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

delivering quality care in the home and community

CENTRAL COMMUNITY CARE ACCESS CENTRE
ANNUAL REPORT TO THE COMMUNITY 2013-2014

Care coordination

The foundation for outstanding care in the community

Each year, Central CCAC serves an increasing number of patients with complex, chronic health conditions. Over 71% of our patients have very high or high needs, compared to 56% just four years ago. In the past, these people would have stayed in hospital or moved to long-term care.

Meeting the needs and expectations of these patients requires a focused and integrated approach to care, including individualized and coordinated care plans and services. That's where the Central CCAC comes in.

Our care coordinators are nurses and other regulated health professionals with clinical expertise and in-depth knowledge of health and community services. Helping patients transition to different care settings and mobilizing the right care and services in the community to help them stay healthier and more independent at home is at the heart of what Central CCAC care coordinators do.

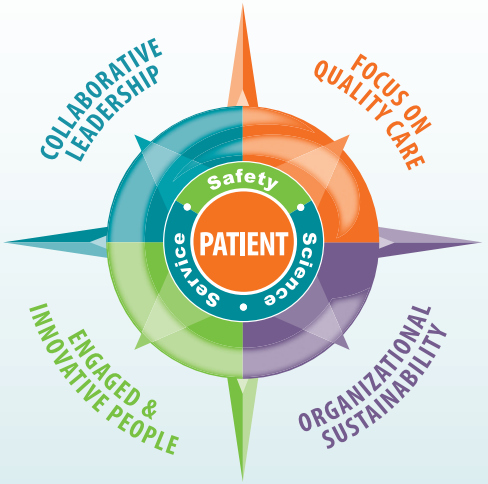
With the increasing complexity of our patients, Central CCAC's care coordinators are focusing more than ever on working closely with primary care providers and other health professionals to co-create individualized, coordinated care plans that meet the needs and goals of our patients.

Take the example of Health Links. These patient care networks are a new approach to providing support to patients with extraordinary health care needs. Central CCAC's Health Link care coordinators are helping complex patients to improve their health and to live independently in the community.

And that's just one instance of how care coordination helps people get the care they need. By developing evidence-based care plans, organizing the care needed to meet the patient's changing needs over time, and providing guidance that helps people make the best choices about the care and services available to them, our care coordinators are improving our patients' health and quality of life and creating a stronger, more integrated health system.

"Central CCAC's care coordinators get to know my patients and their families. More importantly, they find out what really matters to them about their health. The benefit to my patients is better, high quality care."

– Dr. David M. Kaplan, Primary Care Physician Lead, Central LHIN



Outstanding care – every person, every day

Central CCAC's Strategic Plan (2011-2014) has guided our efforts to achieve our vision of *Outstanding care – every person, every day*.

With a commitment to continuous quality improvement, system leadership, value for money and enabling staff to succeed, the Plan strengthened our capacity to meet the needs of our patients, our community and the health system.

It also prepared us for the important work ahead, as we move forward over the next three years with a new Strategic Plan (2014-2017).

Focusing on patient-centred care, the new Plan outlines three priorities to improve how Central CCAC and its partners deliver integrated care to patients with complex needs, increase access to health and community care options and improve patients' health outcomes.

Leslie and Bob's story

Leslie MacDonald wanted to improve her health and avoid the emergency department - Central CCAC helped her achieve those goals

At 67 years old, Leslie MacDonald is a loving wife, mother and grandmother. She also suffers from multiple sclerosis. Although Leslie lives with her supportive husband Bob and has adult children living nearby who are involved with her care, her very complex clinical care needs meant she would benefit from the intense care coordination offered by a Central CCAC care coordinator from the South Simcoe Northern York Region Health Link.

Before Health Links, serious health complications frequently sent Leslie to the emergency department. Leslie and Bob wanted to prevent these unnecessary and exhausting trips to the hospital, and improve her quality of life.

Karen Taylor is Leslie and Bob's CCAC care coordinator. After Leslie was discharged from yet another stay in hospital, Karen met with the couple to assess Leslie's current health and services, and possible factors that could be leading to her recurring hospitalizations. Just as important, Karen wanted to talk about their concerns and goals.

"My first priority was listening to Leslie and Bob, so I could understand what they really wanted and needed," says Karen. "Once I had that information, I was ready to work with Leslie and lead her care team in creating a coordinated care plan to meet those needs and help Leslie to feel better and stay well in her own home. "

After connecting with Leslie's family doctor, Karen arranged a care conference in the MacDonald's home, attended by her visiting nurse, personal support worker and family doctor. This collaborative approach resulted in a Coordinated Care Plan that was shared with Leslie, Bob and all members of her health care team.

Over time, Karen has met with the MacDonalds many times to review the care and service options available to meet Leslie's needs in the community, and to update her plan as her health needs change.

"Our Central CCAC Health Link care coordinator is someone we can turn to when we have questions or concerns about my care plan or services," says Leslie. "Thanks to her, everyone is working as a team and focusing on the things that are important to us. I feel better and I don't have to go to the hospital as often. It's made a big difference in our lives."

"Thanks to our Central CCAC care coordinator, everyone is **working as a team** and focusing on the things that are important to us. I feel better and I don't have to go to the hospital as often. **It's made a big difference** in our lives"

– Leslie MacDonald, Health Link patient

Leslie and Bob MacDonald ▶

A message from the Central CCAC

This Annual Report highlights our successes over the past year in delivering better care for patients and value for the health system

Ontario's health system is changing, with greater emphasis on providing care for people with complex, chronic illnesses, at home and in community settings other than hospitals and long-term care facilities. Through innovative, high quality services, specialized care coordination and strong relationships with our health system partners; the Central Community Care Access Centre (CCAC) is helping people receive the care they need to stay healthier and more independent.

Central CCAC's pivotal role in the health system continues to grow and evolve. Last year we provided assessment and determined eligibility for adult day programs, assisted living, and exercise and falls prevention classes. We also became the single point of access for all publicly-funded in-home physiotherapy in our region , streamlining and improving people's access to these important services.

Through direct nursing services and initiatives aimed at reducing falls, preventing serious medication issues and restoring people's health and mobility after a hospital stay, we helped many of our most vulnerable patients avoid emergency department visits and readmissions.

Working with our hospitals and primary care providers, Central CCAC made significant contributions to the Health Link patient care networks in our region, improving quality of life for complex Health Link patients and their families.

Central CCAC also undertook a highly consultative and participative process to develop a new Strategic Plan for the next three years, which will guide our efforts to provide patient-centred, quality care through integration, better access to care and services, and improved outcomes for patients. The full Strategic Plan (2014-2017) – Excellent Service, Compassionate Care and a companion Executive Summary are available at healthcareathome.ca/central

We would like to thank our Board of Directors, our dedicated staff, the Central Local Health Integration Network (LHIN) and our health and community partners. We could not provide outstanding care without you.

Most important, thank you to our patients and their caregivers and families. You are the inspiration for us to always try harder and do better.

Nevzat Gurmen
Board Chair

Leigh Scott
Interim Chief Executive Officer

Nevzat Gurmen
Board Chair

Leigh Scott
Interim Chief Executive Officer

Board of Directors

The following individuals served on the Board of Directors during the 2013-2014 fiscal year

Joyce Bailey[1]
Katherine Berg
Eugene Cawthray *(Vice Chair)*
Julie Corden[1]
Mike Dibden
Noam Goodman[1]
Nevzat Gurmen *(Chair)*
Susan Kwolek[2]
David Y.Y. Lai
Teddene Long
Al Luciani
Joe Parker *(Treasurer)*
Cathy Szabo[3] *(Secretary)*

Full biographies of our Board members are available at healthcareathome.ca/central

[1] appointed October 2013
[2] resigned January 2014
[3] resigned effective April 1, 2014

The difference Central CCAC made in 2013-2014

Last year, Central CCAC helped thousands of people stay healthier and live more independently at home and in their community. Here's how:

- Provided care and services to **77,862** people, **8.9%** more than in the previous year
- Supported approximately **33,000** patients on any given day
- Made it possible for **37,471** patients to come home directly from hospital with CCAC care and services
- Supported **8,487** children, while attending school, with critical CCAC care and services
- Enabled **1,343** patients to go home from the hospital on our Home First program instead of into a long-term care home, **29%** more than in the previous year
- Provided quality, specialized nursing care to **5,081** people through our community clinics
- Provided **2,999,082** hours of personal support to help frail seniors and others with complex health issues manage their personal care
- Provided **642,027** at-school and in-home nursing visits
- Delivered physiotherapy to **12,140** people, including many seniors, to help increase their mobility, reduce muscle loss, prevent falls and avoid hospitalization
- Provided short-term, intense, at-home support for **1,852** seniors and children with complicated health issues, through our Rapid Response Nurses
- Helped **3,401** people find a new home in long-term care, when they could no longer manage their health and personal needs independently at home
- Managed **262,332** calls – including on evenings and weekends – from patients, caregivers and others wanting to learn about how our care and services can help
- Connected **14,311** people in Central region to a primary care provider in their community (since 2009), through Health Care Connect, including **2,107** patients with high needs

Awards and Recognition

Central CCAC was recognized with several provincial, national and international awards in the last year for our efforts to deliver quality care for patients and create an exceptional workplace for staff.

Greater Toronto's Top Employers Award (2014), fourth year in a row

Ontario Hospital Association's Quality Healthcare Workplace Award (2013), Gold, third year in a row

Medication Management Support Services

Institute of Public Administration of Canada-Deloitte Public Sector Leadership Award (2013), Bronze

National Research Corporation Canadian Innovative Best Practice Award (2013)

Minister's Medal Honouring Excellence in Health Quality and Safety – Honour Roll (2013)

Focus on Quality Care

Building a culture of continuous quality improvement

Key accomplishments 2013-2014

- 92% of our patients surveyed by an independent research firm consistently **rated their Central CCAC services positively.**
- Developed and posted our **first Quality Improvement Plan (QIP)**, to reduce falls, improve overall patient satisfaction and keep people healthy and out of hospital.
- **Improved patient safety by training 600 CCAC and contracted service provider staff** to prevent medication errors. Workshops were based on innovative Central CCAC-sponsored University of Toronto research into community Never Events (errors that should never occur). 99% of participants said they would apply what they learned to their work with patients.
- Launched a **multi-year strategy to increase patient and caregiver involvement** in key decisions and operational changes, which is a proven way to improve care quality. Working directly with us, over 20 patients and caregivers challenged us to find better ways to deliver patient-centred care and service quality.
- Held **16 quality events** with over 326 patients, caregivers, staff and health and community partners to find better ways of working together to meet patient needs.
- Initiated a more comprehensive, regularly scheduled review of information from our **quality reporting system** – for example, about risks, incidents or complaints – using what we learn to drive quality improvements.
- Introduced Centralhealthline.ca to give patients, families and health care providers **a fast and easy way to research thousands of health and community services** in the Central region and across the province – everything from meal delivery to in-home hairdressing. The site also links to additional health information, such as a new diabetes resource page, and a section that helps caregivers with information, support and a place to share their concerns and coping strategies with one another.

View our Centralhealthline video at youtube/user/centralccac

"It was so important that my wife was able to spend her last weeks in such a **caring environment** with an impeccably high standard of care, delivered with such warmth. **Thank you to everyone in the Central CCAC** for the wonderful work you do."

– Hussein C.,
spouse of Central CCAC patient

Collaborative Leadership

Demonstrating system leadership that strengthens patient care transitions and system flow

Key accomplishments 2013-2014

- Worked with our partners to adopt a **new physiotherapy model to better serve patients in our region.** CCAC is now the single point of access for all publicly funded in-home physiotherapy, in addition to providing assessment and determining eligibility for exercise and falls prevention classes, which improves people's access to these important services.
- Made it easier for people to access adult day programs (ADPs), which improve quality of life for patients and support caregivers in their important role, by implementing an e-referral process that helped us complete **1,656 ADP referrals** last year.
- **Helped 471 at-risk youth** through Mental Health and Addictions Nurses who focus on early intervention and who work with school boards to strengthen student mental health strategies. Our nurses also **held 43 education sessions** for students, parents and teachers, including joint presentations with community partners such as York Regional Police and Public Health.
- Strengthened the palliative care model as the operational lead for the **Regional Hospice Palliative Care Program**, through collaborative development of a strategic plan, creation of a governing council and working groups, launch of a website and free education sessions on end-of-life planning delivered in communities across the region.
- Strived to give the best possible in-home care to patients with serious, life-limiting illnesses, by creating a direct link between home care teams and primary care providers through our **Palliative Nurse Practitioners**.
- Worked with Holland-Bloorview, Ontario March of Dimes, and Reena to **support young adults with complex care needs** to transition from an institutional environment to a congregate care setting in the community.
- Found new ways of reaching out to patients and families to help them understand the care and services they need, for example, through the creation of seven **patient care videos hosted on YouTube**. Topics range from child and family services to end-of-life care and community clinics.

"Working together, we've improved how people access adult day programs and assisted living. The benefit for patients is **timely access** to the right services."

– Christina Bisanz,
Chief Executive Officer, CHATS

Engaged and Innovative People

Enabling staff to succeed in delivering outstanding care

Key accomplishments 2013-2014

- Held **321 in-person and online development sessions**, focused on improving our ability to operate efficiently and deliver quality care and value for money including:
  - Training for Central CCAC's leadership team to adopt **experience-based co-design**, an approach to planning and improving care and services that seeks input directly from patients and caregivers.
  - Launched the **first of its kind Capacity Knowledge Foundation Test** on Ontario's Consent and Capacity legislation to protect the rights of our patients.
  - **Protected patient privacy** by training our employees on privacy and freedom of information legislation and policies.
- Strengthened our ability to continuously improve patient care by adopting a **standardized, national care coordination competency framework** to give our care coordinators the skills they need to meet the needs of patients now and in the future.
- Helped employees focus on patient care, by adopting **new technology and processes** that make us a more efficient organization.
- Connected with the public, community leaders and health care partners in our diverse communities at **over 150 events and presentations** to provide information about Central CCAC care and services, including sessions conducted in Cantonese, Russian and other languages.

"I provide front-line care and counselling so it is important to keep updated on best practices and resources to benefit patients. Central CCAC supports me with opportunities for professional growth that enable me to provide excellent care."

– Carrie Haupt,
Central CCAC care connector,
Health Care Connect (which helps people find a primary care provider)

Organizational Sustainability

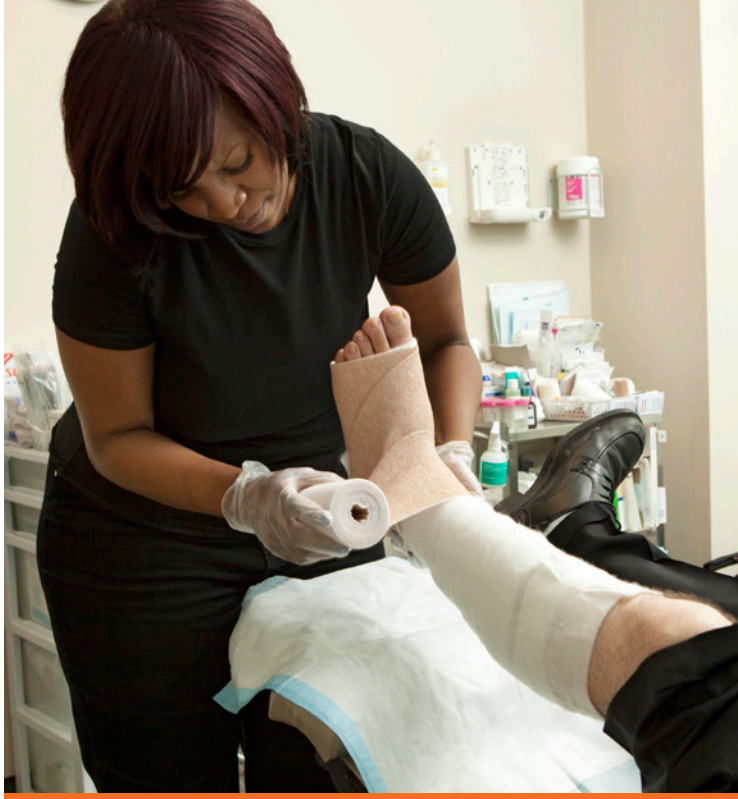
Delivering value for money throughout the organization with a focus on new and innovative patient-centred care models

Key accomplishments 2013-2014

- Met the requirement of a **balanced budget**, while managing pressures relating to our region's rapid population growth and increased complexity of care needs.
- Opened a seventh community nursing clinic to provide patients with quality, specialized nursing care close to where they live and work. Last year **5,081 patients received care through 67,391 cost-effective clinic visits.**
- Contributed to **improved patient outcomes** through our ongoing testing of an outcome-based approach for wound care, slated to be adopted by CCACs across the province.
- Consistently **maintained a low 8% administrative rate** including reduced costs for telecommunications and translation, and through the introduction of new electronic ordering of medical equipment and supplies.
- Made it easier to effectively manage our resources, which is essential to providing care when and where people need it most, through a **new financial reporting tool** that automates and streamlines the reporting, forecasting, and budgeting processes.

Meeting our financial and performance obligations

Audited financial statements for 2013-2014 and a report on Central CCAC's Multi-Sector Accountability Agreement (M-SAA) 2013-2014, which details our performance obligations, are available at healthcareathome.ca/central



"I appreciate having this option for getting care closer to my home and business. My clinic visits are quick. They're easy. And I get the excellent care I need."

– Edgar Pint, clinic patient

Central CCAC care and services

Central CCAC's priorities are guided by the changing face of our diverse communities and increasingly complex needs of our patients

Key population facts 2013-2014

- **1.8 million people live in the highly diverse communities** of South Simcoe, York Region, North York and areas of northern Toronto.
- **The number of people in Central region over 65 years of age is increasing** at a faster rate than elsewhere in Ontario and will make up 16.1% of our region's population by 2021.
- Our region's **population is projected to increase 20.3%** between 2011 and 2021.
- **The Central region is one of the province's most diverse**, with immigrants accounting for 48 percent of the population, compared to the provincial average of 28.3%.

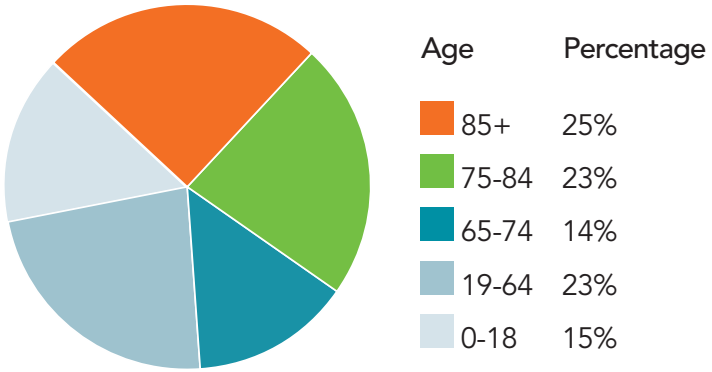
About our patients

- The complexity of Central CCAC patients is rapidly increasing. **71% of our patients now have very high or high needs**, up from 56% just four years ago.
- **51% of our patients now come directly from hospitals.** In 2013-2014 this was a total of 37,471 patients, 5.9% more compared to the previous year.

Our typical patient may be:

- Recovering from surgery or illness
- Returning home from hospital or rehabilitation
- Suffering from a chronic or terminal condition
- A senior who can no longer live safely at home
- A child with special health needs
- Someone looking for information about health or community care options

Breakdown of patients by age



What the numbers mean

CCACs are required to balance their budget every fiscal year. At the same time, there is an increasing number of patients requesting our services, and more patients living in the community with very complex clinical needs, who require additional services.

Central CCAC continues to respond to these changes by finding new ways to deliver care and to focus our quality patient-centred care and services to those with the greatest need.

Last year, Central CCAC added a seventh community nursing clinic; providing care to thousands of people close to where they live and work. The benefit to patients is high quality, specialized nursing at convenient appointment times; the benefit to hospitals is fewer emergency department visits; the benefit to the health system is a cost effective alternative to traditional in-home care.

Changes in the way physiotherapy services are delivered in Ontario resulted in an increase in patients receiving in-home physiotherapy from the CCAC. We also helped patients access group physiotherapy and exercise and falls prevention programs led by community support organizations.

As care continues to shift from hospital to the community, Central CCAC continues to provide increased overall service volumes.

In-home and community services

	2013-2014		2012-2013		2011-2012	
	Patients	**Visits**	Patients	Visits	Patients	Visits
Nursing	**21,221**	**642,027**	20,964	599,756	21,079	567,293
Nursing Shift, incl. hospice	**393**	**287,735**[1]	321	252,306[1]	364	238,928[1]
Nursing, in community clinics	**5,081**	**67,391**[2]	4,307	69,241[2]	3,192	64,520[2]
Personal Support, incl. hospice	**20,520**	**2,999,082**[1]	19,045	2,904,507[1]	19,498	2,682,071[1]
Occupational Therapy	**14,993**	**49,195**	14,026	47,629	14,304	53,886
Physiotherapy	**12,269**	**91,829**	8,227	40,039	7,903	40,025
Speech Therapy	**7,922**	**51,940**	7,104	40,826	6,711	45,761
Social Work	**409**	**1,453**	640	2,348	1,188	4,289
Nutritional Counselling	**1,430**	**4,642**	1,149	3,867	1,340	4,454

All above numbers include in-home, in-school and hospice activity.
[1] Nursing Shift and Personal Support services reported in hours [2] Includes nursing provided to people in supportive housing

Leading Practices

Central CCAC's leading practices are innovative, evidence-based services designed to meet the changing needs of patients, many of whom are living in the community with complex medical conditions.

Home First provides, for a limited time, the level of services and intense care coordination necessary for patients to return home safely from hospital, to continue healing and make decisions about their care.

2013-2014 results

1,343 patients received care and services through Home First

72% of patients remained well enough to stay at home after Home First

98% of patients surveyed would recommend Home First†

Medication Management Support Services is an award-winning service that provides in-home education and support for people with complex, chronic conditions to ensure their medications are working well for them.

2013-2014 results

1,153 patients received Medication Management Support Services

58% of patients reported a decrease in emergency department visits*

60% of patients reported a decrease in falls*

34% of patients reported a decrease in pain*

99% of patients rated MMSS as good or excellent*

† 195 patients surveyed * 260 patients surveyed

OUTSTANDING CARE - **EVERY PERSON, EVERY DAY**

Central CCAC sites

Newmarket
1100 Gorham Street, Unit 1
Newmarket, ON L3Y 8Y8

Richmond Hill
9050 Yonge Street, Suite 400
Richmond Hill, ON L4C 9S6

Sheppard
45 Sheppard Avenue East, Suite 700
North York, ON M2N 5W9

Toll-free
1 888 470 2222
TTY 416 222 0876
310-2222

Central CCAC staff work onsite in all publicly funded Central region hospitals to help patients safely transition from hospital to in-home and community care

Additional information

GREATER TORONTO'S TOP 2014 EMPLOYERS

For job opportunities, visit
ccacjobs.ca

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ACCREDITED • AGRÉÉ

To inquire about CCAC services, please call us at
1 888 470 2222

Health partners in our region include six hospitals, 46 long-term care homes, 33 service providers and numerous community agencies

Funded by:
Ontario
Central Local Health Integration Network

Stay connected with us

Healthcareathome.ca/central

View our patient care videos to learn more about how Central CCAC can help

For more information about health and community services visit
CentralHealthline.ca

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