Report to the Community

Annual Report 2009 – 2010

Outstanding care – every person, every day

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

Our Foundations

Vision

Outstanding care – every person, every day

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.

Values

Central CCAC is committed to ensuring that everything we do is guided by the following values:

- Client-centred service that encourages wellness, enhances user experience and surpasses client expectations;
- Leadership that inspires excellence;
- Integrity, trust, respect and professionalism that characterizes all of our relationships;
- Communication that is accessible, open, transparent and understandable in our culturally diverse community; and,
- Collaboration that drives innovation and creativity in our quest to successfully manage continuous change.

Outstanding care – every person, every day

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A Message from the Board Chair and Chief Executive Officer

Teddene Long
Board Chair
Central CCAC

Cathy Szabo
Chief Executive Officer
Central CCAC

A Year of Achievements and Opportunities

The past year was highlighted by major achievements and significant opportunities for the Central Community Care Access Centre (CCAC). Above all, we take pride in our commitment to outstanding care – every person, every day.

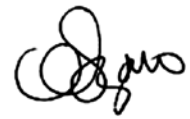
In 2009/10, the increasing need to provide care to clients after a hospital stay, and the ever growing number of clients with complex needs, brought even greater focus on our organizational priorities, the "4Cs" – Customer Service, Case Management, Collaboration and Culture.

Close collaboration with our partners, including hospitals, service providers and community agencies, continues to be key in getting the most value from our available resources to provide the best possible care to those who need it the most in our community. Community-based clinics have also extended our outreach so that specialized nursing, wound care, and IV therapy are more accessible for our clients.

We also extend our thanks to the unwavering support of our Board of Directors, to the ongoing commitment, creativity and hard work of our staff, and to the dedication of our service providers and health care partners. We also extended our thanks to the Central LHIN for their continued support in so many of our endeavours throughout the past year.

Sincerely,

Teddene Long, Board Chair



Cathy Szabo, Chief Executive Officer

Board of Directors (April 1, 2009 to March 31, 2010)

Teddene Long *(Board Chair)*
Marlene Close
Lorraine French
Nevzat Gurmen
Bryan Kettlewell
Mark Marchand
Angela Morris*
Lan Nguyen
Charlie Regan*
Cathy Szabo *(Executive Director)*

* Resigned during the year

In Memoriam – Bryan Kettlewell

The Board of Directors and staff of the Central CCAC were saddened to learn of the sudden passing of Bryan Kettlewell, in January 2010. A long-time resident of Queensville, a husband and father of five, Mr. Kettlewell spent 35 years as a teacher and administrator with the York Region Board of Education. He was a valued, hard-working and respected member of the Central CCAC's Board of Directors and is very much missed.

About Central CCAC

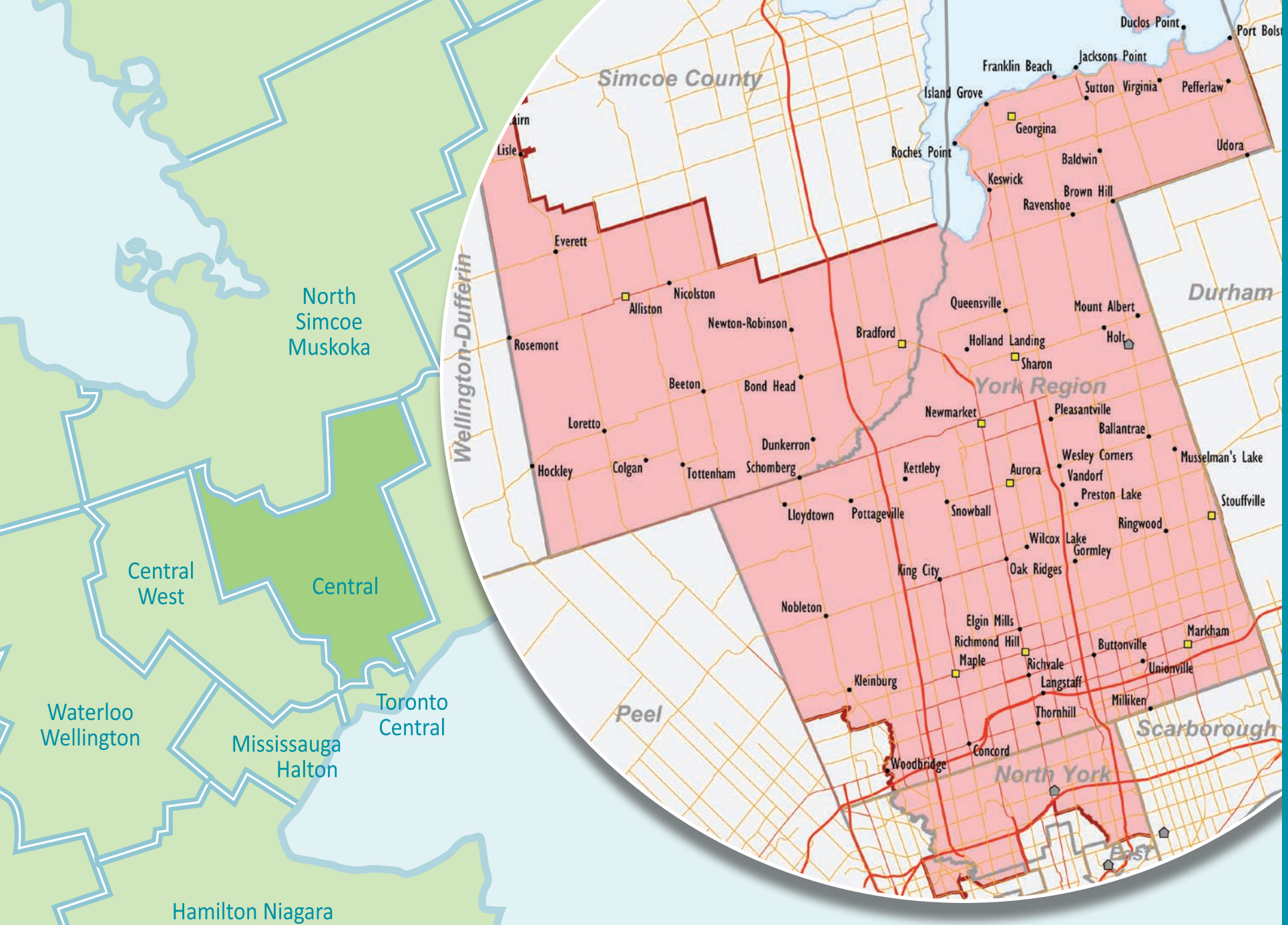
The Central Community Care Access Centre (CCAC) helps people:

- Maintain independence in their own home
- Avoid hospital admission
- Connect to health and community services upon discharge from hospital
- Find the right housing options when living independently is no longer possible

Our role is to work with clients, their caregivers, and their families to find the services that are right for them. Some of the services the CCAC provides are:

- Case Management
- Nursing
- Personal Support/Homemaking
- Physiotherapy
- Occupational Therapy
- Speech Therapy
- Social Work
- Nutritional Counselling/Dietetics

The Central CCAC will also connect people to health and community organizations that provide services beyond what is offered by the Central CCAC directly. For example, meal programs, driving services, and homemaking.


North Simcoe Muskoka
Central West
Central
Waterloo Wellington
Mississauga Halton
Toronto Central
Hamilton Niagara Haldimand Brant
Simcoe County
Wellington-Dufferin
Durham
York Region
Peel
Scarborough
North York
East
Duclos Point
Port Bolster
Jacksons Point
Franklin Beach
Sutton
Virginia
Pefferlaw
Island Grove
Georgina
Udora
Roches Point
Baldwin
Keswick
Brown Hill
Ravenshoe
Lisle
Everett
Alliston
Nicolston
Newton-Robinson
Rosemont
Bradford
Queensville
Mount Albert
Holland Landing
Holt
Sharon
Beeton
Bond Head
Loretto
Newmarket
Pleasantville
Ballantrae
Dunkerron
Hockley
Colgan
Tottenham
Schomberg
Kettleby
Aurora
Wesley Corners
Vandorf
Musselman's Lake
Preston Lake
Stouffville
Lloydtown
Pottageville
Snowball
Ringwood
Wilcox Lake
Gormley
King City
Oak Ridges
Nobleton
Elgin Mills
Richmond Hill
Markham
Buttonville
Maple
Richvale
Unionville
Kleinburg
Langstaff
Milliken
Thornhill
Concord
Woodbridge

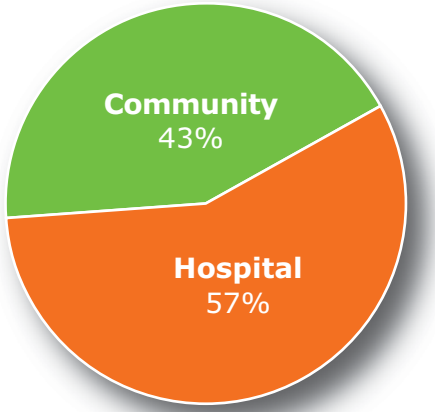
Facts About Central CCAC

The Central CCAC is funded by the Ministry of Health & Long-Term Care through the Central LHIN. Serving more than 1.7 million people, the largest population of all CCACs in Ontario, the Central LHIN covers an area of 3,074 square kilometres. Our population is highly diverse and many languages are spoken with the top three languages, after English, being Italian, Cantonese, and Russian. Recent immigrants make up 10% of the population, particularly in Toronto, Richmond Hill, Markham and Vaughan. We are respectful of the unique needs of each client.

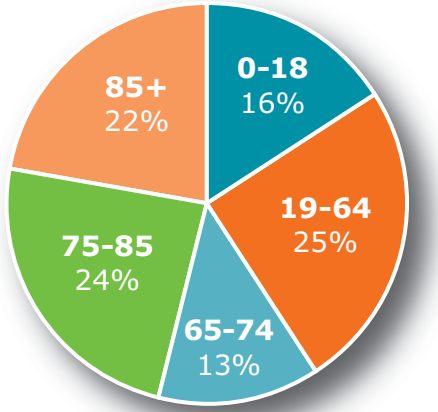
Key Statistics for Central CCAC 2009–2010

Funding	$204 Million
Number of Employees	709
Number of Unique Clients	65,000
Number of Clients on Service on any Given Day	26,000
Largest Referral Source within Central LHIN	Southlake Regional Health Centre (4,200)
Largest Referral Source outside Central LHIN	Sunnybrook Health Sciences Centre (1,900)
Emergency Room Referrals from Central LHIN Hospitals	7,000
Clients from Hip and Knee Replacement	938
Community Clinics	6
Number of Contracted Service Providers	32

Referral Sources



Clients by Age



Service	Clients	Visits
Nursing	17,640	787,748
Personal Support	22,649	2,283,821 (hrs.)
Occupational Therapy	12,096	53,726
Physiotherapy	7,542	42,180
Speech Therapy	5,081	42,608
Social Work	1,391	5,874
Nutritional Counselling	1,255	5,481
Case Management Face to Face	51,927	63,048
Placement	11,110	N/A

Note: Clients may receive more than one service

- Central CCAC is the **most populous** LHIN in Ontario
- Population growth rate is **two times** the provincial average
- **25% increase** in high-needs clients

Client-Focused Culture – Aging at Home

Helping Clients Stay in their Homes/Communities

Central CCAC is expanding and refining a number of initiatives designed to support the Aging at Home strategy throughout the Central LHIN. Two common objectives for safely maintaining individuals in their own homes are:

- Relieving the pressure on Alternative Level of Care (ALC) hospital beds being used by patients who no longer require acute care
- Reducing the number of readmissions to hospital and/or visits to emergency departments

Home First

Home First is an alternative to remaining in hospital if acute care is no longer required. The program supports individuals 65 years of age and older who, if eligible for CCAC services, are discharged upon determination that they could safely return home with enhanced in-home supports and services.

Service levels can include up to 56 hours of personal support each week, along with professional services and equipment rental, as required, up to a maximum of 90 days.

The CCAC Case Manager will work closely with the client and the caregiver, and with community agencies to ensure the client is recovering according to expectations.

To date, 51 clients have gone through the program: 4% stayed the full 90 days, 66% had shorter stays and one client went to a Long-Term Care Home.

Home First clients use about 40 hours of personal care per week.

Launched as a pilot project with North York General Hospital and Central CCAC, Home First soon expanded to include patients from Sunnybrook Health Sciences Centre. The strategy has proven to reduce the number of days patients wait in ALC hospital beds. The number of patients waiting in ALC beds at any one time has decreased from 39 to 23, and the number of crisis placements in long-term care has been reduced.

The program is now being evaluated to determine its overall effectiveness with an eye to future expansion.

Balance of Care

Balance of Care is an alternative to long-term care placement. The program supports clients who are 65 years of age and older who are waiting in the community for admission to a Long-Term Care Home and are already receiving CCAC in-home services. A Case Manager will provide an assessment to determine whether the client could remain in their home safely, instead of being admitted to a Long-Term Care Home, with an enhanced basket of services provided by the CCAC and community support agencies. Balance of Care is funded by the Central LHIN through the Aging at Home strategy.

For some, help with activities such as shopping, transportation or laundry can make the difference between independence and dependence. For others, personal services that may include help with bathing and dressing, and/or meal programs can improve their quality of life, allowing them to stay in familiar surroundings.

Once clients are assessed as eligible for Balance of Care, a Case Manager will work with them to develop a comprehensive resource plan to provide in-home services for as long as is needed. To date, 17% of clients have deferred long-term care and have been able to remain at home. There has also been a significant decrease in hospital admissions and visits to emergency rooms among Balance of Care clients.

Medication Management Support Services

Medication Management Support Services (MMSS) helps reduce the risk of adverse drug events that can result in emergency department visits and falls in the home. The program is available to individuals 65 years of age and older who take three or more prescription medications and have at least one chronic condition.

The CCAC Case Manager arranges for a nurse or pharmacist to visit the client in their home to review their health status and all medications they are taking. They will also determine how the client is managing with blood glucose monitoring, insulin administration, or the use of inhalers. They may also contact the client's family physician or community pharmacist for additional information. Two visits are scheduled within a 60-day period for initial and follow-up visits.

Over the past year, a total of 865 clients have been served by Medication Management Support Services. Follow-up surveys for 347 discharged clients indicate an improvement in the client's ability to self-manage, and 98% of those clients surveyed rated the service as good or excellent. The program has resulted in the reduction of one medication per client on average, with a cumulative savings of more than $35,000 to the Ontario Drug Benefit program. A reduction in negative reactions to medications and subsequent emergency department visits was also noted. In addition, clients reported fewer falls in the home and better control of mild to severe pain.

This program is funded by the Central LHIN through the Aging at Home Strategy, and involves the collaboration of the Central CCAC, service providers, hospitals, pharmacists, and family physicians. The average age of clients using Medication Management Support Services is 80 years.

What our Clients are Telling Us

"On behalf of my mother, I would like to take this opportunity to thank the CCAC and our Case Manager for the assistance, care and attention you gave to my mother.

From the first home visit two years ago, everyone was caring, compassionate, professional and interested in my mother's welfare. She could not have remained independent and in her own home if not for the services of the Central CCAC.

Our phone calls were always answered in a timely fashion, visits made on a regular basis, you listened to our concerns and tried to meet our expectations. In this time of shrinking budgets and diminished expectations, you provided the best care and service possible and it has been a great comfort to know that our mother was not just an impersonal client. For this, we are extremely grateful."

"All too often when a loved one passes, the organizations that provided care are overlooked. Therefore, on behalf of my family, I would like to express our sincere gratitude and appreciation to the CCAC for the outstanding support and guidance during the last six months of Margaret being with us.

Your staff are angels in disguise and true assets to your organization. Being the primary caregiver of my elderly mother living with dementia, their dedication, professionalism, knowledge, empathy and, I might add, humour, certainly helped alleviate some of the stresses I encountered.

Words simply cannot express my gratitude for your unwavering support and care."

Collaboration – Working with our Partners

Convalescent Care – A Case Manager's Story

Convalescent Care provides clients with extra care and support after a hospital stay and before they are able to return home safely. Susan Dupuis is a Client Services Case Manager in Placement Services with the Central CCAC. She works from an office in Union Villa, a Long-Term Care Home located in York Region. Her focus is Convalescent Care and she works closely with staff from Markham Stouffville Hospital and Union Villa.

When Susan receives a hospital referral, she conducts a comprehensive client assessment. If it is expected that an individual would be able to return home following Convalescent Care, she makes arrangements for admittance to the 15-bed convalescent unit at Union Villa.

While the maximum length of stay is 90 days, the average stay is 55 to 60 days. Reasons for admission can vary from orthopaedic problems involving fractures or hip/knee replacements, a range of medical issues, or the need to regain strength and functioning after a hospital stay.

Typically, clients have multiple health issues and are aged 75 and up, although one client was 99. He returned home after successfully completing the rehabilitation treatment program.

Convalescent Care clients have access to a multidisciplinary health care team that includes physical and occupational therapists, dietitians, along with the Case Manager, who work together to develop a convalescent plan of action. An individualized program is completed for each client and the health care team keeps a close eye on each client's progress and targets the probable discharge date. When it is time for the client to go home, Susan will conduct an exit assessment of their needs to determine whether they need CCAC in-home services or whether they need to be linked to community-based supports. She finds her role both challenging and rewarding as she follows clients through their convalescent journey. Another facet of the CCAC's partnership with this Long-Term Care Home is the Wound Care Clinic Central CCAC operates within Union Villa.

Convalescent Care – A Client's Story

Jeremiah didn't fit the typical client profile Susan Dupuis generally worked with. For one thing he was younger than most, in his late 40s, the victim of a workplace accident. He'd fallen from quite a height and landed on his feet. His injuries were severe and, following surgery and treatment at Scarborough General Hospital, he was transferred to the convalescent unit at Union Villa. Since he was unable to walk at all he began his rehabilitation using a wheelchair and later graduating to a walker. What everyone remembers about Jeremiah was his overwhelming motivation towards recovery.

"He was totally committed to the program developed for him," said Susan. "He knew he had a lot of work to do and he tackled everything with great enthusiasm, so much so that he was an inspiration to the other patients. He took photos of the progress being made and generally made life brighter for everyone else on the unit."

Because his injuries were so serious, Jeremiah stayed the full 90 days in the unit. When it was time for Jeremiah to go home, Susan liaised with the Workplace Safety Board to find physiotherapy in his community to ensure his treatment would continue.

Congratulations to Jeremiah on a remarkable recovery.

Community Clinics

Community Clinics provide an outpatient service to our mobile clients. Our Clinic nurses specialize in wound care, injections, and IV therapy. The Central CCAC is currently operating six community nursing clinics throughout the Central LHIN: Alliston, Branson, Keele, Maple, Newmarket and Unionville.

Case Management

Evolution of a Case Manager's Role

Laurie Fisher has worked with CCACs for the past 11 years, most recently as a Community Case Manager with Central CCAC working in Aurora. She is responsible for an adult case load, with clients ranging in age from the early 20's up to 106. The area is growing quickly. It has young families in new housing developments, along with seniors' homes and Long-Term Care Homes.

"There is no shortage of challenges in this job," says Laurie. "Every day is different, every situation is unique, every client is special. I really enjoy getting out and meeting clients on a face-to-face basis."

As the CCAC continues to evolve as a key player within the Central LHIN, the role of Case Manager also develops and adapts to the changing needs. "Technology is a major feature of our day-to-day activities," explains Laurie. "We carry our laptops when we visit clients and do the assessment right in their living room. In fact, a couple of clients refer to me as the lady with the computer." The advantage to involving the client in the assessment process in their home is client satisfaction and the expedience of service delivery.

Laurie finds that clients today are more knowledgeable about the health care system and about their rights. They are better equipped to advocate for themselves and they know what services they are looking for.

The Community Case Manager now has far more direct responsibility in working with clients. The role of the Case Manager involves balancing client care, as well as being accountable for the individual budget of their client caseload.

"Many of our clients have complex needs and require more intense and costly case management. This is a prime consideration as we strive to provide equitable services and supports to our entire caseload," says Laurie.

The rewards of the Case Manager's role make it all worthwhile, according to Laurie. "I enjoy my job. I work with great colleagues and community partners and am able to regularly interact with interesting clients and caregivers. In addition, my role offers me great opportunities for professional and personal growth. It's a win-win scenario."

Statement of Operations and Change in Net Assets

As of March 31, 2010	**2010 ($)**
Revenue	
MOHLTC/LHIN	204,789,004
Interest Income	544,479
Miscellaneous Income	1,444,854
Amortization of Deferred Capital Contribution	955,169
	207,733,506
Expenses	
Purchased Client Care Services	131,826,056
Client Care Medical Supplies and Equipment	15,646,145
Salaries and Benefits	51,750,976
Other Non-Salary	9,714,415
Amortization of Capital Assets	955,169
	209,892,761
Excess of Expenses Over Revenue	(2,159,255)
Net Assets, Beginning of Year	(370,143)
Net Assets, End of Year	(2,529,398)

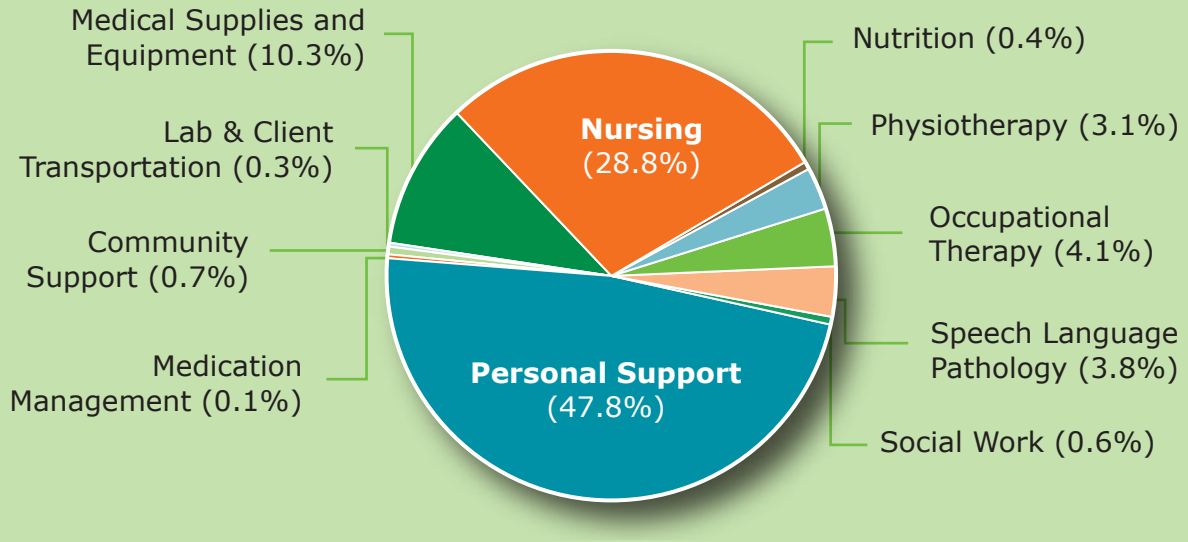
Expenditures by Service Type:

The 2009 to 2010 actual funding for Central CCAC was $204 million. Of the $204 million, 72% is contracted out for services, supplies and equipment for clients.

Expenditures by Referral Source:

Southlake Regional Health Centre	$9,161,135	University Health Network	4,471,818
Humber River Regional Hospital	8,659,478	Other CCACs	3,893,534
York Central Hospital	7,905,983	Markham Stouffville Hospital	3,485,036
North York General Hospital	7,120,495	Hospital for Sick Children	3,165,852
Sunnybrook Health Sciences Centre	6,468,903	St. John's Rehabilitation Hospital	2,184,942

Direct Service Expenditures 2009–2010:



Central CCAC Service Providers *(as of March 31, 2010)*

Nursing

- Bayshore Healthcare Ltd.
- Calea Ltd.
- Closing the Gap Healthcare Group
- Comcare Health Services
- Nursing & Homemakers Inc.
- ParaMed Home Health Care
- Regional Nursing Services
- Saint Elizabeth Health Care
- Spectrum Health Care Limited
- SRT Med-Staff International
- VHA Home HealthCare
- VON Canada – Toronto-York Region Branch
- We Care Health Services LP

Personal Support and Homemaking

- Bayshore Healthcare Ltd.
- Canadian Red Cross
- CanCare Health Services Inc.
- CANES – Central and North Etobicoke Home Support Services
- Circle of Care
- Comcare Health Services
- CBI Health Group
- ParaMed Home Health Care
- Preferred Health Care Services Inc.
- ProHome Health Services Inc.
- Regional Nursing Services
- Saint Elizabeth Health Care
- Spectrum Health Care Limited
- SRT Med-Staff International
- VHA Home HealthCare
- We Care Health Services LP

Physiotherapy and Occupational Therapy	1to1 Rehab Inc. Closing the Gap Healthcare Group Comcare Health Services	Exceptionalities Inc. Saint Elizabeth Health Care VHA Rehab Solutions
Speech Language Pathology	1to1 Rehab Inc. Closing the Gap Healthcare Group Comcare Health Services	Exceptionalities Inc. The Speech Clinic VHA Rehab Solutions
Dietetics	1to1 Rehab Inc. Closing the Gap Healthcare Group	VON Canada – Toronto-York Region Branch
Social Work	Closing the Gap Healthcare Group Comcare Health Services	Exceptionalities Inc. VHA Rehab Solutions
Medical Supplies and Equipment	Calea Ltd. KCI Medical Canada, Inc. Medigas, a Division of Praxair Canada Inc.	Pharmx Rexall Drugstores Ltd. Shoppers Home Health Care Smith & Nephew Inc.
Laboratory Service	LifeLabs	

Health Fairs and Events

72 community fairs and presentations with over **6,500** people in attendance

Hospital Partners Include:

There are seven acute hospitals at eight sites and one rehabilitation hospital within the Central LHIN boundaries:

- Markham Stouffville Hospital, Markham
- North York General Hospital Main Site, Toronto
- North York General Hospital Branson Site, Toronto
- Saint John's Rehabilitation Hospital, Toronto
- Southlake Regional Health Centre, Newmarket
- Stevenson Memorial Hospital, Alliston
- Humber River Regional Hospital Church Site, Toronto
- Humber River Regional Hospital Finch Site, Toronto
- York Central Hospital, Richmond Hill

Number of Mental Health & Addictions Agencies: **22**

Number of Community Support Agencies: **33**

Health Care Connect

The Central CCAC is pleased to work in support with Health Care Connect, a ministry program that helps people find a primary care physician or nurse practitioner in their community. Just call 1 800 445 1822 to register for this service.

Community Care Resources

www.central.communitycareresources.ca is a website that provides easy access to community and health services. There are over 1,350 organizations on the site. You're one click away from the services you need.

Central CCAC / CASC
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Centre d'accès aux soins communautaires du Centre

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Ontario
Central Local Health Integration Network

September 2010