



Putting people at the heart of all we do

CCAC Quality Report – 2011/12

*Getting people the care
they need at home and in the
community – and improving
quality of care each day.*

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CCAC care coordinators are dedicated nurses, occupational therapists, social workers and other health care professionals, who work directly with patients in hospitals, doctors' offices, communities and at home to ensure that people get the care they need.

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Executive Summary

Better care. Better access. Better value.

Every day, in communities across the province nurses, doctors, therapists, personal support workers, care coordinators and many others are working together to provide better quality of care for our patients. We are working as a team to transform our health care system in order to deliver the health care that people need.



In alignment with the goals laid out in *Ontario's Action Plan for Health Care*, the Community Care Access Centre (CCAC) 2011–2012 Quality Report measures our performance, shows our progress, and sets targets for continuous quality improvement for CCACs to deliver outstanding care – every person, every day.

The right kind of care in the right place – at home

CCACs get people the care they need so that they can continue living in their homes and communities. Caring for people effectively and efficiently, CCACs coordinate care seamlessly across a range of different home care and community services. With primary health care at the heart of the health care system, CCACs are bridging home care and primary care, including helping patients find a family doctor or primary care practitioner if they don't have one.

Last year CCACs:¹

- Supported 308,104 seniors to stay in their homes independently, only moving to long-term care when they were no longer able to safely stay at home.
- Supported 82,991 younger adults and children with health care at home or at school, including people with chronic diseases.
- Reduced the number of CCAC patients readmitted to emergency departments by 2.2 percentage points over the previous year.
- Helped 196,928 people return home from hospital with CCAC care.
- Provided 9,400 more people with personal support care than the previous year.

In the year ahead, we are committed to:

- Continuing to build a safe home care system.
- Increasing our connections to family physicians and nurse practitioners to better support patients as they move through the health care system.
- Continuing to improve transparency and providing patients with the information they need to make important care decisions.
- Improving patient care by eliminating duplicative procedures through the sharing of information and enhancing efficiency to get greater value for every health care dollar spent.

¹ Data reported in the CCAC Quality Report - 2011/12 pertains to the 2011/2012 fiscal year (April 1, 2011 to March 31, 2012), unless otherwise specified.

90%
Satisfied

Patient experience

On average, 90% of CCAC patients reported they were satisfied overall with the care they received from their CCAC.

The numbers behind the satisfaction

23 million hours of personal support

6 million nursing visits

2 million hours of extended nursing care*

1 million visits from therapists and other allied health providers

2 million interactions with care coordinators

*This applies to shift nursing, which is extended nursing care for patients with high care needs. For example, those who need end of life care. This may include care that occurs after hours, overnight or during school hours to enable children with high care needs to go to school.





“The support of the CCAC has helped us to feel empowered and Nana is much happier at home.”

- Ivy's granddaughter and caregiver Lorraine

Only one per cent of Ontario's population uses 33 per cent of health care resources, including patients with the most complex, chronic health conditions.²

Caring for people with high care needs at home requires increased collaboration across the health care system.

² Ontario Hospital Association HealthAchieve 2012: Remarks by Deb Matthews, Minister of Health and Long-Term Care

Ivy was able to return home to her family after a stay in a long-term care home with an individualized care plan, and helpful support from her CCAC, following a health crisis.

Better access, safer care

Supporting more patients who need higher levels of care

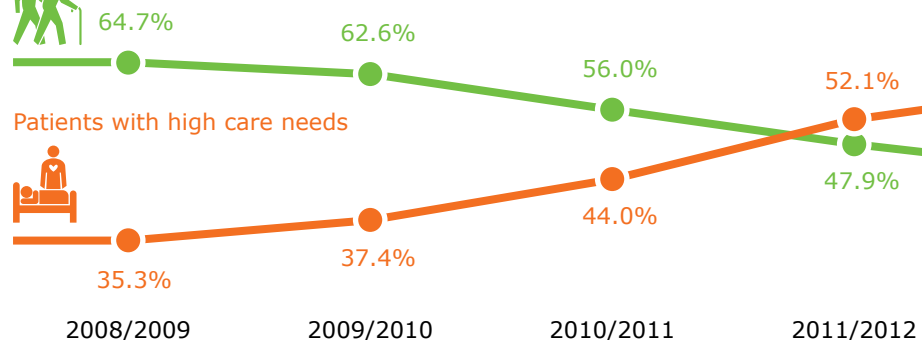
Putting people at the heart of all we do, CCACs are serving more and more patients in the greatest need of coordinated care, including frail elderly, children who are medically fragile, and people who are managing complex health conditions. Last year, CCACs cared for, on average, 2,600 more adult patients with

chronic and complex needs than the previous year, to meet the increasing needs of Ontario's population.

To improve our support for those with intensive care needs, CCACs are providing specialized care that matches the right level of CCAC care coordination, resources and services to the specific care needs of patients. CCACs continue to develop standards of care to consistently improve health outcomes for the more than 637,000 people receiving care in homes and communities across Ontario.

Caring for more patients with high care needs at home and in the community

Patients with less intensive care needs



Monthly average active referrals – this indicator examines the proportion of people with high care needs who are served by CCACs.

As CCACs shift towards supporting more patients who need higher levels of care, we are working with Community Support Services (CSS), primary care and other partners so that between us, we can support more people to live at home and in their communities, as long as possible. CSS are increasingly providing basic supports at home to more patients with less intensive care needs, including meals, transportation and housekeeping – enabling CCACs to focus on helping people who need more intensive coordinated care. CCACs are supporting their partners by providing a single point of access to adult day programs, assisted living, supportive housing, complex care and rehabilitation beds. As a result, more people who would previously have been in hospital beds or long-term care homes are now living at home with the supports they need, longer.

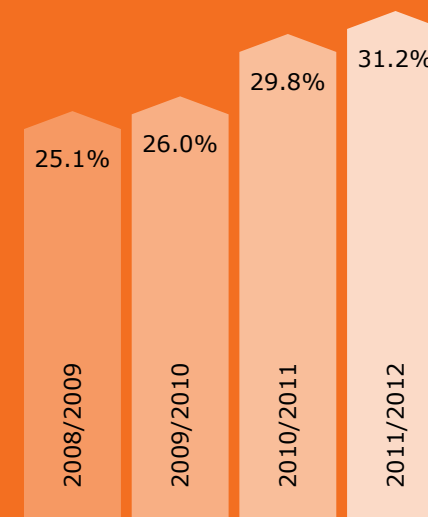
Putting focus on safety

Providing quality health care means a continuous focus on patient safety. CCACs are working locally with health care partners to improve safety and reduce risks so that patients can stay safely at home, avoiding unnecessary visits to the emergency department and hospital admissions.

CCACs are also improving our tracking of patient safety incidents. For example, over the last few years, as CCACs support more people with high care needs, we are seeing more home care patients reporting falls. Having better information about falls can help us find ways to keep people safer and reduce the incidence of falls. Falls can lead to serious injuries and increase the likelihood of admission to a long-term care home by five to ten times.³

Supporting more patients with high care needs and seeing more patients reporting a fall

The percentage of patients who report a fall on a follow-up assessment.



³ Source: Medical Advisory Secretariat. The Falls/Fractures Economic Model in Ontario Residents Aged 65 Years and Over (FEMOR). *Ontario Health Technology Assessment Series* 2008;8(6).



CCAC safety initiatives include:

- **Improving medication safety** – Taking medications at the right time and right dose is very important to maintain good health. Several CCACs have created programs to improve medication safety and have patients' medications reviewed by a nurse, pharmacist or doctor.
- **Reducing falls** – Many CCACs are working with their local partners and their Local Health Integration Networks (LHINs) on ways to reduce falls for seniors. This may include exercise programs, providing mobility aids such as walkers, and medical equipment such as grab bars in washrooms.

- **Preventing pressure ulcers** – A pressure ulcer is a localized injury to the skin and/or underlying tissue, caused by pressure, cuts, and/or friction. They can be prevented by pressure redistribution devices such as alternative foam mattresses, nutritional supplementation, patient repositioning regimens and incontinence management.⁴ Pressure ulcers can cause severe pain and other health issues. Front-line nurses and personal support workers are working together to reduce the incidence of pressure ulcers using clinical expertise to develop shared customized care plans.

Through effective care coordination, creating customized care plans and improving patient safety at home, CCACs are helping relieve pressure on emergency departments and hospitals. Delivering safe care in the home is cost effective and keeps patients where they most want to be.

⁴ Source: www.HQOntario.ca (2012) Prevention and Management of Chronic Pressure Ulcers - Health Quality Ontario (HQO). Available at: <http://www.hqontario.ca/evidence/publications-and-ohat-recommendations/ohat-reports-and-ohat-recommendations/prevention-and-management-of-chronic-pressure-ulcers> [Accessed: November 23, 2012].



16,000 people/month

Each month, approximately 16,000 people are supported to go home from hospital with care from their CCAC.



CCACs help patients find primary care providers



Since Health Care Connect launched in February 2009, 134,500 patients have been connected to a primary care provider, including over 13,300 patients with high care needs.*

Working together to build a stronger care team



Care Coordinators Family Health Teams

CCACs have dedicated care coordinators working with **one-third** of family health teams and growing.

*Since the data reporting system for the Health Care Connect program was upgraded and changes were made to data extraction/compiling methodology, previous years' reports cannot be compared to the numbers noted.

Building bridges to fill the gaps

Supporting people as they move from one part of the health care system to another ensures their needs are met throughout their care experience. This also advances Ontario's goals of decreasing hospital stays, avoiding unnecessary hospitalizations, improving transitions between care settings and supporting healthy aging at home.

Working together to enhance the patient experience

Through the Ministry of Health and Long-Term Care's Health Care Connect program, CCACs are connecting people with a family physician or nurse practitioner. Ensuring people have a primary care provider is a key priority in *Ontario's Action Plan* and an important determinant of health.

CCACs apply their care coordination expertise to bridge family health care with home care and the rest of the health care system to help provide a better patient experience.

CCACs are working more and more with our primary care partners, especially through new initiatives like Health Links. CCACs have dedicated care coordinators that are already working with approximately one-third of Ontario's 200 family health teams, and 20 per cent of Ontario's 73 community health centres across the province. CCACs also have dedicated care coordinators linked with other types of primary health care practices, including solo physician practices.

Partnering to improve care transitions

CCACs help patients as they move between different health care providers, services and settings to address their changing health care needs. CCACs and hospitals work together to explore every opportunity for patients to stay at home, before considering other options. The benefit to the patient – staying in their own homes longer while receiving care longer – is obvious; the benefit to the health care system is a high-quality and cost-effective alternative to institutional care for the patient, freeing up hospital and long-term care beds for those who need them most.



*“The way I looked at it, if I had a chance
to come home and be with my family,
I’d take it and enjoy whatever time I had.”*

- Faye, 85 year old CCAC patient



Following a hospitalization, it looked like Faye would have to move to a long-term care home, but with intensive care coordination and support from her CCAC, Faye was able to go home to her family and little dog.

Measuring our progress

A positive patient experience

Feedback from our patients is the best way for us to know if we are doing a good job in supporting people at home with the services they need. Last year more than 16,000 patients and caregivers were asked for their feedback on the care they received – 90 per cent reported they were satisfied overall with their care.

Survey results tell us where improvements are needed, and whether our patients see improvements over time. Two years ago, CCACs started reporting our patient and caregiver experience survey results to the public. Over the next two years, we will also begin reporting publicly on the quality of care delivered by each of the service provider organizations contracted by CCACs to deliver care to our patients.

We have heard from our patients that they would like us to improve how we communicate with them. Based on this feedback, several CCACs implemented a new approach to patient-focused communication between the care team and the patients and their families. Through this approach, care coordinators encourage a dialogue to get at the heart of patients' needs. Early results show patients are seeing a difference and feel that the CCACs are doing a better job of providing more choices and options for their care. As a result, other CCACs and our service providers are getting ready to make these changes as well.

Reducing emergency department visits

CCACs are helping relieve pressure on emergency departments and hospitals through effective care coordination, creating customized care plans and improving patient safety at home. Since last year, readmission rates to emergency departments decreased by 2.2 percentage points.

Bringing more people home from hospital

Across the province, health care partners are working together to reduce the amount of time patients remain in hospital while they wait to be

transferred to more appropriate care settings, such as a long-term care home. Last year, 8,711 of these patients were discharged from hospital and instead of going to long-term care, many received enhanced care at home with intensive care coordination and other interdisciplinary care, such as pharmacists, nursing and physiotherapy. As a result, 22.5 per cent less people were discharged from hospital directly to long-term care than in 2009-2010.

Most encouraging, CCACs are finding that a significant number of people who are able to come home from hospital with enhanced home care, to wait for long-term care, are ultimately able to continue living at home longer.



Reducing expenses

For every patient with high care needs served in the community instead of a hospital, the health care system saves approximately \$384 dollars per day.

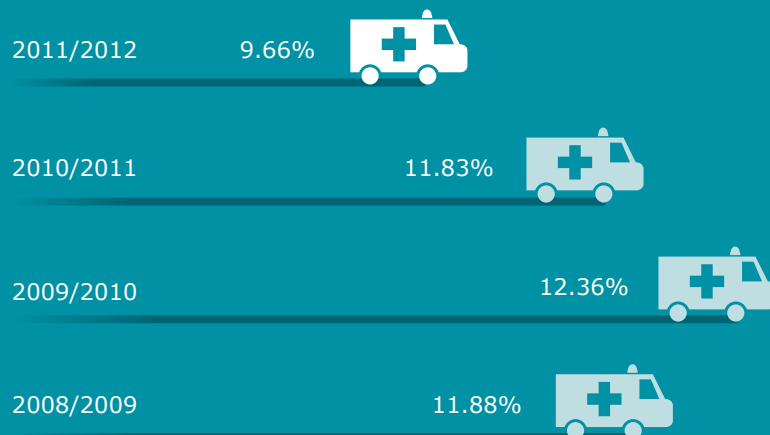
Savings of

\$384 /day*

* Data Source: Ontario Hospital Association (2012), OACCAC Utilization Reports Q1-Q3, FY11/12, Ministry of Health and Long-Term Care Mar 2012; Boston Consulting Group's Valuing Home and Community Study 2010.

Fewer CCAC patients readmitted to emergency departments

Percentage of ED readmissions (%)



Bringing more people home from hospital

22.5 per cent fewer people are going to long-term care from hospital (since 2009).



Number of CCAC patients admitted to emergency departments for a non-scheduled ED visit with a low triage level (count of new referrals who are admitted to home care).



Wait times reduced

Fifty per cent of patients referred through the community get home care service within six days, and 50 per cent referred through hospital get home care service within one day of referral. We are continuously working to decrease wait times for our patients, so that they receive the care they need as soon as possible. Over the past two years, CCACs have reduced wait times by 21 per cent for 90 per cent of patients. That's a strong improvement, and with increased investment in the home and community sector, we can reduce that further.

Ensuring people receive the right care in the right place

People prefer to be at home, so whenever possible, the first priority of CCACs is to get them the care and supports they need to stay in their homes. When living independently at home is no longer possible, CCACs help patients and their caregivers understand all their options and help them make the transition to long-term care homes.

The percentage of people with less intensive care needs being placed in long-term care homes has decreased over time. For every person with less intensive care needs served in the community instead of a long-term care home, the health care system saves approximately \$50 dollars per day.⁵

⁵ Data Source: Ontario Hospital Association (2012), OACCAC Utilization Reports Q1-Q3, FY11/12, Ministry of Health and Long-Term Care Mar 2012; Boston Consulting Group's Valuing Home and Community Study 2010.

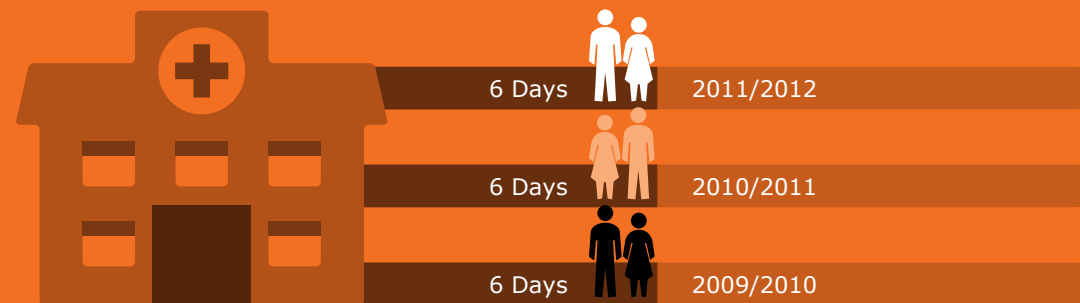
Shorter wait time for home care

Referral from community: 90th percentile number of days from referral to first visit



50% of patients referred through the community get home care service within 6 days

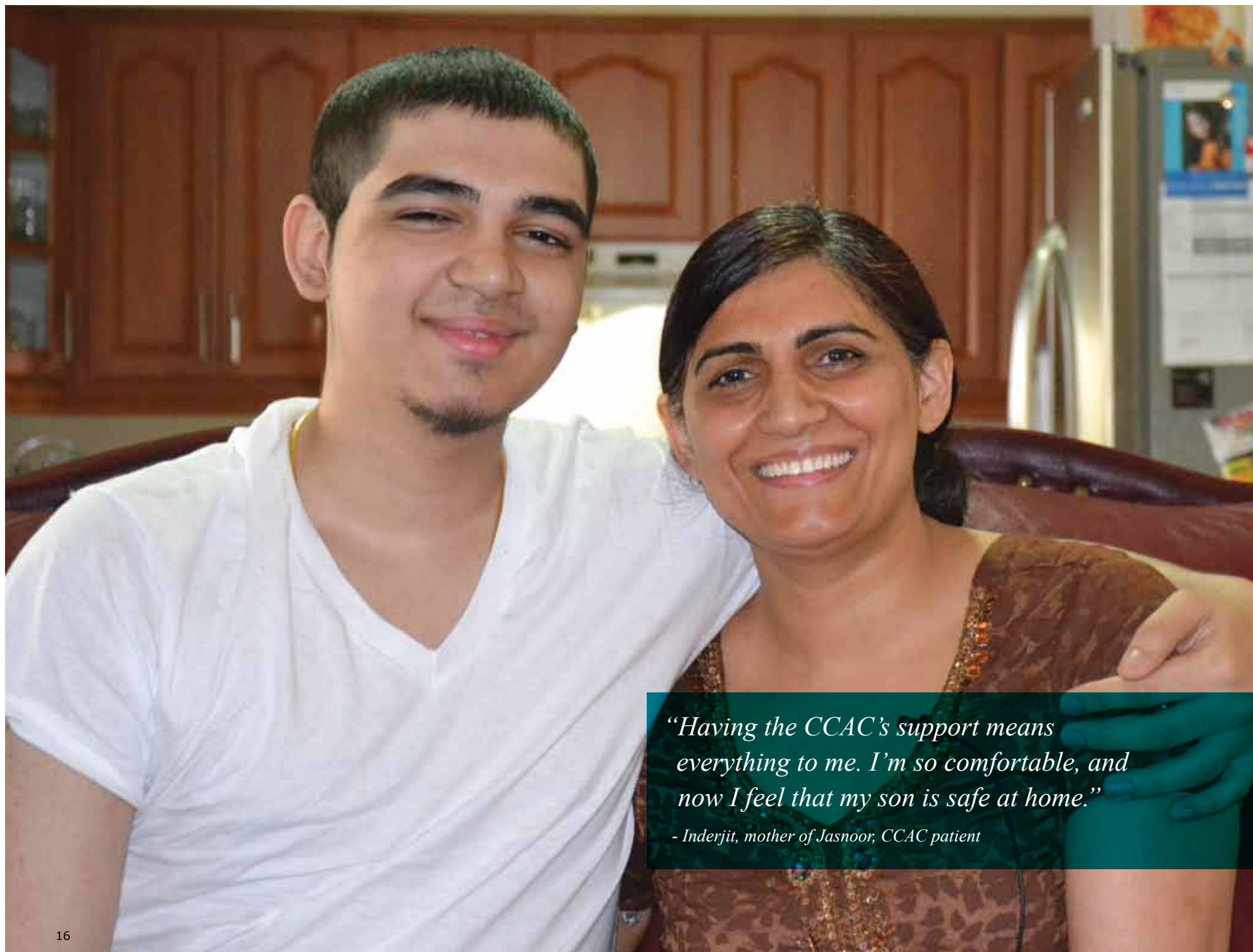
Referral from hospital: 90th percentile number of days from referral to first visit



50% of patients referred through hospitals get home care service within 1 day of referral

The number of days from when a patient is referred to CCAC service through the community or hospital, to the first time the patient receives a home care visit (other than by a care coordinator).

The 90th percentile is the point at which 90 per cent of the patients received their service, while the other 10 per cent waited longer.



“Having the CCAC’s support means everything to me. I’m so comfortable, and now I feel that my son is safe at home.”

- Inderjit, mother of Jasnoor, CCAC patient



Inderjit was nervous about bringing her son home after he was diagnosed with Acute Lymphoblastic Leukemia.

Bringing value home in communities all across Ontario

At only 4.6 per cent of the overall health care system funding, the funding received by CCACs annually from the Ministry of Health and Long-Term Care through the LHINs ensures that people across the province receive high-quality care at home and in the community. Over the last eight years, the government has been investing in CCACs so that we can care for more people than ever before.

Reducing administration costs and putting millions more towards patient care

Committed to maximizing value for every health care dollar spent, CCACs spend 91.4 per cent of our budgets on direct patient care and are reducing the amount spent on general administration. A small portion of our budgets, 1.4 per cent, is spent on office and

clinic space, and another 2.5 per cent is spent on information technology to maintain and continuously improve our provincial electronic health record system that supports home care for patients across the health system.

CCACs have reduced administration expenditures from 4.6 to 4.3 per cent over the past three years.

With additional funding investment from the Ministry of Health and Long-Term Care, and CCAC efficiencies, CCACs have been able to put \$136 million more towards direct patient care. This includes:

- Providing care in the home, community and schools.
- Supporting people to come home from the hospital when care requirements can be met at home.
- Providing individualized clinical assessment and care planning for patients.
- Getting people care in the right place, for example long-term care homes or other supportive programs.

Using data to improve patient care

Our investments in capable IT systems put patients first by providing the richest source of data on home and community care in Canada, possibly the world. Data obtained from our assessment tools and e-health records is used to improve quality, enhance evidence-based care, measure performance and health outcomes, develop patient-based payment models and inform health system planning.

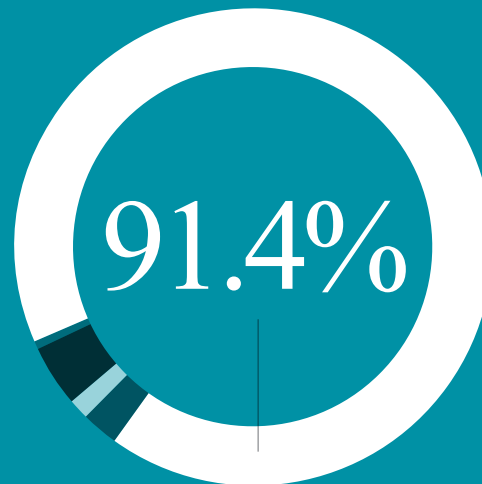
CCACs are the only part of Ontario's health system that has a fully operational e-health record system for our patients that gives all CCACs access to common information. Leveraging technology to support strong connections and effective communication between home care, hospitals and primary care, our e-health record system improves our ability to efficiently respond to people's needs and arrange for more integrated care.

CCACs receive 4.6% of health system funding



Percentage of total health system funding that goes to CCACs

CCACs spend 91.4% of their budget on direct patient care



- 91.4% Spent on direct patient care
- 0.4% Other
- 4.3% Spent on general administration
- 1.4% Spent on office and clinic space
- 2.5% Spent on information technology

Percentage of total budget that is spent on general administration, office and clinic space, information technology and direct patient care.

Health care for an aging population

The population of seniors in Canada increased more than 14 per cent between 2006 and 2011. Within the next 30 years, the proportion of people over age 80 is expected to increase considerably, and the number of seniors with a disability and requiring assistance could double.⁶ This demographic shift increases the importance of supporting seniors to stay healthy and stay at home longer.

CCACs are doing more for patients with greater needs. Care coordinators use clinical expertise to determine the appropriate supports to keep

people safe at home. As a result, CCACs are steadily increasing the number of personal support hours for our patients with the highest care needs. Last year, the average number of personal support hours increased to 135.4 per patient, from 128.8 in the previous year, while providing nearly 9,400 more patients with this service – adding up to a total of 23 million hours of personal support services provided last year.

With 92 per cent of Canada's seniors currently living at home,⁷ the personal support provided by Ontario's CCACs will be pivotal in enabling seniors to remain at home as demographic pressures increase in the coming years.

More people



More care



2.3 million more
hours of personal
support services

⁶ Source: Statistics Canada, 2011 Census Data.

⁷ *ibid.*



“As a care coordinator, part of my role is to help both patient and family to get through this huge transition and change in their life. It is so important to listen and advocate on their behalf, as the long-term care process can be very overwhelming.”

- Michelle, CCAC care coordinator



Moving Forward: A commitment to continuous improvement

Over the next few years, CCACs and our partners will be focusing on improving quality care and helping patients reach clearly defined health outcomes. These individualized health goals will be achieved by interdisciplinary teams using evidence-based care. By measuring the quality of care that home care patients are receiving, and paying for care that achieves the best possible results, we will be able to reward innovations in care that will help our patients get healthier, faster.

When Ian could no longer continue caring for Shirley in their home with support from the CCAC, their care coordinator, Michelle helped them make the transition to long-term care.

Opportunity #1: Making home care delivery even safer

To better understand trends in home care safety across the province, CCACs are working together to link our risk management reporting systems. This is a significant step in creating a safer home care system for all Ontarians.

GOAL:
Link risk management reporting systems of all 14 CCACs by March 31, 2014

Opportunity #2: Reducing duplication across the health system

Working with our partners, we will streamline and improve the home care sector by reducing duplication of efforts to provide a smoother journey for patients through our health care system. The efficient use of shared assessments for the CSS and CCAC sectors will limit the number of times patients have to tell their stories, minimizing the burden on them and also optimize the use of health care resources.

GOAL:
All CCACs will implement the Integrated Assessment Record (IAR) by March 31, 2013

Thehealthline.ca, now being implemented across the 14 CCACs, is a one-stop-shop to help patients navigate the health services they need in their

communities. With multiple electronic tools and databases currently in place across the province, thehealthline.ca reduces duplication by bringing together current information tools and databases into a single solution.

GOAL:
All CCACs will implement thehealthline.ca by March 31, 2013

Providing greater value for each and every health care dollar spent, CCACs and our partners are clarifying our roles and reducing duplication within our sector. We can do better for our patients and are dedicated to continually maximizing the resources we dedicate towards patient care.

GOAL:
Maintaining administration costs at or under 4.3 per cent



Advancing our quality agenda

As an important step in improving the quality of care we provide, our 2009-2010 CCAC Quality Report identified third-party accreditation as a goal to be achieved by all 14 CCACs. Accreditation is a process that evaluates the quality of the care and services we provide to patients and measures our quality improvement initiatives against national standards. Delivering on this goal, by December 2012, all CCACs were accredited.

Opportunity #3: Building stronger relationships

Every community in Ontario has a wide variety of organizations offering hundreds of health care supports for people. CCACs bring these all together, ensuring the patients we care for quickly and easily get the care they need. We are committed to strengthening our partnerships so that people are supported throughout their health care journey and we are setting goals for working with our primary care partners to support patients more effectively as they move through different care settings.

Health Links patient care networks – a new way of caring for people – are a tremendous opportunity for Ontario's health care system. These new patient care networks, designed to organize care around patients, enable flexibility and allow the movement of resources between health service providers to better address community and patient needs. Through the networks, care providers will share information about patients, for example, what medications they are on, what tests they have had, and what their results are. CCACs are ready to work hand

in hand in these new networks with physicians, nurse practitioners, pharmacists, hospitals and service providers to ensure people get the right care, at the right time, in the right place.

GOAL:

All Health Link early adoption projects will have CCAC care coordinators engaged with the participating primary care teams within three months of business case approval

Opportunity #4: A province-wide commitment to transparency and quality improvement

The Auditor General of Ontario's Report on Long-term Care Home Placement recommended that CCACs publicly report on long-term care home wait times by the level of priority and type of accommodation per long-term care home to help people choose which homes to apply to. CCACs are committed to ensuring people have reliable information to help inform their choices. Public reporting on expected wait times for long-term care homes is already part of the CCAC provincial transparency plan. Five CCACs have

begun reporting these numbers publicly on their websites and planning for wider adoption of this reporting is underway.

GOAL:

All CCACs will publicly report on long-term care home wait times by September 30, 2013

Under *Ontario's Excellent Care for All Act*, health care organizations (currently, only applied to hospitals) develop annual Quality Improvement Plans (QIPs) which are reported publicly. QIPs are local plans designed to improve patient experience, guided by provincial priorities for high-quality care as highlighted in *Ontario's Action Plan for Health Care*. The plans set measures and targets for performance improvement, including patient experience, safety, access, and effectiveness. Although CCACs are not required to develop QIPs, they are an important tool for ensuring accountability and a continuous focus on quality improvement.

GOAL:

All CCACs will develop QIPs based on a provincial template, and post on their individual public websites by April 1, 2014



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

English 310.CCAC (2222)

Français 310.CASC (2272)

www.ccac-ont.ca

