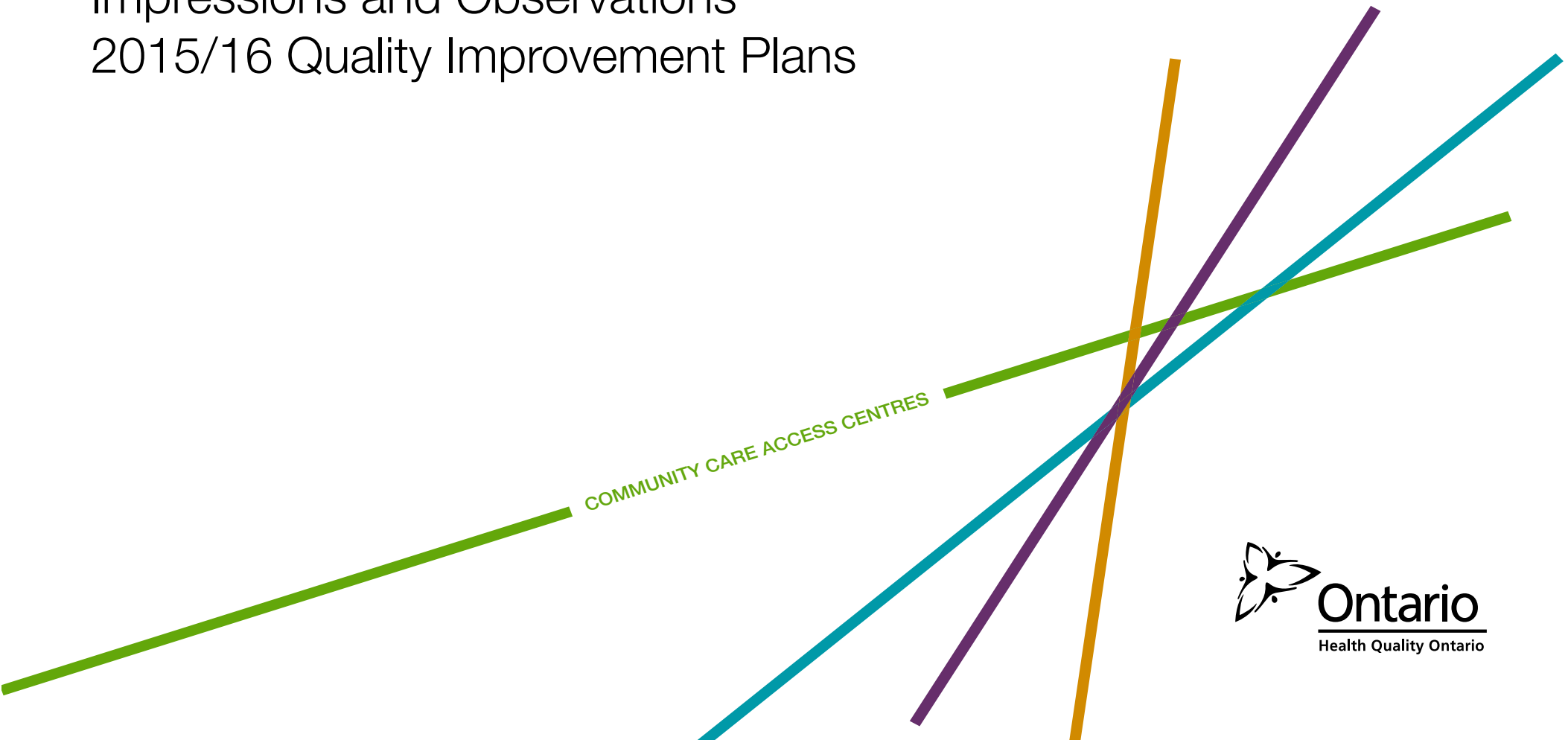
Community Care Access Centres

Impressions and Observations
2015/16 Quality Improvement Plans



Ontario
Health Quality Ontario

About Us

Health Quality Ontario is the provincial advisor on the quality of health care. We are motivated by a single-minded purpose: **Better health for all Ontarians.**

Who We Are.

We are a scientifically rigorous group with diverse areas of expertise. We strive for complete objectivity, and look at things from a vantage point that allows us to see the forest and the trees. We work in partnership with health care providers and organizations across the system, and engage with patients themselves, to help initiate substantial and sustainable change to the province's complex health system.

What We Do.

We define the meaning of quality as it pertains to health care, and provide strategic advice so all the parts of the system can improve. We also analyze virtually all aspects of Ontario's health care. This includes looking at the overall health of Ontarians, how well different areas of the system are working together, and most importantly, patient experience. We then produce comprehensive, objective reports based on data, facts and the voice of patients, caregivers and those who work each day in the health system. As well, we make recommendations on how to improve care using the best evidence. Finally, we support large scale quality improvements by working with our partners to facilitate ways for health care providers to learn from each other and share innovative approaches.

Why It Matters.

We recognize that, as a system, we have much to be proud of, but also that it often falls short of being the best it can be. Plus certain vulnerable segments of the population are not receiving acceptable levels of attention. Our intent at Health Quality Ontario is to continuously improve the quality of health care in this province regardless of who you are or where you live. We are driven by the desire to make the system better, and by the inarguable fact that better has no limit.

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Executive Summary

The Community Care Access Centres (CCACs) in Ontario submitted Quality Improvement Plans (QIPs) on April 1, 2015. This marks the second year of submissions for all 14 CCACs.

The QIPs submitted this year show that CCACs are maintaining progress on gains sustained so far. All 14 CCACs improved on at least one of the priority indicators and seven improved on three or more indicators. Additionally, many detailed key observations on new initiatives and motivations behind their improvement activities.

While it is clear that CCACs are committed to improvement, overall progress was generally modest, with most indicators remaining stable. Examples highlighted throughout this report demonstrate where progress has been achieved and what the sector is doing to improve care.

This report is part of Health Quality Ontario's ongoing *Insights into Quality Improvement* series. In an effort to continue sharing information about continuing improvements to care, it will touch upon all three components of the QIPs (Narrative, Progress Report and Workplan) submitted by CCACs and largely concentrate on the lessons CCACs learned over the past year.

About This Report

Over the past five years, health sectors across Ontario have submitted Quality Improvement Plans (QIPs). A process that initially began with Ontario's hospitals has now extended to organized primary care organizations, Community Care Access Centres (CCACs) and long-term care homes.

The annual submission of QIPs demonstrates the ongoing commitment of more than 1,000 health care organizations to deliver higher quality in Ontario. These plans allow organizations to articulate their quality objectives, formalize their improvement activities and pinpoint precise ways of achieving those goals.

Each QIP details an organization's work on a set of priority indicators. These indicators align with the Common Quality Agenda, a set of more than 40 indicators developed in collaboration by Health Quality Ontario and other health system partners. The Common Quality Agenda is an effort to focus performance reporting, lend greater transparency and accountability to the health system, and promote integrated, patient-centred care. It forms the foundation of Health Quality Ontario's yearly report, *Measuring Up*, which shows how Ontario's health system is performing. Healthcare organizations can use the information available in *Measuring Up* and *Health Quality Ontario's Insights into Quality Improvement* reports to gain a greater understanding of quality improvement from both an organizational and system-wide perspective.

The QIPs also align with *Quality Matters*, launched by Health Quality Ontario in October 2015, which provides a new framework and vision for a quality health system in Ontario. It is designed to bring everyone in the health system to a shared understanding of quality health care and common set of principles to guide our work to improve quality in Ontario.

The preparation and detail that goes into each QIP represents an impressive effort on the part of each health care organization. Health Quality Ontario recognizes this work by carefully reading each QIP in order to examine and evaluate the data and change ideas provided. Using QIPs to highlight progress and identify areas in need of improvement is one way in which Health Quality Ontario works with the 1,076 health care organizations across all four sectors to transform the quality of care within the health system at large.

Health Quality Ontario hopes that the findings in this report will help inform decisions about quality care for people being supported at home and will encourage further testing of innovations.

This report is part of the ongoing *Insights into Quality Improvement* series. It will touch upon all three components of the QIPs (Narrative, Progress Report and Workplan) submitted by CCACs and largely concentrate on the lessons CCACs learned over the past year. Both quantitative and qualitative data is included. The qualitative data is presented as change ideas and organization profiles, pulled from all priority indicators. The quantitative data is drawn only from those CCACs who selected a particular indicator and chose to measure that indicator using Health Quality Ontario's original, technical definition.

Introduction

Last year, Ontario's Community Care Access Centres (CCACs) supported over 653,000 people receiving care in homes and communities across the province. CCACs work collaboratively with patients, families, providers, and community organizations to ensure that patients receive the care and support they need to allow them to stay at home and in their communities for as long as possible. As such, they play a critical role in both the health of individual patients, but also the broader health care system.

This was the second year that CCACs submitted Quality Improvement Plans (QIPs), and the first year that they completed a Progress Report. Building upon last year's QIPs, which primarily focused on each organization's efforts to become familiar with the priority indicators, this year's QIPs demonstrate innovative strategies for quality improvement and capture the efforts of CCACs to examine underlying causes of existing performance levels. In the spirit of progress, this year's QIPs show how CCACs are collectively transitioning from the foundational step of establishing ongoing data analysis and quality monitoring to articulating long-term improvement initiatives.

As noted in the QIP guidance documents, health care organizations are encouraged to select the priority indicators to contribute to large scale change across the system. This year, the majority of CCACs selected all the priority indicators; in addition, four CCACs selected custom indicators based on local needs. These custom indicators (not explored in this report) involved the timeliness of patient re-assessments, patient-centred appointments, revenue-to-expense ratios, employee engagement and experience and whether individual organizations met their strategic goals for the year.

This report will concentrate on the six priority indicators identified for Ontario's CCACs:

- Reducing Falls for Long-Stay Clients
- Improving Five-Day Wait Times for Nursing Visits
- Improving Five-Day Wait Times for Personal Support Worker Visits
- Reducing Unplanned Emergency Department Visits Within 30 Days of Discharge
- Reducing Unplanned Hospital Readmissions Within 30 Days of Discharge
- Improving Patient Experience

CCAC Indicator Selection QIP 2015/16

This graphic shows the percentage of CCACs that selected each of the priority indicators and the percentage that also focused on the custom indicators, noted as "other." Where a priority indicator wasn't selected, the rationale provided showed the CCAC either had a high current performance or chose to focus its efforts on indicators requiring more improvement.

100%	93%	86%	93%	100%	86%	29%
Reducing Falls for Long-Stay Clients	Reducing Unplanned Emergency Department Visits	Reducing Unplanned Hospital Readmissions	Improving Five-Day Wait Time for PSW Visits	Improving Five-Day Wait Time for Home Care Nursing	Improving Patient Experience	Other

Throughout this report, graphs show the current performance levels and targets for improvement set by individual CCACs. In addition to a quantitative analysis of the indicators, this report also highlights issues of interest within the broader health care system that provide context to the improvement efforts of CCACs. Key observations round out the high level summaries for each indicator.

Along with key observations derived from each indicator, some overarching themes emerged during Health Quality Ontario's analysis of the CCAC QIPs.

- **Progress has generally been modest:** Performance on the priority indicators remained stable, with most CCACs essentially maintaining current performance from their 2014/15 data. Some CCACs noted improvements in five-day wait times for home care and unplanned emergency department visits within 30 days of discharge. All 14 CCACs improved on at least one of the priority indicators and seven improved on three or more indicators.

- **CCACs are developing more strategies to support complex patients:** Patient acuity was one of the most commonly cited challenges by CCACs, with many describing an increase in clients with more complex care needs. This trend is forecasted to continue; as a result many CCACs are implementing approaches to increase their capacity to care for more acute patients, and where appropriate, work with community agencies to transition lower acuity patients to community agencies for care.

- **CCACs are investing in staff training:** CCACs are also investing in CCAC staff training in quality improvement to ensure key processes are optimized, and care is focused on improving the patient experience.

    - In North Simcoe Muskoka CCAC, an all-staff education event was co-designed with families to support direct engagement and reflection on their care experience and values in the delivery and communication of care.
    - Champlain CCAC implemented training and education with service provider organizations on falls awareness with clients.
    - Erie St. Clair CCAC used an organizational readiness assessment from the Institute for Patient and Family Centred Care (IPFCC) in order to develop an action plan.
    - North East CCAC developed an education module to support staff in engaging patients, family members, and others in difficult conversations about changes in health care needs and other topics.

- **CCACs are connecting Health Links to their QIP activities:** Commonly cited projects related to improving integrated care include Health Links, with 10 out of 14 CCACs mentioning them. Furthermore, five of the 10 CCACs referenced Health Links in their Workplans as a way to support improvement.

- **CCACs are sharing data to drive improvement:** Data sharing is occurring more often between CCACs and across sectors, contributing to smoother care transitions and targeted improvements in delivery of integrated care. Examples include:

    - Central CCAC has recently implemented new dashboard tools to provide leaders with easy and timely access to key performance data including QIP data, balanced scorecard measures, and key statistical and financial information
    - Erie St. Clair CCAC is developing a safe and secure means of sharing information between other CCACs, hospitals and community partners.
    - North West CCAC has also implemented a Community Health Portal (CHP) that allows service providers access to sections of shared client records for ease of information sharing.

- **CCACs are integrating mental health and addictions into their QIP:** Mental health and addictions are becoming a significant focus for CCACs. Many QIPs highlighted the work CCACs are doing with local schools to develop school-based mental health programs and other community programs to offer early interventions.

- **Many CCACS are joining forces and collaborating together on quality improvement, patient experience, and patient safety:** As an example, Central West CCAC, Headwaters Health Care Centre and William Osler Health System committed to an innovative partnership in 2014, resulting in an integrative focus on quality. Initially the partnership focused on integration of non-clinical support functions, such as administration. It was intended to foster a new partnership as a catalyst for collaboration, allowing all three organizations to explore joint investment opportunities and system-level planning.

  Since then, this partnership has evolved, with all three organizations working together to submit a common narrative for their 2015/16 QIP. They now have regular meetings and planning sessions to address initiatives. Examples of recent work include a focus on reducing readmissions and falls. Staff at Central West CCAC have already noticed that there appear to be fewer barriers to "reaching out," and that staff at all three organizations are working together more to improve care for their patients.

These observations and others will be expanded upon throughout this report. The structure of this report is as follows: the priority indicators detailed above will be divided into three chapters, based on the nature of the improvement efforts they necessitate. Some indicators, like reducing falls or five-day wait times, require sector-specific or organization-driven improvements – work that occurs within an individual organization. These indicators will be explored in this first chapter. Other indicators, like reducing readmissions and emergency department visits, are better addressed when sectors collaborate, going beyond their own organization to work with others both within their sector and across the care continuum. The second chapter will address these indicators. Given the growing role that patient experience and engagement play in quality improvement, both of these topics are explored in more detail in the third chapter. The concluding chapter will share reflections on the QIPs as a whole, along with additional overall themes noted during Health Quality Ontario's analysis.

Chapter One

Working Within the Sector: Sector-Specific Advances on Priority Indicators

This chapter explores the individual efforts of CCACs to improve upon three priority indicators, which require sector-specific improvement activities. These indicators include falls for long-stay home care clients, five-day wait times for nursing visits and five-day wait times for personal support workers (complex patients).

INDICATOR: FALLS FOR LONG-STAY HOME CARE CLIENTS

About this Indicator: This indicator measures the percentage of adult long-stay home care patients who have recorded at least one fall within the last 90 days following a RAI-HC assessment. The Resident Assessment Instrument – Home Care (RAI-HC) tool provides a standardized evaluation for capturing the care needs of adult patients in hospital and community settings.

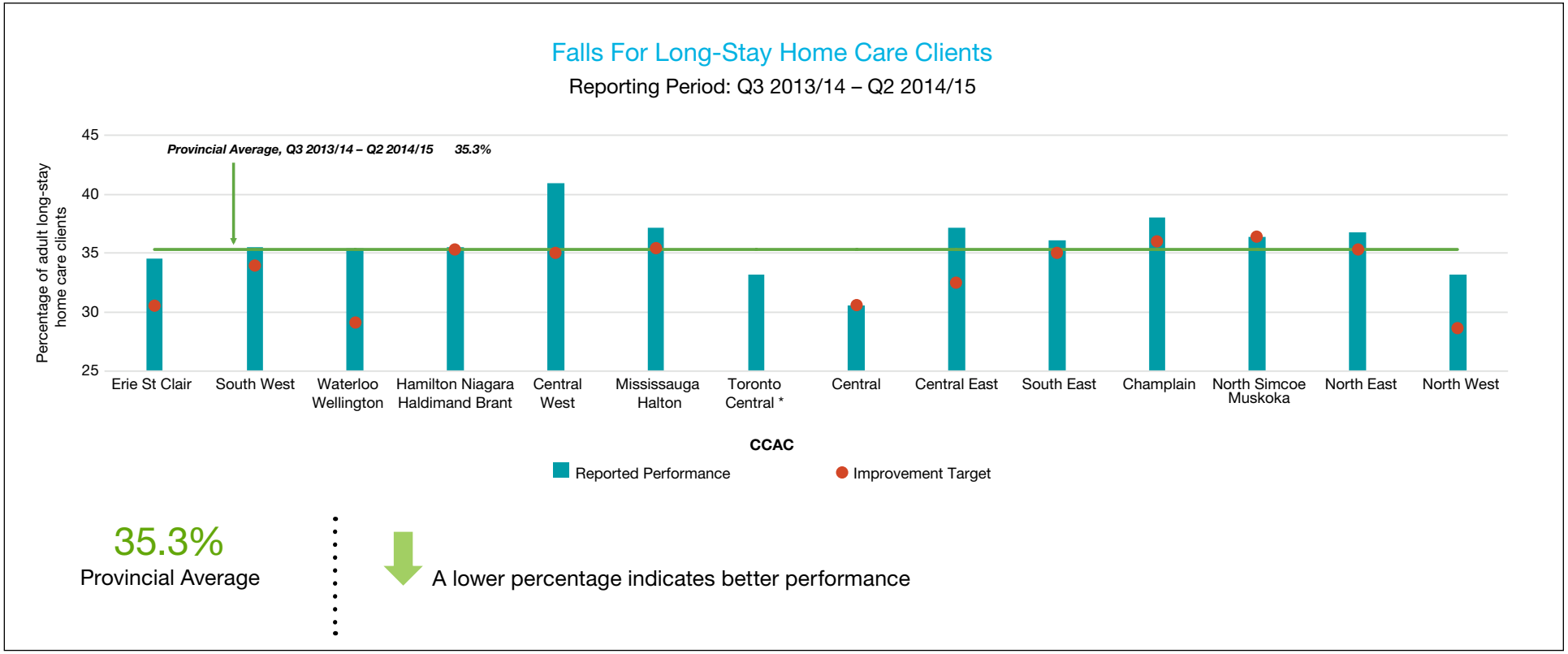
Understanding this Indicator: Falls may be symptomatic of safety hazards in the home or a patient's functional decline, reaction to medication, delirium, infections or other conditions.[i] Many CCACs noted increasing patient complexity as a challenge in meeting their falls targets and are putting mitigation strategies in place as a result, including implementing medication reconciliation programs for complex patients. Coordinated efforts to reduce falls are important when we consider the recent findings by the Canadian Patient Safety Institute (2013) that 56% of adverse events for those in home care were judged to be preventable, the majority of which were falls, infections, or medication related incidents. They were also judged to negatively impact the broader system, with 91.4% of them associated with an increased use of healthcare resources.[ii] Furthermore, it has been shown that home care patients who fall once are often at a greater risk of falling again.[iii]

Analyzing this Indicator: All 14 CCACs selected this indicator. Twelve set targets to improve and two set targets to maintain current performance.

- Provincial average: 35.3% of patients had a least one fall
- Current performance range: 30.6% to 40.9%
- Range of targets selected: 0% to 36.4% (average: 31.0%)

The graph below provides the unadjusted fall rate within each CCAC. It shows the provincial average for the indicator, current CCAC performance (as listed in their 2015/16 QIP), and the target each individual CCAC hopes to achieve in 2015/16.

Notes on this Graph: While Toronto Central CCAC is working on this indicator, they did not select a target for this year. Of the other CCACs working on this indicator, two are targeting to maintain their current performance, but the rest have targeted to improve. Of this last group, Waterloo Wellington, North West, and Central West CCACs set the most ambitious targets.



Achieving Progress on this Indicator: Nine CCACs, who measured their data in the same way in 2014/15 and 2015/16, continued to report struggles with meeting their targets. Many attribute the increasing complexity of patient populations to the difficulty in reaching their chosen target. Falls rates can also be difficult to manage in an uncontrolled environment, such as a person's home. To improve, many CCACs are focusing on targeted interventions for complex patients.

Here are some examples of innovative ideas that CCACs implemented as outlined in their Progress Reports.

- Tailoring interventions (e.g., physical therapy, occupational therapy pathways, and decision support tools that promote the early activation of such therapies) specific to the patient's environment, for those who have fallen previously.

- Initiating falls prevention and specific programing for high-risk patients, such as referrals to mobile falls prevention clinics, exercise programs and developing individualized care plans to reduce falls.

- Working with falls prevention coordinators.

- Using falls risk assessment tools and care debriefs to identify patients at risk of falling.

    - Central East and Central West CCACs said they are both using these methods to help prevent reoccurrences of falls.

- Managing medications, using community pharmacy programs such as Medication Management Support Services and Meds Check.

    - Several CCACs had intended to focus on broadening the capacity of medication reviews, however this strategy was abandoned due to resourcing shortfalls. Many CCACs will revisit this change idea next year.
    - Central East CCAC piloted the use of the Rapid Response Nurses (RRN) Program to focus on medication reconciliation for high-risk patients.

- Providing consistent education and messaging to patients/care providers.

    - Champlain CCAC started engaging patients and including their perspectives as part of its training by asking patients, "What does safety mean to you?"
    - Central East CCAC noted the need to provide patients with more consistent education on preventing falls, such as falls programs available within the community, as well as educating providers and care coordinators to recognize patients who could benefit from home safety assessments.

- Identifying key resources for engaging and educating staff on best practices and the latest guidelines, including the Registered Nurses' Association of Ontario's best practice falls prevention guidelines, which was referenced in several QIPs.

- Improving communication between CCAC staff and service provider organizations regarding patient assessment/reassessment.

    - Champlain CCAC trains District Care Coordinators and Intake Care Coordinators on falls prevention programming via an e-Learning module, reporting a 98% compliance rate.
    - North East CCAC supported 81.6% of Care Coordination and Clinical Services staff in completing a Falls Prevention e-Learning module, thus enhancing their knowledge and skills in falls prevention.

★ **Spotlight: Here is one example of an organization that is currently testing out a new change that may contribute to improvement on this indicator.**

South East CCAC:

The CCAC conducts falls assessments every three to six months, but suggests that monthly assessments may be beneficial. *"A standard protocol was implemented for complex patients identified as high risk for falls. The protocol, which includes follow-up from the Care Coordinator at 30 days and 60 days after reassessment, was implemented for 29 complex patients… The number of patients so far is small, but early data suggests that following up with these patients 30 days after their reassessment is critical to supporting a sustained falls prevention plan. Twelve patients have had a six-month reassessment, and eight have reported a decrease in falls since their last assessment… This has prompted us to expand the rollout of the falls protocol to all complex patients, enhance focus on the 30-day follow-up, extend it to another population and continue closely monitoring falls."*

Advancing this Indicator: Many CCACs identified the increasing complexity of their patients and how this might impact falls. They noted that improving on this indicator can take a long time, and immediate gains may not always be apparent in terms year-over-year progress. Many CCACs are still working on change ideas from the previous year. In order to better measure progress, many suggested creating patient subgroups to evaluate falls based on patient condition. Many CCACs are also working with their association to improve data reporting in the Client Health and Related Information System so that they can better track falls within their population and take steps to prepare for an increase in at-risk patients.

INDICATORS: FIVE-DAY WAIT FOR HOME CARE: NURSING VISITS AND PERSONAL SUPPORT WORKER VISITS

About these Indicators: CCACs evaluate wait times for home care services using two priority indicators to measure visits to patients. The first indicator measures the time to first visit to any patient from a nurse. The second indicator measures the time to first visit to complex patients from personal support workers.

Each indicator measures the percentage of patients who receive either their first nursing or personal support worker (PSW) visit within five days after the service has been authorized by the CCAC. The Five-Day Wait Time for PSW Visits indicator takes into account only complex patients, which include those who have one or more health or chronic health conditions requiring high levels of care in order to live at home.

Understanding these Indicators: Accessing care in a timely fashion can be challenging for patients at different stages in their health care journey. The consequences of delayed access to nursing or PSW services may include increased confusion and stress for patients and caregivers and potential re-hospitalization. Therefore receiving care within the five-day window is important to maintain continuity of care, facilitate patient rehabilitation and identify deterioration. In some cases however, delays are deemed acceptable (such as patient choice or clinical need for a visit at a later date).

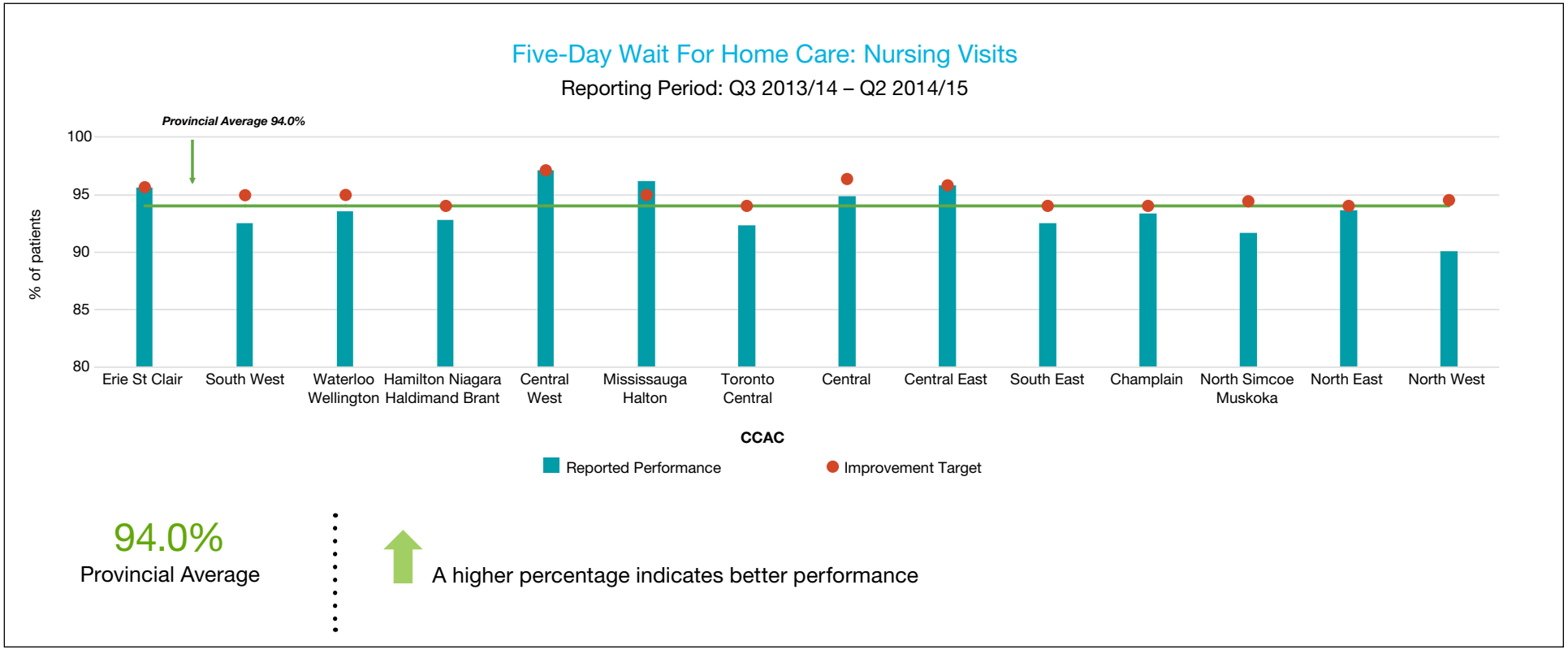
As these indicators were introduced to the sector for the first time last year, CCACs had to design ways to accurately measure the wait times and to understand the factors that may contribute to those wait times. At this time there is not yet a provincial target. In January 2015, steps were taken to allow CCACs to better track both indicators and reasons for delays.

Analyzing these Indicators: Of the 14 CCACs that selected the nursing visits indicator (using the original definition), 10 set targets to improve, three set targets to maintain current performance, and one set a target worse than current performance. (This target was very close to its current performance, with the CCAC stating it would continue monitoring closely should it fall below current targets.)

Of the 13 CCACs that selected the PSW indicator (using the original definition), eight set targets to improve, four set targets to maintain current performance, and one set a retrograde target near to its current performance level.

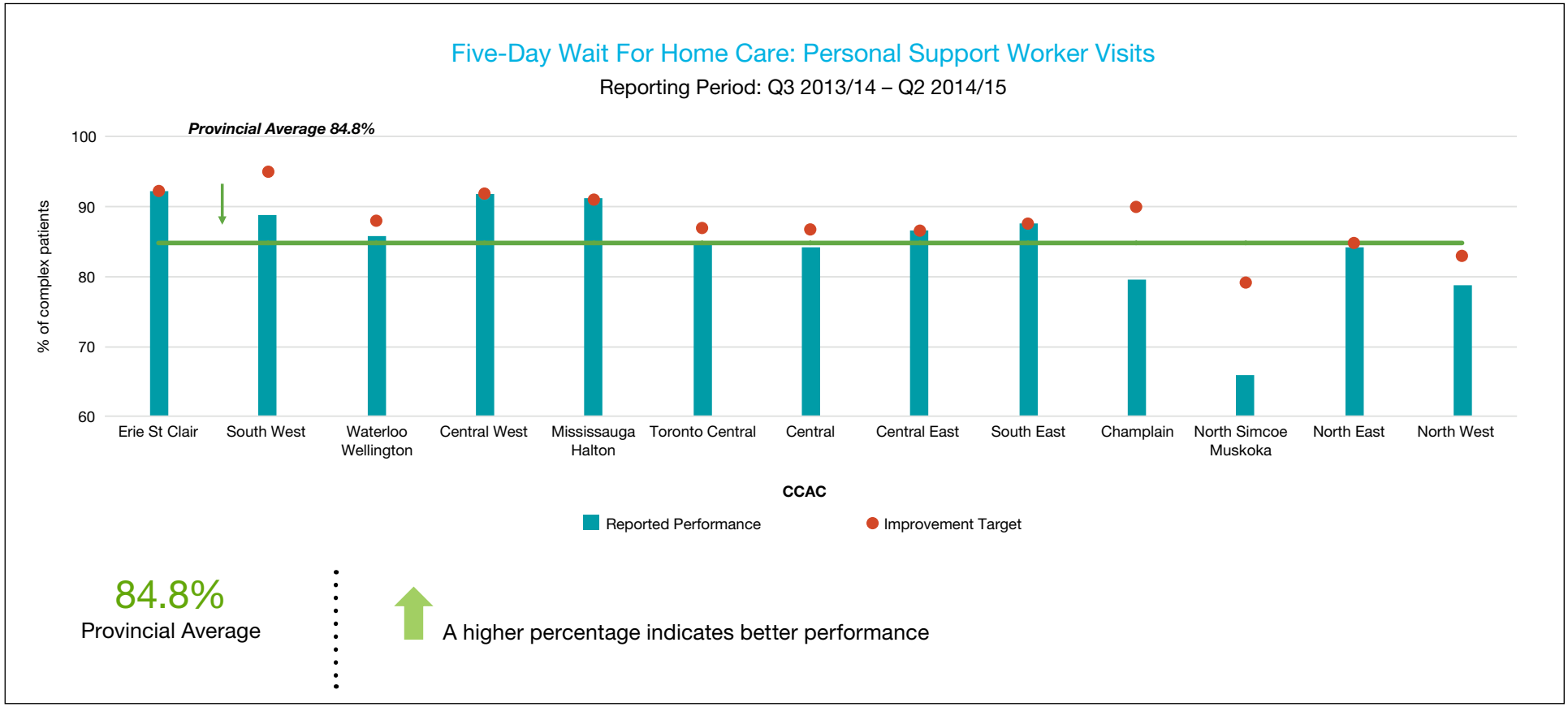
Nursing Visits	PSW Visits
Provincial average: 94% of patients had their first visit from a nurse within five days	Provincial average: 84.8% of patients had their first visit from a PSW within five days
Current performance range: 90.1% to 97.1%	Current performance range: 65.8% to 92.3%
Range of targets selected: 94% to 97.1% (average: 94.9%)	Range of targets selected: 79.1% to 95% (average: 87.9%)

Notes on this Graph: Plans for progress on this indicator appear quite uniform. Current performance for all organizations is greater than 90%. North West CCAC has the largest stretch target between its current performance and improvement target (4.9%).



Notes on this Graph: There is more room for improvement for reducing wait times for PSW. Five of 14 CCACs are currently reporting that less than 84.8% of clients access care from a PSW within five days. North Simcoe Muskoka CCAC reports the largest stretch goal. All CCACs have reported variability due to availability of PSWs and travel distance. Hamilton Niagara Haldimand Brant CCAC is not included here because it did not select this indicator for its 2015/16 QIP.

Achieving Progress on these Indicators: Of the CCACs who measured these indicators the same way in 2014/15 and 2015/16, three out of seven met their target for nursing visits; two out of three showed progress on their targets for PSW visits, with one improving by 6.0% against their previous performance.



Here are some examples of innovative ideas that CCACs implemented as outlined in their Progress Reports.

- Sharing patient information with improved technology to support coordinated and timely care planning with health system partners. This includes continued integration of clinical data technologies for shared care planning.
    - Mississauga Halton CCAC continues to work with its service provider organizations to increase uptake/utilization of information technology portals (Integrated Assessment Record, Connecting GTA, and Reach) *"as a means to assist in getting patient services going even more quickly."*
- Identifying reasons for why certain cases are not seen within the five-day window allowing for targeted improvement plans to address root causes.
    - Champlain CCAC implemented an 'auto offer' feature in the Client Health and Related Information System (CHRIS) to the contract organizations *"to reduce manual work involved in the previous process, reduce the risk of late offers, errors and duplication and reduce the time required to fill complex client care plans. Advice for other organizations implementing auto offer is to provide multiple avenues for education and communication regarding the process*." Ultimately this process improvement may reduce the wait times for first visit by nursing or PSWs.
- Providing regular updates to CCAC staff and Service Provider Organizations regarding current performance on both indicators.
    - Champlain CCAC said in its QIP that increasing staff and service awareness of both indicators is essential to consistent implementation.

★ **Spotlight: Here is one example of an organization that is currently testing out new changes that may contribute to improvement on this indicator.**

North Simcoe Muskoka CCAC:

This CCAC had a challenging time with its PSW wait times, which were worse than the provincial average. However, they experienced a 6.0% improvement in PSW wait times, moving closer to the 2014-2015 provincial average of 83%. The CCAC reported data from June 2015 that shows that their efforts are paying off, in part by implementing the following change ideas, with their current rate reaching approximately 82%.

- Communicating to agencies that provide personal support (issuing a service offer) to indicate that the first visit must be completed within five days or less of offer date, for complex patients.
    - While the change idea had a positive result, a practice audit highlighted the need for additional staff education to reduce variation in adopting this practice. ***"Formal follow-up post training and communication on this change initiative were key to reporting confidence in the adoption of this new practice."***
- Populating the service authorization form with service authorization date (on the date the form is signed and locked).
    - "This change idea was completed and [the organization] continues to audit this process. The results as of Q3 show ***this was a successful change with a positive impact on overall wait time results***."
- Ensuring all complex patients requiring PSW visits are direct offers for service (no wait listing).
    - This change idea is still in progress and will be monitored over the next year.

Advancing these Indicators: Many CCACs are taking the next steps toward progress on both indicators by looking beyond determining root causes to outlier cases and instead completely redesigning their service-offering processes. Some change ideas include: integrating care plans with hospitals to obtain 24-hour discharge notifications and tracking wait times from Service Provider Organizations. South West CCAC, for example, plans to evaluate a new service initiation time tool in the coming year. In these ways, many CCACs are forgoing quick fixes for long-term gains.

Chapter Two

Reaching Out and Working Together: Cross-Sector Improvements on Priority Indicators

This chapter examines two indicators, unplanned emergency department visits within 30 days of discharge and unplanned readmissions to hospital within 30 days of discharge, which may be reduced when organizations across sectors collaborate together. It reviews how specific organizations are reaching out and working with others to improve care through integrated services.

INDICATOR: UNPLANNED EMERGENCY DEPARTMENT VISITS WITHIN 30 DAYS OF DISCHARGE

About this Indicator: This indicator measures the percentage of home care patients who experience an unplanned, less-urgent ED visit within the first 30 days of discharge from hospital. An unplanned, less-urgent ED visit is defined as patients with a Canadian Triage and Acuity Scale (CTAS) level of four or five who are not admitted.

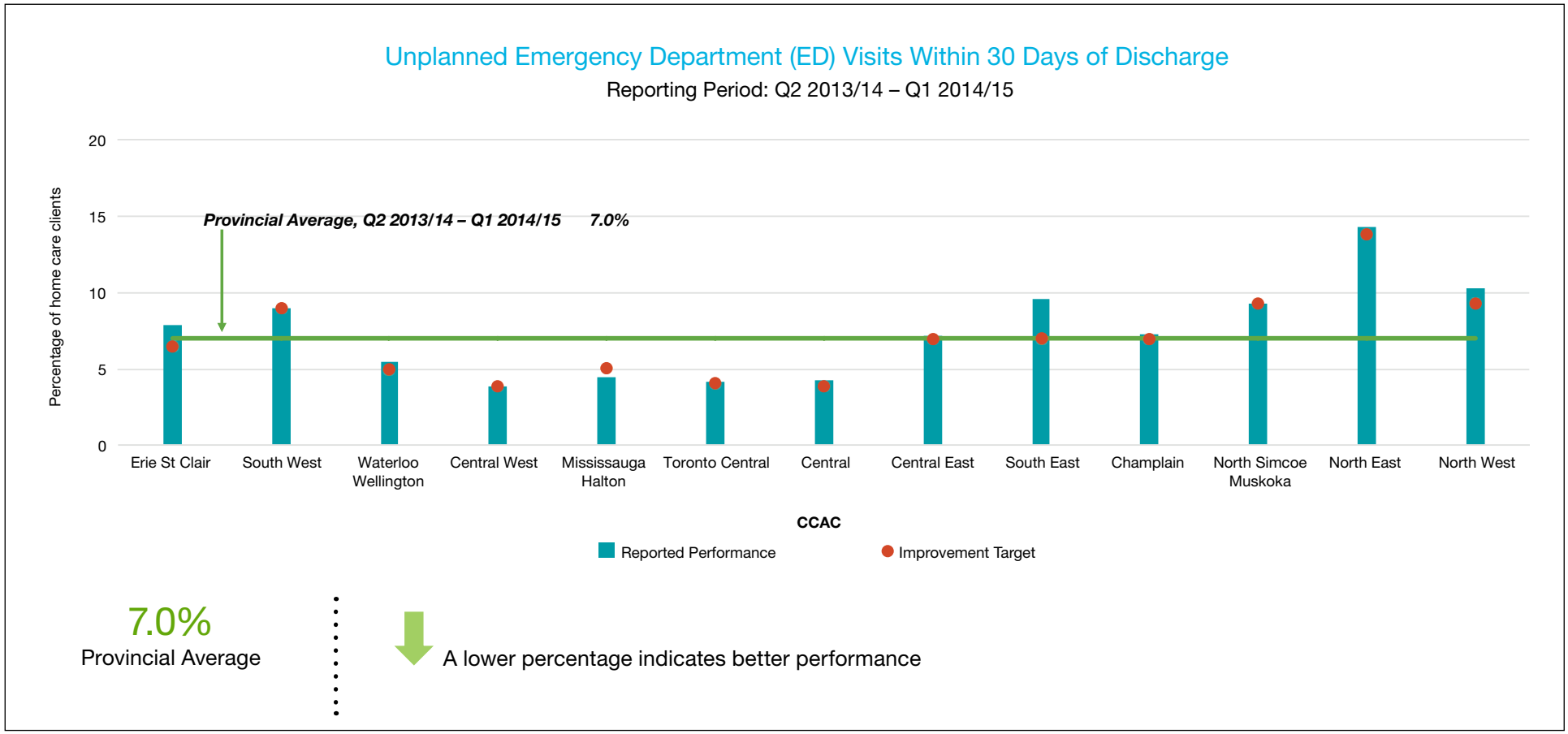
Understanding this Indicator: Ideally, people living at home with the care of a CCAC should continue to be treated in the community for minor/chronic issues in order to promote continuity of care while avoiding higher cost services, reducing congestion in the ED and improving patient flow. By reducing unplanned ED visits, CCACs enhance system-wide integration between community and acute care organizations.

Analyzing this Indicator: Of the 13 CCACs that selected this indicator, nine set targets to improve, three set targets to maintain current performance and one set a target worse than current performance (retrograde). The CCAC that omitted this indicator stated they chose to do so because its current performance is better than the provincial average.

- Provincial average: 7.0% of patients had an unplanned ED visit after discharge
- Current performance range: 3.8% to 14.3%
- Range of targets selected: 3.8% to 13.8% (average 7.0%)

The graph below shows the current performance for 13 CCACs (as listed in their 2015/16 QIPs), along with their 2015/16 targets. Hamilton Niagara Haldimand Brant CCAC is not included here because it did not select this indicator for its 2015/16 QIP.

Notes on this Graph: All but one CCAC reported on this indicator in their Workplan. The percentage of clients with unplanned, less urgent visits is already at or below the provincial average for five out of the 13 CCACs. The provincial average is 7.0%. In North East CCAC, the current performance is twice the provincial average, though they have set a modest improvement target.



Achieving Progress on this Indicator: When looking at progress over two years, only three CCACs measured this indicator in the same way in 2014/15 and 2015/16. Of those three, all noted improvements and two (Champlain and North West CCACs) surpassed their targets.

The following highlights examples of innovative ideas that CCACs implemented as outlined in their Progress Reports.

- Ensuring needs of clients are met with regular ongoing client status assessments
    - Champlain CCAC implemented a "change of status" tool for Service Provider Organizations to promote consistency across providers and the region.
- Implementing an e-alert notification to allow CCACs to track patient ED visits, along with reasons for visits. This effort allows CCACs to identify common reasons and fill gaps.
- Providing assisted living programs to better meet needs of high-risk seniors.
    - Central East CCAC works in partnership with the community support service Assisted Living for High Risk Seniors to support at home living for seniors requiring PSWs, homemaking, security checks and reassurance services on a 24-hour basis. This program allows for greater flexibility of care for seniors with needs better met outside of a "scheduled visit model."
- Sharing data with other care providers to identify and address common factors contributing to ED visits.
    - Many CCACs have been making progress with targeted programs to reduce common factors that contribute to ED visits.
    - Central West CCAC, the top performer on this metric, has also cited the value of integrating services with primary and acute care organizations.
- Providing additional services for high-risk patients through Rapid Response Nursing (RRN) Programs.
    - Half of the CCACs specifically mentioned the success of RRNs.
    - Most of the RRN programs in these CCACs targeted patients with Chronic Obstructive Pulmonary Disease (COPD) and Congestive Heart Failure (CHF), two conditions associated with the largest number of ED visits.[iv] Plans are in place to expand these programs to other high-impact populations, with some CCACs citing as the next area of focus their categorization of "chronic" seniors.
    - Connecting CCAC Care Coordinators with primary care physicians (who may not be part of a Community Health Centre or Family Health Team) and communicating together to provide coordinated and sustainable home care and inter-professional practices. For example, in early 2014, Waterloo Wellington CCAC partnered to develop three new multi-disciplinary teams to help primary care providers without access to a CHC or FHT. These teams include a pharmacist, care coordinator, nurse practitioner, mental health and addiction workers and outreach workers. Comments from the Progress Report indicated that teams developed coordinated care plans and reduced ED and hospital admissions substantially.

★ **Spotlight: Here is one example of an organization that is currently testing out new changes that may contribute to improvement on this indicator.**

Champlain CCAC:

This CCAC demonstrated the most progress on this indicator over the past year, from 9.1% to 7.3% representing a 19.8% improvement. The CCAC shared data with The Ottawa Hospital to identify factors contributing to unplanned visits, the CCAC and service provider organizations in the region developed and utilized a tool to identify changes in client status (a significant impact), there was improved client information transfer to primary care physicians, and an improvement in the percentage of clients seen within 24 hours of hospital discharge by a Rapid Response Nurse. Looking ahead, Champlain CCAC hopes to reach the provincial average of 7.0% in 2015/16. Champlain said that collaboration with other health sector organizations, among other initiatives, helped reduce unplanned ED visits. *"Collaboration between stakeholders such as The Ottawa Hospital, Service Provider Organizations and Primary Care has been shown to be a driver towards helping to improve hospital admissions for Home Care Clients."*

Cross-Sector Conversations: In the spirit of promoting system integration, the following high-level references show how organizations are working together across sectors for quality improvement.

- All CCACs are working in partnership with nurses within local district school boards to focus on early intervention for students with mental health and addiction issues. They are working with the Mental Health and Addiction Nurses (MAHN) Program to recognize and respond early. Central and Central East CCACs integrated their work with the MAHN Program into their QIPs. Central CCAC's goal is to provide service to 620 students in this program.
- Partnering with Health Links and other primary care integration initiatives to form inter-disciplinary care teams. Central CCAC is improving care planning for complex patients with intensive care coordination, comprehensive system navigation and evidence-based clinical service delivery to ensure faster care with fewer delays. *"Our Care Coordinators ensure Health Links patients have a primary care physician and work closely with the most responsible physician to develop a Coordinated Care Plan… Over the past year, we established connections with Family Health Teams (FHT), Community Health Centres (CHC), and solo-practitioners. Communication to physicians has been formalized through introductory letters, confirmation of services letters, and patient reports.* ***"In 2015/16, our goal is to increase the percentage of primary care physicians connected to an identified Care Coordinator from 29% to 50%. By improving physician access to a CCAC Care Coordinator, the intent is to improve communication and care planning for shared patients."***

Advancing this Indicator: Planning, integrating services and patient engagement have taken precedence this year in the ongoing efforts of CCACs to reduce unplanned ED visits. Most notably this is seen in the collaborative initiatives between CCACs, Health Links and primary care organizations. The expansion and success of e-alert notifications and RRN programs will continue to be evaluated.

Like other sectors, CCACs are trialing ways to predict patients who are at risk for unplanned ED visits. Some CCACs referenced the DIVERT Scale, a decision-making tool to prioritize risks for more effective service provisions and care, in their QIPs. Developed by University of Waterloo researchers, DIVERT identifies seniors at the highest risk of ED use and assesses other feasible options (such as moving seniors to other health care services) to avoid such use. One advantage of this tool is in its possibility to draw census-level data from both RAI-HC and CIHI data sources.[v]

INDICATOR: UNPLANNED READMISSIONS WITHIN 30 DAYS OF DISCHARGE

About this Indicator: This indicator measures the percentage of home care patients who experience an unplanned (all cause) readmission to hospital within 30 days of discharge.

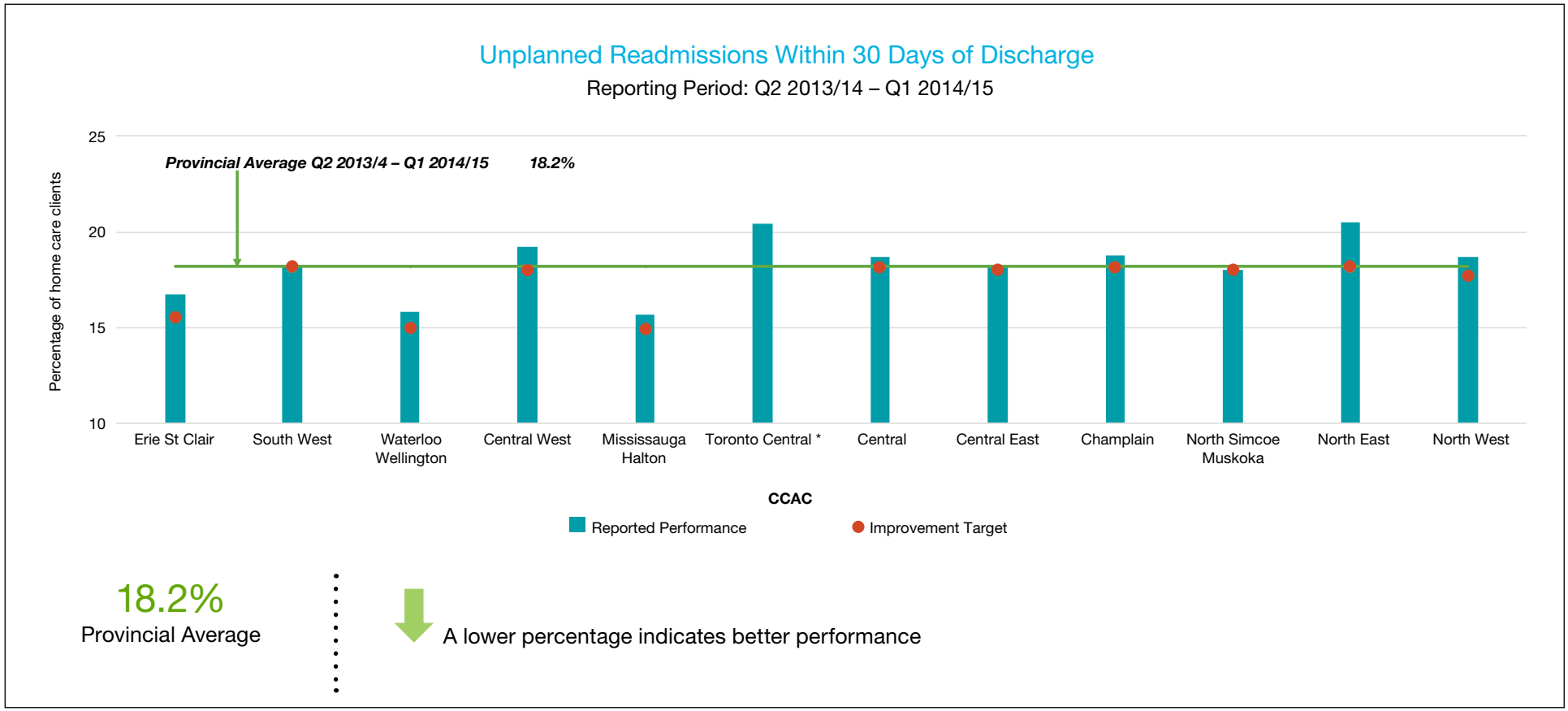
Understanding this Indicator: In order to promote system-wide integration and improve patient experiences, it is important to review and understand why unplanned readmissions occur. Unplanned readmissions are shown to have an emotional and health impact on patients, and should be avoided where possible.[viii]

Analyzing this Indicator: Of the 12 CCACs that selected this indicator, nine set targets to improve, two set targets to maintain current performance and one did not set a target (reasons unknown).

- Provincial average: 18.2% of patients had an unplanned readmission to hospital
- Current performance range: 15.7% to 20.5%
- Range of targets selected: 14.9% to 18.2% (average 17.3%)

This graph shows the targets set by 11 CCACs this year, omitting the CCAC that did not set a target.

Notes on this Graph: Toronto Central CCAC did not set a target for this indicator. Six of the 12 CCACS reporting on this indicator demonstrated a current value at or below the provincial average of 18.2%. Hamilton Niagara Haldimand Brant and South East CCACs are not included here because they did not select this indicator for their 2015/16 QIP.



Achieving Progress on this Indicator: Only three CCACs measured this indicator the same way in 2014/15 and 2015/16. Of these CCACs, two (Champlain and North West CCACs) experienced a small improvement in their readmission rates.

The following highlights examples of innovative ideas that CCACs implemented as outlined in their Progress Reports.

- While many of the CCACs are now alerted when their patients visit the ED, they have limited clinical information regarding reasons for re-admission (typically just the admitting diagnosis). To address this, CCACS are building stronger relationships (specifically in communication and data-sharing agreements) with area hospitals to coordinate care.

- Supporting strong connections with primary care organizations and Rapid Response Nurse (RRN) teams to ensure patients are seen within 24 hours of hospital discharge by an RRN.

- Implementing a "case conference" process following a complex discharge with all care providers involved, sharing lessons learned. Many CCACs indicated a need to focus on this effort.

- Working to coordinate care with Health Links Partnerships for seniors and others with complex conditions.

    - Ten out of 14 CCACs cited involvement with Health Links in their QIPs, and two included Health Links in their change initiatives. Early evidence suggests these connections should continue to be explored and fostered.
    - Mississauga Halton CCAC works with the seven Health Links within its LHIN (all currently in various states of development) to create processes that improve communications between health service providers, primary care physicians and other providers for improved care coordination. East Mississauga Health Link is another early adopter of this process and an IDEAS alumni.
    - Erie St. Clair CCAC said it has initiated a primary care liaison care coordination position to work with patients utilizing the highest amount of health care resources.
    - Central East CCAC is collaborating with the Assisted Living for High Risk Seniors initiative and other Community Support Services to aid in home living for seniors requiring PSW support.

- Strengthening known evidence-based pathways to guide patient care, including regular follow-up, reassessment, and patient navigation.

- Using a standardized patient assessment tool.

    - Champlain CCAC's Personal Support Services Quality Sub-Committee, made up of a representation from the CCAC and Service Provider Organizations, uses a 10-point tool to identify changes in patient status, ensuring consistency across SPOs within the Champlain region. Champlain has set additional stretch targets to better focus their efforts.
    - Ensuring palliative care nurse practitioner programs are in place for palliative patients without primary care physicians who wish to stay at home. Currently all 14 CCACs are receiving government funding to support this initiative.

- Expanding Telehomecare.

    - North West CCAC is extending its Telehomecare program LHIN-wide, with palliative care nurse practitioner programs for patients who wish to stay at home.

★ **Spotlight: Here is one example of an organization that is currently testing out new changes that may contribute to improvement on this indicator.**

Mississauga Halton CCAC:

This CCAC integrated services in partnership with the Mississauga Halton Local Health Integrated Network (LHIN) and primary care physicians to better support shared patients. Together they connected patients with family physicians and helped CCAC Care Coordinators work more closely between the two. The Mississauga Halton LHIN also appointed the CCAC as lead for a Regional Primary Care Integration strategy, which includes developing a specialist e-compendium and physician database/engagement tracker, the support of a physician-led Primary Care Network and the launch of Primary Care Advisors, who work in Health Links using a one-on-one approach to inform and engage physicians in new programs and services within the local system network.

Cross-Sector Conversations: In the spirit of promoting system integration, the following high-level references show how organizations are working together across sectors for quality improvement.

- The eNotification initiative (funded by eHealth Ontario) has improved cooperation between North East CCAC and EDs in the region. When patients arrive at the ED, their information is sent to a provincial database that notifies both the hospital and CCAC, allowing CCAC services to know what services to prepare ahead of their discharge. These efforts lead to smoother transitions between acute and community care and fewer readmissions.[ix]

- In March 2015 to reduce hospital readmissions for home care clients, Champlain CCAC implemented Community Health Evaluation using Paramedicine Services (CHECUPS) program, in conjunction with Renfrew County Paramedics. This program is an extension of the referral partnership that Champlain has had with the Renfrew County paramedics over the past several years. When not responding to emergency calls, the program allows Advanced Paramedics to apply their training and skills beyond the traditional role of providing emergency response. It is not meant to replace or duplicate the Rapid Response Nurse (RRN) or Care Coordination role of the CCAC, but instead would further support complex situations once the goals of the RRN have been met, as well as augmenting the services offered by the CCAC. While the program is still in its early stages, services may include wellness checks, medication adherence reviews, chronic disease management and education, bloodwork, injections, mini-mental health assessments, and specific supports to reduce falls at home.

Advancing this Indicator: Avoiding unplanned readmissions often involves a group effort, and many CCACs are taking active steps toward integrating their services with diversified primary care teams and LHINs, and often utilizing Rapid Response Nursing (RRN) programs in order to better meet the needs of complex patients. CCAC Care Coordinators are also fostering connections between patients and primary care organizations within the local system network.

The RRN programs were referenced as change ideas by several CCACs. The purpose of the provincial RRN program is to reduce re-hospitalization and avoidable emergency department visits by improving transitions from acute care to home care for patients with complex clinical needs. Unpublished preliminary results and early reporting by the OACCAC on value highlight how RRNs are improving medication reconciliation.[x]

SYSTEM PERSPECTIVE:

Other tools are being developed to support the need to predict which patients are at greatest risk for hospital readmission. The Clinical Frailty Scale is a tool that measures a patient's difficulty in daily living activities such as preparing meals, to predict risk of readmission within 30 days of discharge. Results showed that patients whose frailty was considered moderate to severe were at increased risk of readmission.[vi,vii]

Chapter Three

Understanding the Patient Voice: Patient Engagement and Experience

Patient engagement is a growing priority across Ontario's health system, and more organizations are listening to the patient's voice in order to strengthen the delivery of care. New regulations (introduced under the *Excellent Care For All Act, 2010* for hospitals) reinforce the growing importance of patient engagement in the health care system, and are providing an impetus for other health care sectors to adopt a standardized approach to engaging patients in developing the patient relations process.

CCACs measure patient experiences in order to engage patients in their improvement efforts. Measuring patient experience involves promoting surveys, including patients on designing improvement initiatives and using patient councils and/or advisory groups to drive improvement activities.

INDICATOR: PATIENT EXPERIENCE

About this Indicator: This indicator measures the percent of home care patients who responded "Good," "Very Good" or "Excellent" on a five-point scale to a list of patient experience survey questions concerning the overall rating of CCAC services, management/handling of care by care coordinators and service providers.

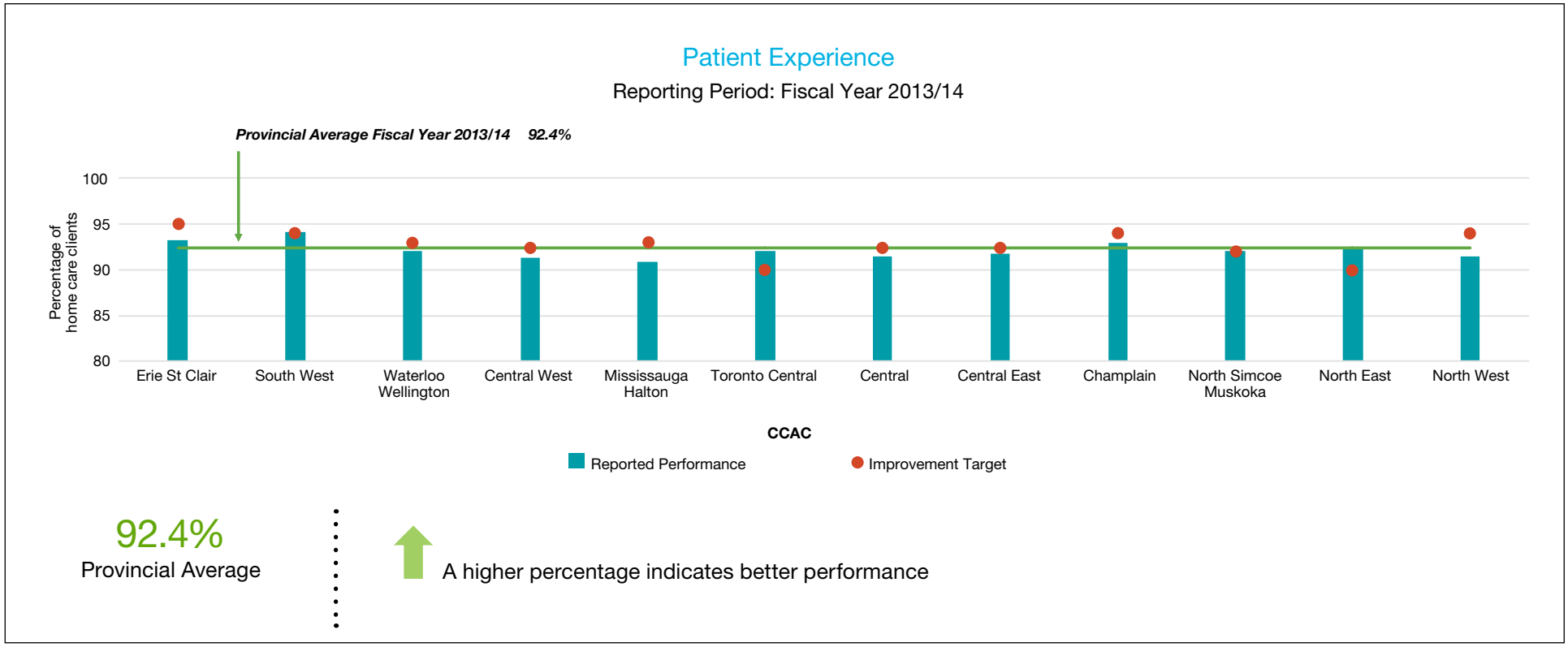
Understanding this Indicator: By rating different aspects of their care, patients can help individual CCACs with the coordination of their care. In turn, this indicator may have a ripple effect across all other priority indicators.

Analyzing this Indicator: Of the 12 CCACs that selected this indicator, using the original definition, eight set targets to improve, one set a target to maintain current performance and three set targets worse than their current performance.

- Provincial average: 92.4% of patients responded that their care was "Good," Very Good," or "Excellent".
- Current performance range: 90.9% to 94.2%
- Range of targets selected: 90.0% to 95.0% (average 92.7%)

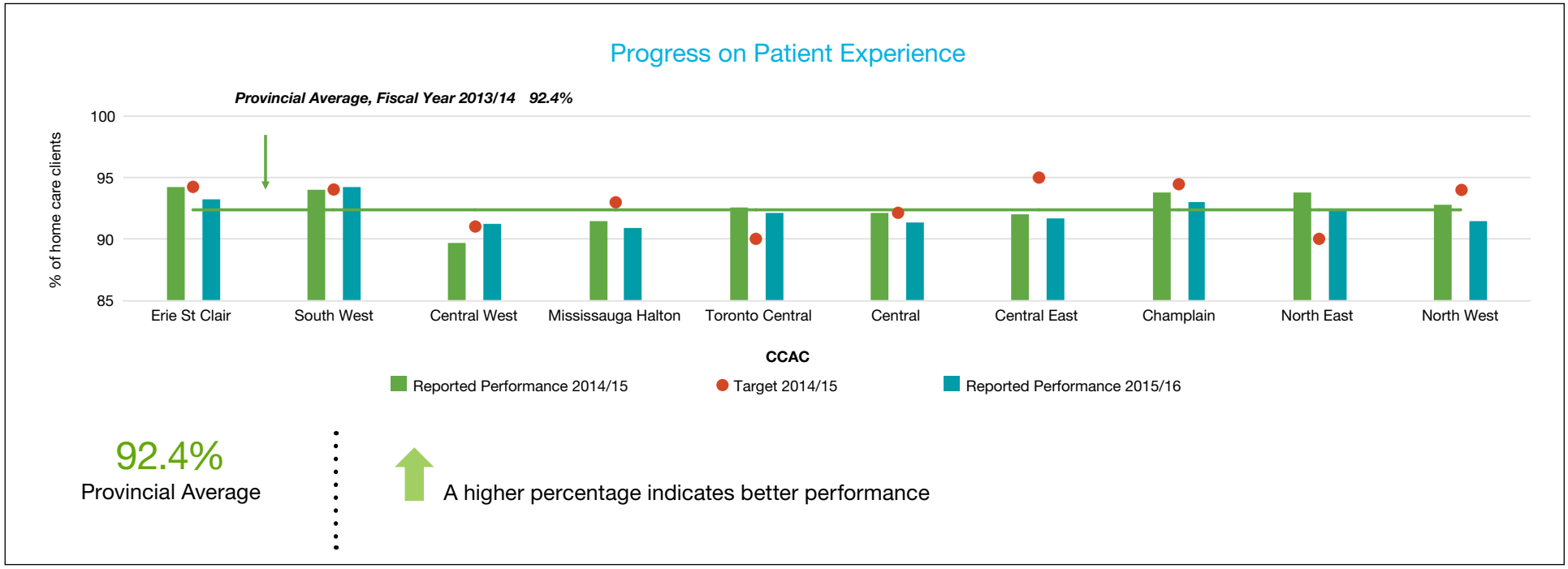
The graph below shows that the 12 CCACs are scoring above 90.0% on patient experience; the provincial average is 92.4%. Hamilton Niagara Haldimad Brant and South East CCACs are not included here because they did not select this indicator for their 2015/16 QIP.

Notes on this Graph: The scores for patient experience are very high, when using a combination of good, very good or excellent on a five point scale. In the case of the CCAC reporting for this indicator, the current reporting is based on "Good," "Very Good" or "Excellent" on a five-point scale. This may be an opportunity to move to a "top box[xi]" (i.e., just Excellent) scoring for this indicator. Top box scores are a quality method to report on only the highest measurement "box" or level of the measurement scale provided to the respondent.



Notes on this Graph: As noted in the preceding graph, a blue bar (right side) higher than the green bar (left side) indicates better performance over prior year. The scores for patient experience over the past two years are very high, without much change in progress. It may be worth considering moving toward a focus on "top box" scoring in the future in order to readily see more progress on this indicator.[xi]

Achieving Progress on this Indicator: Ten CCACs measured this indicator the same way in 2014/15 and 2015/16. Of these 10 CCACs, two reported an improvement in their patient experience scores. In terms of improving performance levels, it is worth noting that all 14 CCACs already scored very high (above 90%) on patient experience. It may be difficult to push this indicator further, however many CCACs are still making great efforts to go beyond maintaining current performance.



Here are innovative ideas that CCACs implemented, as outlined in their Progress Reports.

- Toronto Central CCAC first introduced the *Changing the Conversation* philosophy of care, which creates opportunities for service providers to deliver more flexible, customized care experiences by listening and responding to immediate patient needs rather than relying on pre-established care plans. By allowing patients to voice what is "most important" to them, many judge home visits to feel more comfortable. This may contribute to more effective care overall.
    - In 2014/15 Central West CCAC extended *Changing the Conversation* philosophy across all its patient populations receiving Personal Support Worker services.
    - Hamilton Niagara Haldimand Brant CCAC recently completed training their staff to use Changing the Conversation.

- *Crucial Conversations* is another program aimed at improving patient experience levels. Central West CCAC, which made the most progress on this metric over the past year, provided staff with opportunities to learn the specific communication strategies to mediate difficult conversations.

- Creating new workplace roles to link patients to additional helpful services for a more user-friendly experience.
    - Mississauga Halton CCAC plans to add an Information and Referral Specialist role; a move expected to improve the way patients access additional services.

- Identifying barriers to successful transitions between providers as patients move from hospital to home.
    - Three CCACs (Central East, Hamilton Niagara Haldimand Brant and Mississauga Halton) stressed the importance of smoothing transitions from hospital to home, with Mississauga Halton partnering with Trillium Health Partners to design a new approach called Seamless Transitions.
    - Hamilton Niagara Haldimand Brant CCAC standardized the phone queues across one of its branches, but did not see improvement. They have since abandoned this change idea.

This year the QIP Narrative also asked CCACs how they engaged patients and how this engagement informed the development of their QIP. Ten CCACs specifically mentioned change initiatives aimed at improving patient/caregiver engagement over the next year. Here are some highlights:

- Mississauga Halton CCAC created the Share Care Council, a forum where patients and caregivers can directly influence quality improvement initiatives. This 15-member committee consists of patients, substitute decision-makers and family caregivers. It is a partnership that Mississauga Halton says *"helps us learn what matters most to patients and their families through an authentic, engaging forum."* Since launching in 2014, the council has introduced a new Patient & Caregiver Bill of Rights and redesigned how patients leave hospital to recover at home (an initiative known as Seamless Transition: Hospital to Home). The Seamless Transitions Approach relied on the Council to identify and define the problem and validate the test process. Tested over 39 weeks and compared to the rest of the patients within the hospital's Medicine program, patients transitioned home using the Seamless Transitions Approach had significantly reduced readmission rates (a 52% reduction in readmission rates for any diagnosis within 30 days).

- Central and Central West CCACs created positions/divisions dedicated to the patient experience.
    - Central established the Patient Experience Office alongside a robust patient and caregiver engagement framework, both with patient relations strategies aimed at increase patient/caregiver involvement in key decisions and operational changes. *"In 2014/15, we engaged at least 31 clients/caregivers through this process, and we hope to increase to 35 in the next year."*

  - Central West started a new cross-appointed position, Chief Patient Experience Officer, to ensure patients are at the heart of everything they do. There are plans to further expand the patient/caregiver advisor role. Notably, this is a shared position with Headwaters Health Care Centre and William Osler Health System, thus allowing the organizations to work collaboratively to improve the patient experience, particularly with respect to transitions of care.

- Hamilton Niagara Haldimand Brant CCAC and Toronto CCAC are conducting research into the patient experience. Both commenced an academic patient experience research project, using in-depth qualitative interviews with CCAC patients and their Care Coordinators to explore what patient engagement and experience mean to them.

SYSTEM PERSPECTIVE:

As part of the ten step plan in Patients First: A Roadmap to Strengthen Home and Community Care, a common charter is in development with input from the sector and patients to provide a foundation for home care that is truly client- and family-centred.[xii] Grounded upon the principle that everyone who has needs that can be reasonably met in the home or community should receive assistance to do so, the draft charter aims to help organizations make transparent commitments to design care to meet expectations. It also encourages patient engagement in its intentions to help organizations work more effectively to give patients the care they need, want and deserve.

★ **Spotlight: Here is one example of an organization that is currently testing out a new change that may contribute to improvement on this indicator.**

South West CCAC:

This CCAC implemented "always events," defined by patients and families as specific aspects of care that are essential for providers to perform consistently for every patient, every time. The South West CCAC conducted patient interviews and shared the findings with staff to improve the patient experience.

- *"We will leverage the opportunity [of "always events" interviews] as a launching point to gather patient stories. With consent, these interviews will be videotaped and transcribed. Patients will be asked what they might see as solutions.* ***Experiences will be shared with staff to provide opportunities for quality improvement****."*

Advancing this Indicator: Patient experience is a key overall health outcome. Many CCACs are focusing on improving conversational communication between care providers and patients, by determining early on what is most important to the patient. In this way, the patient voice is taking precedence. Patient-led forums and research into the patient experience are also emerging as key drivers for improvement. Due to the already high performance levels of CCACs on this metric, however, there is an opportunity to raise the bar. Seven CCACs set targets to maintain in 2015/16. It may be time to measure Patient experience using only the top box score of "Excellent".

Conclusion

Moving Forward

This report took a close look at the priority indicators identified for CCACs and reflected back to the field the work being done by CCACs to improve the quality of care provided to Ontarians. The change ideas and the spotlight profiles included within the report demonstrate the commitment of Ontario's CCACs to continuous improvement and large-scale system change. This commitment is particularly evident in how CCACs are working to increase capacity and to help develop more innovative strategies to support complex patients.

But while there is much to celebrate, there is also room for improvement. Overall, CCACs showed modest progress on their indicators, with many of them remaining stable, but not improving. There was some improvement noted in five-day wait times for home care and unplanned emergency department visits within 30 days of discharge and it will be important for CCACs to leverage these successes – and the excellent change ideas highlighted in this analysis – to spread these improvements to other priority issues. There are also opportunities for CCACs to reflect on target setting and possibly consider more ambitious targets for their next QIP submission.

Health Quality Ontario is committed to working with CCACs to support this process. In addition to the recommendations described above, Health Quality Ontario and the CCACs will be working together to review the CCACs' existing indicators and consider whether there are measures that would be more reflective of the work of the home and community care sector and the population they care for that should be incorporated into future QIPs. More work is also needed to help ensure that organizations – across the health care system – have more timely access to data to help drive improvement. While these are not insignificant challenges, addressing them will be critical to improving the quality of home and community care and Health Quality Ontario and the CCACs look forward to working on this together.

This report, along with the public posting of QIPs, offers CCACs and other sectors an opportunity to learn from each other and apply this learning to their own practices. Through continuous measuring, we can mark growth and ensure that home and community care delivered today is even better tomorrow.

ENDNOTES

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This report could not have been put together without the help of Health Quality Ontario's partners, the Ontario Association of Community Care Access Centres (OACCAC), the 14 Local Health Integration Networks, and Health Quality Ontario's Cross-Sector QIP Advisory Group. Members of the Advisory Group include Dr. Richard McLean, Jillian Paul, Joanne Iacono, Karen Lu, Kelly Gillis, Dr. Cathy Faulds, Marsha Stephen, Sonja Glass, Anne Wojtak, Leah Levesque, Dr. G. Ross Baker, and Dr. Jeffrey Turnbull.

Committed to Quality Improvement

We promote ongoing quality improvement aimed at substantial and sustainable positive change in health care, fully leveraging emerging evidence and public reporting to help identify improvement opportunities. We then help build the health system's capacity for quality improvement by supporting the collection and use of data for improvement, sharing insights into innovations that are working to make improvement and promoting skills development in QI. We actively support the development of a culture of quality and connect the QI community to learn from each other.

Quality Matters

Quality Matters is an initiative at Health Quality Ontario designed to bring everyone in the health system to a shared understanding of quality health care and a shared commitment to act on common goals.

Quality Matters takes a two-pronged approach. One involves a patient engagement process, called *Quality Is…* that allows patients, caregivers, and the public to help shape the quality care agenda. A second involves a deep dive by an expert panel into understanding health quality, delivering system-wide quality, and developing a culture of quality. The panel's first report, *Realizing Excellent Care For All*, builds the case for a provincial quality framework and lays out key factors to consider.

This is just the start. In the months ahead, we will continue to engage with patients, experts, and those across the system. *Quality Matters* will result in a road map, informed by patients and the public, to help policy makers, clinicians, and health system leaders build a quality-first health system in Ontario.

Learn more about *Quality Matters* by visiting www.hqontario.ca

The Common Quality Agenda

The Common Quality Agenda is the name for a set of measures or indicators selected by Health Quality Ontario in collaboration with health system partners to focus performance reporting. Health Quality Ontario uses the Common Quality Agenda to focus improvement efforts and to track longterm progress in meeting health system goals to make the health system more transparent and accountable. The indicators promote integrated, patient-centred care and form the foundation of our yearly report, *Measuring Up.* As we grow our public reporting on health system performance, the Common Quality Agenda will evolve and serve as a cornerstone for all of our public reporting products. Health Quality Ontario is the operational name for the Ontario Health Quality Council, an agency of the Ministry of Health and Long-Term Care.

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