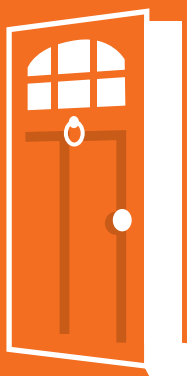


Home. Where we want to be.

HNHB CCAC
Annual Report to the Community 2012/2013

Hamilton Niagara Haldimand Brant
CCAC Community Care Access Centre
CASC Centre d'accès aux soins communautaires

Our Vision: Outstanding care – every person, every day.

Our Mission:

To deliver a seamless experience through the health system for people in our diverse communities, providing equitable access, individualized care coordination and quality health care.

About HNHB CCAC

The Hamilton Niagara Haldimand Brant Community Care Access Centre (HNHB CCAC) connects people in our region with the health and support services they need to:

- remain at home,
- avoid hospital admission,
- access support upon discharge from hospital and
- explore long-term care options.

Clinical care in your community

HNHB CCAC staff lead the delivery of home care services, in collaboration with our service providers and system partners. Care coordinators have clinical backgrounds. They are regulated health professionals who have expertise in nursing, social work, occupational therapy, physiotherapy or speech therapy. They also have additional training in case management and pride themselves on their professionalism, caring and compassion.

HNHB CCAC staff know the communities they serve to help people connect to the right health care, at the right time, in the right place.

Message from the Board Chair and CEO

Carole Ward Chair

Melody Miles CEO

The Hamilton Niagara Haldimand Brant Community Care Access Centre (HNHB CCAC) is pleased to provide this Annual Report to the Community highlighting our commitment to patient care. We hope that the presentation will help to illustrate the care needs our patients have and the value we aim to bring to enhance the patient experience.

During the fiscal 2012/13 year, Ontario's Ministry of Health and Long-Term Care continued to emphasize the critical role home and community care plays in helping people to live independently at home for as long as possible. For HNHB CCAC, this is an opportunity to ensure that we, as regulated health care professionals, offer the best possible care to the 75,000 patients who relied on our services last year. That is why we are so pleased that third-party research found that 97.4% of patients and caregivers would recommend HNHB CCAC service to family and friends.

The region we serve is home to the largest seniors population in Ontario, and 60% of the patients we serve are 65 years of age and older. In 2012, Deb Matthews, Minister of Health and Long-Term Care said, "We've made the right choice to invest our precious health care dollars where they are most needed – in home and community care. This will allow more seniors to live independently at home, and reduce pressure on hospitals and long-term care homes."

In addition to an aging population, we are also working with patients with more complex needs than ever before. Typically, the greater the complexity of patient need, the greater the cost of caring for those patients. Last year, nearly 60% of HNHB CCAC's patient care service budget was spent on 10% of our patients. We believe dedicating resources to ensure we can meet the needs of the patients who need it most is simply the right thing to do.

The emphasis on the value of home and community care also means that we must understand our role within the context of the local health care system and strengthen relationships with our partners to benefit our patients. With HNHB CCAC staff in hospitals and doctors' offices every day, we are working hard to provide care to our patients and to support them on their journeys across the continuum of health care. Over the past two years, in conjunction with our hospital partners and service providers, we have been able to support more patients to return home from hospital, resulting in nearly 150 beds being available in hospitals for patient care each and every day.

Thank you for your interest in HNHB CCAC. As a part of our ongoing commitment to engage with our patients, partners and the public, we welcome your feedback about our work and about this report.

97.4%
of patients & caregivers would recommend HNHB CCAC services to family and friends

Sita and Ashok's Journey

Sita, 80, has advanced dementia, as well as diabetes and severe arthritis.

She needs 24-hour supervision and support for the activities of daily living. Thankfully, she has her husband **Ashok** by her side. It's not easy, but they want to live in their own home for as long as possible.

Ashok was connected with CCAC care upon discharge from hospital, after surgery. Later, as Sita's dementia advanced, Ashok realized he could no longer help her on his own.

Ashok called CCAC

Loretta, their CCAC care coordinator, supported their choice to delay long-term care for as long as possible and **provided ongoing leadership to coordinate her care.**

As Sita's condition advanced, Loretta **adjusted her customized care plan** to meet the family's needs every step of the way.

A **personal support worker, nurse** and **a dietitian**, as well as **caregiver respite** and **meals** from local support services, have all helped to extend Sita's time at home.

Home. Where Sita and Ashok want to be.

the stats

- HNHB CCAC's Health Care Connect staff linked **4,043** patients to primary care providers
- HNHB CCAC is using resources efficiently and supporting patient choice by increasing the use of nursing clinics by **18.9%**

"what people are saying...

Without the CCAC's help, my patient would have required an admission to hospital and would have decompensated significantly, likely requiring long-term care. I was so impressed with the amount of work that CCAC staff did to avert this hospital admission and was also impressed that this was all done based on one physician phone call.

Dr. Kollek, *Emergency Physician*

Jack's Journey

Jack, 77, just arrived home after a hospital stay for treatment of heart failure.

While in hospital, the care coordinator noticed that Jack seemed confused about his new medication regimen, which involved several different drugs. She also noted that Jack lives alone.

The care coordinator called CCAC to arrange a home visit from the Rapid Response Transitional Team, a service that manages the transition from hospital to home care for patients at high risk for readmission.

Within 24-hours of discharge Paula, a **registered nurse (RN),** visited Jack. She assessed his health and reviewed his medications with him.

Jack reported some shortness of breath and Paula discovered that a "water pill" (diuretic) prescription was not filled. **She called Jack's pharmacy** and arranged for the prescription to be delivered that afternoon.

Paula **phoned Jack's primary care physician** to confirm Jack's post-discharge plan. She also helped Jack make an appointment with him within the coming week, and informed the doctor about the shortness of breath and the missing medication.

Paula then thoroughly discussed the details of Jack's medications with him, and taught him the signs of worsening heart failure and when to seek medical help.

week 2

At Paula's Week 2 visit, she confirmed that Jack had been taking his medication properly and that his shortness of breath had gone away. She answered questions Jack had about when he needed to take a particular pill, and whether or not it can be crushed up and mixed with food.

week 3

At the final Week 3 visit, Jack agreed that he felt comfortable with his medications and that his heart failure symptoms had improved. He was happy not to have been readmitted to hospital for shortness of breath, and is looking forward to a visit from his grandchildren...at home.

Home. Where Jack wants to be.

the stats

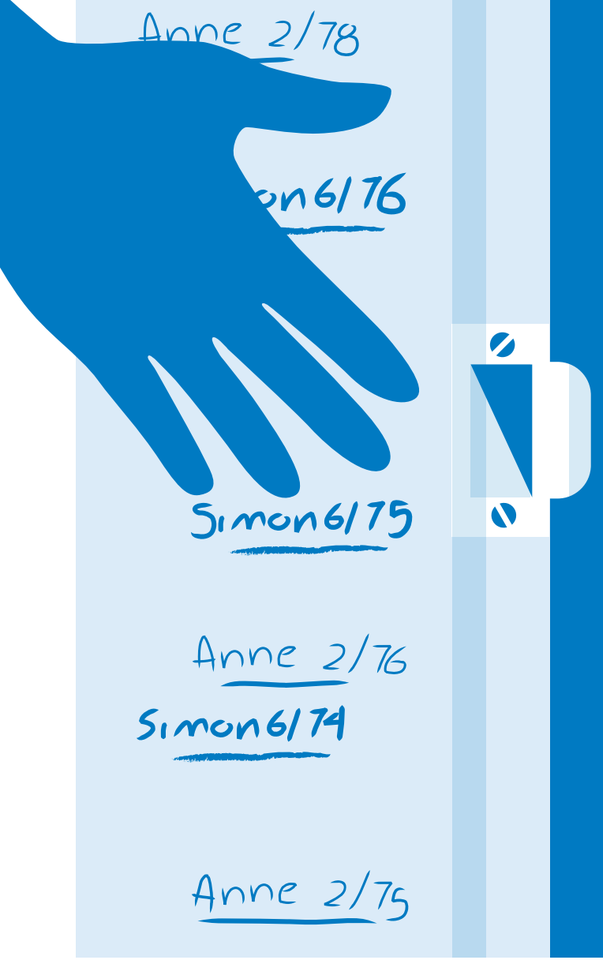
- HNHB CCAC has staff at **21 hospital sites**
- HNHB CCAC staff work directly with more than **250 doctors**

"what people are saying...

Having seen my father go in and out of hospitals over the years, I am grateful that the CCAC was there to help us. The Rapid Response Nurse helped my father transition home and the care coordinator helped him stay home where he wanted to be. They truly are people who do not view this just as a job.

Anthony Pinelli,
son of an HNHB CCAC patient

Diane's Journey



Diane was 69, and in the final stages of terminal brain cancer.

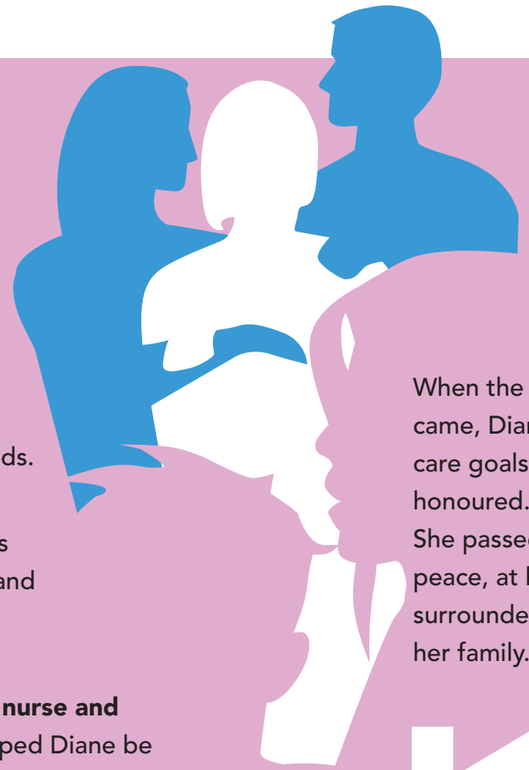
Her family wanted to honour her wish to spend her remaining time at home surrounded by her family.

They contacted CCAC to arrange for end-of-life support

Rose, a CCAC care coordinator, specializing in palliative care organized Diane's health care while her grown children attended to her day-to-day needs.

Rose provided Diane's family and friends with access to information, counselling and emotional support to help them cope.

Rose arranged for a **visiting nurse and palliative physician** who helped Diane be comfortable at home by keeping her pain and other symptoms well-managed.
She also arranged for **personal support workers** to help with Diane's care, which provided relief for family members and allowed them to enjoy quality time with Diane at home.



When the time came, Diane's health care goals were honoured.
She passed away in peace, at home, surrounded by her family.

Home. Where Diane wanted to be.

the stats

- HNHB CCAC staff work closely with **five hospices**
- Specialized staff cared for **3,082** end-of-life patients at home or in a hospice

"what people are saying...

I felt totally alone in my struggle to care for my mom properly. I frequently felt anxiety, wondering where to turn to for guidance and knowledge to help my mom as she was fading. Then CCAC arrived - a true angel sent from heaven...Everyone was totally committed, helpful, kind and gracious. Mom died very peacefully in her own home for which I was so grateful.

Lynne Heaman, *daughter of an HNHB CCAC patient*

Navigating by the Numbers

HNHB CCAC **fast facts**

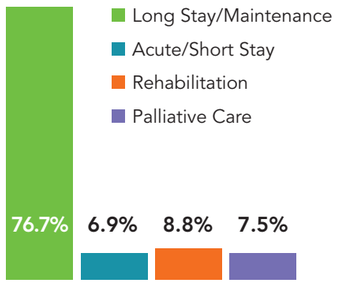
- Catchment population: 1.4 million people
- People receiving care: One out of every 18 people in the region
  : Half of all seniors aged 85+

HNHB CCAC **financial highlights**

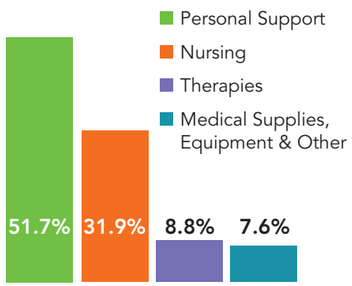
Patient Care Services	**$184,274,428**
Patient Care Medical Supplies & Equipment	**$15,045,336**
Salaries & Benefits	**$62,090,820**
Other Expenses & Amortization of Capital Assets	**$11,598,954**
Total Expenses	**$273,009,538**

Please visit **hnhb.ccac-ont.ca** for a detailed copy of the 2012/13 audited financial statement.

Expenditure by Type of Patient



Expenditure by Service Type



About HNHB CCAC **patients & programs**

HNHB CCAC's 707 full-time equivalent staff supported:

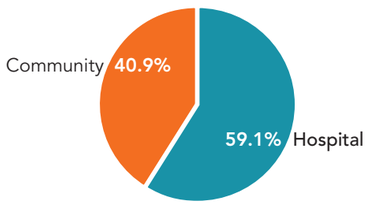
- 4,798,606 patient visits
- 3,180 patients to move to a long-term care home
- 7,300 children to receive school health support services
- 3,224 patients per month on average on a wound care path
- 976 high-needs patients per month

HNHB CCAC received 48,015 patient referrals from hospitals:

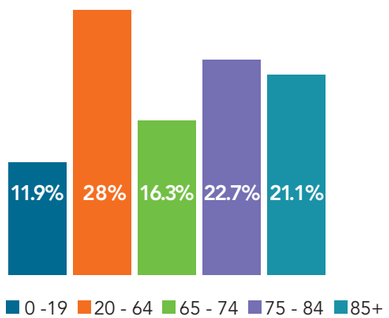
- Over 3,700 hospital admissions were avoided
- 26% fewer Alternate Level of Care bed days (over two years)

More than 77.9% of hospital patients in an assess/restore bed were discharged home, helping 914 people return home rather than moving to a long-term care home.

Admission Source



Patients by Age Grouping



Board of Directors

The HNHB CCAC Board of Directors is a volunteer board, which provides governance and strategic direction to the organization. Board meetings are open to the public.

To learn more about our board members, meeting dates and times please visit **hnhb.ccac-ont.ca**

BOARD OF DIRECTORS

Bernice (Bunny) Alexander (Vice Chair)
Dr. Valerie Bayley (partial year)
Barry Brownlow
Sheila Hosking
Jerry Lawlor
Len Lifchus
Bruce McIntosh
George Nakamura
Gary Ostofi
Dave Ringler
Carole Ward (Chair)
Cindy Ward

Partnerships

are at the heart of what it takes to help people live at home, where they want to be. HNHB CCAC thanks all of our partners including staff, service providers, hospitals, primary care providers and community agencies, as well as the leadership provided by the HNHB LHIN and the Ministry of Health and Long-Term Care. The most important relationships we have, of course, are with our patients and their caregivers – the family members, friends, neighbours and volunteers who provide exemplary care to help people live at home. **Thank you.**

HNHB CCAC is proud to recognize people in our communities as **"Heroes in the Home,"** unpaid caregivers, whose kindness and commitment allows our patients and others to live full lives in their communities, despite the limitations of age, illness, or disability.

Since the inception of the program more than 600 nominees have been honoured at special ceremonies across our region. To learn more about Heroes in the Home and to nominate someone you know, please visit **celebratecaregivers.ca**

Contact Us

Call the HNHB CCAC toll free: 1-800-810-0000
or contact the office in your area.

Area	Phone	Address
Brant	519-759-7752	195 Henry Street, Unit 4, Bldg 4, Brantford ON N3S 5C9
Burlington	905-639-5228	440 Elizabeth Street, 4th floor, Burlington ON L7R 2M1
Haldimand-Norfolk	519-426-7400	76 Victoria Street, Simcoe ON N3Y 1L5
Hamilton	905-523-8600	310 Limeridge Road West, Hamilton ON L9C 2V2
Niagara	905-684-9441	149 Hartzel Road, St. Catharines ON L2P 1N6

For more information please visit our website: **hnhb.ccac-ont.ca**

Susan and Eric's Journey

Susan and Eric have been married for 51 years.

For a while now Eric has been mixing-up words. Lately his moods have been more unpredictable than ever before. Susan was afraid to leave him alone and wanted some help to care for him at home.

She called CCAC.

We helped Susan and Eric connect with a doctor and access supports in their neighbourhood. Now Susan and Eric are both getting the health care and services they need.

Hamilton Niagara Haldimand Brant
CCAC CASC
Community Care Access Centre
Centre d'accès aux soins communautaires

Funding support provided by:
Ontario
Hamilton Niagara Haldimand Brant Local Health Integration Network
Réseau local d'intégration des services de santé de Hamilton Niagara Haldimand Brant

BPSO RNAO BEST PRACTICE SPOTLIGHT ORGANIZATION CANADA
ORGANISME VEDETTE EN PRATIQUES EXEMPLAIRES

ACCREDITATION CANADA
AGRÉMENT CANADA
Driving Quality Health Services
Force motrice de la qualité des services de santé