



Key Observations
2014-15 Quality Improvement Plans
Community Care Access Centres

Introduction

Ontario has now had close to four years of experience with Quality Improvement Plans (QIPs), which started in the hospital sector and, over the course of the last few years, extended to interprofessional primary care organizations, Community Care Access Centres (CCACs), and will soon be rolled out in Long-Term Care (LTC) Homes (some of which voluntarily submitted QIPs this year).

QIPs play a pivotal role in improving the quality of care that is delivered in Ontario. They allow organizations to formalize their quality improvement activities, articulate their goals, and identify concrete ways of achieving their goals.

In order to focus the quality improvement activities that will be underway in Ontario in the coming year, CCACs were asked to consider six priority indicators, and most addressed them in their plans. However, it is understood that organizations have their own priorities, and are encouraged to consider and address them in their annual QIPs. To account for regional variation, organizations are free to set their own targets for improvement.

The purpose of this report is to provide information about what CCACs in Ontario are focusing on to improve quality of care, what change ideas have been provided, and where there may be opportunities to learn from others. The report will hopefully stimulate new ways of thinking about how to improve quality. It is designed to fuel conversations about quality among board members, senior leaders, individual clinical leaders and teams. It will provide a sector-specific look at the priority indicators of the 2014-15 QIPs. Future reports will strive to bring cross-sector perspectives and provide more detailed insights into quality issues.

Health Quality Ontario (HQO) is committed to ensuring that QIPs are an integral part of the coordinated quality effort in Ontario. We hope this report will help maintain momentum in quality improvement and help organizations benefit from one another's experiences throughout the quality journey.

A By-the-Numbers Look at CCACs Quality Improvement Plans

This infographic provides a snapshot view of the quality improvement plans (QIP) submitted by Ontario's Community Care Access Centres (CCACs). It addresses the commitment Ontario's CCACs have made on the principles of the province's *Excellent Care for All Act*, which stipulates that health care organizations develop an annual QIP and make that plan available to the public.



14 QIP submissions

6 Priority indicators

A closer look at the priorities: Here's the percentage of CCACs that included the following priority areas in their QIPs

100% Improved Patient Experience

93% Fewer Unplanned Emergency Department Visits

93% Fewer 30-Day Hospital Readmissions

100% Fewer Falls for Long-Stay Clients

100% Improved Five-Day Wait Time for Personal Support Worker Care

100% Improved Five-Day Wait Time for Nursing Care

A closer look at the priorities:

We identified the following themes from the QIP submissions:

1

CCACs are changing the way they communicate and coordinate within, and beyond, their sector.

CCACs are utilizing information technology to coordinate care across sectors.

- o Four CCACs are planning to expand and improve the process by which CCACs are notified when CCAC patients are seen in a hospital emergency department.
- o Ontario Telemedicine Network (OTN) and e-shifts (a smartphone-based application which allows personal support workers to provide care in a home setting with the support of an off-site nurse) are currently being explored in some CCACs to provide clinical expertise to caregivers in home settings. Two CCACs are already planning to broaden the use of these technologies, such as the use of the OTN for patients newly diagnosed with chronic obstructive pulmonary disease.

10 CCACs described the importance of strengthening their relationships with primary care practices.

- o Several CCACs plan to place care coordinators in the primary care setting.
- o One CCAC plans to hire primary care liaison care coordinators to work with primary care physicians, Community Health Centres, and Family Health Teams to establish communications regarding CCAC programs and services.
- o One CCAC explicitly stated that it plans to improve client information transfer to primary care physicians.

Eight CCACs are implementing specific change ideas related to the Rapid Response Nursing program to improve the quality of care provided during the transition from acute care to home care.

2

CCACs are putting physiotherapy change ideas into practice

In 2013, there were changes to how OHIP-covered physiotherapy services are managed; CCACs are now the consistent, single point of access for in-home physiotherapy services across the Province.

Five CCACs are planning further improvements to physiotherapy services

- o Several CCACs are developing processes to appropriately transition patients from more intense individual services to community exercise programs to maintain mobility.
- o One CCAC is developing a focused treatment pathway with the aim of preventing falls for patients that are receiving a newly developed restorative physiotherapy program.

Unplanned Emergency Department (ED) Visits

This indicator measures the percentage of home care patients with an unplanned, less-urgent ED visit within the first 30 days of discharge from hospital. Of the 13 CCACs (93%) that included this indicator in their QIPs, five selected improvement targets, five stated that targets would be determined over the next year, and two did not set targets. This may indicate that CCACs want to better understand which patients access the ED for low acuity visits and the reasons behind their visits.

WHY IS IT A PRIORITY?

People living at home and being cared for by a CCAC should ideally be treated outside of an acute care environment for more minor or chronic ailments. Using the emergency department for minor ailments is a higher cost service, possibly contributing to congestion, and is not ideal for patients and their families. Measuring this indicator allows CCACs to understand the scope of the issue and the potential impact on other sectors of the health care system.

CHANGE IDEAS

- Collaborate with hospitals to develop strategies for addressing why some patients use the ED instead of other health care services.
- Implement a LHIN-wide electronic notification process between the ED and the CCAC for current CCAC patients. This will allow CCACs to plan for appropriate follow-up care. This will also allow CCACs to identify common causes of ED visits and to collaborate with system partners to fill in any gaps in care.
- Consider the use of DIVERT (Detection of Indicators and Vulnerabilities for Emergency Room Trips), a new tool for identifying patients at risk of ED use and for planning appropriate care.

Unplanned Emergency Department Visits

8% The Ontario rate for CCAC patients who experienced an unplanned ED visit within 30 days of discharge from hospital for the time period Q2 2012-13 to Q1 2013-14

4-13% In QIPs, CCACs reported unplanned ED use rates in this range

WHAT WE'RE SEEING:

Many CCACs stated a need to better understand which patients access the emergency department with low acuity needs, and the reasons behind their visits. They indicated that they are working with local health system partners to better understand the role of CCACs in reducing ED visits.

KEY OBSERVATIONS

We observed several cross-sector approaches that aim to reduce unplanned ED visits and hospital readmissions. Multiple CCACs plan to integrate care to reduce unplanned visits and readmissions through two distinct strategies:

(1) Utilizing the Rapid Response Nursing (RRN) Program

- All 14 CCACs implemented a Rapid Response Nursing (RRN) program in 2012-13, with the intention of avoiding ED visits and reducing rehospitalization. The program targeted transitions from acute care to home care for two population groups: (1) medically complex/vulnerable children and frail adults; and (2) seniors with complex needs/high-risk conditions, such as chronic obstructive pulmonary disease and congestive heart failure.
- Six CCACs outlined the need to improve the percentage of times RRN nurses visit patients

30-Day Hospital Readmissions (all cause)

This indicator measures the percentage of home care patients who experienced an unplanned readmission to hospital within 30 days of discharge from hospital.

Of the 13 CCACs (93%) that included this indicator, five selected improvement targets that are better than the current performance.

WHY IS IT A PRIORITY?

The purpose of measuring this indicator is to identify factors that might prevent similar hospital readmissions in the future. Unplanned readmissions have an emotional and health impact on the patient. Studies suggest that some readmissions may be avoidable, so there may be unnecessary costs added to the health care system.¹

CHANGE IDEAS

- Collaborate and conduct root cause analyses with system partners to identify themes in patients prone to readmissions.
- Work more closely with primary care practices to coordinate care and improve the type and quality of patient information transferred to primary care physicians.

¹ Canadian Institute for Health Information (CIHI). All-Cause Readmission to Acute Care and Return to the Emergency Department. June, 2012. Available from: https://secure.cihi.ca/free_products/Readmission_to_acutecare_en.pdf

30-Day Hospital Readmissions (all cause)

- 18%** The 30-day hospital readmissions rate for CCAC patients in Ontario from Q2 2012-13 to Q1 2013-14
- 15-20%** In QIPs, CCACs reported 30-day readmission rates in this range

WHAT WE'RE SEEING:

Many CCACs are implementing change ideas that involve information sharing to help lower readmission rates.

within a specific time frame. For example: One CCAC aims to improve the number of times that RRN nurses visit patients within 24 hours of hospital discharge from 52% of the time the patient is seen within 24 hours of discharge to 75% of the time a patient is seen within 24 hours of hospital discharge. To accomplish this, the CCAC will ensure a full compliment of RRNs are hired, will educate hospital care coordinators regarding new processes for informing RRNs earlier in the referral process to facilitate earlier care planning.

(2) Improving the coordination of care in the community with primary care practices to determine “right care at the right time”

- Seven CCACs will work more closely with family physicians, family health teams, and Health Links in their region to better address the needs of patients with complex needs. As an example, one CCAC is hiring primary care liaison coordinators to establish lines of communication regarding CCAC programs and services. This will ensure primary care providers are aware of available resources and are kept informed about care that is provided to primary care patients.

Patient Experience

This indicator measures the percent of home care patients who responded “good,” “very good,” or “excellent” about different aspects of the care provided. Of the 14 CCACs (100%) that selected this indicator as an area of focus, eight set targets better than current performance.

WHY IS IT A PRIORITY?

Patient experience is particularly important to understand in the home care setting, as some patients are dependent on the provision of home care in order to remain in their homes and often have the potential to feel vulnerable. CCACs survey home care patients rating different aspects of their care, including overall CCAC services, overall care by service providers, and management and handling of their care by care coordinators.

CHANGE IDEAS

- Train staff on how to improve communication with patients and philosophy of care.
- Survey patients and incorporate their patient perspectives and feedback into care and service provision.
- Redesign processes to ensure easy access to care coordination resources.

Patient Experience

- 93%** The Ontario average for overall positive ratings of CCAC services, management/handling of care by a care coordinator and overall service provided in fiscal year 2012-13
- 90-95%** In QIPs, CCACs reported satisfaction rates in this range

WHAT WE'RE SEEING:

Many CCACs are focusing on improving communication at all levels of service, with the knowledge that effective communication is essential to improving patient experiences and the delivery of high quality care.

KEY OBSERVATIONS

We observed that many of the change ideas are focused on improving the connection between care providers and the patients.

Several CCACs are implementing the philosophy of “changing the conversation” where care providers are focusing on talking with patients before beginning health care tasks.

- First care providers ask, “What is the most important thing I can help you with today?”
- Approximately ten minutes before the session is complete, care providers ask, “Is there anything I can help you with before I go? I have the time.”
- At the end of the service provision, care providers ask, “Is there anything you would like me to tell the agency?”

Another strategy is to ensure that care coordinators, team assistants and service providers provide their name, occupation and duty at each patient interaction.

One CCAC is providing staff with the opportunity to learn and enhance their communication and conflict management skills in “Crucial Conversations.” These are the conversations that staff often are required to have with patients and families to provide the best level of care.

Falls for Long-Stay Clients

The indicator measures the percentage of adult long-stay home care patients who experienced a fall, as recorded on their follow-up interRAI Home Care Assessment System (RAI-HC). Of the 14 CCACs (100%) selected this indicator, 13 selected improvement targets better than the current performance.

WHY IS IT A PRIORITY?

This indicator looks at a variety of factors within home care settings that may contribute to falls. The rate of falls in home care is an important indicator, as a 2013 Canadian study found that 56 percent of falls for those in home care were preventable.²

CHANGE IDEAS

- Identify best practices for falls prevention and perform chart audits to inform the development of new falls prevention plans.
- Improve communication related to the risk of falls by streamlining protocols between health teams to flag high-risk patients.
- Advance ongoing education strategies for patients deemed most at-risk for falls.
- Spread change ideas relating to physiotherapy service management and manage transitions for patients in rest and retirement homes who no longer need CCAC physiotherapy – for instance, shift patients from more intense, individual services to community exercise programs to maintain mobility.

Falls for Long-Stay Clients

- 33%** The percent of all CCAC long-stay patients in Ontario who reported a fall on their follow up RAI-HC assessment in fiscal year 2012-13
- 30-37%** In QIPs, CCACs reported fall rates in this range

WHAT WE'RE SEEING:

Multiple CCACs included change ideas that involve increasing patient education, improving provider-patient communication, and putting more best practices into practice

²Canadian Patient Safety Institute. (2013) Safety at Home; A Pan-Canadian Home Care Safety Study. Page 5. <http://www.patientsafetyinstitute.ca/English/research/commissionedResearch/SafetyatHome/Documents/Safety%20At%20Home%20Care.pdf>

KEY OBSERVATIONS

Many CCACs are promoting long-term independence for patients by spreading the use of rehabilitation services and medication management

5 CCACs specifically mention implementing the province-wide physiotherapy changes that were introduced in 2013.

- 2 CCACs plan to adopt the Home Independence Program (HIP), which has been used in other CCACs.
 - HIP helps patients regain independence in activities of daily living, such as dressing or bathing, following a decline in health or hospitalization.

2 CCACs plan to test the Resident Assessment Instrument Contact Assessment tool to assist in determining the best rehabilitation services for each patient.

5 CCACs said they would continue to refine medication management services, especially for complex patients. This includes strategies such as increasing the referrals to the provincial MedsCheck community program.

1 CCAC included a change idea to improve the processes utilized by the CCAC home visiting pharmacist, for medication reconciliation of those participating in the Home Independence Program (HIP).

Five-Day Wait Times for Nursing Care

This indicator measures the percent of patients who receive service from a nurse within five days of their service plan being approved within the CCAC.

Of the 14 CCACs (100%) that selected this indicator, seven set targets better than current performance.

WHY IS IT A PRIORITY?

Receiving care as soon as possible is important for patients who require nursing care in the home environment, in order to maintain continuous care, facilitate rehabilitation and identify risk and deterioration of health as early as possible. Maintaining continuity of care can be challenging, especially for patients at different stages in their health care journey. The consequences of delayed access to nursing care include confusion and stress for patients, and the potential need for re-hospitalization.

CHANGE IDEAS

- Identify which patients require urgent care and need to have their first visit on same or next day
- Perform a root cause analysis of the delays in service provision for those who did not receive their first visit within five days of service approval.

Five-Day Wait Times for Nursing Care

94% The Ontario rate of people who receive required nursing care within five days during fiscal year 2012-13.

90-97% In QIPs, CCACs reported five-day waits for nursing care in this range

WHAT WE'RE SEEING:

The majority of change ideas provided were identical for the Five-Day Wait Times for Nursing Care and the Five-Day Wait Times for Personal Support Worker Care indicators.

KEY OBSERVATIONS

As this is a new indicator, many CCACs will continue to discover new opportunities for improvement, especially in regard to why visits were not provided within five days. Despite some concerns with the data, the indicator does provide an additional lens for CCACs to review and analyze the critical services that they provide for those living at home with illness. Some of the early analysis performed in 2014-15 indicates that wait times are affected by specific issues, including:

Five-Day Wait Time for Personal Support Worker (PSW) Care

This indicator measures the percentage of complex patients who receive care from a PSW within five days of the service plan being approved within the CCAC. It is a new way for CCACs to assess wait times.

Of the 14 CCACs (100%) that included this indicator in their QIPs, seven noted that they will be conducting some quality improvement analysis to determine reasons why a visit from a PSW isn't provided within five days. Eight CCACs set targets better than current performance.

WHY IS IT A PRIORITY?

This indicator is intended to show how quickly the system is able to provide personal support assistance for people who have complex care needs, but are not sick enough to need the level of care that is provided in an acute care setting or a long-term care home. Personal support services can include assistance with bathing, dressing, eating, or with routine hand or foot care. Personal support allows the patient to stay in their own home longer than if there weren't any supports available.

CHANGE IDEAS

- Create a more centralized approach to care coordination, including adopting a triage model requiring a dedicated care coordinator in each team to review, prioritize, and assign referrals based on urgency, as well as establishing a "one care coordinator" approach with a single point of accountability throughout a patient's transition of care.
- Introduce joint PSW and care coordinator visits if there are urgent PSW needs.

Five-Day Wait Time for Personal Support Worker (PSW) Care

83% The Ontario rate of complex patients who receive care from a personal support worker within five days in fiscal year 2012-13

62-94% In QIPs, CCACs reported five-day waits for PSW care in this range

WHAT WE'RE SEEING:

The majority of change ideas provided were identical for the Five-Day Wait Times for Nursing Care and the Five-Day Wait Times for Personal Support Worker Care indicators.

- Waits for pre-planned surgery: For many elective, pre-planned surgeries, post-hospital care is pre-booked with CCACs. The wait time starts at the referral.
- Waits for weekly (e.g., peripherally inserted central catheter [PICC] line care) or monthly services (e.g., assistance with catheters).
- Patient preference. Sometimes preference requires the service to be provided outside of the five-day window.

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