model is a self-management workshop that brings patients/clients/participants with various types of chronic conditions together for a weekly workshop that runs for 6 sessions. The classes provide tools to learn day-to-day management skills to help participants overcome the challenges faced when living with a chronic disease. The key skill taught and practiced is how to implement their active role by using action planning or goal setting with problem solving techniques.

Other topics include managing pain, fatigue, exercise, medications, difficult emotions, future planning, and working with your health care team.

The workshop is currently running in 11 communities with outreach to neighbouring communities, access available through OTN, and future sites having leaders trained this Fall.

Self-Management education and awareness has also been brought to Health Care Professionals through 3 series of Choices and Changes workshops, as well as, regular presentations to Health Care agencies and Community Groups.

What Patients/Clients/Participants are saying about Healthy Change:

"It can be difficult for people with a chronic disease to have regular medical support that doesn't involve the E.R. or Walk-In Clinics. The Chronic Condition Self-Management Program empowers people to better cope with their conditions."

Ryan Sigurdson, Thunder Bay
Age 30, Past Participant and Future Program Leader

"Not everyone has a condition they think of as a disability. Attending the Chronic Disease Self-Management workshop helps you to be more pro-active and prevent your condition from escalating to a more severe level."

"Everyone in the workshop worked towards improving their situation."
"Having a chronic condition can cause a person to feel down. The workshop shows you how it's all connected – the pain, the fatigue, the limitations added to your life, and of course the depression. It involved goal setting which was really helpful. We all learned how to look at things in a different way and how to have a more positive attitude."

Jennie Hunda, Thunder Bay
Past Participant

healthychange
Chronic Conditions Self-Management

Website: www.healthychange.ca

Partnerships

Wound Management Program:

This North West Local Health Integration Network (NWLHIN) funded program ran from February 2009 until the end of March, 2011.

The purpose of this Program was to promote best practice in wound care throughout the NWLHIN in all care settings.

The 47 organizations that were engaged in this Program represented a wide variety of health care professionals who examined wound indicators, options for delivering wound education and promoting best practices, reviewed system wide improvement projects, fostered physician engagement and promotion of the team concept in delivering wound care.

The strategy worked closely to develop a partnership with the Canadian Association of Wound Care.

100 wound assessment tools and 31 wound assessment devices were able to be purchased with the Program funds which benefitted 35 communities.

The Program built momentum over the 3 year project and created wound care champions in many organizations through the NWLHIN. Three multidisciplinary wound clinics were held in the last year where resource staff mentored their peers in wound clinics in Dryden and Thunder Bay.

Strategic Directions / Key Achievements

Partnerships

Intensive Case Management Program (ICMP)

This program is designed for clients who have very high needs; various strategies are utilized to connect seniors and their caregivers to supports and services in the community to enable them to remain happy and healthy at home.

The ICMP also reduces unnecessary ER visits, Alternate Level of Care (ALC) admissions, and facilitates Long-Term Care arrangements.

What our Clients are saying about our Intensive Case Management Program:

Over 92% of the people surveyed:

- Feel that the services provided have helped them to remain in their own home.
- Feel that the services provided by the NWCCAC have helped them avoid hospital visits.
- Feel that their needs are being met by the NWCCAC
- Would recommend the NWCCAC to their friends and family.

"Fantastic"
"You better believe it. I could not do it without them."
"I am very pleased"

Our Intensive Case Management Coordinators have many different types of clients on their caseloads; however, sometimes a specific example can demonstrate how the ICMP is a valuable asset to both the NWCCAC and the community. This is a story of a couple married for over 60 years:

This story involves a client who has advanced dementia, diabetes, and his spouse is the primary caregiver who has her own health concerns. Over time she has found it increasingly difficult to provide personal care to her spouse, whose health has declined. A phone call from a family member alerted the Community Care Coordinator (Coordinator) of a change in health status for both clients. The next day a home visit was made by the Coordinator to support and discuss the couple's homecare needs.

During the home visit the Coordinator identified that an increase in homemaking was needed. A personalized homecare plan was created that combined both clients' homemaking services, as it better met their care needs as a couple. The implementation of additional therapies, nursing, and equipment enabled the couple to continue to live independently within the community for another few years without any hospital or emergency admissions.

Sometime later, for two different reasons, each person was admitted to hospital due to a decline in health. The hospital alerted the Coordinator to the change in health status of the couple. The decline had been significant enough that it was time for the couple and their family to begin planning for the future. The Coordinator met with the couple to support and discuss their personal care needs, an application for long-term care was completed and an increase in homecare services were provided to support the couple while they awaited long-term care placement from home.

It is with the care and assistance of the Intensive Case Manager that the couple was able to be closely supported in the community along their journey from home to long-term care.

Committees

The North West CCAC participates on multiple local and provincial committees actively planning and designing health care services pertinent to our region.

North West LHIN Committees

- ALC Committee
- Centre of Excellence for Integrated Seniors' Services (CEISS) – Steering Committee
- Centre of Excellence for Integrated Seniors' Services (CEISS) – Community Supports Working Group
- Centre of Excellence for Integrated Seniors' Services (CEISS) – Communication Working Group
- e-Health Advisory Committee
- e-Health Project Management Office
- Mental Health and Addictions Advisory Team
- System Integration Committee
- Home First Steering Committee (LHIN)
- Home First Operational Committee (LHIN)
- Joint Discharge Operational Team (LHIN)
- Kenora Supportive Housing Committee (LHIN)
- Network of Individualized Community Enhancement (NICE) Fund Advisory Committee

Provincial Committees

- Assessment Steering Committee
- Client Services Committee
- Corporate Services Working Group
- CEO Advisory Council
- E-Health Assessment Committee
- ER ALC Steering Committee and Business Working Group
- ER CCAC Notification Project
- Governance Committee
- Human Resources Committee
- Intake & Referral Committee
- Information Technology Advisory Committee (ITAC)
- PM&A Committee
- Privacy Officer Committee
- Procurement Committees
- Supplies and Equipment Project Team
- Information & Referral Committee (OACCAC)
- Proof of Concept Project Team (OACCAC)
- Resource Matching and Referral Steering Committee (OACCAC)
- Senior Finance Leads Committee
- CCAC OHRS/MIS Advisory Working Group
- FSM GPM Advisory Working Group
- Provincial Decision Support (PDS) Group
- Change Advisory Board (CAB)

Local / Regional Committees

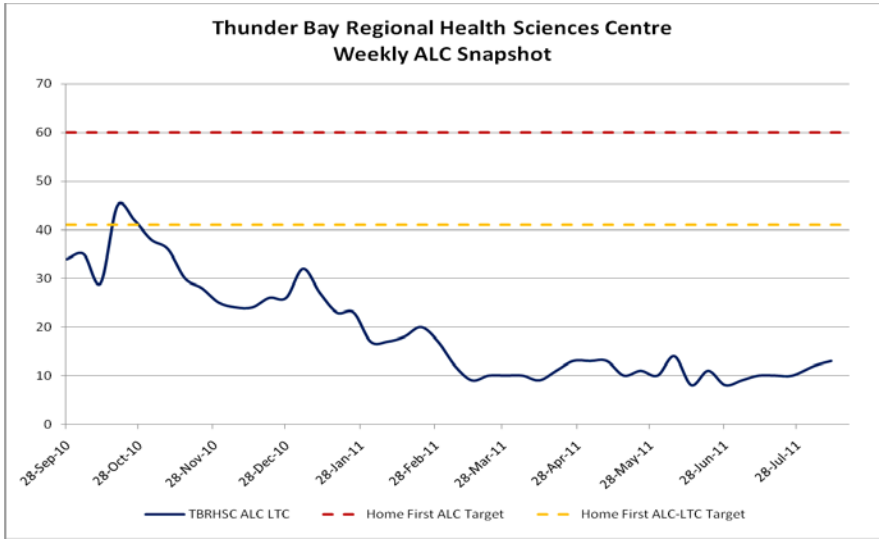
- Bioethicist Collaborative Services Agreement
- Centre for Health Care Ethics Committee
- Community Support Services Network
- Elder Abuse Committee
- End-of-Life Care Network Steering Committee
- End-of-Life System Integration Steering Committee
- Falls Injury Prevention
- First Link Advisory Committee
- Joint Hospital / CCAC Committees
- Northwest Health Network
- Northwest Ontario Infection Control Network
- Palliative Care Integration Project
- Pandemic Flu Planning
- Peritoneal Dialysis Committee
- Placement Services Committee
- Primary Health Care Committee
- Regional Cancer Advisory Committee – Northwest
- Regional Stroke Strategy Committee
- Service Provider Committees: Homemaking / Nursing / Therapies
- Thunder Bay Regional Health Sciences Centre Surgical Care Team
- Wound Care Best Practices Committee
- North West Region Self-Management Program Advisory Council

Strategic Directions / Key Achievements

Supporting People at Home

Home First

Home First is a philosophy that is grounded in the belief that once the acute or rehabilitation phase of a person's hospital stay is complete, it is best for them to leave the hospital and go home to a familiar environment. Going home enables them to recuperate in a familiar environment with the right services and appropriate community supports in place. It is about enhancing the way health care providers deliver high quality care for individuals, so they are safe and receiving the best care, in the best place. Home First allows people the option to make decisions regarding the next stage of their care in the comfort of their own home.



Between September, 2010 and April, 2011, the number of people waiting in Thunder Bay Regional Health Sciences Centre for a Long-term Care Home decreased by 62%.

Mr. B., 80 years old, had been to the emergency department seven times with various diagnoses and was admitted twice.

A Community Care Coordinator met with Mr. B. and his family to discuss the *Wait at Home* program which provides extensive home care and nursing support at home. During the meeting, Mr. B. also agreed to be placed on the waiting lists for long-term care.

Mr. B. returned home and ten days later, received a call to move into a long-term care home. Three days later, he ended up back in the hospital.

During his hospital stay, Mr. B. continued to be adamant that he wanted to return to his home. His home was modified and equipment installed to make it accessible for him. A physical therapist visited him at home and set up an exercise program to help build his strength and endurance. Nursing help was arranged for wound care and a personal support worker assisted him with his personal care needs. Mr. B decided he needed to reapply for long-term care and an application was completed.

Mr. B. remains at home and is managing well with the support services that have been put in place. His Community Care Coordinator has contact with him on a regular basis to ensure his needs are being met.

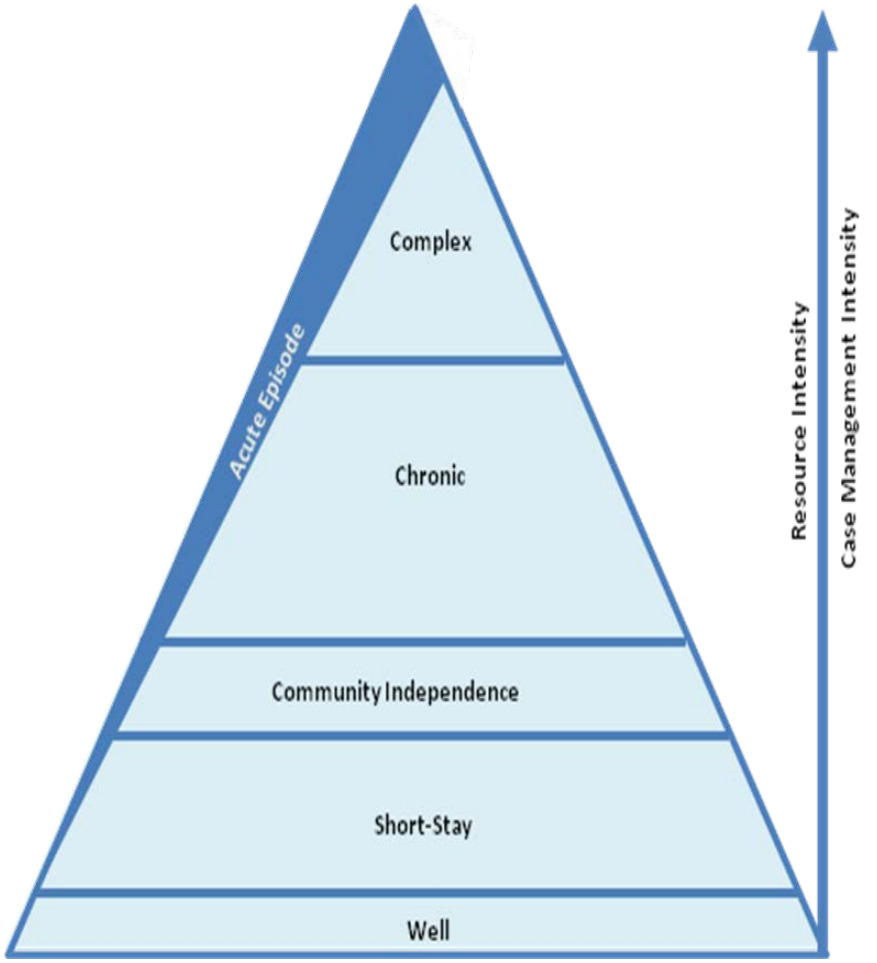
Strategic Directions / Key Achievements

Supporting People at Home

Client Care Model

The North West Community Care Access Centre (NWCCAC), following participation in a provincial pilot project, is working on a Client Care Model which has evolved from the collaborative work of all 14 CCAC's in the province.

The Client Care Model focuses the appropriate resources to clients based on a population based model. It provides consistent and appropriate level of care coordination to better meet client needs and improve client outcomes. It supports system navigation; ensuring clients are connected to the appropriate resources within the health care system.



Implementation of New Electronic Assessment Tool

A new electronic assessment tool was implemented this year. The "RAI Contact Assessment" (RAI-CA) means that only one assessment instrument and one intake assessment process is used for Community Case Access Centre (CCAC) adult clients, for in-home services and or clients looking for information and referral.

Any adult client who is 18 years of age and older who may need service will be assessed using this tool. All CCAC's in the province have implemented this new tool as well.

Supporting People at Home

CONNECTING WITH PRIMARY CARE:

Community/Palliative Care Nurse Practitioner

The Community Nurse Practitioner provides services to clients with chronic conditions who do not have a family doctor or who can no longer access outpatient services. By providing home visits, the Community Nurse Practitioner focuses on disease prevention, such as immunization, routine health screening, medication review, and diagnostic testing. Working with primary care and with the health care team is an important part of this role in the community. Teaching clients about their chronic diseases and linking them to health care services help clients to remain at home, preventing hospitalization.

The Palliative Care Nurse Practitioner service has greatly added to the system's ability to support choice for individuals approaching the end of their life. The Palliative Nurse Practitioner visits clients in their own home and works with the health care team to support people at the end of their lives. Important aspects of this role consist of assessing medical needs, providing education, reviewing medications, and communicating with family physicians. The Palliative Care Nurse Practitioner helps to avoid unnecessary visits to the emergency department and hospitalizations.

Health Care Connect

In February 2009, the Ontario Government launched Health Care Connect (HCC) – A program designed to refer unattached patients to family health care providers who are accepting new patients in their community. Care Connectors, who are nurses employed by Community Care Access Centres, work with unattached patients to connect them to family physicians and nurse practitioners. They also provide patients with valuable information about available health care options.

To date, more than 4,900 unattached patients have registered with HCC across the North West, and more than 1,900 have been connected to a health care provider.

Health Care Connect
Call 1-800-445-1822
www.ontario.ca/healthcareconnect

Strategic Directions / Key Achievements

Teamwork and Learning

Number of Staff (as at March 31, 2011): 148

Bargaining Units:
Canadian Auto Workers (CAW), Local 229
Ontario Nurses' Association (ONA), Local 014

Staff Development and Training Sessions:

- 2010 Ontario Association of Community Care Access Centres (OACCAC) Conference
- Accessibility for Ontarians with Disabilities Act, 2005 (AODA)
- Accreditation Canada Training Session
- Case Management – McMaster University
- Client Health Related Information Systems (CHRIS) – Upgrade Training
- Point Click Care (PCC) Integration Training
- RAI-CA (Contact Assessment) Training
- Employee Engagement Survey
- Bill 168 – Bullying, Violence and Harassment in the Workplace

Staff Appreciation Days:

Each year the North West CCAC plans an event in recognition of the dedication and contributions by our staff in achieving our organizational goals.

The following Service Awards were presented to staff in recognition of their years of service:

- 5 Year Service Award – 13 recipients
- 10 Year Service Award – 12 recipients

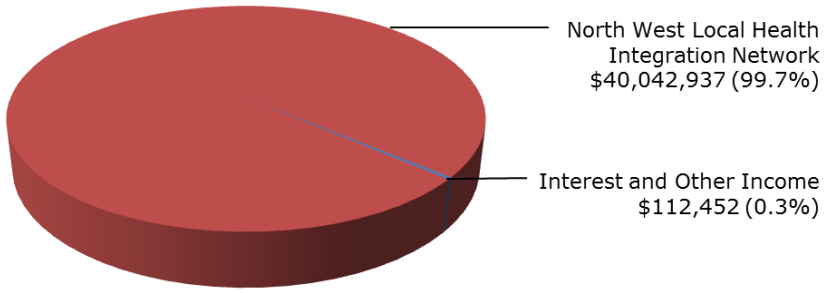
Congratulations to all recipients with thanks for your ongoing contributions!

Our Contracted Service Providers:

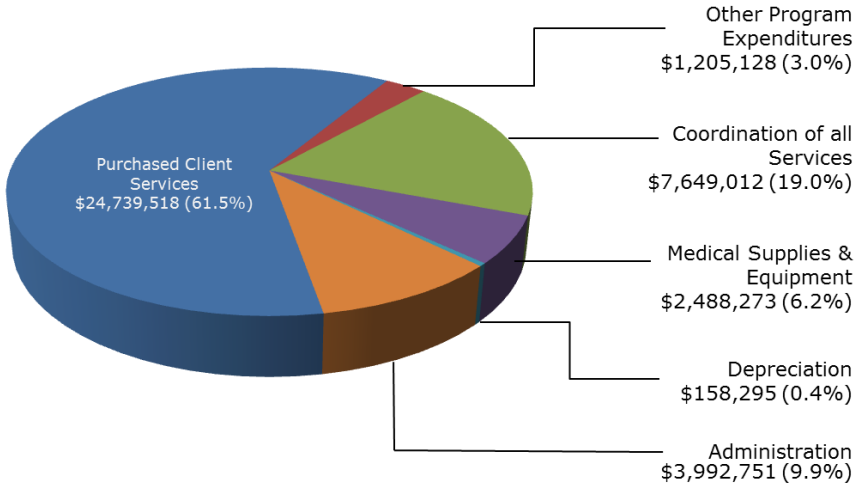
- **Atikokan General Hospital**: Physiotherapy, Occupational Therapy, Speech Language Pathology
- **Bayshore Home Health**: Nursing, Homemaking
- **Comcare Health Services**: Nursing, Homemaking, Nutrition
- **Creative Therapy Associates**: Occupational Therapy, Speech Language Pathology
- **Dryden Regional Health Centre**: Physiotherapy, Occupational Therapy, Nutrition
- **Kenora Physiotherapy and Sports Injury Centre**: Physiotherapy, Occupational Therapy
- **Lake of the Woods Child Development Centre**: Speech Language Pathology
- **Lake of the Woods District Hospital**: Nutrition
- **Landry Speech Language Services**: Speech Language Pathology
- **New Hope Speech Language Pathology Services**: Speech Language Pathology
- **Partners in Rehab**: Physiotherapy, Occupational Therapy, Speech Language Pathology
- **Riverside Health Care Facilities Inc.**: Nutrition
- **Saint Elizabeth Health Care**: Nursing, Homemaking
- **Sean Sloan**: Physiotherapy
- **Shoppers Home Health Care**: Equipment
- **Superior Speech Services**: Speech Language Pathology
- **Superior Therapy Services**: Occupational Therapy
- **Tilley's Pharmacy**: Equipment & Supplies
- **Trout Forest Physical Therapy**: Physiotherapy
- **Victorian Order of Nurses**: Nursing, Homemaking, Physiotherapy, Social Work
- **Woit's Pharmacy**: Equipment & Supplies

Financial / Statistical Information

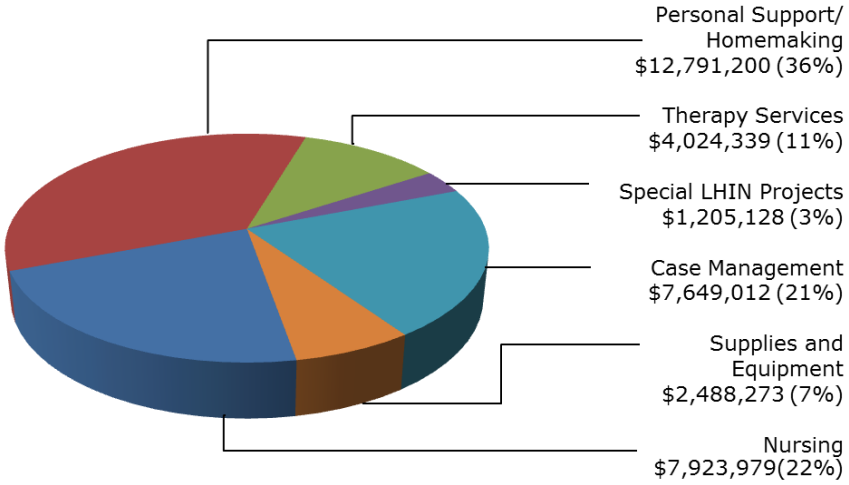
Revenue
$40,155,389



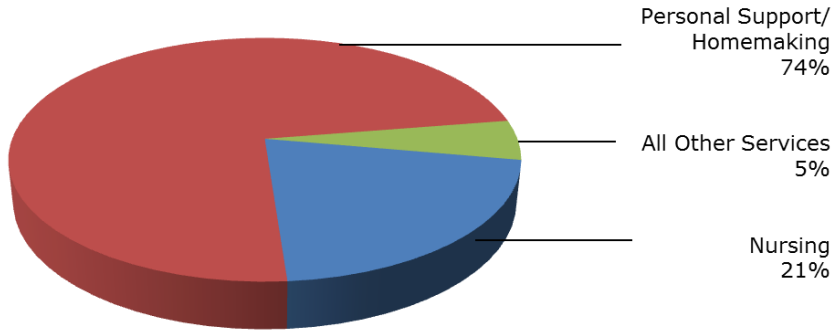
Expenditures
$40,232,977



Total Client Service Expenditures
$36,081,931



Allocation of Services



Balance Sheet

As at March 31, 2011

	2011	2010
ASSETS		
Current		
Cash	**$ 3,085,785**	$ 3,057,150
Accounts receivable	**295,413**	73,523
Due from the North West Local Health Integration Network	**106,982**	-
Prepaid expenses	**58,030**	32,539
	3,546,210	3,163,212
Capital assets	**154,812**	244,225
	$ 3,701,022	$ 3,407,437
LIABILITIES		
Current		
Accounts payable and accruals	**$ 3,477,921**	$ 2,223,071
Due to the North West Local Health Integration Network	-	907,744
Due to the Province of Ontario	**26,357**	26,357
Deferred revenue	**43,512**	-
Current portion of obligation under capital lease	**16,807**	20,520
	3,564,597	3,177,692
Obligation under capital lease	**-**	17,744
Deferred capital contributions	**14,006**	4,373
NET ASSETS		
Operating	**122,419**	207,628
	$ 3,701,022	$ 3,407,437

Statement of Operations

Year ended March 31, 2011

	2011	2010
Revenue		
North West Local Health Integration Network		
General	**$ 38,851,397**	$ 37,010,747
Other programs	**1,191,540**	879,105
Other revenue	**112,452**	105,039
	40,155,389	37,994,891
Expenses		
Client services –		
Purchased services and supplies	**27,227,791**	25,071,613
Other client services costs	**7,649,012**	7,724,345
Other programs	**1,205,128**	879,105
	36,081,931	33,675,063
Corporate services and administration –		
Administration	**3,992,751**	4,210,670
Amortization	**158,295**	202,304
	4,151,046	4,412,974
	40,232,977	38,088,037
Shortfall of revenue over expenses for the year	**$ (77,588)**	$ (93,146)

Statement of Cash Flows

Year ended March 31, 2011

	2011	2010
Cash provided by (used in) operating activities		
Cash received	**$38,947,320**	$ 38,208,174
Interest received	**16,977**	17,257
Cash paid to suppliers and employees	**(38,845,323)**	(38,185,292)
	118,974	40,139
Cash used in investment activities		
Purchase of capital assets	**(68,882)**	(28,757)
Cash used in financing activities		
Repayment of obligation under capital lease	**(21,457)**	(6,959)
Net cash increase (decrease) during the year	**28,635**	4,423
Cash position, beginning of year	**3,057,150**	3,052,727
Cash position, end of year	**$ 3,085,785**	$ 3,057,150

**Complete audited statements available upon request.*

Office Locations / Contact Information

Thunder Bay (Head Office)
961 Alloy Drive
Thunder Bay, ON P7B 5Z8
Tel: 1 807 345 7339
Toll-free: 1 800 626 5406

Atikokan
120 Dorothy Street
Tel: 1 807 597 2159
Toll-free: 1 877 661 6621

Dryden
6 – 61 King Street
Dryden, ON P8N 1B7
Tel: 1 807 223 5948
Toll-free: 1 877 661 6621

Fort Frances
110 Victoria Avenue
Fort Frances, ON P9A 2B7
Tel: 1 807 274 8561
Toll-free: 1 877 661 6621

Geraldton
510 Hogarth Avenue West
Tel: 1 807 854 2292
Toll-free: 1 866 449 2424

Kenora
Suite #3 – 35 Wolsley Street
Kenora, ON P9N 0H8
Tel: 1 807 467 4757
Toll-free: 1 877 661 6621

Marathon
26 Peninsula Road
Tel: 1 807 229 8627
Toll-free: 1 866 449 3313

Rainy River
113 – 4th Street
Tel: 1 807 852 3955
Toll-free: 1 877 661 6621

Red Lake / Ear Falls
200A Howey Street
Tel: 1 807 727 3455
Toll-free: 1 877 661 6621

Sioux Lookout
1 Meno Ya Win Way
Tel: 1 807 737 2349
Toll-free: 1 877 661 6621

North West
CCAC CASC
Community Care Access Centre
Centre d'accès aux soins communautaires du Nord-Ouest

Copies of this Report can be obtained from:

Head Office
North West Community Care Access Centre
961 Alloy Drive
Thunder Bay, Ontario
P7B 5Z8

1 807 345 7339
1 800 626 5406

www.nw.ccac-ont.ca

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