HOW WE CARE.

2012-2013 CCAC Quality Report

ccac Community Care Access Centre

casc Centre d'accès aux soins communautaires

Last year, CCACs helped over 653,000 people receiving care in homes and communities across Ontario by:

- Providing care at home to **532,000** patients[1]
- Supporting **318,000** seniors, enabling them to stay in their homes independently[2]
- Ensuring **82,000** children received health services at school[3]
- Supporting **25,000** people through their end-of-life experience with care at home[4]
- Helping **26,000** people transition to long-term care, when it became too difficult for them to live independently at home[5]
- Supporting an average of **4,000** people discharged from hospital per week with CCAC care[6]
- Connecting **61,700** people to a family physician or nurse practitioner through Health Care Connect, including **5,800** patients with high-care needs[7]
- Making thousands of referrals each day to other community support services to ensure people have the support they need to live independently

GETTING PEOPLE THE CARE THEY NEED AT HOME AND IN THE COMMUNITY – AND GETTING BETTER EVERY DAY.

As Ontario's population ages and people's needs are more diverse, our current health-care system is evolving to better address the burden of chronic disease, the reality of age-related health challenges, and help people to maintain their independence.

Increased investment in home and community care by the Ministry of Health and Long-Term Care ensures people across the province can remain in their homes and communities—and out of hospital or long-term care homes, for as long as possible. Embracing this call to action, Ontario's 14 Community Care Access Centres (CCACs) are working with our partners: hospitals, community support services, primary care, community health centres, service provider organizations and long-term care homes—to build a system that works for Ontarians.

[1] Ministry of Health and Long-Term Care Health Data Branch Web Portal, Individuals Served In-Home Health Care (Table 3).
[2] OACCAC Home Care Database, count of active patients age → 65.
[3] Ministry of Health and Long-Term Care Health Data Branch Web Portal, Individuals Served – Publicly Funded Schools and Private/Home Schools (Table 3).
[4] OACCAC Home Care Database, count of active End of Life Patients.
[5] Long-Term Care Home System Report (July 30, 2013), Ministry of Health and Long-Term Care Health Data Branch, Health System Information Management & Investment Division.
[6] OACCAC Home Care Database, analysis undertaken June 2013.
[7] Ministry of Health and Long-Term Care, Monthly Health Care Connect Reports

CCACs focus on continuous quality improvement in everything we do.

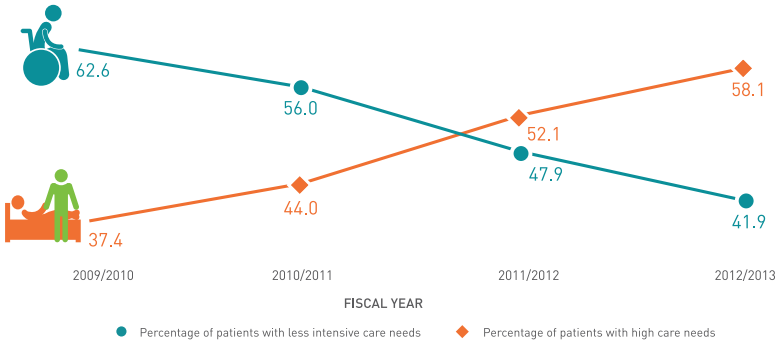
We provide:

- *better access* to care for people in homes and communities across the province, providing intense support for people with the highest care needs
- *better care* by working as a team to innovate to improve care and participating in new approaches and models for caring for patients, including Health Links—to ensure connections between primary care and care coordination for the patients' full journey through the health-care system
- *better value* by creating efficiencies to improve the patient experience and facilitating successful transitions to deliver the care that people need, now and in the future

The 2012-2013 Quality Report measures our performance, tracks progress on the targets laid out in our last report, and looks to the future—setting new targets for the years ahead.

2012-2013 IN REVIEW

CCACs ARE CARING FOR PATIENTS WITH HIGHER AND HIGHER CARE NEEDS

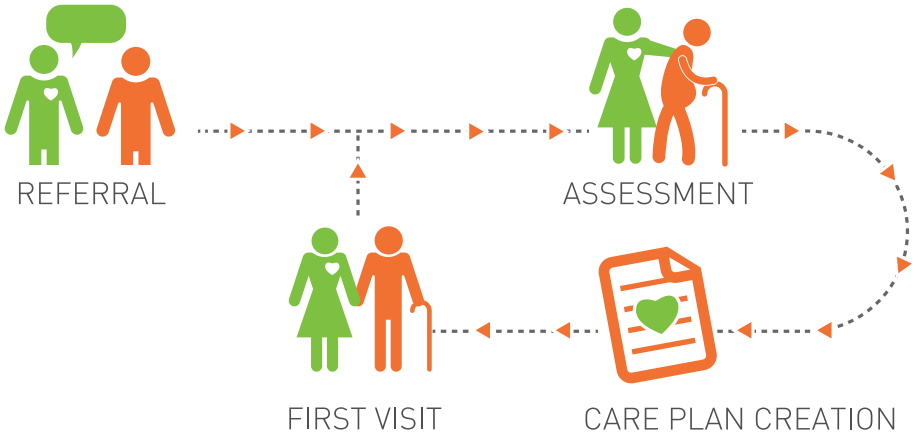


INCREASING PERSONAL SUPPORT SERVICES FOR PATIENTS WITH THE HIGHEST NEEDS

8 per cent increase in personal support services since 2011-2012
1.8 million more hours

23 per cent increase since 2009-2010.

WORKING HARD TO DECREASE WAIT TIMES FOR OUR PATIENTS



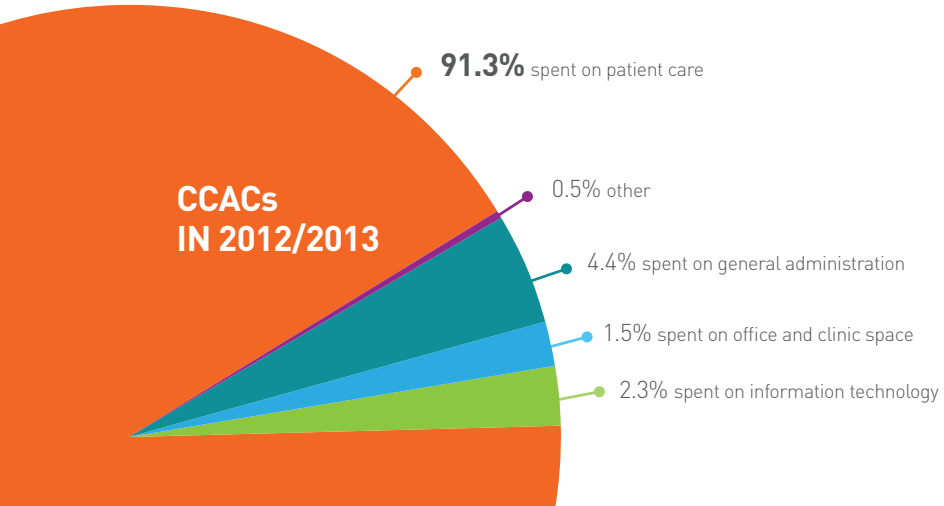
Hospital Referral

Half of patients with complex care needs referred through hospital had their first service visit within **1 day**. And 90% of patients with complex care needs had their first service visit between **1 and 5 days.**

Community Referral

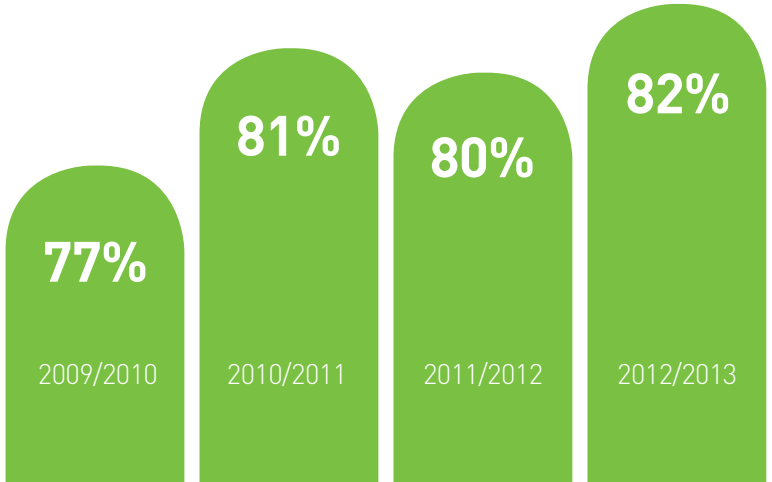
Half of patients with complex care needs referred through the community had their first service visit within **9 days**. And 90% of patients with complex care needs referred through the community had their first service visit between **1 and 30 Days.**

MAKING THE MOST OF OUR HEALTH-CARE DOLLARS

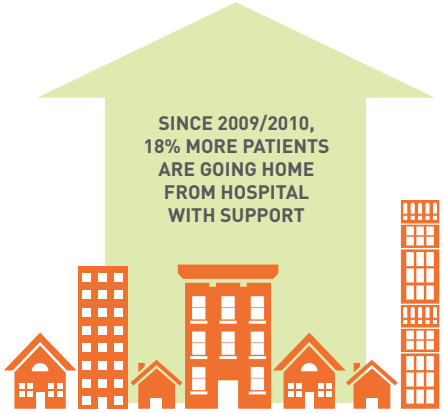


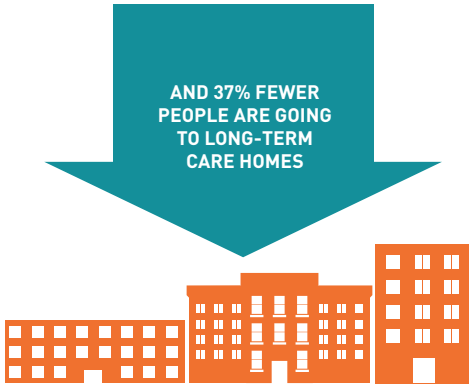
ENSURING PATIENTS IN LONG-TERM CARE NEED TO BE THERE

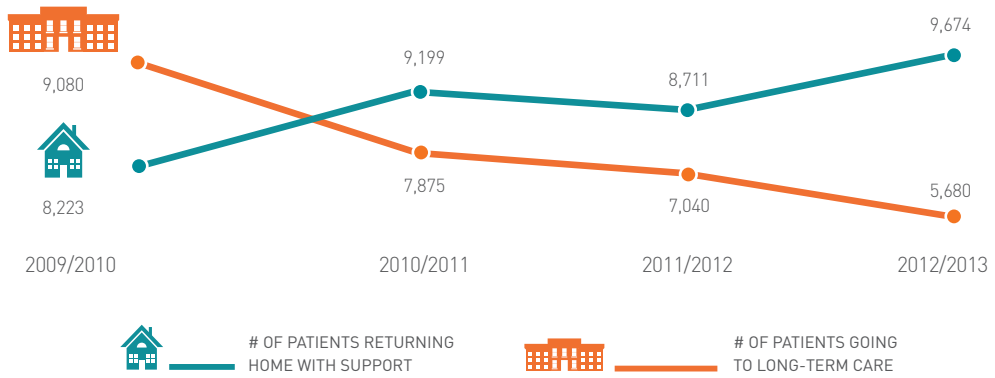
PERCENTAGE OF PATIENTS WITH HIGH NEEDS PLACED



SUPPORTING MORE PATIENTS AT HOME WHILE THEY WAIT TO BE TRANSFERRED TO MORE APPROPRIATE CARE SETTINGS



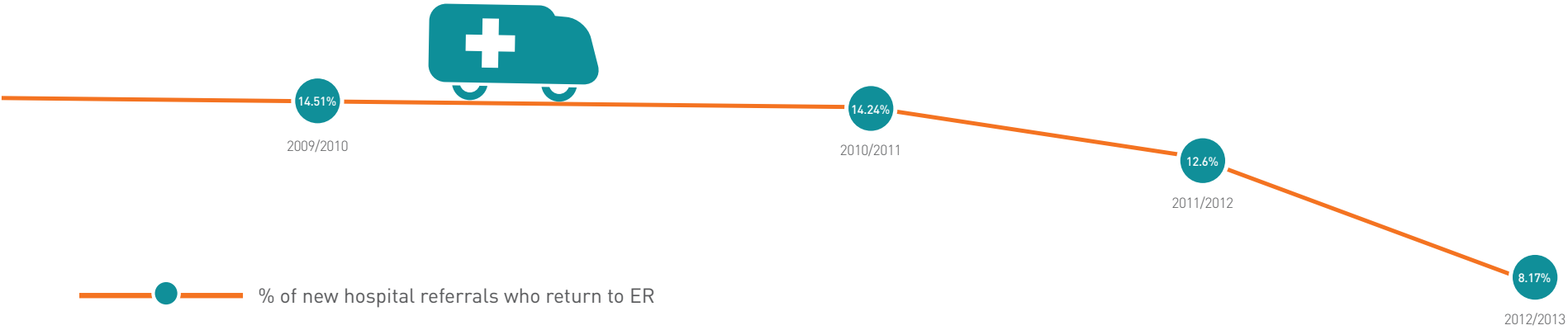




OF THE OVER 27,000 PATIENTS AND CAREGIVERS SURVEYED:

93% SAID THEY HAD A POSITIVE EXPERIENCE WITH THE CARE THEY RECEIVED FROM THEIR CCAC

LOWER READMISSION RATES TO THE EMERGENCY DEPARTMENT FOR CCAC PATIENTS REFERRED FROM HOSPITAL



BETTER ACCESS MEANS GETTING PEOPLE THE CARE THEY NEED IN THEIR HOMES AND COMMUNITIES

"After my mother was discharged from the hospital, she couldn't walk or eat anymore, she just laid in bed. I thought it was the end for my mother and I was at my wit's end because she wanted to die in her home and I had no idea how to help her. I can honestly say that Inna saved my life, not just my mother's. Inna told me what to expect so the process wasn't as scary anymore. She got me through it."

- Eileen, caregiver and daughter of CCAC patient, Charlotte

After hospitalization with acute pneumonia left her near death, 99-year-old Charlotte's health and quality of life improved considerably with help from the CCAC's Palliative Nurse Practitioner program.

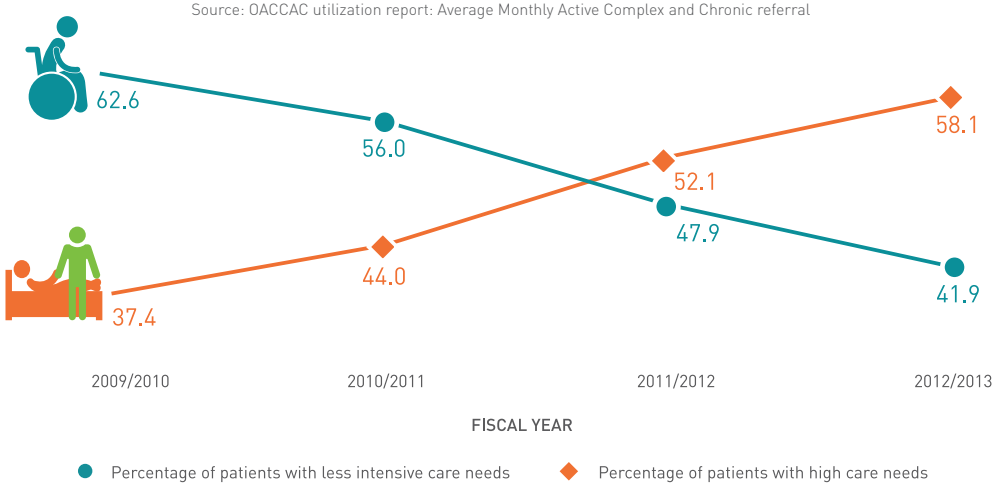
CCACs provide people with care they need so that they can continue living in their homes and communities. Every Ontario community has a wide variety of organizations offering health-care services, including nursing, physical therapy and community supports like Meals on Wheels, and friendly visits. CCACs bring all of these services together, enabling people to get the specialized blend of the health-care services they need, when they need it.

ENHANCED AND MORE INTENSIVE CARE AT HOME

CCACs are caring for more and more people with multiple chronic and complex health issues—an increase of 67 per cent more patients with higher needs than in 2009-2010.[8] Patients with high-care needs include the frail elderly, children who are medically fragile and people who are living with complex health conditions. Providing specialized care and intensive care coordination helps them live in their homes longer.

CCACs ARE CARING FOR PATIENTS WITH HIGHER AND HIGHER CARE NEEDS

Source: OACCAC utilization report: Average Monthly Active Complex and Chronic referral



HELPING PEOPLE MAKE CONNECTIONS IN COMMUNITIES ACROSS ONTARIO

CCACs connect people to the health-care services they need to help them cope with a health problem or functional decline. For people who need information and education resources that can help them remain healthy at home, CCACs provide people with timely and accurate information through the web-based resource, thehealthline.ca, now available in every community across the province.

When living at home is no longer possible, CCACs provide people with options and support to help them make appropriate choices that meet their specific health needs, like assisted living. This means that patients transition to long-term care homes only when necessary. CCAC Care Coordinators use highly specialized skills in the coordination of care across the health-care sector to identify high-needs patients earlier, so they get the right level of care and support in the most appropriate place.

From January to April 2013, of the 10* local Healthline.ca sites live across the province at that time, there were:

- 83,157 unique visitors
- 1,075,932 page views
- 320,390 visits

*South West, Champlain, Central East, Central West, Erie St. Clair, Hamilton Niagara Haldimand Brant, North East, North Simcoe Muskoka, South East, Waterloo Wellington

Source: Google Analytics, January 1 to April 10, 2013

[8] OACCAC utilization report: Average Monthly Active Complex and Chronic referral per cent change from FY 2009/2010 to FY2012/2012.

"We rely on these services—very much so—and we really appreciate the help," says Paul. "Now we have someone come in and that gives me a chance to take a nap, start supper or run errands without worrying. If we didn't have the help from the CCAC everything would just fall apart and then what would we do? The system really works well."

– Paul, caregiver and husband of CCAC patient, Connie

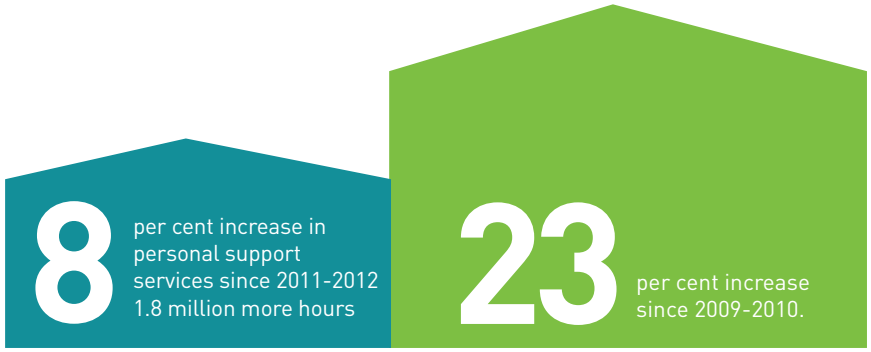
"I am honoured to provide respite care for patients and their caregivers whenever possible. This type of care offering has enabled this patient to remain at home with her husband where they have been happy and comfortable for so many years. It makes my day to see them smile!"

– Sheila, Personal Support Worker, Saint Elizabeth Health Care

Under the direction of a nurse or therapist, PSWs help patients bathe, dress, toilet, remind them to take medication, exercise to gain strength or adhere to a special diet. Most importantly, PSWs provide understanding, kindness and companionship when patients and families need it most.

ENHANCED AND MORE INTENSIVE CARE AT HOME

Personal Support Workers (PSWs) play an essential role in a patient's circle of care. Their important role is to help people do the things that they can no longer do on their own. These services help people stay in their homes. To support our patients with the highest needs, we are increasing the amount of personal support services our patients with the highest needs receive.



Source: Ministry of Health and Long-Term Care Health Data Branch Web Portal, CCAC Comparative Reports (Table 19a)

PROVIDING INCREASED FRONTLINE CARE TO SUPPORT HIGH-RISK PATIENTS

As we continue to care for more vulnerable patients, their health needs are more acute and the interventions and support they need are more complex than ever before.

To address that need, CCACs are hiring more nurses to provide care to the most vulnerable patients: students with mental health or addiction issues; frail seniors and adults; children with complex, serious illnesses; and patients needing end-of-life care.

CARING FOR PATIENTS WITH THE MOST COMPLEX CARE NEEDS AT HOME

The Rapid Response Nurse (RRN) Program helps both adult and pediatric patients with high-care needs transition home from hospital safely and, in doing so, decrease visits to the emergency department and hospital readmission.

As results from this program become available across the province, we will be reporting on the program's impact on emergency department visits and hospital readmissions.

"When I realized Roy wasn't drinking enough fluids, I explained that he needed to drink eight times a day from his favourite mug. I help patients to self-manage their care and teach them how and why they're doing certain tasks. I want them to be able to recognize what's normal versus what's not, and to visit their doctor if they recognize any warning signs."

- Lynda, CCAC Rapid Response Nurse

Roy, a 90-year-old patient with multiple health conditions, met with Lynda, a CCAC Rapid Response Nurse, before his discharge from the hospital. Lynda's first visit with Roy at his home occurred the next day where Lynda re-assessed Roy's needs and reviewed his medications with him. Lynda also helped Roy connect with his family doctor to arrange follow-up appointments.

"The scariest part about going back to school was that I wasn't confident that people would take my needs seriously. My (MHAN) nurse really helped me. She informed teachers about what was going on without being too personal, so that they knew how to support me when I was ready to return."

- Grade 9 student

CARING FOR CHILDREN AND YOUTH IN SCHOOLS

Studies suggest that between 15 and 21 per cent of Ontario's children and youth have at least one mental health disorder.[9] Our Mental Health and Addiction Nurses (MHAN) work together with school boards, teachers and community-based organizations to support students as they deal with mental health and addictions issues.

"Our focus is to meet with students early—before issues develop—to connect with them and link them to the appropriate resources in their school or community."

- Ron Merkley, Registered Nurse, CCAC MHAN program.

[9] Ministry of Children and Youth Services. A Shared Responsibility: Ontario's Policy Framework for Child and Youth Mental Health. 2006. Available from URL: http://www.children.gov.on.ca/htdocs/English/documents/topics/specialneeds/mentalhealth/framework.pdf.

LOOKING AHEAD...CARING FOR PEOPLE AT END-OF-LIFE

As patients approach the end of their lives, many want to be at home surrounded by family and friends. CCACs support people with end-of-life care at home. Hospice Palliative Care Nurse Practitioners are currently being hired to enhance this support and to provide specialized clinical expertise as part of a well-integrated circle of care. Driven by *Ontario's Action Plan for Health Care*, the Ministry of Health and Long-Term Care has provided funding for the Hospice Palliative Care Nurse Practitioner program. These nurses have specialized skills and expertise to enhance the care team's ability to support even the most complex palliative care patients, so that they can continue to live with dignity, as comfortably as possible, in their own homes. This program will help identify palliative patients earlier, increase the number of patients supported to die at home, and reduce avoidable emergency department visits or hospitalization for palliative patients.

With the support of nursing visits, personal support services, therapy, social work, nutrition and respite care, CCACs helped more than 25,000 people through their end-of-life experience.

Source: OACCAC Home Care Database, count of active end-of life patients.

Accreditation Canada's key findings based on the accreditation results for Ontario CCACs*:

- CCACs achieved a high level of compliance with national standards assessed during on-site surveys.
- With respect to safety, medication reconciliation was identified as a strength. Evaluating hand hygiene compliance and implementing workplace violence prevention programs were identified as opportunities for improvement.
- Nine Accreditation Canada Leading Practices have been awarded to CCACs since 2010.

Accreditation Canada, An Overview of Accreditation Results: Ontario Community Care Access Centres, October 2013.

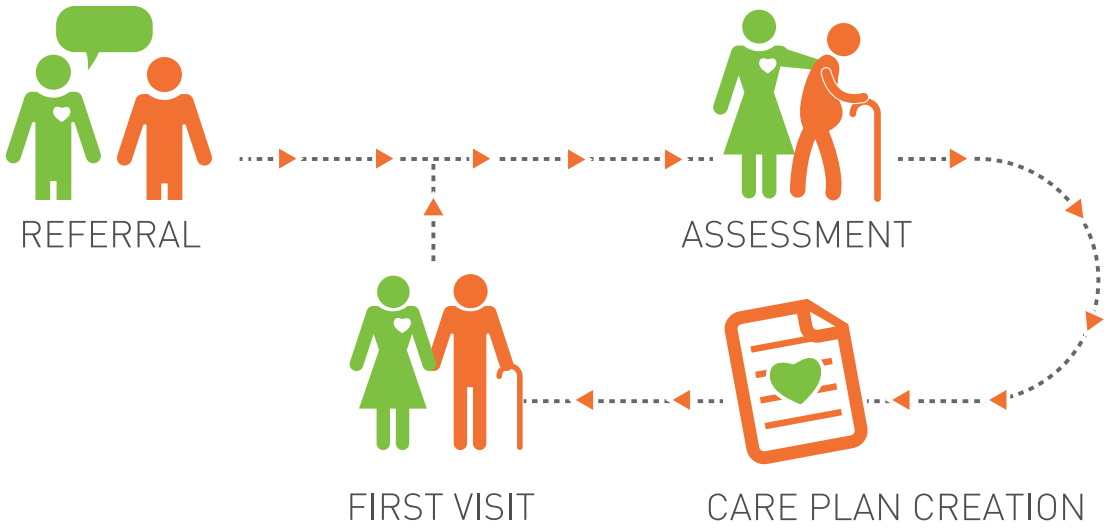
*These results reflect the experience of 10 CCACs that participated in Accreditation Canada's Qmentum on-site surveys between 2010 and 2012. Additionally, two CCACs completed the Accreditation Canada Primer program and two CCACs completed accreditation through the Commission on Accreditation of Rehabilitation Facilities (CARF) International.

REDUCING WAIT TIMES

CCACs have consistently decreased wait times for home care patients, with a specific emphasis on reducing wait times for patients with the greatest needs. When we assess patients for care, we determine how urgently they need services in order to provide care to those who need it most, first. For 90 per cent of patients with high-care needs, CCACs have reduced wait times by 25 per cent for our patients referred through the community, and 50 per cent for patients referred through hospital, since 2009-2010.[10]

MEETING MINISTRY COMMITMENTS TO IMPROVE ACCESS FOR HOME CARE

Although many of our patients already start their home care services within a few days, with the increased investment in the home and community care sector, CCACs are working towards a new 5-day target for starting nursing and personal support visits for patients with high needs. Beginning Spring 2014, we will start reporting our progress against the new Ministry of Health and Long-Term Care 5-day wait time measure currently under development.



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Source: OACCAC reports MSAA Indicators 2011-2014

As regulated heath-care professionals, CCAC Care Coordinators work with patients and their families to determine a person's care needs and goals through an assessment, with the purpose of developing a comprehensive care plan to ensure their needs are addressed.

[10] OACCAC reports Multi-Sector Accountability Agreements (MSAA) Indicators 2011-2014.

BETTER CARE MEANS WORKING TOGETHER AS A TEAM

When 88-year-old Betty began showing signs of memory impairment and confusion, both her family and care team became worried. Her daughter and sisters were concerned about Betty being at home, but Betty was very clear: home was where she wanted to be. So, her care plan was focused on how to keep Betty at home without jeopardizing her safety or health.

"Ultimately, helping Betty remain at home has been a joint effort of her family, her doctor, the CCAC, in-home care professionals, and community services."
- Candace, Betty's CCAC Care Coordinator

Partners across the health-care system are finding new ways to communicate with each other and share our skills and expertise to address patient needs and goals more effectively. CCAC Care Coordinators work with patients and their families, as well as nurses, therapists, specialists, family doctors, pharmacists, community support services and others to deliver the care that people need.

TEAMING UP WITH PRIMARY CARE

Our Care Coordinators help ensure all parts of the health system are working together to deliver a seamless experience for patients, especially those with high-care needs. These connections occur in a variety of ways, including working onsite with family health teams or doctors' offices. CCAC Care Coordinators are the eyes and ears in the home, communicating valuable information to primary care providers about how their patients are progressing, and helping them address any issues proactively.

Care coordination is an essential element of all 19 of the first wave Health Links, announced by the Ministry of Health and Long-Term Care in December 2012. This innovative and collaborative care approach brings together health-care providers in a community to better coordinate the care needs of high-needs patients. CCACs are actively supporting care coordination for patients with the highest care needs in each Health Link as they evolve.

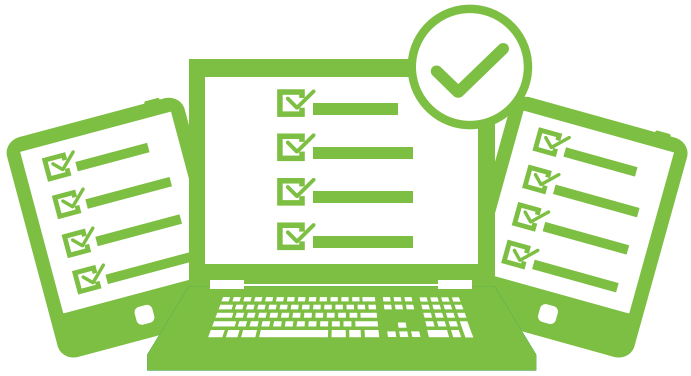
"CCACs are an important collaborating partner for primary care. As we move more towards team-based care, CCACs offer an existing organized team that can provide physicians and our patients with a multitude of services—our relationship is only getting stronger."

Dr. Frank Martino, Family Practitioner and Past President,
Ontario College of Family Physicians

USING TECHNOLOGY TO IMPROVE COMMUNICATION AND ENHANCE THE PATIENT EXPERIENCE

A key priority in *Ontario's Action Plan for Health Care* calls for health-care system partners to work together and share information effectively to improve the patient journey. Sharing patient information and assessments in the home and community care sector is an important part of the solution to this provincial challenge.

CCAC Care Coordinators complete individual patient assessments which, with patient consent, are provided to an Integrated Assessment Record (IAR). Originated by the Ministry of Health and Long-Term Care, the IAR drives efficiency by ensuring all health service providers have ready access to the information they require to provide care to their patients, and may also reduce the number of times a patient has to tell their story. Assessments in the IAR are viewable by staff in CCACs, hospitals, long-term care homes, community support services and other health partners who have been granted permission.



All 14 CCACs share patient assessments using the Integrated Assessment Record

"Care in the home is safer for most patients than hospital stays. Findings from the *Pan-Canadian Safety-at-Home study* showed that about 4.2 per cent* of home care patients experienced patient safety incidents, while the *Baker and Norton Canadian adverse event study* found 7.5 per cent of patients in hospital experienced a safety incident."**

- Diane Doran, Professor Emeritus, Lawrence S. Bloomberg Faculty of Nursing, University of Toronto

*Blais R, Sears N, Doran D, Baker GR, Macdonald M, Mitchell L, Thalès S. (2013). Assessing adverse events among home care clients in three Canadian provinces using chart review. BMJ Quality & Safety. 0:1-9. doi:10.1136/bmjqs-2013-002039. (PMID:23828878).

**Baker GR, Norton PG, Flintoft V, et al. The Canadian adverse events study: the incidence of adverse events among hospital patients in Canada. Can Med Assoc J 2004;170:1678-1686.

LOOKING FORWARD...
INNOVATION: THE KEY TO CARING FOR PEOPLE BETTER AND FASTER

CCACs continue to leverage the provincial eHealth platform for the benefit of patients by enhancing, adding and developing new capabilities and connections. Working with other provincial shared services organizations, the three eHealth Clusters, eHealth Ontario and the Ministry of Health and Long-Term Care, CCACs are playing a key role in enabling eHealth strategies. With the introduction of Health Links, the CCAC platform has been recognized as one of the provincial assets that can be used to connect Health Link teams.

IMPROVING SAFETY IN THE HOME AND IN THE COMMUNITY

In Ontario, a shift to caring for people with higher health and social needs in the community is well underway. Ontario is on the leading edge internationally in supporting people with complex care needs in their own homes.[11]

Care Coordinators work closely with health-care partners and families to improve safety and reduce risks to balance the quality of life that comes with living in their homes, and the risks associated with it.

CCACs ensure that patients receive a review of their medications - 98.6 per cent of long-stay CCAC patients received a medication review

Source: MSAA Indicators 2011-2014 Medication Safety

Through the Ministry of Health and Long-Term Care's Health Care Connect program, CCACs are helping to ensure that people without a family doctor or nurse practitioner are able to find one. **61,700** patients connected with a family physician or nurse practitioner, including **5,800** patients with high-care needs.

Source: Ministry of Health and Long-Term Care, Monthly Health Care Connect Reports

[11] Dr. John Hirdes, Care in the Community presentation, Waterloo Wellington CCAC 2013 Symposium.

"As a result of policy initiatives aimed at helping keep frail seniors with complex needs in community settings, the overall resource needs of Ontario's long-stay CCAC patients have increased substantially over time. Looking at the use of formal health-care system resources, as well as care from informal caregivers, there has been a substantial increase in the intensity of resources needed to support home care patients today compared to just seven years ago."

- John P. Hirdes, PhD, Ontario Home Care Research & Knowledge Exchange Chair Professor, School of Public Health and Health Systems, University of Waterloo

AS THE COMPLEXITY OF PATIENT NEEDS INCREASES, THE RATE OF FALLS ALSO INCREASES

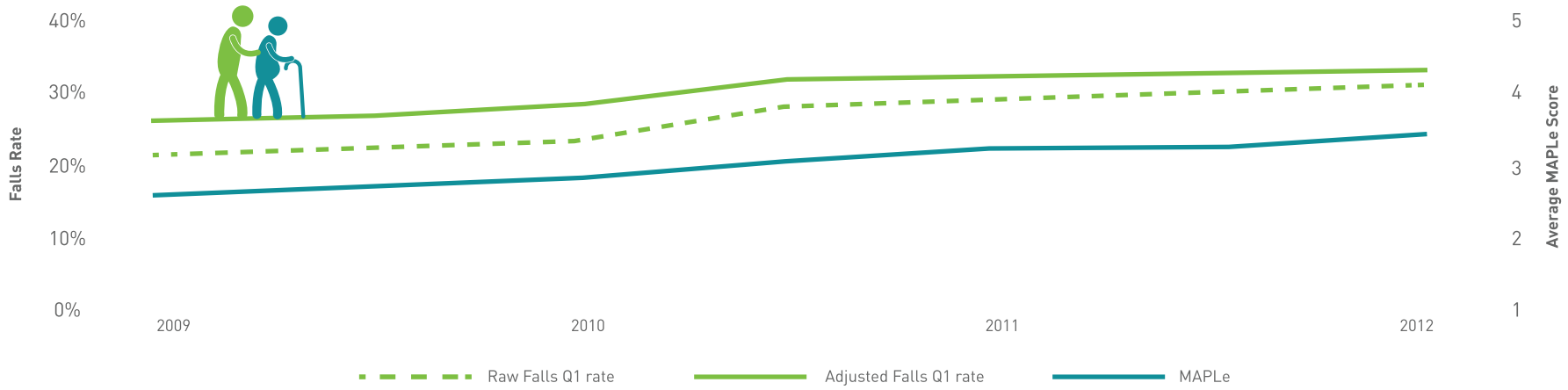
For the last five years, CCACs have been concerned that our patients are reporting a higher rate of falls year over year. Falls at home are self-reported by patients and are documented by CCAC Care Coordinators using our standardized assessment tool, the Resident Assessment Instrument—Home Care (RAI-HC).

Safety risks for high-needs patients are greater. And as the trend towards caring for more patients with intensive health-care needs continues, patient safety considerations are even more critical. The graph below correlates the rate of falls with the change in the profile of patients served by the CCAC. The graph shows that as CCACs care for patients with more complex health-care issues at home (the blue line), these patients have a higher likelihood of experiencing a fall (the dotted green line). When we adjust the rate of falls to take into consideration the increasing medical complexity of our patients, we see that the rate of falls is relatively stable (the solid green line). This means that the increasing rate of falls is related to the increasing complexity of our patients and their health needs.

CCACs are working with researchers at the University of Waterloo to understand how to best target our falls prevention programs to support the patient populations that would benefit the most.

Together, all partners across the home and community care sector are working to continuously improve safety and reduce risks so patients can stay safely in their homes—where they most want to be. While patient safety issues have been studied widely in hospital care settings, there has been little study of this kind within the home care sector. Earlier this year the first study of this kind, entitled *Safety at Home, a Pan-Canadian Home Care Safety Study*, was published, with participation from four CCACs. In addition, CCACs are together working through the recommendations for patient safety and patient and caregiver education contained in the report to add to our existing work on risk.

SEMI-ANNUAL MAPLe AND RAW/ADJUSTED FALL RATES USING NEW HCQI AMONG HOME CARE PATIENTS, IN ONTARIO, 2009-2012



Source: Dr. John Hirdes, School of Public Health and Health Systems, University of Waterloo

BETTER VALUE MEANS CREATING A HEALTH-CARE SYSTEM THAT DELIVERS THE CARE PEOPLE NEED NOW AND IN THE FUTURE

Thomas, who was born prematurely at 32 weeks, spent his first three months in hospital before his mother was able to bring him home. His mother, Stephanie, a single mother, is grateful for support from the CCAC. Her Care Coordinator, Sheena, works in partnership with Stephanie to get her the care she needs to keep Thomas healthy and out of hospital. The intense home care is paying off.

"I can see him making progress. At school, he loves being with the other kids, and playing games. He's always been quick to smile, and the glasses and hearing aids he's been given in the last year have really increased how much he interacts with others. It's actually been a year since Thomas was last admitted to hospital."
- Thomas' mother and caregiver, Stephanie

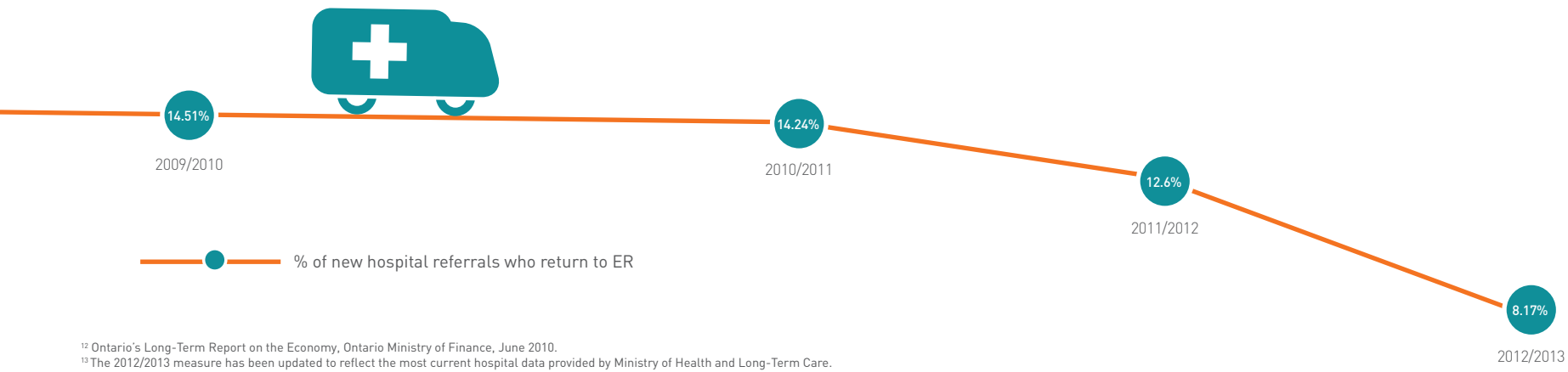
Delivering the care that people need and value is our top priority. We regularly survey patients to ensure they are satisfied with their care. We use this information to continually improve, in an effort to provide the best quality care.

THE CARE THAT PEOPLE NEED FOR TODAY AND TOMORROW

Over the next two decades, the number of Ontarians 65 years and older is expected to double, and the number of adults aged 85 and older will quadruple.[12] As Ontario's population ages, our health-care system must transform along with it so that we can meet the needs of our population. Home and community care is an essential part of meeting these increasing needs.

LOWER READMISSION RATES TO THE EMERGENCY DEPARTMENT FOR CCAC PATIENTS REFERRED FROM HOSPITAL[13]

Source: OACCAC Home Care Database linked to National Ambulatory Care Reporting System (NACRS) Count of new hospital referrals that returned to the Emergency Department in 2012-2013.



Providing the right care and support to help people come home from hospital

Home is where most people want to be. Our Care Coordinators meet with patients and families to identify their needs and learn what matters to them, to ensure they have the right care and support needed to help them come home after a hospital stay following surgery or short-term illness.

With enhanced home care, including care provided by a variety of health-care professionals and intensive care coordination, CCACs are helping more patients wait at home, instead of in hospital, to be transferred to a more appropriate care setting—for example, to a long-term care home.

Providing health care at home is less costly, and by supporting people at home, we help to free up hospital beds for people who need them the most.

Often, people who are able to wait at home for admission to long-term care, or other care settings, find that they are able to remain there with the right support. Supporting people effectively at home helps ensure they are going to long-term care homes, only when necessary and at the right time for them.

[12] Ontario's Long-Term Report on the Economy, Ontario Ministry of Finance, June 2010.
[13] The 2012/2013 measure has been updated to reflect the most current hospital data provided by Ministry of Health and Long-Term Care.

OF THE OVER 27,000
PATIENTS AND CAREGIVERS SURVEYED:

93% SAID THEY HAD A POSITIVE EXPERIENCE WITH THE CARE THEY RECEIVED FROM THEIR CCAC

Source: CCAC Client Experience Evaluation Survey Aggregate Provincial Report Annual Results – National Research Corporation, August 2013

Providing the care and support that patients need to stay at home

By coordinating care effectively and identifying changes in a patient's condition early, CCACs are making a measurable difference. Readmission rates to emergency departments are decreasing steadily for patients that were referred to CCACs through hospital—six percentage points since 2009.[14]

More long-term care beds are supporting higher-needs patients

Caring for more patients with higher needs at home means that more beds in long-term care homes are being allocated to those with the greatest need. Since 2009-2010, CCACs have increased the percentage of high-need patients placed in long-term care by 6.5 per cent.[15]

SUPPORTING MORE PATIENTS AT HOME WHILE THEY WAIT TO BE TRANSFERRED TO MORE APPROPRIATE CARE SETTINGS

Source: Access to Care: Quarterly Alternate Level of Care Highlights Report, Access to Care Informatics, Cancer Care Ontario 2012-2013.

[14] OACCAC Home Care Database linked to National Ambulatory Care Reporting System (NACRS) Count of new hospital referrals that returned to the Emergency Department in 2012-2013.

[15] MSAA 2011-2014 Indicators Patients Placed in Long-Term Care with Method for Assigning Priority Levels (MAPLe) score High and Very High.

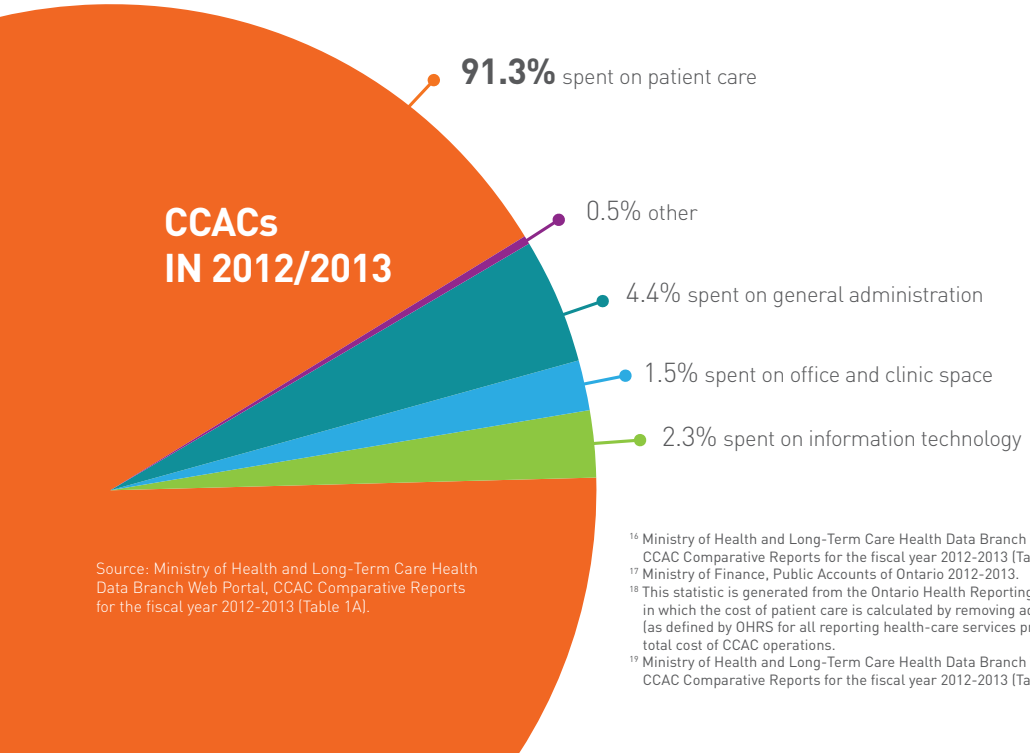
"When it comes to the community sector, when it comes to the home care sector, there is no question that the work CCACs do is better for patients, and does deliver better value for money. So keep doing what you are doing."

- The Honourable Deb Matthews, Ontario's Minister of Health and Long-Term Care

MAKING THE MOST OF OUR HEALTH-CARE DOLLARS

Last year, CCACs received $2.2 billion from the Ministry of Health and Long-Term Care[16]—which accounts for less than five per cent of the total provincial health-care spending in Ontario.[17] CCACs used this funding to deliver care to people in their homes, schools and communities across Ontario.

91.3 per cent of CCAC funding is spent on patient care.[18] We define the cost of patient care as all costs incurred by CCACs to care for patients safely in their homes and communities. This care, delivered by CCAC staff and contracted service providers, includes care coordination, nurse practitioner services, pharmacist services, information and referral services, personal care, nursing, physiotherapy, occupational therapy, dietetics, social work, speech and language pathology, as well as medical supplies and equipment.



Source: Ministry of Health and Long-Term Care Health Data Branch Web Portal, CCAC Comparative Reports for the fiscal year 2012-2013 (Table 1A).

[16] Ministry of Health and Long-Term Care Health Data Branch Web Portal, CCAC Comparative Reports for the fiscal year 2012-2013 (Table 1).
[17] Ministry of Finance, Public Accounts of Ontario 2012-2013.
[18] This statistic is generated from the Ontario Health Reporting System (OHRS), in which the cost of patient care is calculated by removing administration costs (as defined by OHRS for all reporting health-care services providers), from the total cost of CCAC operations.
[19] Ministry of Health and Long-Term Care Health Data Branch Web Portal, CCAC Comparative Reports for the fiscal year 2012-2013 (Table 1A).

Continuously working to create efficiencies and reduce administrative costs, CCACs are keeping administrative costs low—at 4.4 per cent.[19]

A CONTINUOUS FOCUS ON DELIVERING THE HIGHEST QUALITY CARE

CCACs are committed to delivering high-quality care and an outstanding patient experience. Quality Improvement Plans (QIPs) provide goals and targets on quality improvement initiatives, with the overall objective of improving the quality of services delivered to patients in alignment with the *Excellent Care For All Act*. CCACs have developed QIPs and are on track to share their QIPs publicly by April 2014.

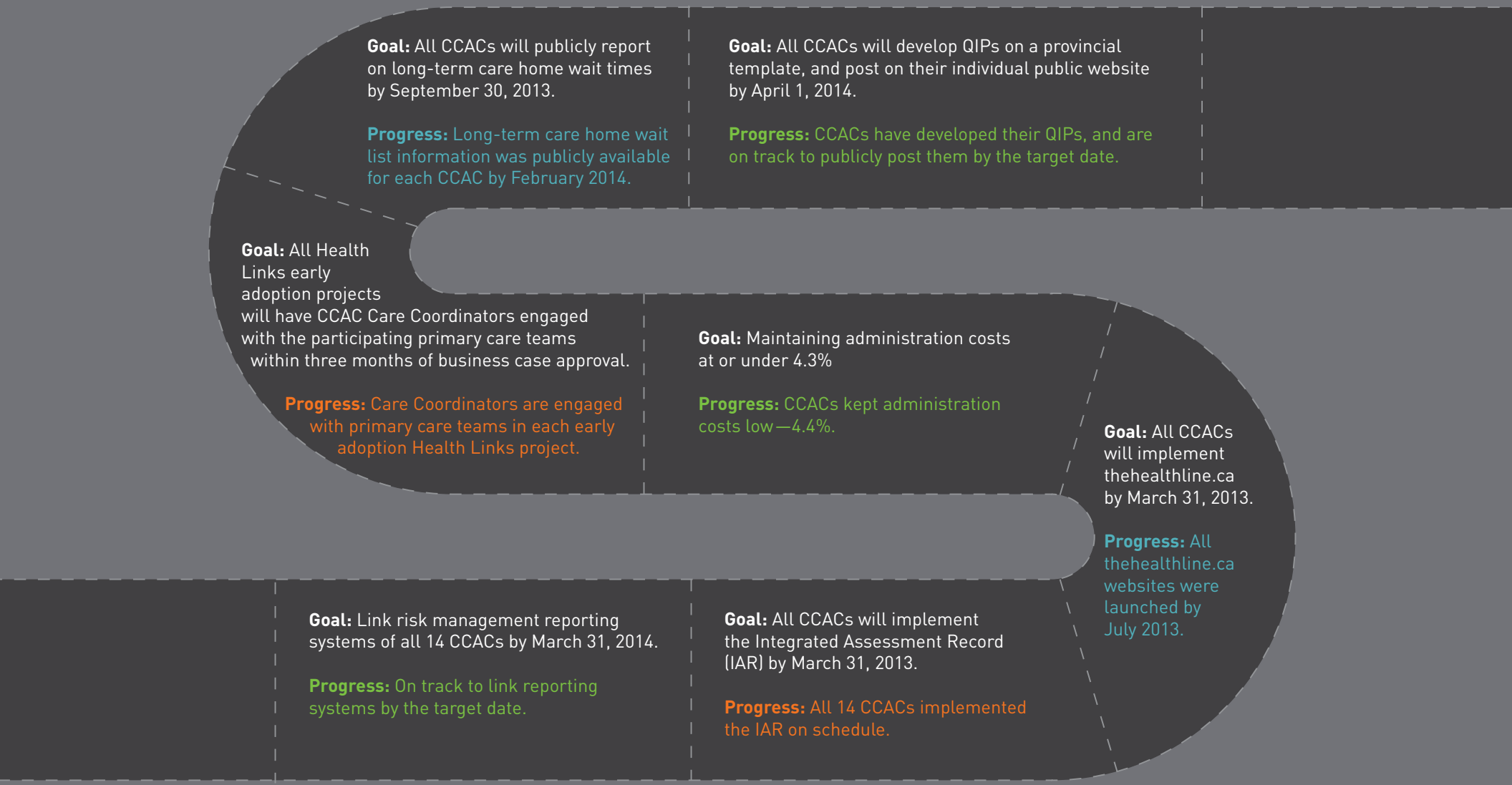
ENSURING PATIENTS IN LONG-TERM CARE NEED TO BE THERE

PERCENTAGE OF PATIENTS WITH HIGH-CARE NEEDS PLACED (%)

Source: MSAA 2011-2014 Indicators Patients Placed in Long-Term Care with Method for Assigning Priority Levels (MAPLe) score High and Very High.

OUR PROGRESS REPORT: A CONTINUOUS QUALITY IMPROVEMENT JOURNEY

Last year's CCAC Quality Report put forward goals and targets CCACs are working towards as we deliver outstanding care—every person, every day. Here's how we are doing...



THE FUTURE: OUR OPPORTUNITIES MOVING FORWARD

OPPORTUNITY #1: WORKING WITH PRIMARY CARE IN ONTARIO'S HEALTH LINKS

CCACs across Ontario are working hand in hand with physicians, nurse practitioners, pharmacists, hospital staff, service providers and others in their local communities in each Health Link to support patients with high needs with care in their homes and communities.

Goal:
As the number of Health Links expands, our goal is to have CCAC Care Coordinators directly engaged with the participating primary care teams in each Health Link to support patients with high needs and provide care coordination.

Goal:
By June 2014, the CCAC electronic health record will have the capacity to register all patients of active Health Links, enabling more timely communication between the CCACs and primary care and early identification of patients who need a physician or primary care.

OPPORTUNITY #2: BUILDING CAPACITY TO CARE FOR THOSE IN THE GREATEST NEED

Funded through the Ministry of Health and Long-Term Care, Rapid Response Nurses, Mental Health and Addiction Nurses, and Hospice Palliative Care Nurse Practitioners are being hired across the province to support patients to safely transition home from hospital, to support children and youth with mental health issues, and to expand support to our high-needs end-of-life patients.

These nurses enhance the ability of care teams to support vulnerable patients at home, and students with more intensive mental health care in schools. This support is key for patients who might otherwise return to the emergency department, be readmitted to the hospital, or who may be unable to continue attending school. In the next year, CCACs will begin reporting on the value these nursing programs bring to people across our communities.

Goal:
To have all three of these nursing programs fully operational, and have the ability to describe the people being served by these programs and demonstrate the impact these programs are having by reporting on:

- How many fewer patients visit an emergency department because of more specialized CCAC nursing care
- How many fewer patients are readmitted to hospital (after being discharged) because of more specialized CCAC nursing care

OPPORTUNITY #3: MEETING AND EXCEEDING OUR WAIT TIME TARGET FOR PATIENTS RECEIVING NURSING CARE AND PATIENTS WITH COMPLEX CARE NEEDS RECEIVING PERSONAL SUPPORT

Many patients who have complex health issues are fearful that they will not be able to manage new treatments or medications after being discharged from hospital. Having home support available as soon as possible helps provide peace of mind. In February 2013, the Premier of Ontario announced, in the budget, a commitment to providing access to home care within five days.

Goal:
CCACs are committed to meeting wait time targets for nursing services and personal support for complex patients and will publicly report on wait times for these patients beginning in Spring 2014.

CCAC Community Care Access Centre

CASC Centre d'accès aux soins communautaires

Ontario's 14 Community Care Access Centres (CCACs) get people the care they need in their homes and communities across the province. CCACs provide a single point of access to a wide range of home and community services, enabling people to get the specialized blend of the health-care services they need, when they need it.

www.healthcareathome.ca
310-2222 (CCAC) English
310-2272 (CASC) French