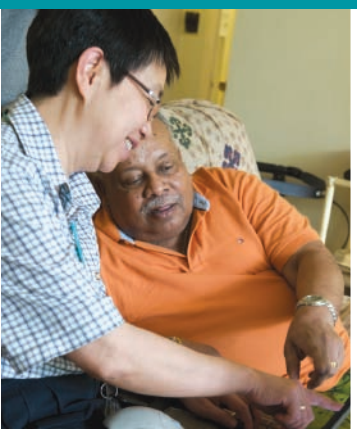
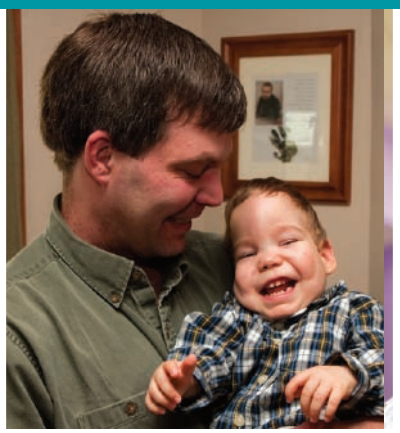
2009 – 2010 CCAC QUALITY REPORT

"If we didn't have CCAC services we wouldn't be able to live at home. Before your help came here, we just existed, now we're living." – *CCAC Client*





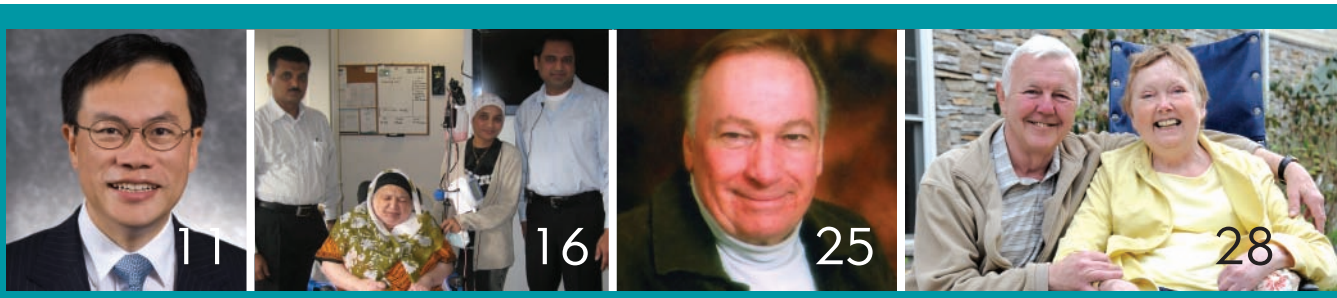

Outstanding care – every person, every day.

Connecting you with care
Votre lien aux soins

CCAC Community Care Access Centre

CASC Centre d'accès aux soins communautaires

CONTENTS



Every day, Ontario's 14 Community Care Access Centres (CCACs) support **50,000** people they have helped go home from hospital, help **120,000** seniors to live safely in their communities, help **2,000** children with complex chronic diseases to go to school, help **6,000** dying people stay at home with their families, and help thousands of people find the different health care services they need.

community

CCAC LEADERSHIP MESSAGE

The efforts of the CCACs are focused on helping Ontarians of all ages find their way through the healthcare system, understand their options and connect them to high-quality community-based healthcare services and resources.

The leaders of CCACs of Ontario are pleased to present our 2010 Quality Report – the first collective annual report by CCACs towards our shared vision of delivering *outstanding care to every person, every day*. This report highlights our commitment to continuously improving the quality of care for the 600,000 Ontarians we serve collectively every year.

Community Care Access Centres are not-for-profit corporations in the province of Ontario that are responsible for the assessment, care planning, care coordination, and quality monitoring of publicly funded home-health services. CCACs also provide significant support for information, referral, and navigation of the wide array of community services available. CCACs offer Ontarians a single point of access and connection to the most appropriate healthcare services to meet their individual needs to ensure right care at the right place, including supporting clients who move into Ontario's long-term care homes, at the right time. Funding for CCAC services is provided by the government of Ontario through the province's fourteen Local Health Integration Networks (LHINs).

Ontario's health system is facing many challenges. We know that, at times, the care experience can vary and that navigating the healthcare system can be a confusing, sometimes difficult, process. Our population is aging, our health system is complex, the demands on resources are greater than ever, and the public's expectations of what our healthcare system can do for them are growing – all of which comes at a time when we are collectively facing the most significant economic crisis in decades.

For these reasons the CCACs, with the support of the Ministry of Health and Long-Term Care, the LHINs, and our many other partners, have for the past three years been introducing a variety of initiatives around the

province – all with the goal of continuously improving the care experience for the people and communities we serve and for the hard-working, dedicated family members, friends, and healthcare workers who care for them. As we continue to develop our services, we are also committed to ensuring that measures are in place to help create a healthcare system that is better prepared to face the challenges now and in the future.

But good intentions are not enough. Ontarians need change that directly benefits those who need our care while ensuring the long-term viability of the healthcare system. Our aim cannot be merely to serve more people or deliver more care. In fact, CCACs already serve more than 600,000 Ontarians annually, and this number increases every day. Instead, only through a focus on continuously improving quality will we be able to deliver on our vision for our clients and help create a more sustainable healthcare system. Our efforts to improve quality are strengthened by the recent *Excellent Care for All Act*, passed in June 2010. The Act promotes a quality-focused approach to the delivery of healthcare across Ontario. The purpose of this CCAC Quality Report is to tell the story of where we have come from and where we are going in our strategy to continuously improve the quality of care and the overall experience for all Ontarians who need the care of a CCAC.

The purpose of this CCAC Quality Report is to tell the story of where we have come from and where we are going in our strategy to continuously improve the quality of care and the overall experience for all Ontarians who need the care of a CCAC.

In particular, the report is meant to

- show how the CCACs measure our efforts to deliver quality care
- share information with the public about CCACs and what we do
- present examples of the type of innovative programs, partnerships, and system integration that are being delivered in the quest for higher quality, higher value healthcare
- acknowledge that, while we have done many things to continuously improve the quality of care we provide and the care experience of our clients, we still have a ways to go in achieving our vision *(Outstanding care – every person, every day)*

The report will complement existing and future reporting efforts of our funders, including the Ministry of Health and Long-Term Care, LHINs, and other dedicated organizations such as the Ontario Health Quality Council. The report highlights four themes in the efforts of CCACs to improve quality.

1. ***Delivering safe and quality care*** supports people to live safely in their homes, to live with dignity, to maximize independence and rehabilitate after injuries, to recover from illness, and to participate in their communities. CCACs are focusing on supporting clients with very complex medical needs to stay at home as long as possible.

2. ***Enhancing the quality of the care experience*** for our clients and their caregivers includes hearing their stories, listening to their feedback, and making improvements based on what they tell us.

3. ***Supporting the delivery of the right care in the right place at the right time*** across the health system means that CCACs are finding ways to help people get the care they need at home and in their community so that hospital beds, emergency rooms, and long-term care homes are available for those who need them the most.

4. ***Ensuring that every dollar we spend provides value*** to our clients and to the health system.

Our four themes also align well with the priorities of the government of Ontario and LHINs and their vision for a healthcare system that helps people stay healthy, delivers good care when people need it, and will be there for our children and grandchildren.

The client stories in our 2010 Quality Report illustrate the many challenges that our clients and their families face as well as the help provided by caring and knowledgeable CCAC staff and the dedicated service providers who work with us. The stories also show our clients' interactions with hospitals, primary healthcare providers, community support service agencies, long-term care homes, and many others – each of which is dedicated to a more fully

integrated system that uses collective efforts to achieve higher value healthcare.

In the same way that we are sharing our clients' success stories, we cannot fail to mention the areas in which we need to evolve and continuously improve. This report also serves to describe the areas where we know we need to do better.

On behalf of the CCACs, we thank you for your support and for your encouragement as we invest in positive change that will drive continuous quality improvement across Ontario's healthcare system.

We welcome your ongoing feedback, and we thank you for reading this report.

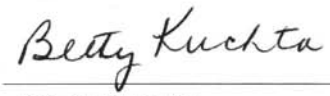
The Chief Executive Officers of Ontario's fourteen Community Care Access Centres are committed to continuous quality improvement across Ontario's healthcare system.

CATHY SZABO
Central CCAC

DON FORD
Central East CCAC

CATHY HECIMOVICH
Central West CCAC

GILLES LANTEIGNE
Champlain CCAC



BETTY KUCHTA
Erie St. Clair CCAC

MELODY MILES
Hamilton Niagara Haldimand Brant CCAC

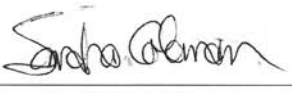
CAROLINE BRERETON
Mississauga Halton CCAC

RICHARD JOLY
North East CCAC

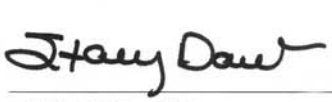
BILL INNES
North Simcoe Muskoka CCAC

TUIJA PUIRAS
North West CCAC

JACQUELINE REDMOND (Interim)
South East CCAC



SANDRA COLEMAN
South West CCAC



STACEY DAUB
Toronto Central CCAC

KEVIN MERCER
Waterloo Wellington CCAC

PURPOSE AND VISION OF CCACs

All CCAC employees are dedicated to realizing the CCAC vision and mission. More than 6,700 people work for CCACs across the province in 200 community offices, at more than 200 hospital sites, and in numerous family health teams to provide a single point of access to health and community support services at the local level in order to better serve our clients. CCACs are the only healthcare service providers that have the same service boundaries as the LHINs.

The CCAC Vision:

Outstanding care – every person, every day.

The CCAC Mission:

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

Community Care Access Centres work in communities across Ontario to connect people with quality in-home and community-based healthcare. We provide information and direct access to qualified care providers as well as a wide range of services to help people come home from hospital sooner or live independently at home longer.

A CASE MANAGEMENT APPROACH TO CARE

CCACs connect Ontarians with the care they need – at home and in their community. Case management is the cornerstone of CCAC work. It is the basis of the relationship between our clients, the CCAC, and the providers who deliver care.

The CCAC case management approach is about getting to know our clients and families in their own homes and communities. By using tools such as electronic health records and internationally recognized health assessment tools, CCACs work with clients and their families to set up individualized care plans tailored to each client's personal care needs. Our case managers (also referred to as care coordinators) are caring and knowledgeable healthcare professionals who are responsible for delivering and connecting people to quality home and community care, tracking client satisfaction, ensuring progress towards our clients' goals, and monitoring the quality of our services. CCACs add value for clients by maintaining a focus on positive health outcomes and by working together effectively and efficiently with physicians, hospitals, long-term care homes, and other healthcare providers and partners.

Of all the many different partners and organizations that CCACs work with across the healthcare system, two are particularly critical in the delivery of quality in-home care. First are the informal caregivers: our clients' families, friends, and neighbours, who provide most of the care and support that our clients need. Second are the service provider agencies and services that CCACs have contracts with to deliver care on our behalf, including nursing, therapies, personal care, medical supplies, and medical equipment.

Informal Caregivers

A recent study called 'Supporting Informal Caregivers – the Heart of Home Care' by the Canadian Institute for Health Information (August 2010) reported that few seniors who are receiving publicly funded long-term home care are able to manage alone. In a sample of 131,000 home care clients age 65 and older in Canada, only 2% were coping without an informal caregiver. Caregivers provided emotional support along with a wide range of services from meal preparation to medication management, shopping, dressing, bathing, and toileting. CCACs acknowledge the critical contributions that family members and other unpaid caregivers make in supporting clients. Several CCACs have launched 'Heroes in the Home' programs (including the Heroes in the Home Program at Hamilton Niagara Haldimand Brant CCAC) to formally recognize the extraordinary lengths to which individuals will go to support their loved ones to stay safely at home as long as possible.

CCAC Service Providers

The CCACs build strong relationships with trusted service providers in the community to coordinate the following in-home services for clients:

- Nursing
- Personal care (help with daily activities such as hygiene, bathing, dressing)
- Physiotherapy
- Occupational therapy
- Speech-language pathology
- Nutritional therapy
- Social work
- Medical supplies and equipment

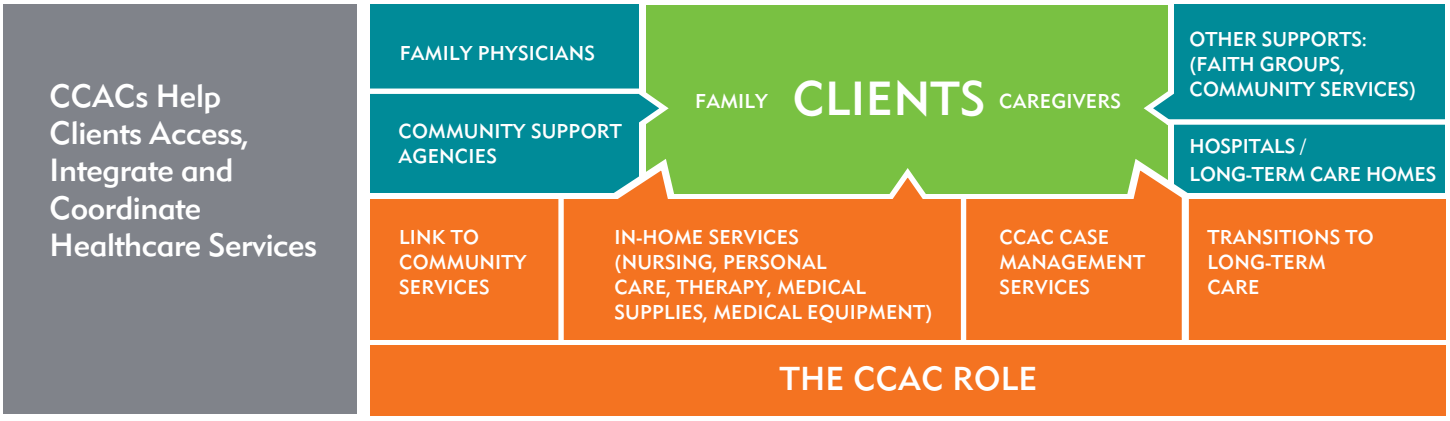
The fourteen CCACs collectively have contracts with more than 150 service providers who deliver services to clients on our behalf. CCACs measure the performance of our service providers against quality standards in our contracts. We also work closely with service providers on quality improvement activities designed to enhance the experience of our clients and their caregivers.

For more information on case management or about the history of CCACs click here or please visit http://www.ccac.on.ca/

CCACs Help Ontarians Get Connected to Care across the Healthcare Continuum

CCACs give Ontarians a single point of access and connection to the most appropriate healthcare services that meet their individual needs, ensuring they receive the right care at the right place at the right time.

CCACs are connected with every part of the health care system; we are focused on providing a comprehensive care plan, based on each client's needs, that includes quality services and a positive client experience. While many organizations coordinate the care they provide, CCACs are the only healthcare organizations that provide service and care across the continuum and border-to-border service aligned with the LHINs and that coordinate client transitions across these LHINs.



COMMITMENT OF ALL FOURTEEN CCACS TO CONTINUOUSLY IMPROVE THE QUALITY OF CARE FOR OUR CLIENTS

Quality improvement is about continuously improving what we do. In order to share our efforts to improve quality, each CCAC will be posting an annual quality improvement plan based on the needs of the local communities we serve. Collectively, we are also working to create common commitments across the province about what quality means in the delivery of home care services. To that end, we have agreed to work on four strategies or themes that will improve quality across the home care system.

commitment

The report highlights four themes in the efforts of CCACs to improve quality.

1. ***Delivering safe and quality care*** supports people to live safely in their homes, to live with dignity, to maximize independence and rehabilitate after injuries, to recover from illness, and to participate in their communities. CCACs are focusing on supporting clients with very complex medical needs to stay at home as long as possible.

2. ***Enhancing the quality of the care experience for our clients and their caregivers*** includes hearing their stories, listening to their feedback, and making improvements based on what they tell us. Each CCAC has established a Client Service and Quality Committee of the Board that is responsible for making quality improvement a priority including setting performance goals and targets for quality improvement, reporting on client and staff safety risks, using evidence-based best practices, and conducting ongoing research and evaluation. CCAC board members are all volunteer members of the communities we serve.

3. ***Supporting the delivery of the right care in the right place at the right time across the health system*** means that CCACs are finding ways to help people get the care they need at home and in their communities so that hospital beds, emergency rooms, and long-term care homes are available for those who need them the most. CCACs work with many partners including hospitals, service providers, community support services, and long-term care homes to deliver care effectively, and we support clients and families in navigating the complexity of our healthcare system. In cooperation with all our partners, we are building integrated teams around clients to better support and coordinate the delivery of care to each individual.

4. ***Ensuring that every dollar we spend provides value*** to our clients and to the health system. CCACs are accountable to our clients and the healthcare system for delivering high quality healthcare as effectively and efficiently as possible; making sure that limited resources are used wisely.

Examples of how we are delivering on our commitments are illustrated later in this report.

In June 2010, the *Excellent Care for All Act* was introduced by the Government of Ontario, and even though CCACs are not yet subject to this new legislation, they are already meeting many of its requirements, such as:

- ✓ All CCACs have Board Quality Committees.
- ✓ All CCACs have annual quality improvement plans.
- ✓ All CCACs have a formal client complaint process and an electronic system to provide for accurate reporting and analysis of complaint information to improve our ability to respond to feedback from our clients.
- ✓ All CCACs have started using a common client satisfaction survey. This allows us to compare the quality of care and experience of clients across the fourteen CCACs.
- ✓ All CCACs use a common satisfaction survey with our contracted service providers to improve the way we work together.
- ✓ All CCACs have satisfaction surveys with our employees to help us make each CCAC an even better place to work.
- ✓ All CCACs use a standard set of tools to assess the needs of clients and identify appropriate services to support clients and caregivers.
- ✓ All CCACs, by the end of 2011, will be using the same electronic system for client information, which is a major step on our path to creating a common electronic record for each CCAC client.

In May 2009, all CCACs, as part of their common provincial brand, committed to working together with our healthcare partners on continuously improving performance and supporting a positive client-care experience. CCACs are in the process of collectively adopting service standards – programs and services that are consistently offered across the province.

The provincial service standards that all CCACs have agreed to so far are shown in the following table.

HOURS OF OPERATION: Live-Voice Answer

All CCACs provide services 24/7 for 365 days per year. All CCACs have committed to a twelve-hour timeframe of daily business operations when a person can expect the CCAC to respond with a live-voice answer to a call or enquiry. This is managed through Information and Referral (a provincial toll-free telephone number 310-CCAC and a publicly accessible database www.310ccac.ca) or or by contacting a local CCAC office.

Dedicated CCAC Case Manager in Hospital Emergency Rooms

A CCAC case manager will be available 100% of their shift (a minimum of eight hours five days per week) to the hospital's emergency room (ER) for hospitals with more than 20,000 ER visits annually.

CCAC Case Manager on Hospital Inpatient Wards

Working in collaboration with hospital partners, priority wards will be identified and these service areas will have case management support on site to respond directly to discharge needs a minimum of eight hours five days per week.

Client Transitions

All CCACs have committed to a common set of practices and protocols to support discharge from hospital whether waiting for an available long-term care option, recovering at home, or transitioning from one CCAC catchment area to another.

While CCACs have taken many steps to continuously improve the quality of care we deliver, we still have room for improvement. At the end of this report, we identify some of the initiatives currently underway that reinforce our commitment to continuous quality improvement.

In June 2010, the Excellent Care for All Act was introduced by the Government of Ontario, and even though CCACs are not yet subject to this new legislation, they are already meeting many of its requirements.


HNHB CCAC

MEASURING QUALITY IMPROVEMENT

A critical step in delivering high quality care is the ability to set improvement targets, measure progress, and show continuous improvement over time. CCACs have been working together for several years on developing and using measures that demonstrate improvement in quality. CCACs are also committed to working with other organizations that have an interest in measuring and monitoring quality care in the home and community care sector.

We have worked closely with the Ontario Health Quality Council, the LHINs, the Ontario Ministry of Health and Long-Term Care, and researchers to define and measure home care quality and are working with a common set of measures and survey tools to ensure accuracy in measurement and reporting.

Some examples of how we measure the CCACs' efforts to deliver quality care include:

- how quickly CCACs are able to provide services to people who need them
- the number of Ontarians seeking a primary healthcare provider who were matched with one through the Ministry of Health and Long-Term Care's Health Care Connect – a CCAC-supported program
- the number of Ontarians who received CCACs services at home, including therapy services after a hip or knee replacement or nursing visits for wound care and intravenous therapy
- the number of clients with very high or complex health-care needs being cared for in the community
- the number of clients we supported in their moves to long-term care (LTC) homes
- wait times for access to LTC homes
- the number of children with medically complex needs that CCACs support to go to school each day

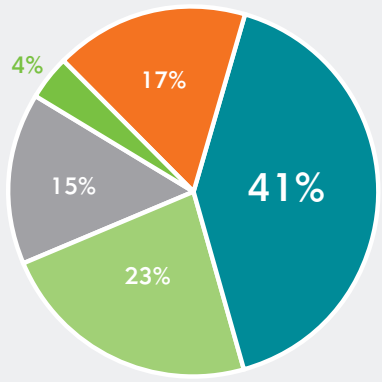
The results of some of these and other quality measures are highlighted in the next few pages.

[1] As part of our efforts to measure quality, CCACs have started using a common survey to measure the experience of our clients and caregivers. Results are not yet available for all CCACs. An update is provided in the last section of this report.

SERVING ONTARIANS

CCACs are perhaps best known for the services they provide to frail seniors, helping people stay safely in their homes when they might otherwise have to move into a long-term care. But in fact, CCACs provide ongoing support to clients of all ages, last year serving over 600,000 clients.

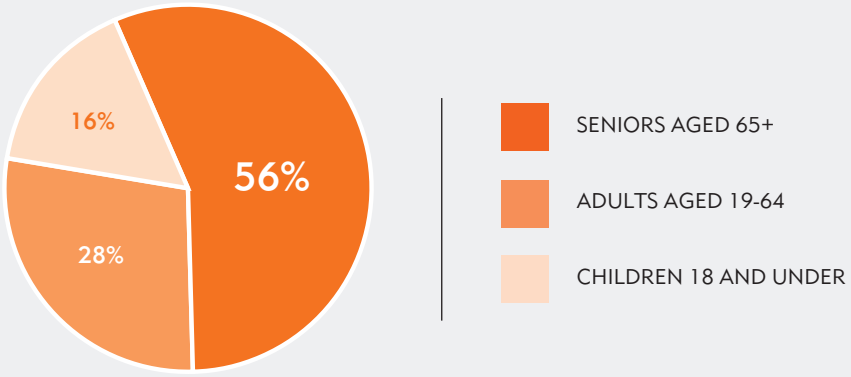
Breakdown of CCAC Clients by Service



- ADULTS REQUIRING ONGOING SUPPORT TO STAY AT HOME
- CLIENTS WITH SHORT TERM ACUTE CARE NEEDS
- CLIENTS NEEDING HELP WITH SHORTER TERM REHABILITATION
- END-OF-LIFE CLIENTS
- SUPPORT FOR CHILDREN 18 AND UNDER AND THEIR FAMILIES

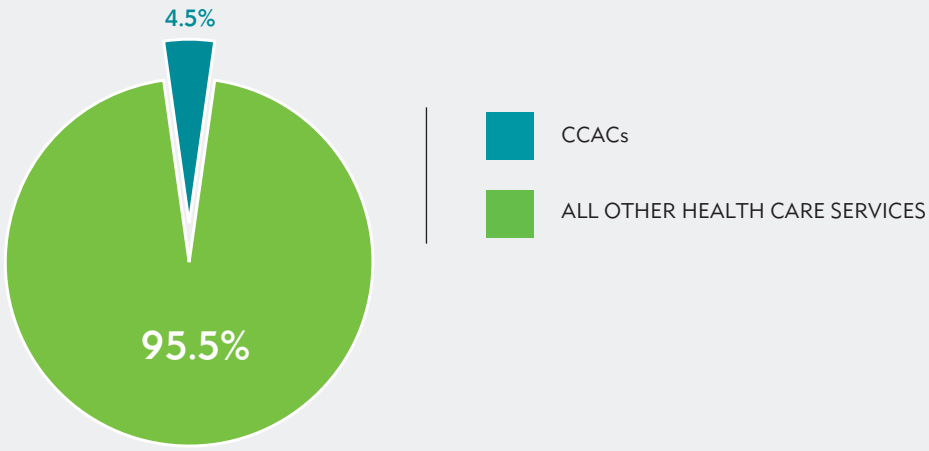
SOURCE: CCAC INTEGRATED DATA STORE (HCD) FY 2009/2010, PROVINCE OF ONTARIO ACTIVE RERERRALS DURING FISCAL YEAR

CCAC Clients by Age Grouping



SOURCE: INTEGRATED DATA STORE (HCD) FY 2009/2010, PROVINCE OF ONTARIO
CLIENTS ACTIVE ANY TIME DURING FISCAL YEAR

Public Expenditures on CCACs as a Percentage of Total Healthcare Expenditures



SOURCE: PUBLIC ACCOUNTS OF ONTARIO 2009/2010 PUBLISHED BY THE ONTARIO MINISTRY OF FINANCE

"I am very pleased to see that CCACs are committed to standardized measurement, public reporting, and continuous quality improvement. The development of customized case management services and integrated care teams demonstrates the CCACs' commitment to advancing care for their clients using evidence-based approaches. I look forward to seeing how these ideas will evolve into best practices for client care".

DR. BEN CHAN,
CEO, Ontario Health Quality Council

The CCAC sector saw a 7% increase in government investment between 2008 and 2010, and CCACs now account for almost $1.9 billion in healthcare funding. Provincially, CCACs spend more than 91 cents out of every dollar we receive on direct client care. While government funding for CCACs has increased, resources in this economic climate are still limited, and CCACs are working hard to keep pace with the growth in demand for our services.

Every day CCACs see a higher number of clients with complex, chronic health conditions. CCACs play an important role in helping individuals return home from hospital sooner and helping seniors maximize their independence and stay at home as long as possible. Ontario's healthcare system is shifting, and more and more clients need the services of CCACs and other home and community services. This is why we feel it's important to highlight the stories of just a few of the 600,000 clients we serve each year. In the next few pages, you will find these stories along with some of the ways we measure the quality of care delivered to these clients. *

Each section describes a CCAC client's experience and answers the following questions:

1. Are CCAC services making a difference to clients and their caregivers?
2. Are clients staying safe?
3. Are clients able to access the care they need in a timely manner?
4. Are CCACs helping maximize the efficiency of the healthcare system?

**Note: Some names of our clients in the stories have been changed to protect their privacy and not all the innovative programs profiled in this report are currently being offered by every CCAC.*

Telling the Stories of Our Clients and Their Care

CCACs Help Clients with **Ongoing Needs** to Stay Home Safely

Most people want to stay in their own home and community for as long as possible. Every day CCACs help people currently living in their homes continue to stay there. CCACs also help people who are currently hospitalized and who might have previously gone to long-term care return to their homes as a result of the Home First philosophy.

CCAC case managers tailor care to meet the needs of individuals and caregivers to optimize their experience and outcomes. They support clients in their choices and work within those choices to provide the best care and reduce risk where possible.

For some clients who need a bit of help to stay at home, CCACs can help them access different community services or provide a few hours a month of personal care services. For other clients and caregivers who have to deal with complex health and support needs (see Mrs. Pathan's story), this means ongoing help from the case manager to navigate the healthcare system and coordinate daily personal support services as well as services provided by a variety of healthcare professionals.

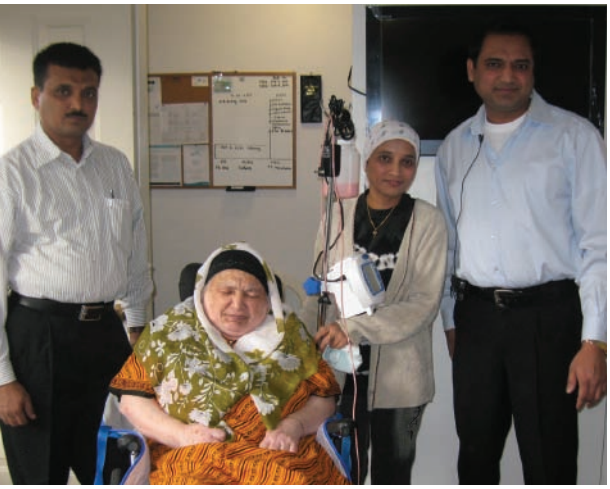
CCAC case managers tailor care to meet the needs of individuals and caregivers to optimize their experience and outcomes.

For our clients with significant healthcare needs, the CCACs' goals are to keep clients safe in their homes by preventing avoidable injuries such as falls or adverse events that may arise from complex medication needs (see Irene's story), helping clients and their caregivers maximize their ability to care for themselves, and finally helping clients and caregivers by providing support to do the things that they can no longer take care of on their own. This in turn provides benefits to the whole healthcare system as we help prevent unnecessary hospital stays or visits to emergency rooms and avoid placing clients in long-term care homes prematurely.

QUICK FACTS

- In 2009/10, CCACs helped **200,000** adult clients who had ongoing care needs to be able to stay home.
- At any given time, there are **85,000** clients age 80 years or older receiving services from CCACs.
- CCACs served almost half **(44%)** of Ontarians age 85 or older in 2009/10.
- Though adults with ongoing needs account for only **40%** of CCAC clients, almost **70%** of CCAC services were provided to these clients.
- The CCACs receive **250,000** hospital referrals on an annual basis.

HOW MRS. PATHAN RETURNED HOME FROM HOSPITAL



Just three months after arriving in Canada, Mrs. Pathan, a 67-year-old resident of Brampton, was recently brought to hospital in March 2008 suffering a cardiac arrest. Following resuscitation, she was in a coma (a vegetative state) and required total care. She became a resident of the hospital's Complex Continuing Care ward for 2½ years.

For the 2½ years that Mrs. Pathan was in hospital, her family was by her side, staying with her every day from morning until late in the evening, taking turns and participating in her care along with hospital staff. The unrelenting commitment to Mrs. Pathan by her family was inspiring, but eventually it became extremely difficult for the family to manage their own daily routines while visiting their mother at the hospital. Most of all, the family knew that Mrs. Pathan longed to be in the familiar environment of her own home, surrounded by those she loved, speaking her language and reading or reciting the religious texts that were so important to her.

Mrs. Pathan requires complex care. She is fed by a G-tube twelve hours per day, requires a Hoyer lift and two persons to get in and out of bed, and must take several different medications. Mrs. Pathan is also a diabetic and requires insulin to manage the disease. She has not regained mobility and requires total attention regarding her personal hygiene and general care.

However, with careful planning the family, hospital staff, and the Central West CCAC decided that Mrs. Pathan could return home to be cared for by family members and supported by CCAC services in her home setting. As part of the discharge planning process, the family, especially her daughter, received extensive practical training to enable them to meet their mother's care needs at home. Mrs. Pathan was discharged home from Brampton Civic Hospital in August 2010. Through the Home First philosophy, Central West CCAC is providing nursing, personal support, occupational therapy, dietetics, and social work as well as supplies to support her care at home. Three months after coming home from hospital, Mrs. Pathan continues to be safely supported at home and is getting the care she requires. Her primary-care physician has extended his support by visiting her at home and manages her care with the support of the family and the home care team.

Without the determination and dedication exhibited by the family and CCAC case managers combined with careful preparation by hospital staff, Mrs. Pathan would have remained in hospital in the Complex Continuing Care ward for the remainder of her life. Mrs. Pathan's story is a classic example of how the Home First philosophy encourages all partners to think creatively about the types of clients who can be safely supported at home. The key to safely discharging or maintaining a client at home is the strong partnership between the client/family, the hospital, CCAC, and other community agencies. And, as demonstrated by Mrs. Pathan's story, family members play a key role in their loved one's care plan.

As part of the discharge planning process, the family, especially her daughter, received extensive practical training to enable them to meet their mother's care needs at home.

What Our Clients, Caregivers and Partners are Saying:

" It's been three months since my mother's return home.
I am pleased to report that we are very happy to have mother home with us, and I am sure mother feels blessed to be surrounded by her family and loved ones in our own home. The training and practice have made us capable of handling this new role. I will be the first to admit that this role is not an easy one, but given the circumstances, we are coping as best as we can. I have only words of thanks for all the support and service extended by the staff at Brampton Civic Hospital, as well as the Central West CCAC".

SHAKIL MALEK, Mrs. Pathan's son

" Mrs. Pathan's care plan is fluid and increases as her needs change.
Her family is aware that there is opportunity for increased help, if needed, and know to contact me with any questions or additional care needs. On my part, I ensure that healthcare assessments for Mrs. Pathan are completed on a regular basis. As community case managers, our role is to ensure that our clients continue to be safely supported in the community. On a personal note, the family reports a great sense of joy and peace knowing that their mother is back in the familiar surroundings of their own home".

JOHANNA GRANT, community case manager, Central West CCAC

" We do not often have the opportunity to transition patients from the complex continuing care ward back into the community.
With a very devoted family and enhanced community supports, we were able to fulfill the Pathan family's wish of bringing their mother home. The story of Mrs. Pathan's return home is a perfect example of how patients and/or caregivers, the hospital, and CCAC can work collaboratively to enhance a client and family's experience/outcome. In this case, the hospital discharge coordinator worked closely with the CCAC case manager, and each relied on the other's expertise in their respective areas, to ensure that Mrs. Pathan would receive the care and equipment she needed for her safe discharge into the community".

TERRI LYNN HANSEN, lead discharge coordinator, William Osler Health System

USING INNOVATION TO DRIVE CONTINUOUS IMPROVEMENT

How Irene was helped by medication reconciliation

Irene is 84 years old and has diabetes mellitus, Alzheimer's disease, high blood pressure, and recently diagnosed ovarian cancer.

Irene currently lives with her son Rene in a bungalow and recently lost her spouse. While she awaits placement in a long-term care home, Irene depends on in-home support from Central CCAC and her son to assist her. With help from the CCAC, Rene manages all aspects of Irene's care.

Irene was brought to the hospital emergency room with a swollen leg, was admitted to hospital, and received treatment for a deep vein thrombosis.

On discharge, Irene was prescribed an anticoagulation injection, and the hospital altered her diabetes and cardiac medications as required. A CCAC hospital case manager arranged in-home services, specifically a pharmacist through Medication Management Support Services (MMSS), to complete a medication review and provide education for Rene on how to administer injections.

Rene was concerned about the increased dosages prescribed by the hospital on discharge and about his mother's symptoms ('shakiness' and lack of alertness). In addition, Irene was uncomfortable to having her son inject her with the medication.

A community case manager conducted a follow-up home visit within fourteen days of Irene's discharge from hospital to determine how Irene and Rene were managing at home.

The pharmacist took time to examine all Irene's medications while in her home and in the presence of Rene since he was the primary caregiver. Irene was indeed shaky, difficult to rouse, and bedridden.

Within forty-eight hours of assessment, the pharmacist was able to work with the family doctor, the CCAC case manager, and a visiting nurse to implement a revised medication regimen due to the urgency of the situation.

The CCAC case manager and the interdisciplinary team worked closely with Irene and Rene to ensure that Rene had sufficient time to learn how to provide the injections safely to his mother and to ensure that the medication regimen as recommended by the pharmacist better addressed Irene's care needs.

This process determined that the anticoagulant medication as ordered on discharge from hospital was dosed incorrectly, and that the antihypoglycaemic medication dosages caused hypoglycaemia after discharge from hospital. The family physician agreed to discontinue her antihypoglycaemic medication.

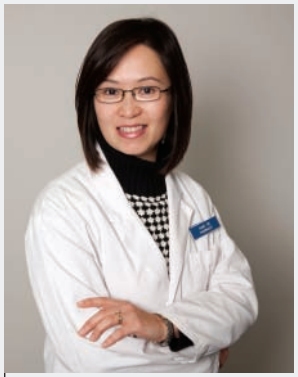
After getting Irene on a proper schedule for medications, Rene saw an immediate improvement in his mother. Irene's shakiness subsided, she was able to stand, and she could even move around with her walker.

THE CCAC COMMITMENT

- CCACs support clients who are living in their homes to stay there.
- CCACs support currently hospitalized clients to return to their homes and stay there as long as possible.
- CCAC processes and tools work to ensure that clients can safely receive quality care in their homes and in their communities.
- CCACs support clients in their choices and will work within those choices to provide the best care and to reduce risk where possible.

What Our Clients, Caregivers and Partners are Saying:

" Promoting safe use of medication is the key component of my work as a MMSS pharmacist. Changes to medications upon hospital discharge are often overwhelming. A MMSS pharmacist provides in-depth education on medications to client and caregiver and works effectively with family physicians to resolve medication issues".



DIANE TIN, pharmacist

MEASURING THE DIFFERENCE CCACS MAKE TO THE HEALTHCARE SYSTEM

Health problems as well as the changes in life associated with aging make depression a common concern for clients with ongoing care needs. In addition, depression can lead to further declines in health when clients don't take proper care of themselves. In 54% of cases, clients showed improvement in depression following the initiation of CCAC services.

Helping caregivers cope better is one of the goals of the CCACs in their support for clients with ongoing needs. Reducing caregiver stress makes good system sense too since studies have shown that caregiver distress often leads to long-term care home placement. About 29% of the time, there was a reduction in caregiver distress following the initiation of CCAC services.

Many CCAC clients have complex medication needs. Medication reviews can help catch medication errors, identify potential interactions, and prevent events such as falls and cognitive or behavioural problems. On average, 50% of patients do not take their medicine properly.[1] Improper use of medication can lead to health complications that account for as many as 23% of hospitalizations.[2] Of long-stay CCAC clients who needed a medication review, 98.6% had one performed by a physician, nurse practitioner, or pharmacist.

Helping caregivers cope better is one of the goals of the CCACs in their support for clients with ongoing needs.

Falls are a leading cause of injury amongst frail clients. For seniors, falls have been shown to hasten moves to long-term care homes and even to hasten death. Injuries resulting from falls are major cost drivers in Ontario emergency rooms and hospitals. It is estimated that falls amongst seniors cost over $2 billion or nearly $500 per capita in Canada in 2004.[3] Fall-related injury rates are nine times greater in seniors than amongst those under 65 years of age.

Falls account for 62% of injury-related hospitalizations for seniors, and 40% of all to long-term care homes result from falls by older people. Of CCAC clients, 64% who had fallen on initial assessment reported fewer falls on reassessment.

[1] A. H. Levbovits, J. J. Strain, S. J.Schleifer, J. S. Tanaka, et al., Patient noncompliance with self-administered chemotherapy, Cancer 65 (1990): 17–22.
[2] R. E. Grymonpre, P. A. Mitenko, D. S. Sitar, F.Y. Aoki, et al., Drug-associated hospital admissions in older medical patients, Journal of the American Geriatric Society 36 (1988): 1092–1098.
[3] The economic burden of injury in Canada, SMARTRISK, 2009.

What Our Clients, Caregivers and Partners are Saying:

" It was important for me as a case manager to follow up and ensure that the client/caregiver received the necessary in-home services in a timely manner. As a team we were able to address both the medication management issues and the necessary teaching required for the son to administer the anticoagulation injections".

MICHELLE BRAMFIT,
Central CCAC case manager

" MMSS was the most important and critical program being sent to the home and the MMSS pharmacist made a difference to my mother's care".

RENE, Irene's son and primary caregiver

MEASURING THE DIFFERENCE CCACS MAKE TO THE HEALTHCARE SYSTEM

Assessment is the first point that a CCAC case manager has a chance to find out about the care needs of a client. CCACs prioritize clients based on their level of need. In this way, clients with urgent care needs can be seen quickly. Fully 50% of community clients are assessed within one day, and 90% of community clients are assessed within sixteen days.

Clients with complex care needs who are living in their own homes are more likely to have adverse events and more likely to benefit from rapid delivery of services than lower risk clients. According to CCAC measurement of the time to first service for complex clients from the community, 65% of such clients in 2009/10 began receiving care within fourteen days.

Emergency rooms (ER) are critical for the healthcare system. Yet many of the people who end up in ER may not actually need emergency care. CCACs have shown that providing strong case management and an effective range of services can reduce the need for their clients to visit ER. Of CCAC clients, 7% visited ER at least once with non-urgent healthcare needs, and we are trying to reduce this number. The Government of Ontario and LHINs have made it a priority for the healthcare system to reduce the length of time that people wait in an ER. CCACs are working to improve our services to make sure that our clients with non-urgent needs only visit an ER if they need to.

Emergency rooms (ER) are critical for the health-care system. Yet many of the people who end up in ER may not actually need emergency care

QUICK FACTS

- Each CCAC works with from **2 to 26** hospitals throughout Ontario.
- Some **225,000** RAI-Home Care assessments are conducted every year to plan ongoing care for **165,000** Ontarians.
- CCACs support the health-care system saving thousands of hospital days by transitioning over **170,000** patients home for care.

THE CCAC COMMITMENT

- CCACs innovate to find more efficient ways to plan, deliver, evaluate, and enhance care.
- CCACs are adapting, optimizing, and providing creative solutions to ensure sustainability of the growing and changing needs of the healthcare system.
- CCACs are flexible, able to quickly shift focus and resources to meet emerging needs.

USING INNOVATION TO DRIVE CONTINUOUS IMPROVEMENT

Resettlement – An Erie St. Clair CCAC Home First Program

Gerald and Rose are senior citizens, managing a number of health conditions. Several years ago, Rose was diagnosed with Alzheimer's and then underwent full knee replacement surgery. Her recovery was not completely successful. Even after managing significant pain, she still had a great deal of trouble walking.

After several days in hospital in recovery, Rose was not doing well. A normally quiet woman, Rose was experiencing discomfort and delirium. For three days and three nights, Rose barely ate or slept and believed that she was going to die before having the opportunity to be sent home.

Instead of waiting for long-term care or having an extended hospital stay, Rose was enrolled in the Resettlement – Home First Program. A collaboration between the CCAC and local hospitals, the program is designed to provide intense short-term services in the home to create greater long-term independence for clients. After a seven-night trial of overnight shift personal support, all in-home service for the couple ceased. It was no longer necessary.

"I cannot tell you what a godsend this program was. We would not be in the shape we are in today had it not been for this program. I cannot emphasize this enough. In our stay at different hospitals, I saw people waiting; these people could be waiting or recovering at home. This is where people do well; they need to be in their home," said Gerald, an Erie St. Clair CCAC client.

Both Rose and Gerald have attended inpatient physiotherapy together and are doing extremely well.

CCACs are implementing a Home First philosophy of care that

- Facilitates hospitals and CCACs working together to help clients transition home from hospitals
- For example, Central West CCAC, in just five months (June–October 2010), saved more than 1,800 hospital days in their region.
- Improves communication between clients and their healthcare teams
- Helps clients return to the comfort of home before they make future decisions about long-term care
- Uses healthcare services as effectively as possible, ensuring that clients receive care in the place that is most appropriate for the level of care they need
- For example, as a result of Home First*, Central West CCAC, in five months (June–October 2010), served 65 more clients than before and increased referrals to enhanced programs by 8.1%.
- Creates better outcomes for seniors
- Reduces the amount of time people stay in hospital

> " Home First is a major culture shift by all members of the healthcare team. We saw our numbers of ALC patients (patients who are in an acute care bed and no longer need to be there) decrease very soon after implementation. It's the right thing to do".
>
> CATHY RAISKUMS, manager of social work and patient flow, Halton Healthcare Services

Instead of waiting for long-term care or having an extended hospital stay, Rose was enrolled in the Resettlement – Home First Program.

Supporting **Children** and Thier Families

CCAC services help children who survive a catastrophic injury at birth or otherwise suffer from serious ailments requiring around-the-clock care. The needs of these children and their families usually involve care both in hospital and at home and, as they get older, care at school. Care in the home often includes nursing services, personal support, and medical supplies and equipment. For children requiring 24-hour care, their families often provide care during the day, and then CCAC nurses and personal support workers assist with the overnight shifts to allow parents to sleep while their children, who might be attached to a ventilator or require other life-sustaining support, are still monitored. CCACs know that caring for a child with special health needs can be overwhelming at times. Getting a break, both physically and mentally, from the day-to-day responsibilities is important. Respite care can provide a period of relief for parents or caregivers while ensuring appropriate care for their children. A wide variety of programs and services are available to help and support children and their families, and CCACs can bring together all of the services from different organizations needed by the child and the family.

CCACs also provide services for children who require assistance in publicly funded, private, and home school settings.

CCACs also provide services for children who require assistance in publicly funded, private, and home school settings. CCACs arrange professional services including nursing, nutritional counselling, occupational therapy, physiotherapy and speech-language therapy for children who require assistance at school. These services may help with issues such as articulation/speech and sound production problems (caused by motor speech disorders including dyspraxias and dysarthrias); as well as assessment for, prescription of, and orientation to augmentative and alternative methods of communication; and swallowing disorders.

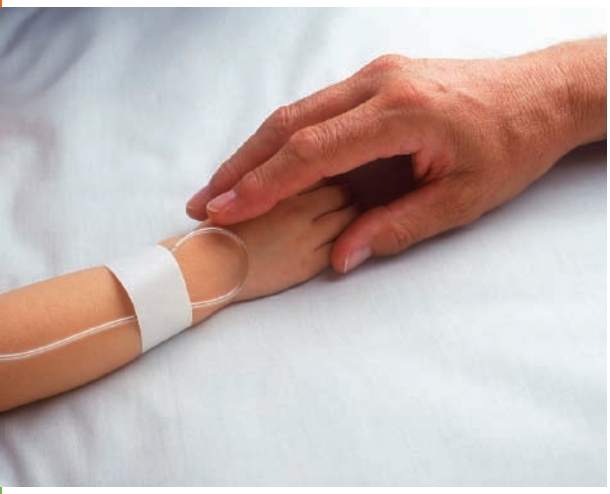
QUICK FACTS

- CCACs support over **50,000** children in any given month.
- Over **20,000** children received school health support services last year.

THE CCAC COMMITMENT

- For children with complex healthcare needs, the CCACs' goal is to work with them and their families to build on the child's strengths, help maximize his or her independence, and support the family in the provision of care both at home and (when children are ready) at school.
- Our School Health Support Services provide children who have special health needs the opportunity to attend school and to maximize their ability to participate in school activities and instruction.

HOW SEBASTIAN WAS ABLE TO STAY HOME WITH HIS FAMILY



In his short life, four-year-old Sebastian has spent more than 700 consecutive days in hospital, endured 500 dialysis treatments, and gone through so many surgeries and procedures that his parents have lost count.

Before Sebastian was born, he was diagnosed with gastrochisis, a rare disorder in which a small defect in his abdominal wall and bowel caused leaking.

"The doctors told us that there was nothing they could do until the baby was born and that even then there could be little hope. It would basically be palliative care," said his mother, Jasmine.

The Toronto Central CCAC case manager was instrumental in helping arrange for nursing and therapy services to help Sebastian with his complex needs both at home and at school. The case manager also ordered a large quantity of medical and intravenous supplies needed for his care. With Sebastian's complex medical needs, it was important to create a plan for him to begin attending school in September 2009.

With the family, the team developed a plan that included an assessment for additional supplies and equipment at the school. As part of the plan, the family agreed to start Sebastian at school two days a week initially and then increase his attendance to five days a week. Arrangements were also made to have a paediatric shift nurse available to provide care for Sebastian at school.

Sebastian's parents are very happy with the care and support they received from the care team.

"The doctors told us that there was nothing they could do until the baby was born and that even then there could be little hope. It would basically be palliative care," said his mother, Jasmine

MEASURING THE DIFFERENCE CCACS MAKE TO THE HEALTHCARE SYSTEM

Last year, CCACs supported 1,572 medically complex children to receive services at home. Each medically complex child that CCACs support is one child who can live at home with his or her family rather than staying in a hospital or other institution.

It is important that families with medically complex children receive services quickly in order to be able to bring their children home and keep them home. Half of clients (50%) receive their first service within five days, and 90% of clients receive their first service within thirty-two days.

Only 3% of the children with complex needs who were receiving CCAC services visited ER in 2009/10.

While not as urgent as care for medically complex clients, rehabilitation services provided in a timely manner have been shown to improve the long-term functionality of children with developmental delays. This is also an area where CCACs have been challenged due to limited resources as well as the lack of availability of specialized practitioners. Of our school rehabilitation clients, 50% receive their first service within 128 days.

USING INNOVATION TO DRIVE CONTINUOUS IMPROVEMENT

South West CCAC tries eShift – an innovative way to support more children at home

Overnight in a client's home isn't like covering an overnight shift in a hospital because the nurse in the client's home is alone one-on-one with the child with few supports. The shifts are difficult to fill – when you're dealing with medically fragile children, you need nurses with a paediatric specialty. Essentially, we needed to find a way to clone the nurses we already had.

The solution was eShift – a technology-based initiative that connects an enhanced-skill personal support worker (PSW) in the home with a registered nurse via a web-enabled iPhone.

PSWs and nurses use the device to share information securely through a web portal. The software developed for the project is intuitive and includes highly customizable clinical decision support tools, a reference library, chat and phone capability, and a supplies-ordering feature.

Instead of working one-on-one with clients, eShift enables each paediatric registered nurse to monitor, mentor, and manage care at up to four locations simultaneously.

Essentially we're giving a nurse who works remotely eyes, ears, and hands on location. It's all of the efficiencies of a hospital without the overhead; the technology allows them to have the real-time information about the client that they need.

– Excerpt from South West LHIN Exchange Newsletter

What Our Clients, Caregivers and Partners are Saying:

" Receiving a drug card (to help pay for medications) and the necessary medical equipment is an enormous burden lifted from us. We are especially delighted that Sebastian will be able to attend a French school in September and not the recommended school for special needs children".

JASMINE,
Sebastian's mother,
Toronto Central CCAC client

" There are so many areas in healthcare where mobile and telehealth solutions can make a difference. But whether we're talking about capacity management, electronic health record integration, or the optimization of healthcare resources, eShift is playing a role. It's very exciting to see this program grow".

MICHAEL BARRETT,
CEO, South West LHIN

Caring for **Clients** with Short-term Needs

Today, more than ever, Ontarians are receiving in their homes and communities care that was previously provided in hospital. These services help people recover from injury or surgery, such as hip or knee replacement, and include rehabilitation and wound care. Other people have acute episodes, such as infections, which may require short-term intravenous therapy (IV) or wound care, both of which can be safely provided at home or in the community. Many local CCACs have community clinics where regulated healthcare providers provide treatment that will address specific healthcare needs. This may include IV therapy, wound care, and rehabilitation.

THE CCAC COMMITMENT

- CCACs provide short-term services to clients to help them regain their level of functioning and independence.

QUICK FACTS

- Over **20,000** CCAC clients received short-term wound care services last year.
- Last year, **16,000** clients received rehabilitation services following hip or knee replacement surgery.
- Each month **30,000** adults receive rehabilitation services from CCACs.

HOW RICK'S DIABETES WAS TREATED IN HOPES HE WOULD HEAL FASTER AND NEED FEWER NURSING VISITS

Rick, a 63 year-old diabetic, underwent a procedure to amputate his big toe in January 2010. The Central West CCAC now provides him with nursing visits for his wound care.

"Initially they came every day. Now it's twice a week," says Rick, whose left foot is still mending from the amputation. Visiting nurses change the dressings on his wound and remove any dead tissue.

Since poor circulation and nerve damage is not uncommon for those with diabetes, Rick's right leg was also amputated below the knee five years ago. Previously, the CCAC would work with three different service provider agencies to deliver nursing services, personal care, and occupational therapy. Now, through a more integrated care approach, CCACs are able to deliver care for clients in a way that allows them to heal better, at home, and faster while also addressing the cause of the problems. In cases of people with diabetes, like Rick, they may also receive help from a dietician and a nurse who specializes in wound care as well as a chiropodist (a specialist in foot care).

The realization is growing that CCAC clients such as Rick could be better served at a lower cost to the system by coordinating services and investing in the latest wound-care products that cost more initially but help accelerate the healing process.

Now, through a more integrated care approach, CCACs are able to deliver care for clients in a way that allows them to heal better, at home, and faster while also addressing the cause of the problems.

USING INNOVATION TO DRIVE CONTINUOUS IMPROVEMENT

CCACs Demonstrate Evidence-Based Practices in Community-Based Clinics

Several CCACs now deliver some of their nursing care through community-based clinics rather than in-home visiting nursing. CCAC clinics have specialized nursing teams with advanced knowledge of wound care and intravenous therapy. By receiving care in a clinic setting, CCAC clients have better access to the expertise of these specialized nurses, and clients can arrange appointments at times more convenient for them. Evidence has shown that clients receiving care from CCAC clinics have better healing rates and use fewer services as compared to clients receiving one-on-one nursing visits in the home.

Clients report high rates of satisfaction with CCAC clinics, and CCACs report better use of nursing resources in a clinic setting.

North Simcoe Muskoka CCAC Demonstrates Accountability in Community Wound Care

Multiple studies have indicated that wound management is a critical patient safety issue. Wounds can lead to pain or disfigurement and can predispose people to infections.

Research indicates that while 35 to 50% of a visiting nurse's practice in the community is directed to wound management, 30 to 40% of clients are not receiving evidence-based care. Consequently, the CCAC identified the need to improve health outcomes for clients living with acute and chronic wounds. This work became a key performance improvement initiative and resulted in the need for a standardized measurement approach.

The CCAC implemented Health Outcomes Worldwide's how2trak® outcome management system. Our service provider partners utilize the system to help inform their own practice and continuous quality improvement efforts. Our client care coordinators and their managers make use of the data found in the system to access essential information used in the authorization of services for clients living with wounds.

The system has enabled us to collect and analyze data as well as identify practice differences, leading to the implementation of consistent standardized best practices. As a result, our clients are receiving improved care and, working together with us, to reach their wound care goals. In addition, we are using our nursing resources and medical supplies more effectively, with the savings enabling us to direct more resources to other client care needs.

MEASURING THE DIFFERENCE CCACS MAKE TO THE HEALTHCARE SYSTEM

For certain client care needs, the rapid involvement of healthcare professionals with clients after hospital discharge has been shown to improve outcomes and reduce hospital readmission rates. Among clients requiring short-term acute services, 55% receive their first service within one day, and 92% receive their first service within fourteen days.

Effective and timely CCAC service provision for these clients has been shown to reduce hospital readmission rates. Readmission rates for shorter-term clients referred to CCACs from hospital are 23%.

All fourteen CCACs are using evidence-based wound care protocols.

What Our Clients, Caregivers and Partners are Saying:

" The daily clinic visits turned out to be just what I needed. You know, people tend to get a little depressed after surgery. I had become very listless, but that clinic appointment forced me to get out of bed, shower, get dressed, and leave the house. It was actually a good thing for me."

COLETTE DESPATIE,
A Mississauga Halton CCAC client

Helping Dying People Stay Home with Their Families

Research shows that 75% of palliative (end-of-life) patients wish to die at home (Carstairs, 2000). The goals of palliative care are to provide compassionate, quality client-centred care to clients and families through psychological support, pain and symptom management, and bereavement support. For many people, planned death at home allows for more sustained relationships with families and loved ones and enhances their sense of control and quality of life.

Carstairs, S. (2000). Final Report: Quality End-of-life Care, the Right of Every Canadian. Ottawa: Standing Senate Committee on Social Affairs, Scienceand Technology.

THE CCAC COMMITMENT

- CCACs will work with clients and families to provide end-of-life care that addresses their needs and wishes and is sensitive to the cultural and spiritual aspects of care. The goal of CCAC palliative care is to provide quality client-centered care to clients and families who are living with or dying of an advanced illness and to ease suffering in order to provide the highest quality of life possible. CCACs also understand that the wishes and needs of clients and families may change as a client's condition changes and available supports will be adjusted or added.

QUICK FACTS

- CCACs provided care for over **20,000** clients dying from a terminal illness or natural causes.
- In 2009/10, **46%** of end-of-life clients were able to stay in their homes until they died.

HOW JEAN AND THE CCAC BECAME PARTNERS IN HER CARE

In the last year and a half of her life, Jean had three lengthy hospital stays, received healthcare in her own home, had countless clinic appointments, moved to a hospice for three months, and then lived in an assisted-living home, where she received regular visits from a CCAC personal support worker, physiotherapist, nurse, and occupational therapist as needed.

Through it all, the Mississauga Halton CCAC was a constant, dedicated partner.

Jean, 60, had a brain tumour that doctors told her was terminal. She and her husband David accepted that reality with a combination of pragmatism and optimism.

The CCAC's support to Jean evolved over the last eighteen months based on her needs – from planning her discharges from hospital to setting up services at her home, the hospice, and then finally in an assisted-living setting.

One of the most important things for Jean was maintaining as much independence as possible. When she first arrived at the assisted-living home she could not move herself from her bed to a wheelchair or from a wheelchair to the toilet, and staff used a mechanical lift to assist her. Although she understood the necessity for it, Jean hated this assault on her dignity.

Despite her declining health, Jean was determined to improve her function, and the CCAC arranged for a physiotherapist to help build up her strength. Regular physiotherapy sessions plus the installation of a support pole enabled Jean to get out of bed on her own, and then the mechanical lift was no longer needed.

"Regrettably, Jean, an incredible fighter, has now lost her battle with serious illness, but her admirable legacy lives on—she donated her eyes to two separate people and her body to research at the University of Toronto," says Marlene Grzesiak, Jean's case manager. "In a palliative situation, I always say we walk a shared journey with our clients".

Despite her declining health, Jean was determined to improve her function, and the CCAC provided a physiotherapist to help build up her strength.

MEASURING THE DIFFERENCE CCACS MAKE TO THE HEALTHCARE SYSTEM

- Among end-of-life clients, 50% receive their first service in three days, and 90% receive their first service in eleven days.
- Prompt and sufficient services provided by CCAC can reduce the need for end-of-life clients to need to visit emergency rooms. Only 36% of CCAC end-of-life clients used the ER in 2009/10.

What Our Clients, Caregivers and Partners are Saying:

" I would like to express our sincere gratitude and appreciation to the CCAC for the outstanding support and guidance during the last six months of my mother Margaret being with us. Your staff are angels in disguise and true assets to your organization. Being the primary caregiver of my elderly mother living with dementia, I found that their dedication, professionalism, knowledge, empathy and, I might add, humour certainly helped alleviate some of the stresses I encountered".

A CENTRAL CCAC CLIENT

" We were happy and confident with the care plan and the back-up plan of a hospice setting just in case. We were very thankful that the system supported us in our wishes".

A NORTH EAST CCAC CLIENT

USING INNOVATION TO DRIVE CONTINUOUS IMPROVEMENT

In 2008, the Government of Ontario announced changes that would allow CCACs to expand the range of services we provide. Since then, several CCACs have hired nurse practitioners, and pharmacists to provide better, more integrated services for our clients. CCACs continue to look for new ways to address our clients' health needs across the entire continuum of care.

Connecting People to **Care** in Their Community

Every day CCACs connect thousands of people to the care they need. Information about services in the community is available through a local CCAC by calling 310-CCAC or through our website at www.310ccac.ca

Connecting people to community services

CCACs work in partnership and help connect clients to the hundreds of community support services available across Ontario. Community support service agencies provide a range of services to help people stay in their homes and communities including day programs for persons with Alzheimer's, attendant services, caregiver support, meal programs, friendly visiting, home maintenance and repair, homemaking, recreational and social services, transportation, and many others. Availability of community support services varies by community and some services have fees. More information about available services can be obtained from a local CCAC at 310-CCAC or the Ontario Community Support Association.

Supporting people who need long-term care

CCACs are connected with every long-term care home in the province. CCACs determine eligibility and priority for access to more than 600 long-term care homes in Ontario, provide counselling and assistance with choices and options to match client needs with resources, manage waitlists, and authorize admissions. Long-term care homes are designed for people who require the availability of 24-hour nursing care and supervision within a secure setting.

CCAC case managers provide support for clients and caregivers in considering a range of options, including long-term care. CCACs assess clients for long-term care eligibility, assist with the application process, and support clients and families through the transition when a long-term care home bed becomes available. Across the province, the wait time for a long-term care bed varies from a few days to a year or longer. For clients who are waiting for long-term care, CCAC case managers can also arrange for home care services, short-term respite care, or other types of supports to enable clients to stay at home as long as possible.

HOW TOM WAS CONNECTED TO CARE IN HIS COMMUNITY

As a 68-year-old man, Tom was used to being active and independent in the community. Recently, he was involved in a serious car accident that resulted in brain injury and a crushed spine.

Tom's mobility was seriously impaired and he was no longer able to function independently. He also experienced severe pain occasionally.

When Tom was discharged from hospital, a case manager with the Toronto Central CCAC, helped coordinate his care in the community. She connected him to a network of 34 community support service agencies in the Toronto area, the Community Navigation and Access Program. The network was able to connect him to St. Christopher House to provide him with meals through their Meals on Wheels program and help with transportation to help him get around the city. They also connected him to West Toronto Services for Seniors for home help.

The CCAC connected him to a network of 34 community support service agencies in the Toronto area.

THE CCAC COMMITMENT

- CCACs innovate to find more efficient ways to plan, deliver, evaluate, and enhance care.
- CCACs are adapting, optimizing, and providing creative solutions to ensure sustainability of the growing and changing needs of the healthcare system.
- CCACs are flexible, able to quickly shift focus and resources to meet emerging needs.

QUICK FACTS

- In 2009/2010, the CCACs connected over **30,000** patients to a family health-care provider via the Ministry of Health and Long-Term Care Health Care Connect Program
- CCACs work with **150** service provider organizations to deliver a range of in-home and in-school services to clients.
- Each month CCACs support **1,800** clients who transition to a long-term care.

USING INNOVATION TO DRIVE CONTINUOUS IMPROVEMENT

Nurse practitioners support CCAC clients with healthcare options

Nurse practitioners in long-term care homes play an integral role in improving the quality and continuity of resident care. They also facilitate the discharge of residents from hospitals back to their LTC homes. The Central East CCAC is one of three healthcare service providers appointed by the Central East LHIN to implement the Nurse Practitioners Supporting Teams Averting Transfers (NPSTAT) program. In October, the NPSTAT LTC outreach team directly intervened in the care of 446 clients, potentially diverting 98% of them from their nearest emergency room.

CCACs coordinate care in the community

The Central East CCAC and Community Care Durham (CCD) partnered in a project to support a CCD referral coordinator and base the role out of the Central East CCAC office. This partnership resulted in a collaborative approach to intake services and was initiated to enhance client care experience and ensure positive outcomes.

The CCD coordinator works within the Central East CCAC office to provide seamless connections between community-based services, linking clients with the care they need in their own community. By working together, the partners are focused on enhancing every client's experience of care. From October 2009 through June 30, 2010, they have facilitated more than 650 successful referrals through this initiative.

CCACs connect people to family physicians and primary care

In 2009, the Ministry of Health and Long-Term Care launched Health Care Connect, a program to help Ontarians without a regular family healthcare provider find one in their community. CCACs, acting as 'Care Connectors,' identify doctors or nurse practitioners who are accepting patients and link them with people who are in need of a family healthcare provider. The Health Care Connect Program is supported by dedicated care coordinators at each CCAC, who help people connect with a family healthcare provider in their community. CCACs are the only community agencies that build relationships with every family physician in the province.

Health Care Connect 1-800-445-1822 or www.ontario.ca/healthcareconnect

CCACs work with Community Support Services to help people live healthier lives

Aging in Place is an Aging at Home initiative funded by the Champlain Local Health Integration Network (LHIN). This innovative project is designed to provide an integrated mix of services to seniors living in Ottawa Community Housing (OCH) apartment buildings. It provides support to clients to help them live healthier lives so that they can remain safely in their homes for a longer period of time. This partnership between the Champlain CCAC, Ottawa Community Support Coalition (led by Ottawa West Community Support), Ottawa Community Housing, and Ottawa Public Health allows seniors to have the right care at the right time and the right place. It targets at-risk seniors who are at high risk for emergency room visits and hospitalization, as well as those who face access barriers to healthcare.

Through Aging in Place, a Champlain CCAC case manager and community support services (CSS) outreach coordinator offer coordinated and integrated services by working together on-site in storefront offices. Their presence, along with such services as short-term home-making, Meals on Wheels, foot care, health promotion group activities, assistance with system navigation, and a nurse practitioner, all work towards the joint goal of reducing emergency room visits and hospitalizations, as well as avoiding premature admission into long-term care homes.

In 2009-2010, the initiative, which involved eleven Ottawa Community Housing apartment buildings, worked with 570 unique CCAC clients and 2,237 combined CCAC and CSS clients. One client became alternate level of care (ALC) from hospital, while another twenty were community admissions to long-term care homes.

MEASURING THE DIFFERENCE CCACS MAKE TO THE HEALTHCARE SYSTEM

- Long-term care homes play an important role in supporting clients who require access to 24/7 nursing care in a supportive environment. Across the province, the wait time for long-term care varies from a few weeks to several years. Yet reports consistently show that some clients who move to long-term care homes who may not need the full level of care that these homes provide. If CCACs are effective at assisting people with complex care needs to live safely in their homes, we can help ensure that more long-term care beds are available for the people who need them. CCACs have an assessment tool for identifying which clients are most in need of long-term care. Clients with "high" or "very high" scores on the assessment tool have the greatest need for placement. Of clients placed in a long-term care home, 77% scored either "high" or "very high".

- CCACs prioritize clients waiting for LTC home placement based on their assessed care needs. The median wait time for clients for long-term care home placement is 111 days.

What Our Clients, Caregivers and Partners are Saying:

" I'm so grateful for the CCAC – helping me get access to the services I need has really made a difference for me. I feel safe and confident in my own home".

TOM,
a Toronto Central CCAC client

The North West CCAC, in partnership with the North West LHIN, has a three-year pilot project for a newly developed CCAC role called a 'system navigator', a staff member who works directly in seniors' apartment buildings, creating a bridge between home and primary care for elderly clients with complex, chronic diseases.

" The NW CCAC system navigator has been great; she helps me get to my doctor's appointments regularly. Sometimes, even simple things, like cleaning, laundry, and preparing meals, can be hard for me and too much work for my daughter, but the system navigator keeps me connected to the right people so I can live in my apartment and play bingo with my friends whenever I want".

A North West CCAC client

The Path Forward

partnerships

The CCACs' first report on quality is not only about showing some of the ways we are successfully caring for clients, it is also intended to acknowledge areas where we need to do better. This section shows where CCACs have identified a need to improve our services and the steps we are taking to make those improvements a reality.

QUALITY IMPROVEMENT OPPORTUNITY #1

Finding a way to measure the experience of clients and caregivers and comparing that experience across CCACs

In 2007, when the fourteen new CCACs were established, we looked for opportunities to measure client feedback in a way that would allow us to compare results across CCACs. The ability to compare results helps us identify where different CCACs are doing well in meeting the expectations of our clients and caregivers and to then learn from each other.

- In 2009, half of the CCACs started using a common Client and Caregiver Experience Evaluation Survey to help us get feedback on quality directly from the people we serve.
- By 2011, all fourteen CCACs will be using a core survey that measures our clients' perceptions of their overall experience, client-centred care, scheduling of home care visits and punctuality, quality of care, relationships and trust with CCAC staff and service providers, integration of care, how well CCACs support clients to access services across the health system, home safety, and other important aspects of care.
- By 2012, we will have enough information to be able to share results and show the feedback from our clients and caregivers on their experiences with the care they receive.

At the request of the Ontario Health Quality Council, the CCAC core client survey includes several standard questions that CCACs can use to compare ourselves to other health-care services across Canada and internationally.

In addition to our common Client and Caregiver Experience Evaluation Survey, CCACs have started using other means to gain valuable feedback from clients and caregivers about their care experiences.

CCACS LISTEN TO WHAT OUR CLIENTS TELL US

As one example, the South East CCAC partnered with Quinte Health Care Corporation in a project entitled 'Having Their Say and Choosing Their Way' that was funded by The Change Foundation in partnership with the Ontario Association of Community Care Access Centres.

The project focused on identifying opportunities for improvement from the client and family's perspective based on their experience in transitioning from hospital to a long-term care home. The findings from the project exposed both areas of deficiency and opportunities for improvement spanning the entire system. For the South East CCAC, several key themes emerged related to providing consistent and timely information, treating the client and their family members with kindness and respect, and assisting the public in understanding what a CCAC offers, the value of the service, and how to access care when needed. A series of projects addressing the quality and timing of the information provided about long-term care home transfer from hospital have been initiated in the aftermath of the project report.

The experience Mrs. Davis shared during her mother's journey from Quinte Health Care to a nursing home illustrates how findings from this project are being translated into continuously improving the quality of care people receive.

"The CCAC case manager was just a lovely person. And just so . . . very informative. And she talked to my mother which I liked, you know, because you're at that age, some people sort of dismiss you sort of thing. And I liked the way she . . . I was there, but she talked to my mother".

quality

QUALITY IMPROVEMENT OPPORTUNITY #2

Delivering better care by customizing care to meet each client's needs

CCACs are committed to ensuring that those who use their services will have an excellent experience and achieve their desired outcomes. Not everyone who uses CCAC services has the same needs; our clients vary as a result of existing health conditions, socioeconomic factors, degree of independence, and risk of experiencing acute episodes.

CCACs are developing a new Provincial Client Care Model, a population-based model designed to recognize that some clients require a higher level of case management intensity and more resources than others. Client services practices, case-management services, and support will be customized to meet the specific needs of the different client populations, including working differently with contracted service providers and other care providers who deliver services to CCAC clients.

The client care model, developed collaboratively by Ontario's CCACs, is intended to build consistency across CCACs in their approach to case management and to target relevant services to the identified client populations. Although the model is still in its development phase, several CCACs are starting to use it and are contributing to the plan's provincial implementation. We expect that all CCACs will start using the new model by 2012.

QUALITY IMPROVEMENT OPPORTUNITY #3

Supporting clients with integrated care teams to improve health outcomes

Research demonstrates that more integrated approaches to care result in better health outcomes and more cost effective care overall. A significant system-wide initiative, the Integrated Client Care Project (ICCP) is testing innovative ways to improve the home care experience for the people who need care, for the people and organizations who provide care, and for the healthcare system that pays for the care. It involves developing, implementing, and evaluating focused sites to study the transition to an integrated client care model. Using a quality improvement approach, the anticipated benefits are healthier Ontarians, improved population health outcomes, and improved value and best use of available resources.

The project organizes care around certain common conditions and client groupings that will benefit from a more coordinated approach, including wound care, palliative care, frail elderly, and medically complex children. This year four CCACs and their service provider partners came forward to focus on clients with diabetic ulcers and venous leg ulcers requiring wound care. In early 2011, some CCACs and their partners, including service providers and LHINs, will begin planning for more integrated client care for palliative clients.

Committed to a quality improvement approach, the

- Building province-wide quality improvement capacity and leadership skills for CCAC employees
- Analysing the current process of care, identifying bottle necks and redundancies, and designing and testing improvement ideas
- Moving toward an outcome-based approach for clinical and process measurement

The project – co-sponsored by the Ministry of Health and Long-Term Care, the Ontario Association of Community Care Access Centres (OACCAC), and the Collaborative for Health Sector Strategy at the Rotman School of Management, University of Toronto – brings together senior leaders, experts, and champions in healthcare, home care, and service delivery. CCACs are proud to be leading innovation in the delivery of client care and know that this transformation can spread to re-engineer Ontario's healthcare system to dramatically improve value for Ontarians.

North East CCAC Integrated Client Care Project (ICCP) continues to move successfully forward in improving quality and client outcomes.

Through involvement with this project and the collaborative efforts of the participants, tools and processes have been developed to improve system integration and client clinical outcomes such as:

- An Interprofessional Assessment Tool
- A Common Chart
- A Clinical Care Path
- A Discharge Process
- A Post-Discharge Client Survey

These efforts are being focused on clients with diabetic foot ulcers and venous leg ulcers.

Demonstrating positive results, the ICCP initiative is showing improvements to length of stay and wound reduction after twelve weeks for diabetic lower leg ulcers, exceeding the targeted objectives of 10% improvement.

effective

QUALITY IMPROVEMENT OPPORTUNITY #4

Supporting clients in their preferences to live at home as long as possible

The majority of seniors, when asked about what is most important to them, tell us that they want to live at home as long as possible. For seniors who are receiving care in hospital, they tell us they would prefer to go home.

On any given day, there are hundreds of patients in acute-care hospital beds who no longer require acute care but who are unable to return home for various reasons. These patients stay in hospital for weeks or months waiting for another care setting better suited to their needs. Many move to long-term care prematurely. The issues of access for different health services were highlighted in the recent Annual Report from the Auditor General of Ontario.

Across Ontario, the demand for home care services is increasing every day. CCACs have to find ways to make sure that the funding we have is spent as effectively as possible. One way to do this is by making sure that clients who need care more urgently get access sooner than those who don't. We have a standardized assessment process that helps us identify and prioritize clients who need care sooner.

CCACs are now working with Local Health Integration Networks (LHINs) and hospitals on a Home First strategy to look at how we can find innovative ways to support clients to come home from hospital and stay at home as long as possible. Some additional funding has been provided to CCACs through the Ministry of Health and Long-Term Care and LHINs to enable us to provide a higher level of service for a short time to help more clients transition home from hospital, but the demand for our services continues to grow.

While there continue to be challenges, CCACs are working with our funders and our partners to figure out better, more effective ways to support as many people as possible with the care they need to live at home.

The majority of seniors, when asked about what is most important to them, tell us that they want to live at home as long as possible. For seniors who are receiving care in hospital, they tell us they would prefer to go home.

QUALITY IMPROVEMENT OPPORTUNITY #5

Helping people access the right care in the right place across the system

On any given day across Ontario, thousands of people are waiting for care in different settings. CCACs are finding new ways to improve access to local healthcare services and enhance services for clients. Some examples of local initiatives include the following.

1) North West CCAC is helping clients, based on their needs and priorities, access supportive housing services in a new supportive housing building – McKellar Place Supportive Housing Project – that opened in November 2010. This project will also serve as the basis to support the occupancy of 132 supportive housing units at the Centre of Excellence for Integrated Seniors' Services, anticipated to open in late 2011 or early 2012.

2) Waterloo-Wellington CCAC has initiated an integrated assisted-living program that combines 24/7 access to personal support with other services to support seniors who wish to age in place in their own neighbourhoods. Through this program, clients are linked to partner organizations and resources for health, wellness, recreation, exercise, social supports, and increasing knowledge for self-managing chronic health conditions.

3) Central CCAC is supporting access to three adult day programs, including one specifically for the Chinese community, providing a range of services that help support people to live at home longer.

These are just a few examples of new initiatives by CCACs that expand the support we provide to clients in our local communities.

QUALITY IMPROVEMENT OPPORTUNITY #6

Investing in an electronic health record for CCACs to enable health system integration and support better client care

CCACs develop and plan shared business technology solutions, such as assessment systems, resource matching and referral, health partner gateway, and a single Client Health Related Information System (CHRIS) to facilitate client transitions and information sharing.

By modernizing, automating and better supporting case management processes through the CHRIS, CCAC case managers are now better able to coordinate care, use less paper, spend more time with clients, and collect and analyse data more effectively in order to track and measure our clients' outcomes. Evidence of safety and continuous quality improvement is based on strong data sets; we need to measure in order to identify what we are doing well and to find ways to do better for the clients we serve.

requiring access to data contained within the provincial CCAC platform. Hospital physicians connect with CHRIS via their respective hospital's portal to query relevant client-specific information. This includes

- Searching for an existing CCAC client by name, health card number, birth date, and/or gender
- Retrieving demographic information for a current CCAC client, such as name, status, and contact info
- Reviewing services being received by a current CCAC client, including type, delivery, frequency, authorization info, and estimated discharge date
- Looking for the designated medical contact and/or the primary contact information for a current CCAC client
- Retrieving a list of long-term care homes chosen by a CCAC client and other placement details

Currently, more than 6,700 CCAC staff members use CHRIS to perform 3.5 million transactions servicing more than 250,000 Ontario residents who are active CCAC clients.

Historically, there has been no single system capturing information for the community health sector. Prior to the creation of 14 CCACs in 2007 we were using 43 disparate systems and different processes to service clients. In 2008, CCACs began using CHRIS for case management, care provisioning, reporting, and financial management. Developed internally by the OACCAC's technology division, the web-based system has been successfully rolled out across the province to thirteen CCACs with the final instalment planned for 2011.

CHRIS was designed to provide case managers and administrators with a common system to enter and track client information and care plans. Currently, more than 6,700 CCAC staff members use CHRIS to perform 3.5 million transactions servicing more than 250,000 Ontario residents who are active CCAC clients.

In addition to CCACs using the system, CHRIS provides system-to-system integration capabilities for hospitals

Since instituting CHRIS, reporting at both the local and province level is more accurate and consistent because of the system's strict rules for how CCACs capture and enter data. Consistent data entry across the province has helped aid decision makers in developing funding models and processes to enhance client care.

In addition to providing care and connecting people to the most appropriate place for care, whether at home (Home First), in school (School Health Support Services), in congregate settings, in family health teams, etc., CCACs are connected to each other and their service providers through CHRIS. An important step towards a CCAC electronic health record, CHRIS is also starting to connect CCACs to other parts of the health system including hospitals and family physicians.

Leading-Edge Technology is a Powerful Integrated Decision Support Solution

The Integrated Decision Support (IDS) data warehouse is a powerful business solution evolving as a key quality initiative in one of the largest regions in Ontario. This leading-edge technology is evolving to gather and analyze timely data from a variety of sources that were not previously linked.

The Hamilton Niagara Haldimand Brant (HNHB) CCAC is proud to be a partner with area hospitals and the LHIN in this regional system built with the ability to link patient-level data across multiple data sources and multiple episodes to track patient flow.

"We are very pleased to be able to contribute meaningful, current data to support building a robust decision support system", says Janet Doering, senior director of performance management and accountability, HNHB CCAC. "The information we can pull from the IDS supports continuous improvement in quality of care and client safety, so it really is good news for clients and their caregivers and supports more efficient and effective decision making for the health sector as a whole".

The data warehouse is secure and allows web-based access to organization's data via an e-health network. The CCAC contributes two major sources of data to the system and is working closely with partners to better understand client populations and needs.

The IDS allows the CCAC and its partners to better understand the impact of home care supports at various points in an individual's care journey from home to hospital. It will also make possible the mapping of a patient's journey between hospitals and the CCAC, allowing for greater support, safety, and quality of care as people move through the system.

"Ultimately, we want to ensure that individuals receive appropriate care in a timely fashion. Because this information is timely and coordinated, it paves the way for better quality care," says Doering.

While the initial phase of development primarily focused on hospital and CCAC data, the architecture is built for scalability and capacity. Over time, the system will grow to include other organizations where people in the region access healthcare, such as long-term care homes and community agencies. Planning for the future will allow for further evolution in providing seamless healthcare across the continuum of services in the community.

QUALITY IMPROVEMENT OPPORTUNITY #7

Comparing our quality of care against national standards

By 2012, all fourteen CCACs have committed to either have completed or to be scheduled to complete a process of accreditation for quality with a recognized accrediting organization.

Accreditation is a voluntary process, independent of government, and organized and administered by a third-party accrediting body. Although there are different ways CCACs can be accredited, the general goal is to help us examine and improve the quality of the care and services we provide to our communities by evaluating our services according to national standards for the delivery of quality healthcare. This is an important step in our efforts to improve the quality of care we deliver.

accountable

How to Contact the CCAC

CCACs have a responsive team of staff who will answer your questions and help you access the care you need. CCAC services are fully funded by Ontario's Local Health Integrated Networks (LHINs) and serve people of all ages.

By phone:
Call us 7 days a week at **310-CCAC (2222)** or français **310-CASC (2272)**.

On the Internet:
www.ccac-ont.ca

Connecting you with care
Votre lien aux soins

ccac
Community
Care Access
Centre

casc
Centre d'accès
aux soins
communautaires