YOUR HOME AND COMMUNITY CARE PARTNER

Central Community Care Access Centre
2014-2015 Annual Report to the Community
Outstanding care – every person, every day

Through the eyes of our patients and families

Each day, Central CCAC’s caring and dedicated employees work hard to achieve our vision of Outstanding care – every person, every day.

Through an independent third party, we conduct regular surveys to find out how well we are meeting the needs of our patients and their families, and how we can improve. The results are shared throughout the organization, including with the Board of Directors, and are vital in helping Central CCAC make changes to enhance our services. In 2014-2015, 91% of patients and caregivers surveyed said we were doing a good job.

“We central CCAC could not have done any more for us. The care was excellent and we were very satisfied with the services. We would highly recommend them to anyone.” — Patient and family survey feedback

We want to do even better

Continuous quality improvement

Central CCAC has a comprehensive, mandatory reporting system that is used by our employees and contracted service providers to track and monitor incidents, risks and complaints. We systematically analyze this information and thoroughly investigate issues, using what we learn to drive quality improvements in collaboration with everyone involved in the patient’s care. We also track compliments, giving us a better understanding of what we need to do more of in our day-to-day work.

Patient experience

A proven way to enhance care quality is to engage directly with patients and families and embed their voice into everything we do. We see patients and families as an integral part of the care team and work hard to listen and respond to their preferences and personal goals. Last year Central CCAC made progress on our multi-year strategy to increase patient and caregiver involvement in key decisions, for example through participation in focus groups and steering committees. We are also in the early stages of creating a Patient and Family Advisory Council to inform our planning and decision-making.

Building on what patients and families value

Our care coordinators are regulated health professionals with specialized training and expertise in helping patients and families understand their options and make good decisions about their health and services. Given the growing number of people with complex health and social needs requiring home and community care, care coordinators play a critical role in getting people the right care in the right setting – whether CCAC services, or supports offered by others in the health system. That’s why achieving best practice in care coordination and increasing the time patients and families spend with our care coordinators is a priority.

Acknowledging caregivers

In recognition of the essential role caregivers play in the health system, Central CCAC launched its Heroes in the Home Caregiver Recognition Awards. The awards are a chance to say ‘thank you’ to the family members, friends or volunteers, and health professionals who make it possible for people to stay safe, healthier and able to manage living in their own home. We also introduced CaregiverExchange.ca, a province-wide networking and information website to support caregivers in the important work they do.
How Central CCAC helped in 2014-2015
Delivering care and services that meet our patients’ needs

In collaboration with our partners, Central CCAC delivered more care and services last year than ever before. Here’s a look at some of the ways we helped people in the communities we serve.

• Provided care and services to 82,587 patients, 6.1% more than in the previous year
• Supported 36,437 patients on any given day
• Safely transitioned 39,283 patients home directly from hospital, 5% more than in the previous year
• Supported 10,494 children to attend school, an increase of 23.7% compared to the previous year
• Enabled 1,465 patients to go home from the hospital on our Home First program, instead of into long-term care, 9.1% more than in the previous year
• Helped 249 patients become active partners in managing their chronic illness, through our innovative new Telehomecare program
• Delivered quality, specialized nursing care to 6,529 people through our community clinics, 28.5% more compared to the previous year
• Provided 3,428,549 hours of personal support to help frail seniors and others with complex health issues manage their personal care, an increase of 14.3% from the previous year
• Helped 3,860 people make the transition into long-term care, 13.5% more compared to the previous year
• Provided 652,263 at-school and in-home nursing visits, 1.6% more than in the previous year
• Delivered physiotherapy to 14,102 people of all ages, an increase of 16.2% compared to the previous year
• Provided short-term, intense, at-home support for 1,711 seniors and children with complicated health issues, through our Rapid Response Nurses
• Helped 783 youth in schools through our Mental Health and Addictions Nurses, 66.2% more than in the previous year

Better workplace means better patient care

In 2014-2015, Central CCAC was named a Greater Toronto Top Employer for the fifth consecutive year. We were also awarded a Gold level Quality Healthcare Workplace Award for the fourth year in a row. The recognition is the result of our efforts to collaborate with staff to create an effective workplace that supports them to deliver quality, person-focused care.
A message from the Board Chair and the CEO

In 2014–2015 Central CCAC focused on patients, partnerships and increasing access to quality care

Every day the Central CCAC provides care to 36,437 patients, and every year that number grows. In 2014–2015 the total number of patients served by the Central CCAC was 82,587, an increase of 6.1% compared to the year before.

The increase is a reflection of the region’s rapidly growing and aging population and the increased number of people living in the community with complex medical issues.

Central CCAC’s 2014-2015 Annual Report to the Community gives an overview of the services and programs we offer – such as our community clinics, child and family services and Home First service for high needs patients – that help people avoid the hospital and live healthier and more independent lives at home and in the community.

Many pages in this Report contain links to online videos that tell our patients’ stories. Click on the video screen icon throughout the document to learn more about the care and service options available to patients and caregivers.

Working with our care partners – including hospitals, long-term care homes, contracted service providers and community agencies – last year Central CCAC identified two Wildly Important Goals that align with our Strategic Plan priorities. These Goals, to increase access to personal support for high needs patients, and to achieve best practice in care coordination, are key to providing high quality, person-focused care.

We worked hard to manage our resources effectively and to make sure every dollar we spent added value for patients and the health system. We achieved a balanced budget, lowered administrative expenses and reallocated the savings to patient services. We met 96% of the service volume targets in our funding agreement. We also reduced the number of people with high needs waiting for personal support from a high of 755 to 92 people as of March 31, 2015.

To be a more effective partner in supporting patients and families as they move through the health system, last year Central CCAC initiated new innovative partnerships, increased our use of technology to improve care, and launched an annual survey of our care partners to learn how we can do better.

We thank our patients and families, the Central Local Health Integration Network (LHIN), and our care partners for collaborating with Central CCAC to improve the patient experience and deliver integrated care, which is better for patients and better for the health system.

Nevzat Gurmen, Board Chair
Jo-anne Marr, Chief Executive Officer

Board of Directors
The following individuals served on the Board of Directors during the 2014-2015 fiscal year

Joyce Bailey
Katherine Berg
Eugene Cawthray
Julie Corden
Mike Dibden
Noam Goodman
Nevzat Gurmen (Chair)
David Y.Y. Lai
Teddene Long
Al Luciani
Joe Parker (Vice Chair)
Charles Schade
Jo-anne Marr (Secretary)

Full biographies of our Board members are available at healthcareathome.ca/central
Better Access, Quality Care

Action on our Strategic Plan goals

Guided by our vision of Outstanding care – every person, every day, Central CCAC’s 2014-2017 Strategic Plan aims to:

- Enhance quality care and the service experience
- Build capacity to improve access and manage growth
- Integrate patient care with system partners

Last year, we reached out to patients, caregivers, partners, providers and others to talk about how to work together to better serve patients. What we heard was a shared determination to move ahead in a way that puts patients first and collaborate in ways that serve patients more effectively and improve access to care.

In the first year of our Strategic Plan we introduced Wildly Important Goals. This is a new approach to help us deliver on our commitment to provide high-quality, person-focused care to more people.

The first Goal is to improve timely access to personal support by eliminating the wait list for high need patients. The second aims to achieve best practice in our core business of care coordination, which helps people access the services they need throughout the health system.

Both Goals were validated with input from many stakeholders, and we are embedding corresponding actions and targets into our ongoing operations, planning and quality improvement activities.

Learn more: Central CCAC’s Strategic Plan Executive Summary is available in English, French, Chinese, Italian, Punjabi, Russian and Ukrainian.

Committed to quality improvement

Central CCAC’s annual Quality Improvement Plan (QIP) is part of our ongoing accountability to our patients, caregivers, community and funders to provide the highest quality care in a fiscally responsible manner. The measures, common to all CCACs are to reduce falls, unplanned emergency department visits, hospital admissions and service wait times for nursing and personal support, and improve the patient experience. Central CCAC’s targets reflect local priorities and are supported by our Goals. New for this year: 2014-2015 QIP Progress Report

CCAC sector quality report

The semi-annual web-based quality report How CCACs Care provides the most recent information on how Ontario’s 14 CCACs are progressing on their commitments to improve quality, the patient experience and patient safety in home care and community care.
Child and family services

Supporting children with medical and developmental needs to lead active lives

When Matthew was two weeks old, a seizure and bleeding caused significant damage in his brain. He spent the next eight months in hospital before Central CCAC services made it possible for him to return home with his family.

Central CCAC has provided Matthew with intense nursing care and other health services, plus personal support, at home and at school. Throughout his entire life, a CCAC care coordinator has worked with Matthew’s family, coordinating his care and adjusting the care plan as his needs and health status have changed.

Matthew is now fifteen years old and, while his care needs are still very high, he enjoys an active life in his community and at home with his family.

According to his mother, Rose, Central CCAC services have enabled Matthew to live at home with his family. “If I had to do it on my own, I wouldn’t have been able to manage,” she says. “I truly believe that without the CCAC, Matthew would not be here with me at home.”

Integrating care for children and youth with special needs

Central CCAC is a key partner at the newly-formed regional planning tables in Toronto, Simcoe County and York Region, to improve care for children and youth through the Ontario’s Special Needs Strategy. Our initial focus is on coordinated, family-centred service planning and integrated rehabilitation service delivery. This will support more timely access and effective services that enable children and youth with special needs to participate fully at home, at school and in the community.

Key facts

• 10,494 children attended school with the support of Central CCAC care and services last year

• We also provided 2,223 children and their families with services to help them live more independently at home
Community clinics

An important home and community care option

After Judy Breckles had surgery for a second time, her new care plan included visits to a Central CCAC community clinic. She was delighted to receive the same level of excellent care at the clinics as she had received previously at home.

“The clinic team was wonderful,” says Judy. “They were just as caring, just as helpful and just as good as the home care team, if not better.”

Staffed by nurses with specialized training, Central CCAC’s seven clinics provide IV therapy, wound care, injections and post-surgical care. Visits are by referral and appointment, as part of the care plan, and for eligible patients are a great alternative to visiting the emergency department for treatments.

Central CCAC clinics help people feel less like “patients,” and speed up their recovery by keeping them more active as they heal. Their convenient locations offer care close to where patients live and work. And because clinics are cost-effective, they also make it possible for Central CCAC to provide more people with safe, high quality care.

Telehomecare

Using simple, home-based technology to manage chronic illness

As Central CCAC sees more patients with chronic health conditions living in the community, we are finding innovative ways to use technology to help them stay healthy. In April 2014, we launched a Telehomecare program for patients with congestive heart failure and chronic obstructive pulmonary disease.

Using electronic equipment located in the patients’ homes, Central CCAC nurses monitor patients’ health through the telephone and Internet. They also provide health coaching and work with patients and primary care providers to set healthy living goals, helping patients become active partners in managing their conditions.

Key facts

- Central CCAC has seven clinics located in communities across the region
- Last year a total of 6,529 patients received care through 93,051 visits to Central CCAC community clinics
- We served 28.5% more patients in our clinics last year, compared to the previous year, and the number of visits increased by 38.1%
Home First

Building a bridge between hospital and home for patients with high needs

When a double hip replacement left 70-year old Patricia frail and facing a move to a long-term care home, Central CCAC provided her with the care and services she needed to achieve her goal of returning home and managing on her own.

Patricia’s health goals were met through Central CCAC’s Home First, an Accreditation Canada-designated Leading Practice that provides 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 future needs.

An occupational therapist helped Patricia make the physical changes in her house that enabled her to get around in a wheelchair. Physiotherapy assisted her to recover strength and mobility, while personal support gave her the help she needed during her recuperation at home.

Patricia got stronger, and with the ongoing support of Central CCAC, was able to gear up for knee replacement surgery. “In the hospital I made it very clear I wanted to be independent,” says Patricia. “Once Central CCAC was called, there began the transition from what might have been long-term care and being bedridden for the rest of my life, to being an independent person.”

Key facts

• 73 percent of our patients have very high or high needs, compared to 56 percent just five years ago
• Central CCAC has more patients with complex needs than any other CCAC in Ontario
• Last year Central CCAC enabled 1,465 patients to go home from the hospital on our Home First program, instead of into long-term care
Health Links

A collaborative approach to integrated care

Imagine having diabetes, chronic renal failure, back pain, hypertension and a wound on your foot that just won’t heal. To manage your conditions you see numerous specialists and take dozens of medications. And, all too often you end up at the local emergency department. That was life for Janelle, a woman with a complex medical history, struggling to live a good quality of life at home in the community with her spouse.

Now, thanks to a new approach to integrating care for patients with complex care needs called Health Links, Janelle has a coordinated care plan that meets her needs and focuses her care team on the health goals she set for herself.

“My Central CCAC care coordinator listened to me. She connected me with a diabetes centre, and now I’ve lost weight and my blood sugar levels are the best they have ever been. She arranged for a pharmacist to help reduce the medications I take, and a physiotherapist to increase my mobility. We are working closely with my family doctor. It saved my life.”

Key facts

- Central CCAC is a key partner in the Health Links in our region
- Health Links aim to help people managing complex health and social issues, who often visit the emergency department, or are frequently admitted to hospital, when they could be receiving care in the community
- In the early phase of Health Links, the Central CCAC collaborated with Dr. David Kaplan, the Central LHIN Primary Care Lead, to develop an initial Coordinated Care Plan, which informed and supported further work at the provincial level
Palliative care

Enriching quality of life for patients and families

When spirited 99-year old Charlotte Sasto was hospitalized with acute pneumonia, she was left weak and near death. Although gravely ill, once her condition stabilized, she was discharged back to her retirement residence.

While Charlotte wanted to remain in the comfort and familiarity of her home for the time she had left, her family struggled to cope, unsure of the best way to make that possible. “I asked my mom, do you want to stay here,” says daughter Eileen. “She said, ‘this is my home.’

To meet Charlotte’s needs, the family worked with a team that included a Central CCAC nurse practitioner, a personal support worker and a visiting nurse. This improved her quality of life.

And with professional guidance available to them, the family felt more confident in their ability to care for their mother and honour her wishes at the end of her life.

Although, sadly, Charlotte passed away shortly before her 100th birthday, her family is appreciative of the support they received from Central CCAC. “I can’t thank the palliative care team enough,” says Eileen. “They really helped us.”

Improving access to palliative resources

With our community partners and the support of the Central LHIN, Central CCAC is leading the implementation of a central point of access for hospice palliative care services and placement in the region. Our work includes creation of bed, patient and resource registries. Last year we also launched a palliative care minisite on Centralhealthline.ca, with dedicated areas for patients, families, health professionals and primary care providers, and links to caregiver guides, assessment tools and pain management guidelines.

There for patients and families when it really matters

“The [Central] CCAC not only gave us whatever time and help we needed, but insisted everything be in place before my mother came home… They were the kindest, gentlest people.”

Bringing mom home to die was both scary and rewarding, Toronto Star, May 29, 2014

Key facts

- Last year Central CCAC helped 2,361 palliative patients and their families
- Central CCAC is committed to supporting palliative patients to die in their place of choice
Long-term care

Making a difficult life transition a little bit easier

The decision to move to a long-term care home can be difficult. Central CCAC works with patients and families to understand the available options and to ease the transition. Wherever possible, we arrange the care and support needed for people to stay in their own home, such as adult day programs that offer stimulation, recreation and caregiver respite.

Once it becomes necessary to consider alternative living arrangements, Central CCAC provides information and streamlines the process to access assisted living, supportive housing or retirement homes.

When a long-term care home is the best option, Central CCAC offers useful resources such as our Guide to the long-term care application process, information on substitute-decision making and long-term care home virtual tours.

Our staff guide patients and families through the application process, helping them to complete the necessary forms, choose their preferred long-term care homes, and prepare for the transition into their new home.

Helping people plan for their future care needs

In partnership with local hospitals, community support agencies and others, Central CCAC hosted free education sessions last year on topics including advance care planning, care and services available in the community, and the long-term care placement process.

Sessions were held in communities around the region, and were attended by patients, caregivers, health care providers and members of the public. Central CCAC is planning a new educational series for fall 2015, based on feedback from participants about the health care topics that would be most relevant and useful to them.

More information will be available at healthcareathome.ca/central

Key facts

- Last year Central CCAC helped 3,860 people find a new home in long-term care, when they could no longer manage their health and personal needs independently at home
- We also placed 486 people in short stay convalescent care to help them recuperate so they could safely return home
When you hear CCAC, you may think of the many health services we provide. But Central CCAC also has a key role in assisting people of all ages who need that extra bit of support to stay healthier or remain living independently in their own home.

Central CCAC works collaboratively with the numerous community agencies in our area, to help people access a range of community-based wellness, social and recreational supports.

Our staff also assist people in learning more about the supports available to them in the community, and can develop a list of personalized options to address each person’s health issues, challenges in maintaining their home, and social or active lifestyle goals. This could include:

- Chronic illness education programs
- Social and recreational programs
- Transportation
- Grocery, meal or pharmacy delivery
- Housekeeping and home maintenance services

Central CCAC’s caring and professional staff are available 365 days a year, to help people and their families connect to care and services in the community.

Information and referral

Collaborating to connect people of all ages with the extra support they need

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Key facts

- Central CCAC managed 261,220 calls last year – including on evenings and weekends – from patients, caregivers and others wanting to learn about our care and services
- Since it was launched in 2009, Central CCAC has helped 19,110 patients find a primary care provider through the Health Care Connect program, 4,799 in one year alone
Community programs and supported living

Making it easier to access these important services

For many people, living independently as they age is only possible by accessing services that contribute to their overall health and well-being. Working with our partners, Central CCAC helps people explore and access a variety of health services, community programs and supported living options that may be available to them in the community.

For example, Central CCAC is the single point of access for all publicly funded in-home physiotherapy in our region. We also provide assessment and determine eligibility for exercise and falls prevention classes, which improves people’s access to these important services.

Our care coordinators assess high-risk seniors, determining eligibility for assisted living programs, which offer personal support in residential settings and empower people to be more self-sufficient with the safety and security of services on an as-needed basis.

A focus of community supports is often to promote mental and social health by socializing with friends, getting out into the community and enjoying new activities. Adult day programs, which improve quality of life for patients and support caregivers, are another important service that patients and families access through Central CCAC.

Key facts

- There are over 110 adult day programs offered by community agencies in the Central LHIN
- Last year Central CCAC helped 2,101 people access adult day programs in our region, an increase of 26.9%. We also completed 1,735 assisted living/supportive housing referrals
- Central CCAC delivered physiotherapy to 14,102 people last year to help improve their mobility, prevent falls and avoid hospitalization, an increase of 16.2% compared to the previous year
Partnering for integrated care

Every year more people with complex, chronic illnesses are being cared for at home and in community settings other than hospitals and long-term care homes. To meet their needs with the most care options possible, Central CCAC is finding new ways to work together with our many partners. Here are a few examples.

Supportive Care Clinic

With funding from the North York General Hospital Foundation, Central CCAC is collaborating with Dr. Warren Lewin, a palliative care physician and researcher at the Hospital, to develop a supportive care clinic for end stage congestive heart failure patients. Central CCAC is providing nurse practitioner support for patients at home and participating in new models of collaborative care, including weekly rounds and patient conferences with partners such as the Temmy Latner Centre for Palliative Care and family physicians.

Assess and Restore

Central CCAC is leading the expansion of Assess and Restore (A&R) programs in the Central region for the frail elderly and those at high risk of hospitalization or long-term care placement. The goal of A&R is to improve, maintain or delay decline in functional ability. Sharing overall project management with North York General, the two organizations will build on the Health Links model of integrated, collaborative care, and work together on program planning, implementation, evaluation and knowledge exchange across the Central LHIN.

Educating future doctors

Through an ongoing partnership with the University of Toronto, 24 first-year medical students joined Central CCAC’s care coordinators on patient home visits, with the aim of exposing these future doctors to the care and social needs of people managing health issues at home. The students have called the visits “eye-opening,” and said a new perspective was gained on community health care outside an acute care setting.

Central CCAC’s care partners

- 33 Community support service agencies
- 2 Community health centres
- 1500 Primary care providers
- 6 Public hospitals
- 2 Private hospitals
- 46 Long-term care homes
- 21 Mental health & addiction agencies
- 7 School boards
- 33 Contracted service providers
Fiscal Stewardship

Meeting our financial and performance obligations

Making the best possible use of our resources so we can deliver care to more people is a priority for Central CCAC. Our commitment is to direct the maximum amount of our budget to patient care. We strive to be a more efficient and sustainable organization, for example by introducing cost-effective ways to deliver care such as telemedicine and our community nursing clinics. This helps us to meet the growing need for CCAC services, support our care partners, and build capacity in the home and community care sector.

In 2014-2015 Central CCAC introduced a balanced scorecard and monthly monitoring of progress on our goals. This makes us a more transparent and accountable organization. It also supports us to identify early on in the year, any areas we may need to address to optimize quality services and balance the budget, as per the requirements of our funding agreement – or Multi-Sector Service Accountability Agreement (M-SAA).

As of March 31, 2015, Central CCAC met 96% of the service volume targets in our funding agreement. We also achieved a balanced budget.

With an emphasis on greater operational discipline and rigour, in 2014-2015 Central CCAC reduced our administrative spending rate to 7.5% from the previous year’s rate of 8.0%. As a result, we were able to successfully reallocate the savings to patient care, including increasing access to personal support for patients with high needs.

Access to timely care is important to patients and caregivers, and is a measure of the quality of care a person receives. Last year the Ministry of Health and Long-Term Care introduced a five-day wait time measure for home nursing visits and personal support visits for patients with complex care needs. Central CCAC exceeded the Ministry’s target in the first year.

Current information on Central CCAC wait times compared to provincial targets is available on the Health Quality Ontario website under Home Care Reporting. Audited financial statements for 2014-2015 and Central CCAC’s 2014-2015 M-SAA, which details our performance obligations, are available at healthcareathome.ca/central.
Our Mission
To deliver a seamless experience through the health system for people in our diverse communities, providing equitable access, individualized care coordination and quality health care.

Stay connected with us

healthcareathome.ca/central

Central healthline.ca

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

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

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

Central CCAC staff work on-site in all publicly funded Central region hospitals to safely transition patients from hospital to in-home and community care. Our care coordinators also make home visits to help over 85,000 patients and their families each year.

TOLL-FREE
1 888 470 2222
TTY 416 222 0876
310 2222 (no area code required)