



Making a Positive Difference: One Patient at a Time

HNHB CCAC Annual Report to the Community 2014–2015



Hamilton Niagara Haldimand Brant
ccac casc
Community
Care Access
Centre
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.

Our Values

Accountability • Excellence
Care • Fairness
Collaboration • Innovation



Message from the CEO: Melody Miles

I am most fortunate to lead a team focused on delivering safe, high quality patient-centred home and community care. Faced with the changing realities of our health system, we remain committed to building even better supports and services, creating an environment where people can anticipate exceptional patient experience.

We're moving rapidly toward transformational change in home care. To achieve success, we're working collaboratively with our patients and each of our health system partners including the LHIN, primary care providers, community support services, hospitals, service provider agencies, long-term care homes, hospices and schools. We have the ability to establish a value system and common vision collectively, while setting strategic goals and aligning efforts to achieve success.

Serving within a changing sector, our aim is to appeal to our patients, engaging them to share input and ideas about their health care needs. We are working with our partners to keep improving our model of care delivery.

Inspired to make home and community care work better for our patients and their families, we're open to embracing new ideas, adopting innovative solutions and fostering greater collaboration with our partners. With positive patient experience and health outcomes as our top priorities, we hope to create greater awareness of new initiatives undertaken by HNHB CCAC.

We're doing everything possible to provide maximum value and working to ensure greater transparency and accountability for our patients and caregivers in everything we do.

Our greatest strength toward achieving success is in our people; dedicated health professionals, front line staff and leaders committed to making a positive difference in the lives of the people we serve through continuous improvement of patient care.

We're already encouraging open dialogue and collaborative partnerships with our patients, partners and the community to bring forward innovations and solutions. Together, we will make home and community care work better than ever before.





Message from the Board Chair: **Barry Brownlow**

The provision of health care continues to evolve in Ontario. There is now greater importance on the delivery of home and community care to respond to the growing care needs and preferences of our patients.

During my two years serving as Board Chair, HNHB CCAC has provided care for even more people – an increase of over 7,600 patients – for a total of 82,686 patients receiving care and services this year. In addition, we continue to enhance programs and services that provide care for a growing number of patients with high care needs.

HNHB CCAC's Board of Directors remains committed to optimizing resources, facilitating research and building partnerships to deliver seamless, patient-centred, evidence-based care while providing greater value for our stakeholders.

It has been my honour and privilege to provide leadership as a volunteer to the HNHB CCAC Board of Directors. I extend sincere thanks and appreciation to my Board colleagues for giving so generously of their time and expertise as we continue to deliver exceptional patient care and value for the system.



Carole Ward

Jerry Lawlor

Deidre (Dee) Henne, Treasurer

Melody Miles, CEO

Bruce McIntosh

Sharon McDonald

Barry Brownlow, Chair

Janine Van Den Heuvel, Vice-Chair

Absent from photo:

Paul Armstrong

Sheila Hosking

HNHB CCAC in 2014-2015

Health Links

Provided ongoing leadership for two health links and participated in nine others throughout HNHB.

Speech Clinics for Children

Launched new speech therapy clinic in Burlington to provide children with more access.



CSS-CCAC Collaborative

Worked together with community agencies to expand personal support care in the community.

Advancing Best Practices

Completed RNAO Advanced Clinical Fellowship: Multi-Branch Implementation of RNAO Assessment and Management of Pain Best Practice Guideline.

Patient Experience

Led research on patient experience and engagement priorities as defined by people receiving CCAC service.

Recognizing Caregivers



Honoured more than 150 unpaid caregivers throughout HNHB for Heroes in the Home awards program.

Rural Stroke Rehabilitation Model

To improve stroke care, partnered with Brant Community Healthcare System, Norfolk General Hospital, West Haldimand General Hospital and HNHB LHIN. Provided rapid access to intensive community-based stroke rehab resulting in significant functional improvement for patients leaving hospital.

HNHB CCAC in 2014-2015

Health Sector Leader

Received Bronze level Quality Healthcare Workplace Award from Ontario Hospital Association/Ministry of Health and Long-Term Care.

Promoting Patient Safety

Increased patient safety awareness through Patient Safety Dialogues promoting medication reconciliation, prevention of Ebola and patient safety.

Research: Informing Practice & Partnerships

Participated in two INSPIRED programs, featuring best practices to improve care for people living with Chronic Obstructive Pulmonary Disease (COPD) and supporting caregivers.



HNHB Staff Contributions to our Community

Staff fundraising efforts resulted in more than \$15,000 contributed to United Way charities.

Partnering for Change – P4C

Launched best practices care delivery model in schools focused on children with developmental coordination disorder (DCD) and similar conditions to improve students' ability to participate successfully in school.

HNHB CCAC Total Well-Being Committees

Through TWC efforts, staff contributed approximately \$10,900 to various charities including Canadian Diabetes Association, The Cure Foundation, Alzheimer's Society & ALS Society of Canada.

Working Together to Improve Patient Experience: DIVERT Initiative

As people live longer, home and community-based health care is becoming even more crucial in helping people stay at home safely, where they can live a comfortable, high quality of life. Now more than ever, our health care system is focused on patient-centred home and community care. That means people need more help navigating a complex system to access the services they need. HNHB CCAC's collaboration with health system partners helps create innovative programs and initiatives to improve the patient experience.

The **DIVERT** initiative is one such program developed in collaboration with CCAC and McMaster University. A patient-centred model of care, DIVERT helped educate and support patients to self-manage their chronic health conditions based on their own preferences and goals.

Working one-on-one with patients, DIVERT's specially-trained home care teams helped motivate patients to achieve their goals, coaching them and introducing patient action plans to support patients to self-manage their care.

HNHB CCAC Vice President, Dilys Haughton and Dr. Andrew Costa, Assistant Professor and Schlegel Chair at McMaster University led the DIVERT initiative launched in Niagara. Rapid response nurses, advanced care planning consultants, specialists, pharmacists and CCAC care coordinators were brought together to serve as key players on patient care teams.

"DIVERT supported 100 high risk home care patients, partnering with CCAC rapid response nurses and community care partners to help them achieve their goals," Costa says.

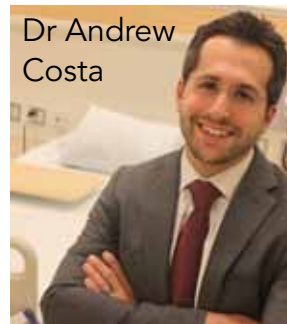
During a 4-month period, nurses coached each patient on achieving their goals; care coordinators organized care through community partners; and advanced care planning consultants assisted patients in making informed decisions about their future needs based on their values and wishes. In addition, pharmacists made in-home patient visits to discuss safe and effective use of medications.

"Thanks to the DIVERT initiative, there was a significant decrease in unplanned ED hospital visits by home care patients in Niagara," says Haughton. "By leveraging existing resources and community care partners creatively, DIVERT was successful in responding to patient risks and care needs."

Designed to be cost-effective and scalable across Canada, DIVERT has developed low cost resources and tools for chronic disease management. DIVERT has created a sustainable, new model of care by leveraging other community care providers, improving multi-disciplinary collaboration and resource-sharing among health care partners. ■

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—Dilys Haughton

DIVERT 



Dr Andrew
Costa



Niagara Health System

From Home Care Provider to Patient

– Bev's Story



Imagine working as a home care provider, caring for patients who need assistance so they can remain living at home where they want to be. You enjoy your role as a personal support worker (PSW) and, as someone devoted to assisting people, you can't imagine any other career as gratifying as home and community care.

Imagine then, how difficult – even devastating – it might be for a home care worker to have to give up a position they so love after a life-changing diagnosis. 73-year old Bev Black knows first-hand about the impacts of declining health and how life can change in an instant.

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After working in the banking industry for 30 years, Bev decided it was time to make a major career shift. She completed her training to become a personal support worker and began caring for patients in the St. Catharines area. After five years

as a dedicated PSW, Bev began having trouble breathing. When she was diagnosed with Chronic Obstructive Pulmonary Disease (COPD), Bev had to leave the career she cherished.

COPD is a lung disease that develops over time and can include chronic bronchitis and emphysema. In 80-90% of cases, COPD is caused by smoking. Other causes of COPD include genetic reasons, occupational dusts and chemicals, second hand smoke, frequent lung infections at an early age, wood smoke and other biomass fuels used for cooking.

In most cases, COPD is diagnosed in people over 40. A person with COPD may not realize they are becoming more short of breath until it becomes difficult to perform such routine tasks as walking up stairs. With COPD, lungs become either obstructed or blocked, making it hard to breathe.

"I spent the first couple of weeks adjusting to my new reality. CCAC was there for me, creating a care plan that made sense."

– Bev



As someone living with COPD, Bev's new reality was extremely challenging in the beginning. She wasn't ready to accept the fact that, to stay living at home safely, she needed assistance.

"Eventually, I realized the time had come for me to understand that I

needed help. I spent the first couple of weeks adjusting to my new reality. CCAC was there for me, creating a care plan that made sense. I still thought I could complete most of the routine household and personal tasks on my own. After about the fourth week, I realized I really did need assistance if I wanted to stay living in my home while managing a chronic illness."

As a new home care patient, Bev felt it was important to share her feelings about her new situation with her care coordinator, PSWs, nurses and other health professionals on the care team. For Bev, that open dialogue has gone a long way in helping her address concerns with the care team and becoming more comfortable with home care.

"I would say to anyone new to home and community care: don't be afraid to speak openly and honestly with your care

team. These health professionals may be with you for a good length of time, so it's important to get to know them, talk to them and let them get to know you."

Bev's first point of contact was with HNHB CCAC care coordinator, Kim Lively. After receiving home care for a number of months, Kim approached Bev about some potential modifications to her care plan through the DIVERT initiative. When Bev realized the program was specific to helping patients with chronic illnesses avoid visits to the hospital emergency department, she was on board immediately.

With DIVERT, care coordinators used specific assessments to help them identify patients who could benefit from the expertise of an expanded care team.

DIVERT supported a group of high risk home care patients who were connected with CCAC rapid response nurses and community care partners to help patients achieve their goals. In addition, advanced care planning consultants, primary care doctors, specialists and pharmacists were brought together to serve as key players on patient care teams.

Team work and communication were critical to the success of the DIVERT initiative and, through regular follow ups and a constant flow of communication among the team and with the patient,

continued



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– Bev

HNHB CCAC care coordinator,
Kim Lively

care teams could remain focused on providing the best care and supports available to their patients. That included in-home visits by a pharmacist who reviewed medications with patients, and also, a package of information about nutrition, immunizations, chronic disease management and exercise programs.

Kim Lively believes that, by empowering people who have an interest in taking control of their health issues and helping them understand what they can do to manage their care, DIVERT has helped patients like Bev Black learn how to self-manage their symptoms.

"Bev is a prime example of someone who has taken control of her condition willingly. She has become a tireless advocate on behalf of others in similar situations, and continues to do all she can to bring about more supports for people."

Rapid response nurse Sally Baerg of HNHBCAC was also on Bev's care team as part of the DIVERT program. As one of Sally's first COPD patients, Bev demonstrated her wealth of knowledge about her illness and how she could best cope on good days and bad.

"With Bev, I certainly learned more about the illness from her experience with the

condition. Bev is a model patient in self-managed care and, as a result, has been successful in avoiding visits to the hospital emergency department. Her continued advocacy work with the Lung Association is an inspiration."

The DIVERT care team included Geoff Straw of Hospice Niagara. Focused on advanced care planning, Geoff helped facilitate discussions between families and chronic patients with deteriorating health. Bev had high praise for this kind of dialogue because it assisted her in broaching difficult subjects with her family in a comfortable environment.

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"At first, I wasn't sure what to make of the psycho-social support available through the DIVERT program. But when my family and I met with Geoff, it opened the door to discussions that covered everything from appointing a Power of Attorney and the option of a living will, to the importance of a DNR and my wishes for end of life care. It also helped me realize that advance care planning isn't just about me, it's about listening to my family and working through things together."

Even though her lung functionality is at 19%, Bev manages to stay positive and active. In fact, if you ask her, she'll tell you the key to staying positive about life is to actually make a point of living it. Spending two hours at the local "Y" three days a week, Bev is more active than some 10-year olds.

"I need to get out of the house and going for my workouts keeps me motivated. When I get there, the sessions start with a warm-up, followed by aerobics, a walk around the track, some time on the exercise bike, and then onto the weight machines to work on my legs, chest and arms. After more cardio, we get to cool down after the 2-hour session."

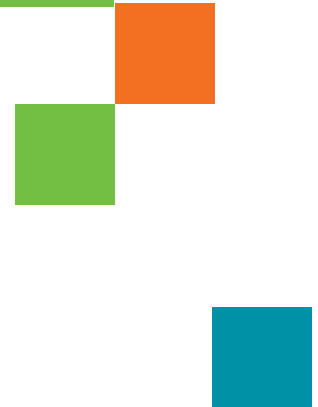
Not only does Bev manage to stay in shape by going to the gym, she has cultivated a support system that includes friendship, fellowship and a lot of laughter. "Even if we can't keep up with the program, we can sit down for a rest and encourage our friends from the sidelines."

Bev understands the importance of being gentle with herself and even though she may have to do things differently now, she doesn't allow herself to get down. Despite being a high risk COPD patient who requires oxygen, Bev's mobility level means she can still go to bingo, visit with her girlfriends and play cards every week. As a devoted mother and grandmother, Bev enjoys spending time with her family, especially her grandchildren.

"I'm really blessed. Thanks to CCAC, I have an amazing care team working with me to ensure I'm getting the best care possible. I have all the supports necessary to assist me in managing my COPD, and avoiding visits to the hospital emergency department. I know I have to be careful, but my life is very rich." ■



Kim Lively, Bev Black and Rapid Response Nurse Sally Baerg



Our Performance

HNHB CCAC fast facts

- We serve a population of more than **1.4 million** people
- **1 out of every 17** people throughout our region received care from HNHB CCAC last year
- CCAC cared for more than **half of all seniors 85+** within the HNHB region

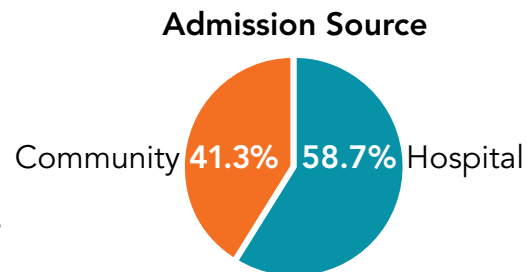
HNHB CCAC financial highlights

Patient Care Services	\$209,069,268
Patient Care Medical Supplies & Equipment	\$17,538,768
Salaries & Benefits	\$72,361,608
Other Expenses & Amortization of Capital Assets	\$11,800,727
Total Expenses	\$310,770,371

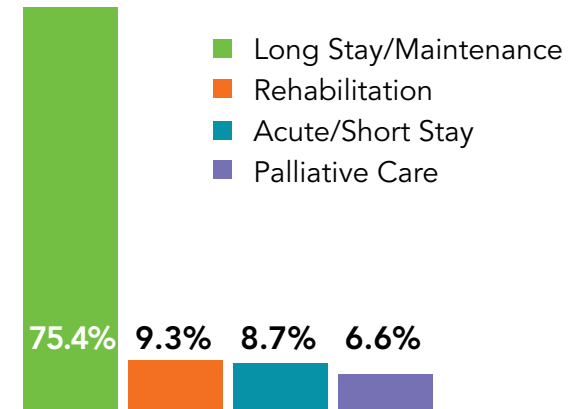
Please visit www.healthcareathome.ca/hnhb for a detailed copy of the 2014-2015 audited financial statements.

HNHB CCAC's 786 full-time staff supported:

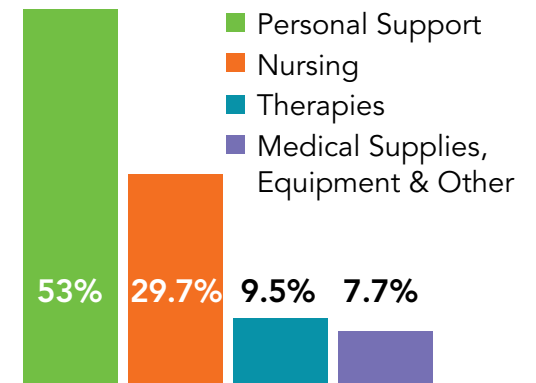
- **5,287,900** patient visits
- **8,938** children receiving school health support services
- **3,110** people received palliative/hospice care
- **3,580** patients on a wound care path on average monthly



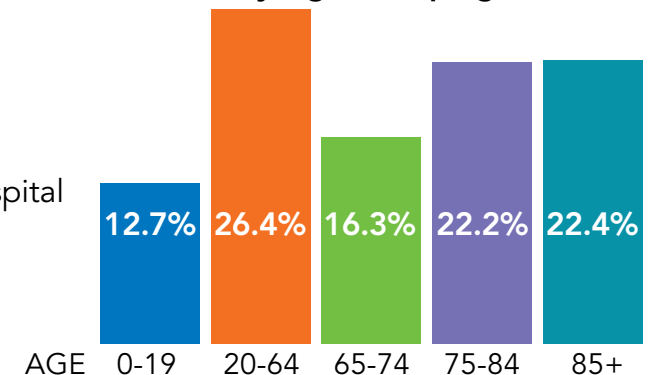
Expenditure by Type of Patient



Service Expenditures



Patients by Age Grouping



Caring for Children and Young People

Supporting access to care is a key focus for CCAC. This year, innovations made it possible for more children and adolescents to access care and support. Approximately 13% of HNHB CCAC's patients are 19 years of age and under. CCAC is committed to providing outstanding care whether we are supporting children who are medically fragile, students attending school with chronic illnesses like diabetes, or other young people living with mental health or addictions challenges. Our aim is to help each child live as independently as possible.



Expanding access to Speech Therapy

Following the success of Speech Therapy Clinics in Niagara and Hamilton, HNHB CCAC launched its newest Speech Therapy Clinic in Burlington for school children. Working together with parents, teachers and school counselors, speech therapy clinics are designed to help children with moderate speech needs to help improve school performance and achieve a better quality of life at home and at school. The clinics enable CCAC to provide more choice and greater access to therapy for children and their parents. In the clinic setting, children work in small groups. Their parents are also encouraged to participate in therapy sessions. Another important program goal is to support parents in learning how to help their child's progress at home. Keeping parents involved in their child's progress promotes the positive effects of therapy between sessions, allowing the child to practice their new skills.

Caring for Children and Young People

Supporting children with Developmental Coordination Disorder



Developmental Coordination Disorder (DCD) is a motor disability that impacts a child's ability to complete routine personal care and educational tasks. About 5% of all children – nearly 400,000 children across Canada – are affected by DCD. HNHB CCAC is working together with McMaster University (CanChild), school boards and occupational therapists on Partnering for Change, a best practices care delivery model in schools focused on children with developmental coordination disorder (DCD) and similar conditions. Working with educators and families, therapists provide support to whole schools and help create classroom environments that encourage successful participation and academic achievement of children with DCD.

Mental Health and Addictions support for Children and Youth

This year, HNHB CCAC Mental Health and Addictions Nurses supported more than 700 children and young people with early identification and intervention services. The program focuses on students with mental health issues and/or addictions and aims to help them thrive and remain in school or get back to school after a hospital stay. CCAC works in partnership with the Catholic and public school boards in Hamilton, Niagara, Brantford and Haldimand Norfolk to deliver the program.



Contact Us

Call HNHB CCAC
toll free:
1-800-810-0000



Putting our patients and caregivers first, HNHB CCAC is committed to engaging our community in ongoing dialogue. We welcome your feedback about our work and the 2014-2015 Annual Report. Thank you!

For more information please visit our website:
healthcareathome.ca/hnhb

Aussi disponible en français.



Funding support provided by:

