

Insights into Quality Improvement

## Advancing Integrated Care

Cross-sector perspectives  
from Ontario's health system



**Ontario**  
Health Quality Ontario

# Executive Summary

Integrating care and ensuring appropriate “hand offs” between providers is one of the quality challenges facing Ontario’s health system today. A number of priority indicators related to advancing integrated care were included in the Quality Improvement Plans (QIPs) submitted in 2014-15 by Ontario’s hospitals, primary care organizations, Community Care Access Centres (CCACs), and long-term care homes. This report explores those indicators and uses data from the 2014-15 QIPs to show how health care organizations in multiple sectors are working together to address these concerns.

The 2014-15 QIPs reveal that more organizations than ever before recognized the need to work across sectors to improve aspects of care. In particular, many health care providers emphasized patient transitions and patient experience or patient satisfaction. Others stressed the importance of initiatives like Health Links, designed to support integrated care for patients with complex medical needs. Health Links are composed of tight-knit combinations of family doctors, specialists, hospitals, home care, long-term care, and community support agencies. They work with Local Health Integration Networks (LHINs) to coordinate more responsive care, ensure access, and improve patient experiences.

This report highlights change ideas and quality improvement activities that promote integrated care and, by extension, improved patient experiences. It intends to increase understanding about how multiple sectors can use QIPs and QIP data to help align quality efforts and tackle common quality issues together – especially those that cannot be solved by acting in isolation.

As part of the *Insight to Quality Improvement* series, this report aims to inspire providers to connect with others to improve the ways in which care is delivered across Ontario.



# Introduction: Delivering Integrated Care & the Benefits of Cross-Sector Collaboration

Integration indicators measure how well individual parts of the health system interact with each other. This is important because many people, particularly those with complex needs or chronic conditions, experience care in multiple settings with multiple providers over extended periods of time. As noted in Health Quality Ontario's (HQO) yearly report, *Measuring Up*, patients "depend on the different sectors of the health system to work well together. When a patient is discharged from hospital, for example, the primary care provider needs to know what happened in hospital so that she or he can follow up with the patient accordingly."<sup>1</sup> Integrating these episodes of care is one focus of quality improvement.

*Measuring Up* explores the quality of health care in Ontario using a concise set of indicators called the Common Quality Agenda (CQA). The indicators measure everything from access to primary care providers on the same day or next day to wait times for surgery in order to develop a comprehensive picture of care across the province. Many indicators within the CQA also relate to integration of care, an area in need of improvement in Ontario. By identifying priority indicators, reports like *Measuring Up* and the QIPs help move the health system toward sustained improvements over time.

In recent years, Ontario's health care organizations and providers identified the delivery of integrated care as a key focus of their quality improvement efforts. In fact, improving the delivery of integrated care was one of the most referenced goals in the 2014-15 QIPs across all sectors.

The QIPs demonstrated that there are different approaches to the delivery of integrated care. However most of Ontario's health care organizations agreed that a well-integrated system is a patient-focused system – as evidenced by more organizations than ever including integration indicators alongside patient experience indicators.

Of the 545 organizations that submitted QIPs in 2014-15, 513 (94%) included measurements of integration as follows:

## Hospitals

- *Percentage of Alternative Level of Care (ALC) Days*: 91% selected this indicator.
- *30-Day Readmission Rates for Selected Case Mix Groups*: 72% selected this indicator.

## Primary Care

*Primary Care Visits within Seven Days Post-Discharge*: 99% selected this indicator.

## Highlights of this Report

This report is divided into three parts. Chapter 1 provides insight into patient transitions and experiences; Chapter 2 explores change ideas that promote collaboration; and Chapter 3 shares a more in-depth look at profiles of successful health care organizations across Ontario.

Of the 545 organizations that submitted QIPs in 2014-15, 513 (94%) included measurements of integration and 526 (97%) included measurements of patient experience or satisfaction.

Many are looking outside their walls – and beyond their sector – for solutions that often require collaborative quality improvement efforts.

The health system is showing a shared responsibility and commitment to improving integration (particularly emphasizing patient transitions and patient experience/satisfaction) through partnerships and collaboration with others.

Organizations have expressed the value of interacting with others in developing their QIPs and found it useful to access QIPs of others online to understand how they are working on various aspects of improvement. The 2014-15 QIPs for hospitals, community care, and long-term care can be viewed [here](#).

Introduction continued...

### Community Care

Hospital Readmission Rates within 30 Days of Discharge: 93% selected this indicator.

### Long-Term Care

Potentially Avoidable Emergency Department Visits for Residents: 89% selected this indicator.

Of those 545 organizations, 526 (97%) included measurements of patient experience or satisfaction.

- Hospitals: 100%, up from 83% in 2013-14.
- Primary Care: 98.3%, up from 87% in 2013-14.
  - 100% of Aboriginal Health Access Centres, up from 70% in 2013-14.
  - 98.7% of Community Health Centres, up from 81% in 2013-14.
  - 97.8% of Family Health Teams, up from 76% in 2013-14.
  - 100% of Nurse Practitioner-Led Clinics, up from 75% in 2013-14.
- Community Care: 100% (first year of QIP submissions).
- Long-Term Care: 85% (of 95 homes that voluntarily submitted QIPs). ■

## A Selection of Cross-Sector Integration Indicators\*

### 1. Primary Care: Primary Care Visits within Seven Days Post-Discharge

Measures the percentage of clients who see their primary care provider within seven days after discharge from hospital for selected conditions.

### 2. Hospitals: Percentage of Alternative Level of Care (ALC) Days

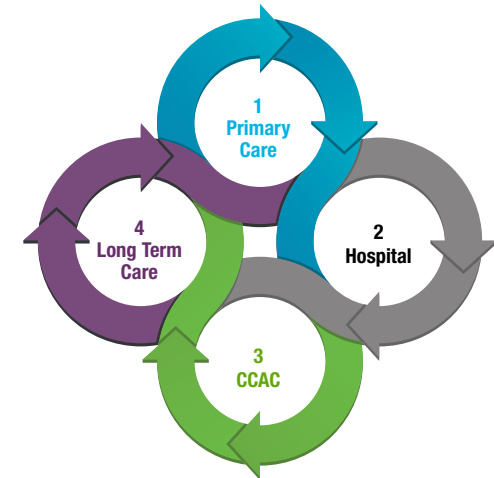
Measures the percent of inpatient ALC days, which refers to those patients who no longer need acute treatment but continue to occupy hospital beds as they await transfer to another care environment.

### 30-Day Readmission Rates for Selected Case Mix Groups

Measures the rate of non-elective readmissions within 30-days of discharge.

### 3. Community Care: Hospital Readmission Rates within 30 Days of Discharge

Measures the percentage of home care patients who experienced an unplanned readmission within 30 days of hospital discharge.



### 4. Long-Term Care: Potentially Avoidable Emergency Department Visits for Residents

Measures the number of unplanned/potentially preventable emergency department visits for residents aged 65 and older.

\* The four sectors depicted in this graphic are the four sectors that submitted QIPs. We are aware that many other sectors are involved in the delivery of care, including (but not limited to) home care, public health, community support services, etc.



**Putting patients first** is not the work of one government or one health care provider. We have come this far together – now it's time to continue the transformation. Now it's time to collectively change our culture and practices to improve the health care system for everyone. – Dr. Eric Hoskins, Ontario's Minister of Health and Long-Term Care, on *Patients First: Ontario's Action Plan for Health Care in February 2015*.





**Chapter 1:**  
Integrating Care and  
Improving Transitions  
and Patient Experiences

# Chapter 1: Integrating Care and Improving Transitions and Patient Experiences

---

Care transitions can involve a number of professionals within and between disciplines and settings, with shared responsibility for an individual patient. Integrating care can create seamless transitions, so that patients and caregivers can effectively navigate the health system.

However, interruptions to a patient's journey can occur for many reasons, such as unclear or delayed discharge plans, conflicting instructions from different providers, or medication errors.<sup>2</sup> Furthermore, organizations that do not place the patient at the centre of their integration efforts often struggle in providing smooth transitions.<sup>3</sup> (See: *"The Story of Kirk & Peter"* on pg. 8 for one example of a patient story that stresses the need for high-quality integrated care.)

More organizations are starting to recognize that they cannot make sustained improvements on priority integration indicators in isolation. In fact, these organizations are looking outside their walls – and indeed their entire sector – for solutions that often require collaborative quality improvement efforts.

The theme of partnerships is evidenced in the graphic, "Collaboration within each sector" (on pg. 7). As the graphic shows, the percentage of times a given sector mentioned another sector within its QIP (and identified it as a collaborative partner) has increased. This upturn is indicative of new integration efforts taking shape across the continuum of care in Ontario.

We cannot yet say if organizations made progress toward their goals until we review the progress report provided with the 2015-16 QIP submissions.

In this section, we will also hear from organizations from across Ontario who put integrated care services at the forefront of their quality improvement efforts. HQO excerpted the following quotes from the 2014-15 QIP submissions because they demonstrate the intent for improved delivery of care. The examples come from geographically diverse organizations, both large and small, to reflect a wide range of demographics. The theme of partnerships is apparent in each quote.

## [Dryden Regional Health Centre \(DRHC\)](#)

"Dryden recognizes that the key to an integrated service delivery model is the strength of the partnerships. The evolution of the partnerships is forming the foundation of the Dryden and Area Health Hub model. The creation of the Dryden and Area Health Hub will leverage our limited community resources to support agencies, including the DRHC, to provide safe, appropriate, quality health care in an accessible and comprehensive manner."

## [Windsor Regional Hospital](#)

"Windsor Regional Hospital... has established strong relationships with health care providers across the Erie St. Clair LHIN... These partnerships are critical, especially when we are working toward creating more capacity in the hospital for patients who require acute care services. QIP indicators such as decreasing the percentage of ALC days and the 30-day readmission rate for selected Case Mix Groups allow for the development of common clinical pathways to create seamless transitions between hospital and community placements/services."

## [Copernicus Lodge](#)

"We have an excellent relationship with many community partners who support our QIP to ensure the safe and effective transitions of care of our residents.... Many education and training initiatives which are critical to the success of our QIP would not be possible without our partnerships with Behavioural Supports Ontario, Public Services Health & Safety Association (staff safety), the Regional Infection Control Network, the Regional Geriatrics Program,

Wound Care and Mobility Specialists, and our many contracted service providers.”

**Sun Parlour Home (Leamington)**

“The Home will continue to participate in the Essex County South Shore (ECSS) Health Link strategy. The participants include managers and staff from our home, the local hospital, Victorian Order of Nursing, Alzheimer’s Society, Mental Health, Geriatric Emergency Medicine nurses, Outreach program, our local LHIN and a group of local physicians. These groups have targeted

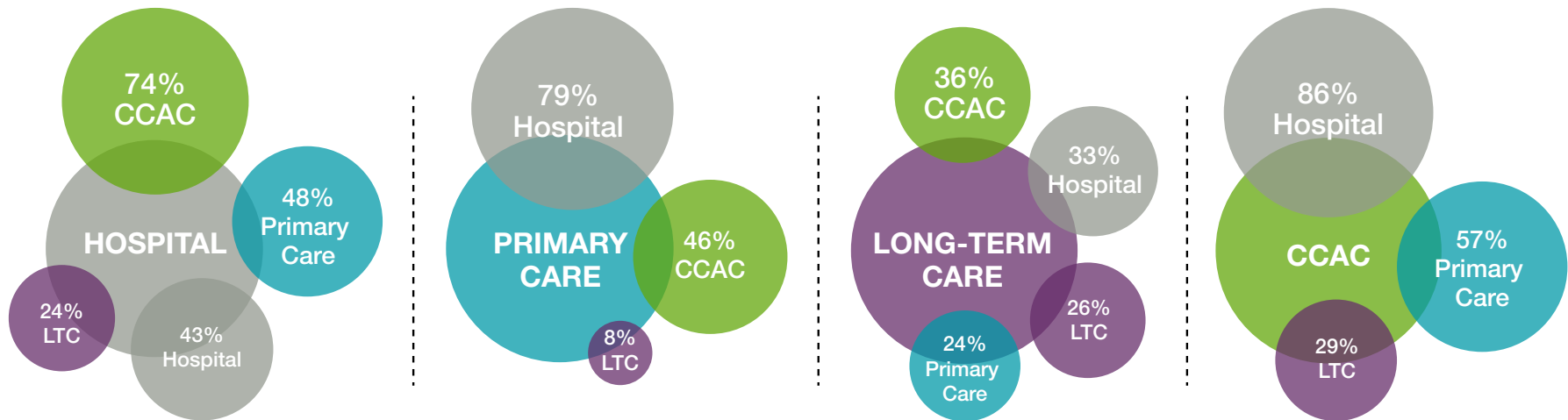
their efforts on two specific health issues to ensure adequate follow up and interventions to enable the elderly person to stay in their home to prevent the need to move into long-term care.”

**Inner City Family Health Team**

“We are working on these transitions through direct staff engagement. We will allocate one of the team’s Registered Nurses to liaise with St. Mike’s discharge team to support a client’s effective transition back into the community. In addition, we will continue to work in partnership

with Houselink and Fred Victor Centre to support service delivery to an identified ‘hot spot’ at 291 George Street through biweekly groups by the health promoter. Over the last 12 months continued outreach to the residents of this location has resulted in primary care referrals to the Inner City FHT. Most of the residents of this facility are individuals who have been previously homeless and/ or have used the shelter system, and are frequent users of emergency room services for routine medical care as well chronic and complex issues.” ■

Collaboration within each sector



The graphic above shows, the percentage of time a given sector mentioned collaboration with another sector within its QIP. The frequency of such partnerships has increased over previous years. It should also be noted that often many other parts of the health system and beyond health were reflected as collaborative partners. Other frequently cited partners included community support services (often >50% of the time), EMS, supportive housing, mental health community providers, public health, fire and justice. As one example, 47% of hospitals indicated collaboration with a Health Link, which often involves collaboration with several of these other organization types.

## The Story of Kirk & Peter

“We need to shift the way we see things to a more holistic view of the patient.”

Kirk Mason, 25, moved to Toronto six years ago for university. His grandfather, Peter, then 76 years old, welcomed him into his home. Five years later things would change abruptly for both Kirk and Peter, when Peter fell and fractured his hip while visiting family outside of Toronto. He was 81.

From that point onward, Peter accessed the health system frequently, and Kirk faced challenges coordinating his care and medical documents. There were times Kirk felt his grandfather experienced potentially avoidable readmissions to the hospital and when he believed a post-discharge follow-up with a primary care provider failed to occur within seven days.

Shortly after his fall, Peter had surgery for his hip and was diagnosed sometime later, during his stay at the hospital, with chronic obstructive pulmonary disease (COPD). During these moments and others, Kirk also felt Peter was not connected with community services that could have eased his transition home.

Kirk realized he would have to shoulder the responsibility of caregiver following Peter’s COPD diagnosis. “I decided to help him as he had helped me,” says Kirk. Kirk was still

enrolled in university, with a part-time job. He had the help of a paid caregiver from community services for three hours a week.

In the months following his hip surgery, Peter started exhibiting signs of depression, memory deficits and had appeared slow moving. Unbeknownst to Kirk and Peter’s doctor at the time, Peter had stopped taking his prescribed antidepressants. “We don’t know how long it would have taken for the system to find that out if I hadn’t brought his symptoms to our doctor’s attention,” says Kirk. Kirk’s grandfather was put back on antidepressants, and some of his symptoms subsided.

One night Peter woke up with heart pains. In the emergency room, tests showed he had heart failure.

At that point, Kirk says, “He was constantly being prescribed conflicting medications from different health care professionals. We never knew who to call to make sure his information was up-to-date.”

Peter’s memory problems increased. He was referred to a specialist and diagnosed with dementia at 82, just six months after his COPD diagnosis. After a long wait, Peter entered a retirement home. It offered Kirk and his family relief from his caregiving duties, but he still felt disappointed by the system. After six weeks, Peter was admitted to hospital for an infection on his foot. In hospital, Peter contracted a *Clostridium difficile* infection and died two and a half weeks later.

Reflecting on his grandfather’s story and his experiences of care, Kirk says, “It reveals ways in which organizations can look to improve the way they deliver care.”

Kirk’s experiences allowed him to work with the health system to constructively improve it. In fact, after Kirk became sole caregiver of his grandfather, he was asked to join the North York Central Health Link Patient and Caregiver Advisory Board. During that time he provided feedback and recommended areas of focus to the Health Link. He was then asked to provide insight into how information technology could enable better access to Coordinated Care Plans. Kirk also helped direct input into the development of a care coordination communication tool, used by the Health Link to connect care professionals to each other. He has since sat on a board that discussed the Health Link system with the Ministry of Health and Long-Term Care.

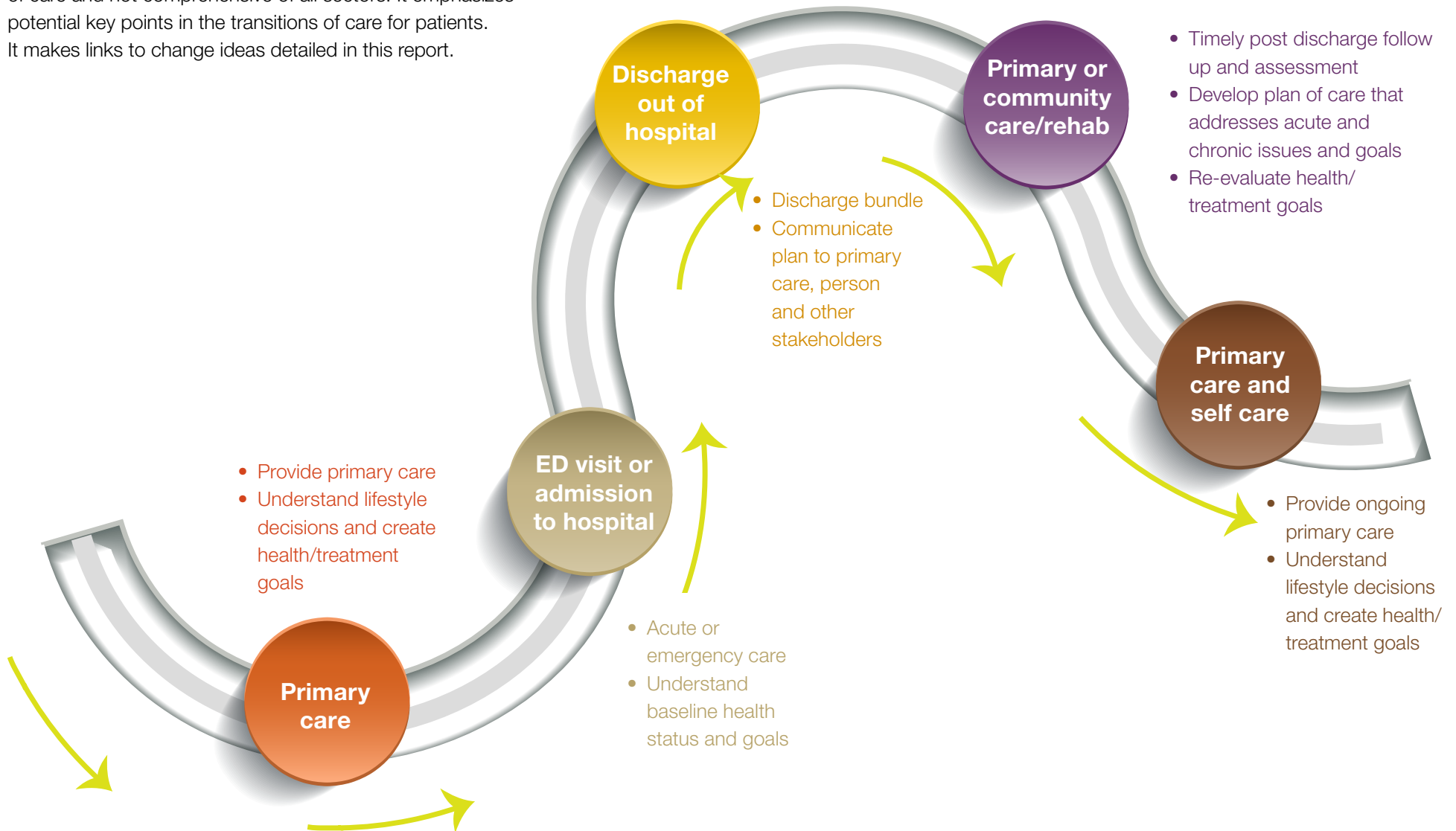
For Kirk, an integrated system ideally would look like this: “Entering a hospital, the staff would be able to pull up a file and know of any pre-existing conditions, dietary restrictions, and medications I take, etc. Upon leaving the hospital, I’d know when a care worker would meet me at my house, and I’d know that my family doctor would be informed of all of this – as well as any family members designated to be my contact in the event that I’m unable to take care of myself.”

Above all, says Kirk, “To me, an integrated health care system would be fluid and quick.” ■



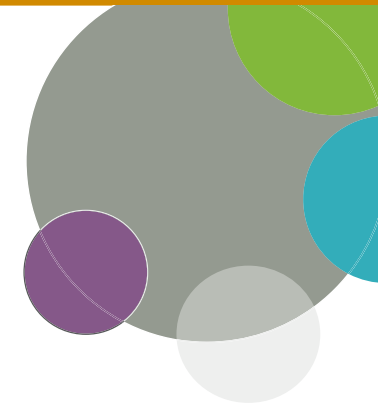
# The Patient's Integrated Journey of Care

This diagram highlights examples of how potential episodes of care could be connected. It is just one example of a path of care and not comprehensive of all sectors. It emphasizes potential key points in the transitions of care for patients. It makes links to change ideas detailed in this report.





## Chapter 2: Exploring Change Ideas that Promote Collaboration



## Chapter 2: Exploring Change Ideas that Promote Collaboration

This chapter explores certain change ideas mentioned in the 2014-15 QIPs that promote cross-sector collaboration. The section **Even Better When** suggests additional ideas that encourage integrated quality improvement efforts in relation to the patient experience. Further information about suggested change ideas can be found on HQO's [Quality Compass](#), which is a comprehensive evidenced-informed searchable tool designed to support leaders and providers with best practices, change ideas linked with indicators, and other resources as they work to improve health care performance in Ontario.

- **Indicator:** *Reducing the percentage of Alternative Level of Care (ALC) Days*

**Change Idea:** 15 hospitals described the importance of improving system processes and flow from hospital to the next level of care through change ideas such as identifying the projected

date of discharge, creating inter-professional groups to regularly conduct patient rounds and address barriers to discharge, and holding routine meetings with CCACs to discuss moving patients home or into the community (as per the [Home First philosophy](#)).

### Even Better When:

- The Home First philosophy includes shared resources based on patient population needs and patient choices and preferences.
- CCAC case coordinators/patient navigators are incorporated within local emergency departments to divert admissions.
- Hospitals collaborate with other hospitals, CCACs, and agencies to develop creative methods to appropriately deliver care elsewhere when patients do not want to be admitted to hospital and care can be safely provided in the patient's own home.

### Spotlight on: St. Joseph's Health Care System (Hamilton) and the Integrated Care Program

In their 2014-15 QIP, St. Joseph's describes the goal of the Integrated Care Program (ICP) as "building our processes of care around the journeys taken by the patient, working closely with partner agencies and our Local Health Integration Network (LHIN) to make those patient journeys simpler, safer, more convenient, and above all, with better clinical outcomes." A collaborative project between St. Joseph's Home Care, the Ministry of Health and Long-Term Care and Hamilton Niagara Haldimand Brant (HNHB) CCAC, the ICP "provides patients with a case manager who organizes both their hospital care and their home care and includes a 24/7 phone number to call if they have concerns. Preliminary results show very high patient satisfaction, improved clinical outcomes, fewer re-admissions to hospitals, fewer emergency department visits, shorter hospital stays, and lower costs."

- **Indicator:** Reducing 30-day readmission rates for selected case mix groups

**Change Idea:** 14 hospitals improved the communication processes and created individual discharge plans in lieu of generic discharge processes/packages.

**Even Better When:**

- Patients/residents, family caregivers, primary care teams, specialists and community providers are involved as full partners in assessing the current state and risk of readmission as part of their individualized care plans.
- Patient/residents and/or family caregivers feel included in their individualized care plan and are asked whether they understand the information discussed.

**Spotlight on: Almonte General Hospital (Champlain LHIN) and individual care and discharge planning (ICDP)**

In 2014-15, this small hospital used individual care and discharge planning (ICDP) within 24 hours of the decision to admit a patient to the medical-surgical unit. They are also developing a specific discharge planning template to communicate with local primary care providers. This strategy is also used by other hospitals.

- **Indicator:** Improving primary care visits within seven days post-discharge

**Change Idea:** 224 primary care organizations mentioned collaborating with hospitals to collect discharge data/information in a timely manner.

**Even Better When:**

- A patient's primary care team is alerted to the time of the patient's admission to hospital or emergency department.
- A patient's primary care provider is involved in developing a patient's individualized care plan and discharge plan – and ensures that those arrangements are made as soon as possible post-discharge.<sup>4</sup>

**Spotlight on: Georgian Bay Family Health Team (NSM LHIN) and coordinated care plans for patients with multiple complex conditions**

In 2014-15 this family health team expressed a goal of increasing the development of cross-sector coordinated care plans for the high users of health care. Very often the high users of health care have multiple care providers, from different organizations, therefore the FHT plans identify the “most responsible care provider” in the community setting. To ensure their use, Georgian Bay is making changes to the daily operational processes of providers to include time to come together as a team to discuss collaborative care plans for patients with complex needs.

- **Indicator:** Reducing hospital readmission rates within 30 days of discharge

**Change Idea:** Half of the CCACs mentioned using Rapid Response Nurses (RRNs), and two CCACs mentioned employing telehomecare services to improve the likelihood that patients with complex needs or chronic conditions receive appropriate care in their home.

**Even Better When:**

- Any relevant information gleaned during RRN or Telemedicine is shared with a patient's primary care provider. While information-sharing has historically been a challenge due to privacy concerns, experiential and research evidence demonstrates that lack of communication between providers contributes to adverse events and potential readmissions.<sup>5</sup>

**Spotlight on: North West CCAC and regional expansion of the Telehomecare program**

In 2014-15 this CCAC planned to spread a Telehomecare program and expand the Thunder Bay Telehomecare program to two regional communities. “We will test different methods of asset management (delivery and set up of the equipment plus ongoing trouble shooting) to determine the best way to proceed. Ontario Telehealth Network (OTN) has developed a patient satisfaction survey, which we will use to track patient satisfaction.”

- **Indicator:** Reducing potentially avoidable ED visits for residents

**Change Idea:** 39% of the long-term care homes that selected this indicator mentioned including additional interdisciplinary team members in planning strategies and providing staff with access to resources, supplies, and huddles/rounds to discuss the care plans of residents with a higher risk of ED visits.

**Even Better When:**

- Shared planning between long-term care homes and hospitals is established, and homes identify best practices for conditions that make up a majority of avoidable ED visits (e.g., wound care, dialysis, and pressure ulcers).

**Spotlight on: Parkwood Mennonite Home (Waterloo Wellington) and care maps\***

In 2014-15, this home used care maps for falls and respiratory illnesses in an effort to reduce ED utilization. The home will also work on collaborative strategies with the Nurse Lead Outreach Teams and hospitals to identify potential causes of ED visits.

\* A care map describes the steps and decision points in the management of a condition. It is based on medical guidelines, recent evidence, and expert consensus. A care map is made up of one or more pages, which together show the complete patient journey for a condition.

# Quality Improvement Plans by the numbers



Here is the total number of organizations that submitted QIPs in 2014-15.

## CCAC

14 QIP Submissions  
6 Priority indicators  
1 Year of Progress

## Long-Term Care

95 QIP Submissions  
6 Priority Indicators  
1 Year Voluntary Participation

## Hospitals

146 QIP Submissions  
7 Priority Indicators  
4 Years of Progress

## Primary Care

292 QIP Submissions  
5 Priority Indicators  
2 Years of Progress

Organizations have expressed the value of interacting with others in developing their QIPs and found it useful to access QIPs of others online to understand how they are working on various aspects of improvement. The 2014-15 QIPs for hospitals, community care, and long-term care can be viewed [here](#).

Looking forward, all organizations across these for sectors will be required to submit a QIP. This means in 2015/16 over 1000 organizations will have a plan for quality improvement.

## Additional Change Ideas

---

● **Indicator:** *Reducing the Percentage of ALC days*

### Change Ideas:

- 15 hospitals created ALC review committees.
- 9 hospitals prepared discharge options in advance of the discharge order.
- 8 hospitals documented plans to work with CCACs as partners to identify and resolve barriers to discharge.

● **Indicator:** *Reducing 30-Day Readmission Rates for Selected Case Mix Groups*

### Change Ideas:

- 68 hospitals (47%) indicated participated in Health Links.
- 30 hospitals included initiatives to strengthen care transitions activated appropriate follow-up.
- 10 hospitals promoted patient self-management through effective education efforts.
- 4 hospitals started supervising medication reconciliation at discharge.

● **Indicator:** *Improving Primary Care Visits within Seven Days Post-Discharge*

### Change Ideas:

- 42 organizations encouraged patients to contact the primary care providers and make the office aware if they had recently visited the ED or hospital.
- 23 organizations educated patients to inform hospitals of the name and contact information of their provider using a “patient passport” or contact card.

● **Indicator:** *Reducing Hospital Readmission Rates within 30 Days of Discharge*

### Change Ideas:

- One CCAC, in collaboration with several community support service partners, implemented Assisted Living Services for High Risk Seniors to support high risk seniors who can reside at home, but require ongoing personal support, such as homemaking, security checks and reassurance services.
- Two CCACs have analyzed which CCAC patients are being readmitted and have decided on an improvement strategy to prevent readmissions for palliative patients. They are working on their Palliative Nurse Practitioner program to ensure consistent pain and symptom management with the aim of helping

palliative clients remain at home as long as possible — regardless if their home is in the community or in Long Term Care

● **Indicator:** *Reducing potentially avoidable ED visits for residents*

### Change Ideas:

- 39 homes identified alternate ways to provide early treatment for common chronic conditions.
- 32 homes employed a team approach, including huddles/rounds with a focus toward residents with higher risks for ED visits.
- 21 homes supported ongoing staff education and mentoring, especially for personal support workers, to proactively identify and monitor for signs of deterioration (such as dehydration) in residents.



## Chapter 3: Cross-Sector Profiles of Success

## Chapter 3: Cross-Sector Profiles of Success

This chapter shines a spotlight on the organizations across Ontario's health system that submitted QIPs and are collaborating to integrate care beyond their four walls. These profiles of success also demonstrate how partnerships, team work, and building bridges across sectors and disciplines can enhance patient experience. In each example, organizations further reflected their commitment by highlighting them in each of their respective QIPs. Examples are provided in alphabetical order.

### Profiles of Success

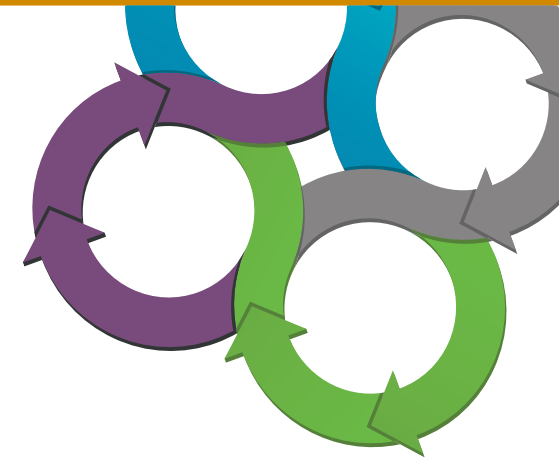
**Barrie Family Health Team and Health Link (BCFHT)** demonstrated a commitment to promote integration and continuity of care by creating an MVP clinic.

*"The MVP Clinic embraces the philosophy that the patient is the 'most valuable player' in their health care and works with each patient to prioritize personal goals and any medical needs identified by the clinicians. For 2014-15 the goal [was] 100% of patients [would] have documented hospital visits and Coordinated Care Plans in their EMR, and five primary care physicians [would] refer patients to the MVP Clinic. The MVP Clinic interdisciplinary team has expanded to include an RN, nurse practitioner,*

*social worker, administrative assistant, pharmacist, registered dietitian, occupational therapist support, and community health worker support through the Barrie Community Health Center." The MVP Clinic will also continue to triage incoming referrals and accept patients, while maintaining a focus on providing "holistic, patient-centred, primary care" to patients, with the goal of reducing financial impact on the health system overall."*<sup>6</sup>

**Baycrest's Apotex Centre, Jewish Home for the Aged** worked with system partners, including Toronto Central and Central CCAC, North York General Hospital, and the Integrated Community Care Team (ICCT), to meet the needs of the sub-acute population with coordinated, patient-focused, and integrated services. Baycrest is also in the process of working with over 15 community partners to form the North West Health Link.

*"Reflected in our QIP is a strong focus on improving access and flow within our clinical programs and also across the system. In the spring of 2013, Baycrest transitioned our acute care unit to a transitional care unit. To ensure that the sub-acute clinical conditions can be managed internally and to avoid preventable transfers to acute care facilities, we embarked on a coordinated, multi-pronged*



“As health care providers, we must create an environment where our clients see and experience a single health care team, working together with them, communicating effectively with each other, and ensuring that every client receives the care they need, when they need it. – Toronto Central CCAC, from its 2014-15 Quality Improvement Plan.”



*capacity building initiative involving advance care planning, improved transition management and the implementation of capacity building tools and techniques for clinical staff.”*

**Huron Perth Health Link** aligned their goals with the 2014-15 QIPs. While Health Links are not required to submit QIPs, all four Huron Perth hospitals and nine family health teams (FHT) participating in the Health Link reflected their work together to create “a system” in each of their QIPs.

*This Health Link implemented a coordinated care planning process and worked with the [IDEAS program](#) in late 2014 on a project to decrease healthcare utilization (ED Visits & Inpatient Days) by the elderly and those with COPD & CHF by 10% by March 31, 2015. The IDEAS project’s specific aim was that 85% of identified complex patients with a care plan would be “confident” or “very confident” that they can reach their identified goals.*

This Health Link also created a Huron-Perth Provider Table for sharing pertinent information and local resources. FHTs work together with clinical and quality leads to develop quality improvement priorities and establish workplans for Quality Improvement Decision Support Specialists (QIDSS).

**VON 360 Degrees Nurse Practitioner-Led Clinic (NPLC)** built strong connections with their local hospital, Peterborough Regional Health Centre (PRHC). They have collaborated with PRHC to ensure that newly registered patients were asked if they had a primary care

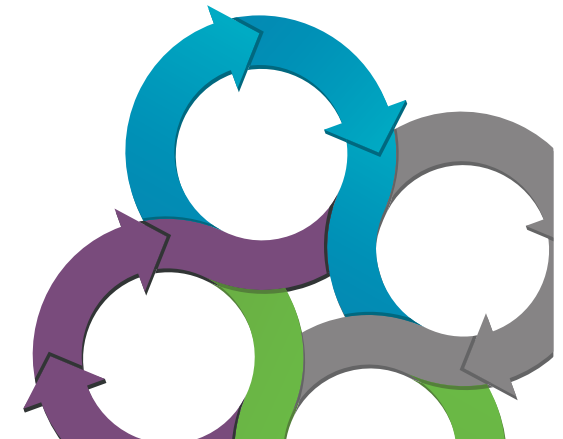
physician or nurse practitioner.

*In this way this NPLC says they ensured “that our nurse practitioners receive records on our patients from the hospital in a timely fashion. PRHC’s emergency department notifies us when our patients have visited the ER so that we can follow-up with them with a telephone call from one of our RNs within 24-48 hours of discharge.” This clinic also says they were “invited to participate at PRHC’s 2013 two-day strategic planning day as a contributing community partner. In addition, we are pleased to report our nurse practitioners became the first in our community to be granted courtesy privileges enabling us to have access to the hospital’s electronic records pertaining to our patients.”*

**Waterloo Wellington Local Health Integration Network (WWLHIN)** approached reducing the percentage of ALC days as a collective. HQO found that the hospitals within the Waterloo Wellington region listed multiple initiatives in their QIPs aimed at reducing the ALC rate.

*“The WWLHIN set a LHIN-wide percentage of ALC days target equal to the provincial target that all hospitals were to strive to achieve by the end of 2014-15. Most of the region’s hospitals selected the upper limit of their Hospital Services Accountability Agreement (HSAA) performance corridor as their QIP target. By July 2014, the LHIN had reduced their percent ALC days by 11%, nearly halfway to their target.”*

The WWLHIN reduced their percentage of ALC days in part due to a process the Waterloo Wellington CCAC rolled out in 2012 called “Easy Coordinated Access.” It is a way to ease the transitions between care providers because it allows primary care providers and CCAC care coordinators to easily locate and refer community support services or specialized geriatric services in the Waterloo Wellington region. In order to take on this expanded role, the CCAC transitioned to a new client care model and shifted appropriately their lower acuity clients to the Community Support Services sector. The CCAC also created a patient flow coordinator position, where an individual is responsible for knowing where all the patients are in the system and what services they can access. A collaborative LHIN-wide expert panel, the Patient Care Transitions Steering Committee, was also formed to monitor all of the region’s health utilization data. This program brought all of the providers together from across the region and across all sectors to target the percentage of ALC days. ■





**Putting it All Together: Cultures of Communication and Collaboration**

# Putting It All Together: Cultures of Communication & Collaboration

The 2014-15 QIPs tell a story of Ontario's health system and its efforts to improve the delivery of integrated care. The desire of organizations to meet and/or exceed provincial targets for each integration indicator prove that many care providers in our health system are dedicated to continuous improvement in this area. It is hoped that these examples inspire others to reflect on their current quality improvement activities and consider how they are addressing integration. It is important to ask questions to drive such change: Are the appropriate partners being identified to help make improvements? In what collaborative ways can integration indicators be addressed? What change ideas are others using that may be relevant to what your QIP is trying to achieve?

The report has also highlighted how organizations participating in priority initiatives for the health system, such as [Health Links](#), are actively working to improve integration of care for patients with complex needs. With the addition of new Health Links, there will be increased opportunities to reflect on these collaborations as part of greater quality improvement efforts. Furthermore, the current call for proposals related to

[Integrated Funding Models](#) signals the importance of assessing how best to align incentives that promote the high-quality delivery of integrated care. Other priority initiatives related to palliative care and mental health require a degree of integration and collaboration across sectors, and in some cases, beyond the traditional health system to include housing and other social services. Reflecting on these efforts within a QIP demonstrates a level of commitment to integration.

We know care could be better coordinated. The story of Kirk and Peter (pg. 8) shows what can happen when care is fragmented, and patients (or their loved ones) feel on the fringes of their treatment plans. As noted in HQO's yearly report, *Measuring Up*, "All of the [integration] indicators [in the Common Quality Agenda] are a reflection of how well the individual parts of the health system work together."<sup>7</sup> Moving forward, in HQO's upcoming review of the 2015-16 QIPs, we will start to examine the impact of some of the collaborative ideas featured in this report. While much of the work being done now will not generate comparable data for some time, it is important to explore and review efforts as they unfold.

Our health system needs to adapt more quickly to meet the needs of patients – and that adaptation requires improving the way individual parts of the system work together. It requires an improved level of coordination and communication between sectors, organizations, providers, and patients. We know this level of integration can promote high-quality care and improved patient experiences because it fosters information sharing, accountability, and the partnership required to take evidence-based change ideas from paper to practice. ■

<sup>1</sup> Health Quality Ontario. (2014) *Measuring Up*, <http://www.hqontario.ca/portals/0/Documents/pr/measuring-up-yearly-report-en.pdf> . p.81.

<sup>2</sup> Health Quality Ontario. (2013). *BestPATH, Transitions of Care, Evidence Informed Change Package*. <http://www.hqontario.ca/Portals/0/Documents/bp/bp-improve-pkg-transitions-interactive-en.pdf>. P.11.

<sup>3</sup> Coddington, D. C., Ackerman, F. K., Jr., & Moore, K. D. (2001). Integrated health care systems: major issues and lessons learned. *Healthc Leadersh Manag Rep*, 9(1), 1-9.

<sup>4</sup> Afilalo, M., Lang, E., Léger, R., Xue, X., Colacone, A., Soucy, N., & Unger, B. (2007). Impact of a standardized communication system on continuity of care between family physicians and the emergency department. *Cjem*, 9(2), 79-86.

<sup>5</sup> Kripalani S, L. F. (2007). Deficits in communication and information transfer between hospital-based and primary care physicians: implications for patient safety and continuity of care. *JAMA*.297(8), 831-841.

<sup>6</sup> *Barrie FHT Annual Report*, <http://barriefht.ca/wp-content/uploads/2014/06/bcfht-2014-annual.pdf>

<sup>7</sup> Health Quality Ontario. (2014) *Measuring Up*, <http://www.hqontario.ca/portals/0/Documents/pr/measuring-up-yearly-report-en.pdf>, p.81.

Health Quality Ontario  
130 Bloor Street West, 10th Floor  
Toronto, ON M5S 1N5  
Tel: 416-323-6868 | 1-866-623-6868  
Fax: 416-323-9261

© Queen's Printer for Ontario, 2015

ISBN 978-1-4606-5493-4 (Print)  
ISBN 978-1-4606-5494-1 (HTML)  
ISBN 978-1-4606-5495-8 (PDF)

[www.hqontario.ca](http://www.hqontario.ca)