

NOVEMBER 2015

HOW CCACs CARE:

AN UPDATE
ON QUALITY IMPROVEMENT
FOR PATIENTS



How CCACs care: An update on quality improvement for patients

Updated November 2015

It is clear that the Ontario government puts home and community care as the cornerstone of its vision for providing care to patients.

Community Care Access Centres (CCACs) are serving more patients year-over-year and continue to focus on providing better care and value for Ontario's patients and families. In addition to increasing access to services, CCACs work together to give Ontarians the information they want and need. CCACs also strive to continuously improve the quality and consistency of home and community care across the province.

CCACs BY THE NUMBERS

CCACs SERVED MORE THAN 713,000 PEOPLE ACROSS ONTARIO IN 2014/2015 BY:

PROVIDING CARE AT HOME TO 580,000 PATIENTS

SUPPORTING 359,000 SENIORS, ENABLING THEM TO STAY IN THEIR HOMES INDEPENDENTLY

ENSURING 96,000 CHILDREN RECEIVED HEALTH SERVICES AT SCHOOL

SUPPORTING 28,000 PEOPLE THROUGH THEIR END-OF-LIFE EXPERIENCE WITH CARE AT HOME

HELPING 27,000 PEOPLE TRANSITION TO A LONG-TERM CARE HOME

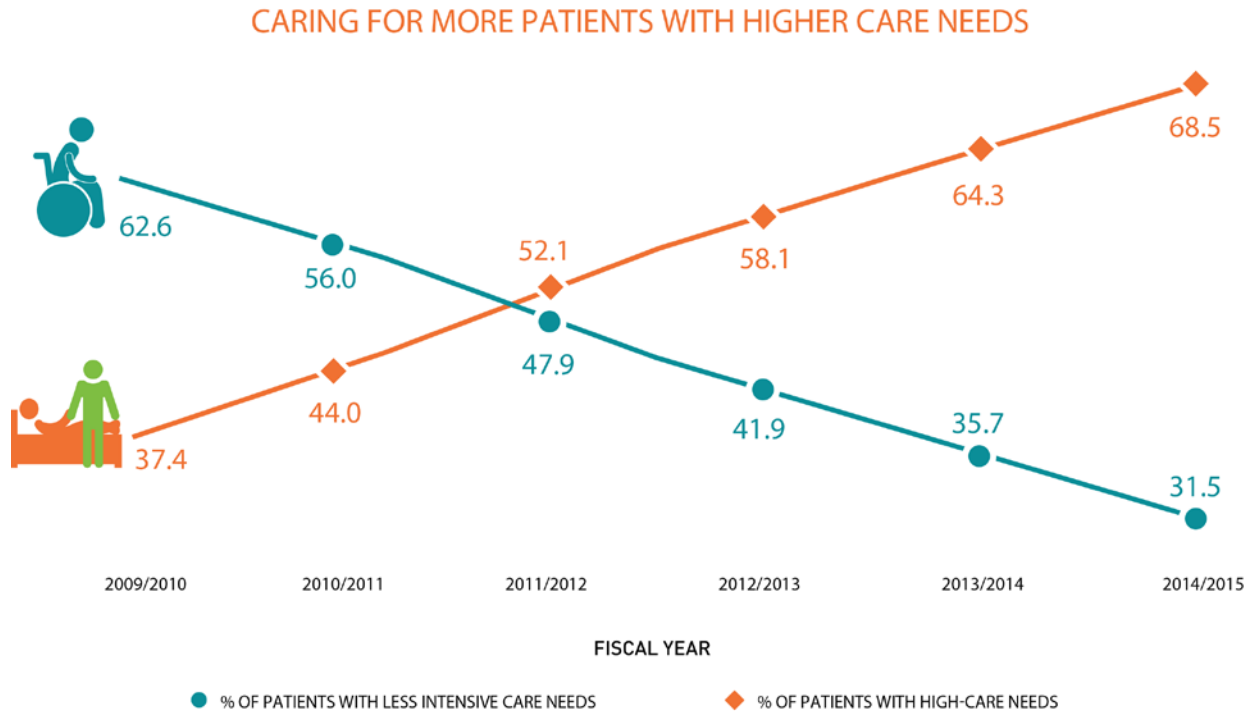
SUPPORTING AN AVERAGE OF 4,000 PEOPLE DISCHARGED FROM HOSPITAL PER WEEK WITH CCAC CARE

CONNECTING PATIENTS AND CAREGIVERS TO LOCAL HEALTH AND COMMUNITY SERVICES THROUGH 5.2 MILLION USER SESSIONS ON THEHEALTHLINE.CA

MAKING THOUSANDS OF REFERRALS EACH DAY TO OTHER COMMUNITY SUPPORT SERVICES TO ENSURE PEOPLE HAVE THE SUPPORT THEY NEED TO LIVE INDEPENDENTLY

Caring for those who need the most support

CCACs are caring for more and more people with multiple chronic and complex health issues – the number of patients with higher needs has increased by 83 per cent since 2009/2010.



Helping patients stay in their homes longer

Personal Support Workers (PSWs) play a vital role in helping people do the things they can no longer do on their own and to continue living in their own homes for as long as possible. Each year, CCACs are providing more personal support services to people in communities across Ontario.

CCACs HAVE INCREASED THE AMOUNT OF PERSONAL SUPPORT SERVICES PATIENTS RECEIVE



Listening to what matters most to patients

CCACs regularly seek feedback from patients and their families to help improve quality of care.

This feedback helps CCACs learn which services need to improve.



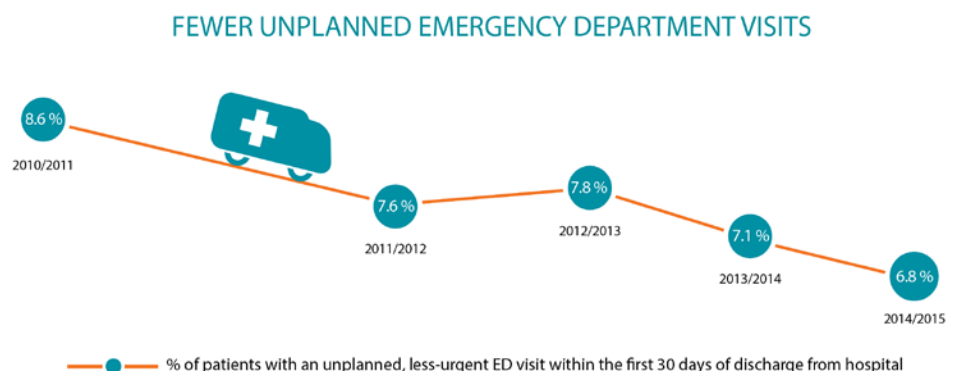
This year, CCACs were asked to look for ways to make it easier for patients when they move between two different locations where they receive care — like from a hospital to their home. CCACs are responding. In partnership with hospitals and the Ontario Hospital Association, CCACs are developing a guide that supports shared planning and improved patient transitions from hospitals to the community. In addition, as of January 2015, all CCACs are using a common protocol to support patients who move from one CCAC to another to make sure that these transitions happen smoothly.

Sharing information about quality

On April 1, 2014, CCACs began publicly posting their annual Quality Improvement Plans (QIPs) online and one year later, began reporting on their progress in achieving the targets set out in those plans. The QIP is one tool to help CCACs define and share their organization's quality improvement priorities. All CCACs report on a core set of quality-based indicators that support the Ontario government's health priorities. QIPs include measures and targets for improving patient safety, access and patient experience. CCACs use these measures to guide their ongoing efforts to improve the care patients receive.

Keeping patients safe and at home

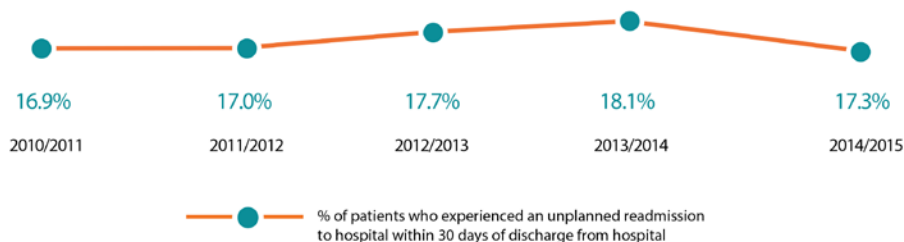
CCACs believe safety for patients at home is a top priority and are always working to ensure patients are as safe as possible. One way CCACs measure safety is by tracking patients' visits to hospital emergency departments, particularly visits that could have been prevented. CCACs continue efforts to reduce these unplanned emergency department visits.



Patients with unstable, chronic health conditions, who have recently been in a hospital, are more likely to have to return there.

CCACs are serving more patients who have high health-care needs, so they are caring for more people who have to return to hospital. Their goal is to help people stay home, so CCACs are providing higher levels of immediate access to in-home care when patients are discharged from hospital. CCAC Rapid Response Nurses are now caring for patients within the first 24 hours after they return home. These nurses also ensure patients visit their family physician within the first seven days following discharge.

HIGHER COMPLEXITY OF PATIENT NEEDS MAY RESULT IN A NECESSARY RETURN TO HOSPITAL



Tracking safety risks *in the home* – such as falls – is an important factor for improving the quality of patient care. By tracking falls at home and other safety information, CCACs gain a better understanding of the reasons behind an increase or decrease in overall safety, and can develop more effective prevention programs, targeted more effectively at the portion of the patient population most at risk. There is work to be done, but we have been having some success. As the graph below shows, the rate of falls among our patient population is slightly lower than experience would lead us to expect, given the growing portion of the patient population with higher care needs and more complex health issues.

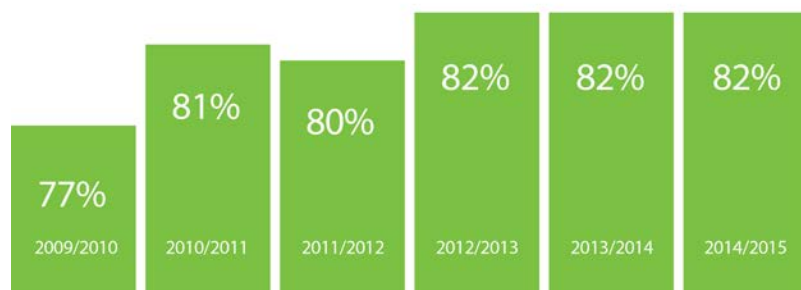
TRACKING FALLS AT HOME



Providing care in the right place



ENSURING PATIENTS IN LONG-TERM CARE NEED TO BE THERE
PERCENTAGE OF PATIENTS WITH HIGH-CARE NEEDS PLACED (%)



By caring for more patients with high-care needs at home, CCACs are ensuring people stay in their homes longer, which helps free up long-term care beds for those who need them the most.

Currently, 82% of patients in long-term care beds have high or very high needs.

CCACs have increased the number of patients whom they help to go *home* from hospital with supports in place, rather than stay in hospital longer or go to other institutions. This increase in service volumes has helped reduce the pressure on long-term care homes and hospitals.

PROVIDING THE CARE AND SUPPORT THAT PATIENTS NEED TO STAY AT HOME



Providing care to patients who need it most – first

Access to care is an important measure of home care quality. When assessing patient-care needs, CCAC Care Coordinators must prioritize people whose care needs are urgent. The Ministry of Health and Long-Term Care has emphasized the need to reduce wait times for patients with the greatest needs. That is why it has implemented a five-day wait time target for all nursing visits and personal support visits for patients with high needs.

IN 2014/2015

94% 
OF PATIENTS RECEIVED
THEIR FIRST NURSING
VISIT WITHIN 5 DAYS

85% 
OF COMPLEX PATIENTS
RECEIVED THEIR FIRST
PERSONAL SUPPORT
SERVICE WITHIN 5 DAYS

Meeting Emerging Needs: Providing the support people need at end-of-life



Studies suggest that 70 to 80 per cent of people would prefer to die at home, if supports were available, yet 66 per cent of Ontarians die in hospitals. CCACs support patients, their families and caregivers at each phase of their care journey. Building on the strong foundation of current CCAC hospice palliative care programs and services, CCACs are working together to develop a hospice palliative care action plan that identifies high-value, high-impact practices and opportunities to improve care across the province.

Supporting some of Ontario's most vulnerable patient populations

CCACs continue to care for more vulnerable patients: their health needs are more involved and the interventions and support they need are more complex than ever before. To address that need, CCACs are providing direct nursing care to the most vulnerable patients: students with mental health or addiction issues, frail seniors and adults, children with complex, serious illnesses as well as patients who need end-of-life care. CCACs' expertise working in different care settings – home, schools, hospitals and primary care – ensured these nursing roles are integrated within their unique settings.

In 2013, these programs were launched in all 14 CCACs. CCACs have been recruiting nurses who have the right expertise for providing this kind of care and the right kind of experience to help launch the programs. While it took longer than expected to find the right people, the majority of these nursing roles are now filled and the valuable care and support they provide are achieving results.

Rapid Response Nurses – These nurses reduce re-hospitalization and avoidable emergency department visits by improving the quality of transitions from acute care to home care for high-risk and medically complex children, seniors and frail adults. CCACs recognize that there is opportunity for improvement in the number of visits by rapid response nurses and are working to increase the number by up to 50% over time.



*86 per cent of Rapid Response Nurses hired

Mental Health and Addictions Nurses (MHAN) –

A strong relationship with the district school boards was necessary as these nurses help educators learn how to recognize students with mental health and addiction issues and provide early nursing interventions and support for students within the school setting. The program has demonstrated early wins by improving students' experiences with moving through the mental health system, decreasing hospital admission rates and increasing school attendance.



OVER 35,000 FACE-TO-FACE AND PHONE VISITS COMPLETED IN 2013/2014, AND

27 PERCENT
MORE VISITS IN 2014/2015.

*81 per cent of Mental Health and Addictions Nurses hired



OVER 21,000 FACE-TO-FACE AND PHONE VISITS COMPLETED IN 2013/2014, AND

44 PERCENT
MORE VISITS IN 2014/2015.

*87 per cent of Hospice Palliative Care Nurse Practitioners hired

Hospice Palliative Care Nurse Practitioners –

Supporting people to die at home or in their place of choice, these nurses work collaboratively with patients, families and other care providers. They work in acute, hospice and primary care settings to reduce hospitalization and avoidable emergency department visits for patients who need hospice palliative care, by enhancing quality of care through combining therapies to comfort and support patients and their families and to better manage pain and symptoms.

2015/2016 Goals to improve patient care

Recently, the home and community care sector has been the focus of academic and government assessment and action-planning. CCACs welcome and support improvement initiatives and are together setting goals and targets for their delivery of outstanding care.

Providing the right information to help people make important decisions about their care

Access to timely and appropriate care is important to patients and caregivers, and is a measure of the quality of health care that a person receives. CCAC Care Coordinators assess a person's care needs to determine which, and how urgently, services are needed. Patients who need care urgently will get the care they need right away, while people with less urgent or less complex care needs may wait for their services to start or be connected with a community resource.

Publicly posting home care waitlist information provides people with the tools they need to make important decisions about their care.

2015/2016 Quality Goal: *By September 1, 2015, all CCACs will publicly post their waitlists for services, including nursing services, personal support services, physiotherapy, occupational therapy, speech and language pathology, nutrition and social work. Waitlist information will be updated monthly.*

Status: Complete

Working together with primary care to provide a seamless experience for patients

Working together and communicating effectively with primary care are essential for responding to the increasing needs of patients with complex conditions and their caregivers. Improved communication helps deliver a seamless care experience and meet the ongoing needs that patients have. CCACs are also making sure that primary care providers have the information they need so they can easily identify their contact at their local CCAC when they need more information about their patients. Together, we're delivering better coordinated and integrated care in the community, closer to home.

CCACs are building meaningful relationships with primary care providers. In addition, the expansion of Ontario's Health Links offers new structures that encourage greater collaboration between existing local health care providers.

CCACs are measuring this collaboration by tracking Care Coordinator connections with Family Health Teams, Community Health Centres, and primary care practitioners. A connection is made when the

primary care provider knows the name of the Care Coordinator and there is an understanding between them that they are working together and sharing in the care of their patients.

As of December 2014, the current connection rates are 72 per cent for Family Health Teams and 54 per cent for Community Health Centres, as reported provincially; and 45 per cent for primary care practitioners, as reported by seven CCACs.

2015/2016 Quality Goal: *By March 2016, CCACs will report the connection rate of CCAC Care Coordinators with all local Family Health Teams, Community Health Centres and primary care practitioners and demonstrate improvement over time.*

Status: Pending

Helping people understand what they can expect from their home care services

CCACs are making sure the right information is available to help Ontario's families understand their options and support them in making well-informed decisions about their care. CCACs are working toward clearly outlining what people can expect from their home care experience, including describing how the CCAC assessment process helps to determine eligibility for a range of home-based services.

2015/2016 Quality Goal: *By April 1, 2016, CCACs will publish the information used to determine the home care services patients receive.*

Status: Pending

Supporting patients better as they move between CCACs

Since January 2015, all CCACs have consistent protocols and practices to support patient transitions between CCACs, and the process for patients transferring from one CCAC to another is the same across the province. CCACs will continue enhancing these provincial guidelines, and are committed to improving the tracking of information about patients transitioning between CCACs, so that their experience can be better monitored and improved.

2015/2016 Quality Goal: *By April 2016, CCACs will be able to report on the success of provincial principles, protocols and practices and use the information as a basis for improving the experience of patients transitioning between CCACs.*

Status: Pending



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

www.healthcareathome.ca
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