CRNCC
Canadian research network for care in the community

RCRSC
Réseau canadien de recherche pour les soins dans la communauté

Leading knowledge exchange on home and community care

Quality Across the Continuum of Care

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The CRNCC is supported by funded from the Social Sciences and Humanities Research Council of Canada and Ryerson University.

Policy Context and Drivers

- Global economic crisis
- Budget deficits
- Health accounts for 40% + of provincial budgets
- Fear of unsustainable publicly funded system with aging population

Quality as a Solution

- Increasing resources not an option
- Improve quality = better value for money
- In health, this has meant parlaying business type tools to quality of care

New Public Management Principles

- Government adapting business-like principles and practices to:
  - reduce costs
  - augment efficiency, effectiveness
  - enhance accountability, transparency
  - improve safety
  - increase accessibility

“Quality of Care”
What do we mean?

Some similar words - different meanings

- Efficient
- Effective
- Safe
- Patient/ client centred
- Accessible

What accounts for the difference in meaning?

Depends on Beginning and End Points…

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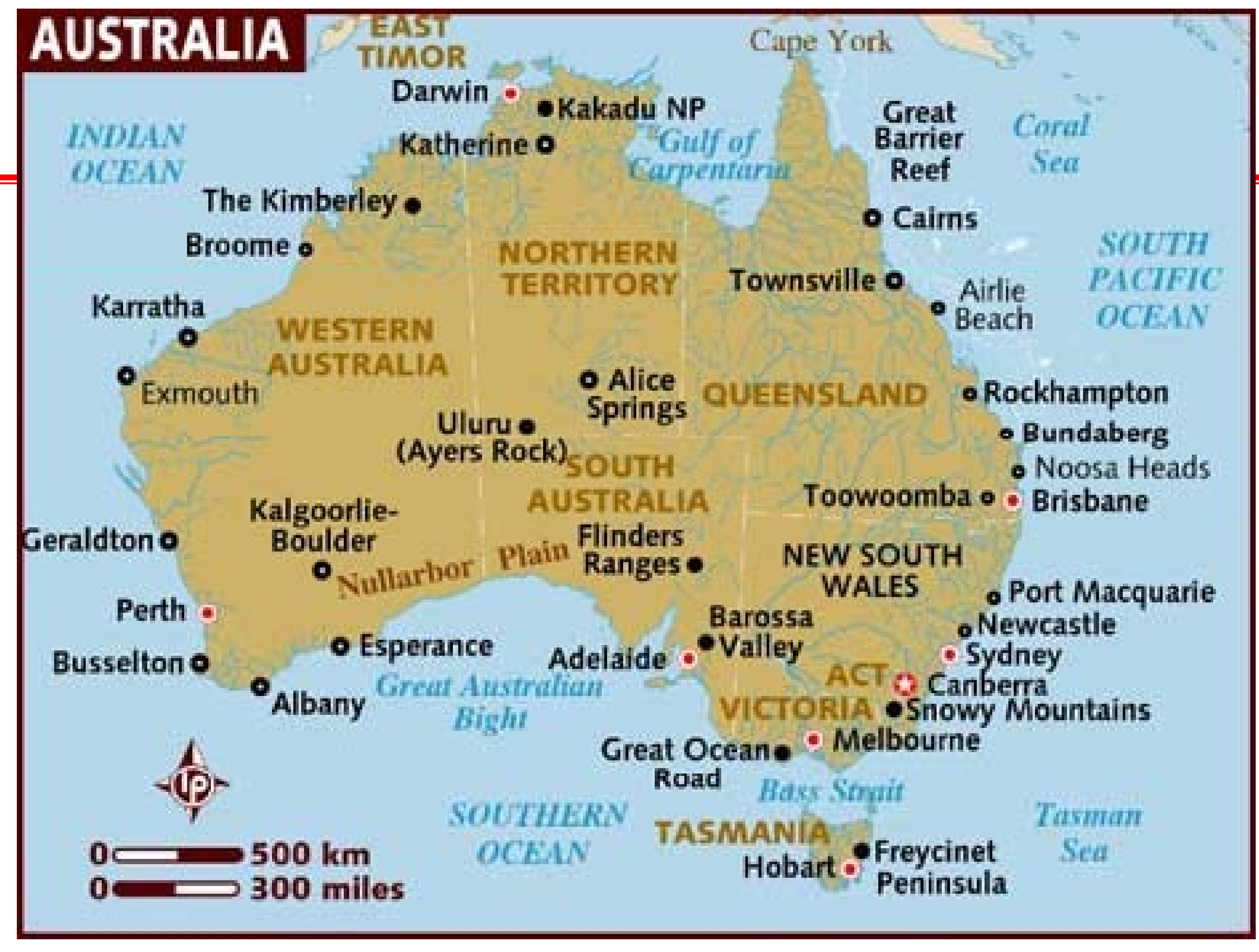
…and Assumptions Embedded in the Health System

- "Can't effectively manage what you don't measure."
- BUT what are you measuring and how?



Australia Population = 22, 725239

Canada = 34, 278400

Australia: Community Care Common Standards

- 3 common standards and 18 expected outcomes
- Covers 4 programs across the entire home and community sector
- Assures quality by emphasizing processes
  - Annual improvement plan by organization
  - Onsite visit every 3 years

4 Programs

1. Home and Community Care Program

- Basic level of support- relatively low level of care needs
- Purpose: to reduce inappropriate use of residential care
- Under federal jurisdiction except for 2 states
    - Nursing care
    - Allied health care
    - Meals and other food services
    - Domestic assistance
    - Personal care
    - Home modification and maintenance
    - Transport
    - Respite care
    - Counselling, support, information and advocacy
    - Assessment of service users and coordination of services.

2. Community Aged Care Package

- Coordinated package of services for clients who qualify for low level nursing homes but are living at home
- Federally funded
    - Personal care
    - Social support
    - Transport to appointments
    - Home help
    - Meal preparation
    - Gardening

3. Extended Aged Care at Home and EACH Dementia Packages

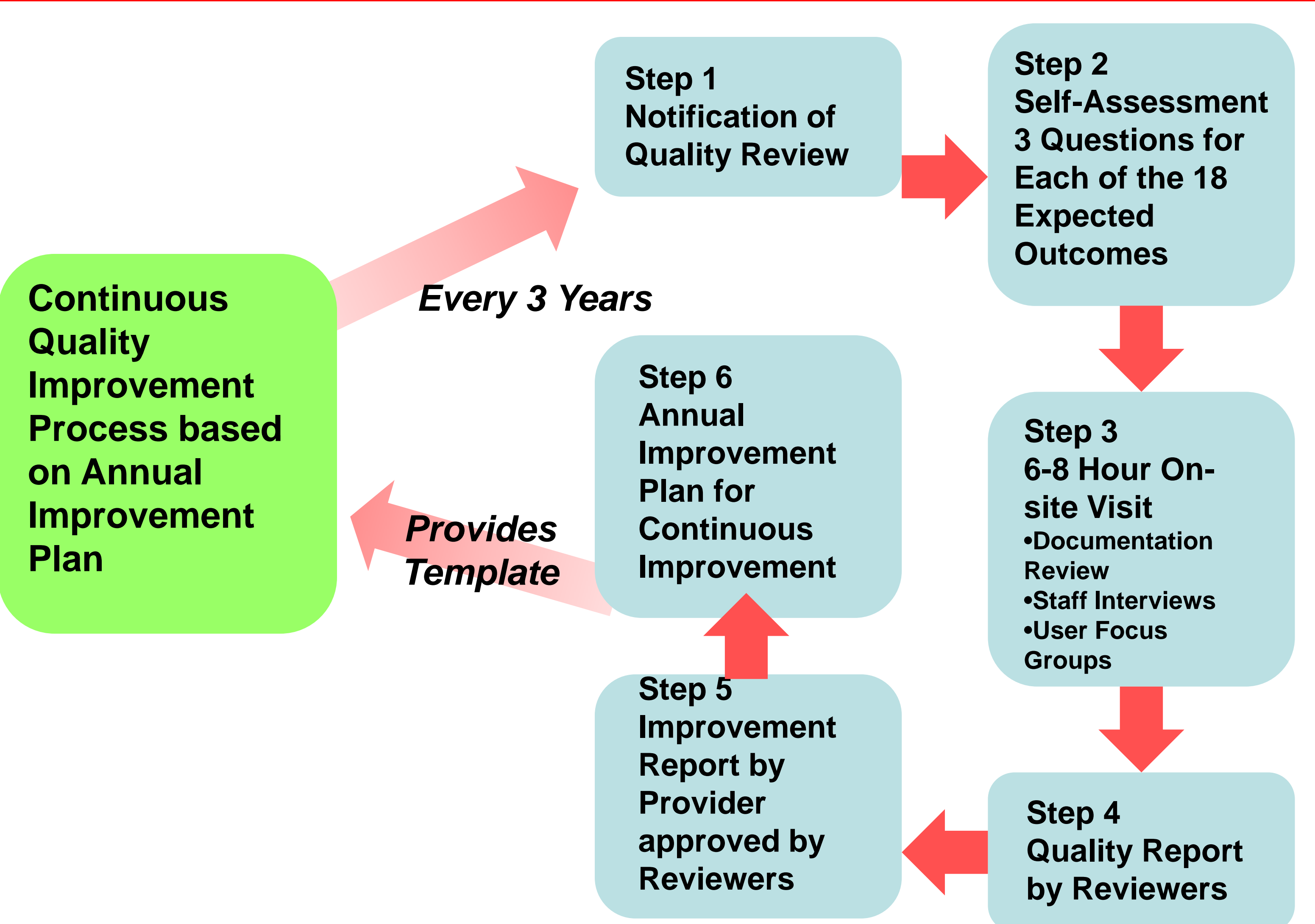
- Individually planned and tailored for those with high levels of care needs living at home
- Federally funded
  - Care provided by a registered nurse
  - Care provided by allied health professionals (e.g., physiotherapist, podiatrist, etc.)
  - Personal care
  - Transport to medical appointments
  - Social support
  - Home help
  - Assistance with oxygen and/or enteral feeding

4. National Respite for Carers Program

- Coordinates access to respite services at the local level
- Arranges 24 hour emergency respite care
- Federally funded
  - http://www.crncc.ca/knowledge/factsheets/pdf/InFocus-InformalCaregiving.pdf

Quality Review Process

20-Week Quality Review Process **Every 3 Years**



3 Common Standards
18 Expected Outcomes

Standard 1: Effective Management

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The service provider demonstrates effective management processes based on a continuous improvement approach to service management, planning and delivery.

Expected Outcome 1.1: Corporate Governance
The service provider has implemented corporate governance processes that are accountable to stakeholders.

Expected Outcome 1.2: Regulatory Compliance
The service provider has systems in place to identify and ensure compliance with funded program guidelines, relevant legislation, regulatory requirements and professional standards.

Expected Outcome 1.3: Information Management Systems
The service provider has effective information management systems in place.

Expected Outcome 1.4: Community Understanding and Engagement
The service provider understands and engages with the community in which it operates and reflects this in service planning and development.

Expected Outcome 1.5: Continuous Improvement
The service provider actively pursues and demonstrates continuous improvement in all aspects of service management and delivery.

Expected Outcome 1.6: Risk Management
The service provider is actively working to identify and address potential risk, to ensure the safety of service users, staff and the organisation.

Expected Outcome 1.7: Human Resource Management
The service provider manages human resources to ensure that adequate numbers of appropriately skilled and trained staff/volunteers are available for the safe delivery of care and services to service users.

Expected Outcome 1.8: Physical Resources
The service provider manages physical resources to ensure the safe delivery of care and services to service users and organisation personnel.

Standard 2: Appropriate Access and Service Delivery

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Each service user (and prospective service user) has access to services and service users receive appropriate services that are planned, delivered and evaluated in partnership with themselves and/or their representative.

Expected Outcome 2.1: Service Access
Each service user's access to services is based on consultation with the service user (and/or their representative), equity, consideration of available resources and program eligibility.

Expected Outcome 2.2: Assessment
Each service user participates in an assessment appropriate to the complexity of their needs and with consideration of their cultural and linguistic diversity.

Expected Outcome 2.3: Care Plan Development and Delivery
Each service user and/or their representative, participates in the development of a care/service plan that is based on assessed needs and is provided with the care and/or services described in their plan.

Expected Outcome 2.4: Service User Reassessment
Each service user's needs are monitored and regularly reassessed taking into account any relevant program guidelines and in accordance with the complexity of the service user's needs. Each service users' care/service plans are reviewed in consultation with them.

Expected Outcome 2.5: Service User Referral
The service provider refers service users (and/or their representative) to other providers as appropriate.

Five Expected Outcomes

- Service access
- Assessment
- Care plan development and delivery
- Client reassessment
- Client referral

What the quality reviewers may look at regarding care plan

- Strategies for promoting independence, social inclusion, QoL - integral part of care plan
- Whether and how services are coordinated
- Processes for monitoring client changes such as physical/cognitive changes, discharges, changes in support arrangements
- How front line staff report the need for changes in care plans – feedback

What the quality reviewers may look at: reassessment and referral

- Also linked to quality of life
- Scheduling, monitoring and reporting reassessments and updating client files - when and how often
- Protocols with other providers
- Coordination with other agencies on information sharing/case conferencing/ provision of care
- Referral forms and care records

Standard 3:Service User Rights and Responsibilities

Standard 3: Service User Rights and Responsibilities

Each service user (and/or their representative) is provided with information to assist them to make service choices and has the right (and responsibility) to be consulted and respected. Service users (and/or their representative) have access to complaints and advocacy information and processes and their privacy and confidentiality and right to independence is respected.

Expected Outcome 3.1: Information Provision
Each service user, or prospective service user, is provided with information (initially and on an ongoing basis) in a format appropriate to their needs to assist them to make service choices and gain an understanding of the services available to them and their rights and responsibilities.

Expected Outcome 3.2: Privacy and Confidentiality
Each service user's right to privacy, dignity and confidentiality is respected including in the collection, use and disclosure of personal information.

Expected Outcome 3.3: Complaints and Service User Feedback
Complaints and service user feedback are dealt with fairly, promptly, confidentially and without retribution.

Expected Outcome 3.4: Advocacy
Each service user's (and/or their representative's) choice of advocate is respected by the service provider and the service provider will, if required, assist the service user (and/or their representative) to access an advocate.

Expected Outcome 3.5: Independence
The independence of service users is supported, fostered and encouraged.

Five Expected Outcomes

- Information provision
- Privacy and confidentiality
- Complaints and service user feedback
- Advocacy
- Independence

What the quality reviewers may look at regarding advocacy

- Whether and what information was provided to clients on the right to an advocate
- Process for clients to locate and use an advocate
- Client knowledge of their right to an advocate
- Documentation related to clients who have used an advocate
- Staff/volunteer education and training records in relation to advocacy that covers:
  - What an advocate is
  - The right of clients to use an advocate of their choice
  - The process for clients to use an advocate
  - Assisting clients to identify an appropriate person to act as an advocate
  - Working with advocates

What the quality reviewers may look at regarding independence

- Processes for ensuring that service staff/volunteers support, foster and encourage client independence and respect clients’ rights to make decisions and choices about their lives

- Information on independence provided to clients
  - E.g., information on how clients can support their own independence
  - Where and how clients can access aids and services that can support their independence

- Whether clients assessments include assessing independence, including:
  - Mobility and dexterity in activities of daily living
  - Whether clients maintain adequate nutrition and hydration (the ability to prepare food)
  - Social networks including family and community links

What the quality reviewers may look at regarding independence

- Whether care plans contain effective strategies to promote and foster client's independence, such as:
  - Retraining in activities of daily living
  - Facilitating access to allied health services such as physiotherapy, occupational therapy and dieticians
  - Encouraging participation in local health-promoting activities
  - Strengthening social support including family and community links
  - Records of ongoing training of staff/volunteers in promoting and fostering independence when working with clients

Take Away Lessons from Australia?

- Process oriented; interviews with clients; front line staff; managers and stakeholders
- Time and labour intensive
- Set internal and external evaluation schedules
- Believes that these processes and steps will result in high quality care
- Continuous quality improvement process

The Netherlands

Population = 16,847,007

Population of Ontario = 13,210,667

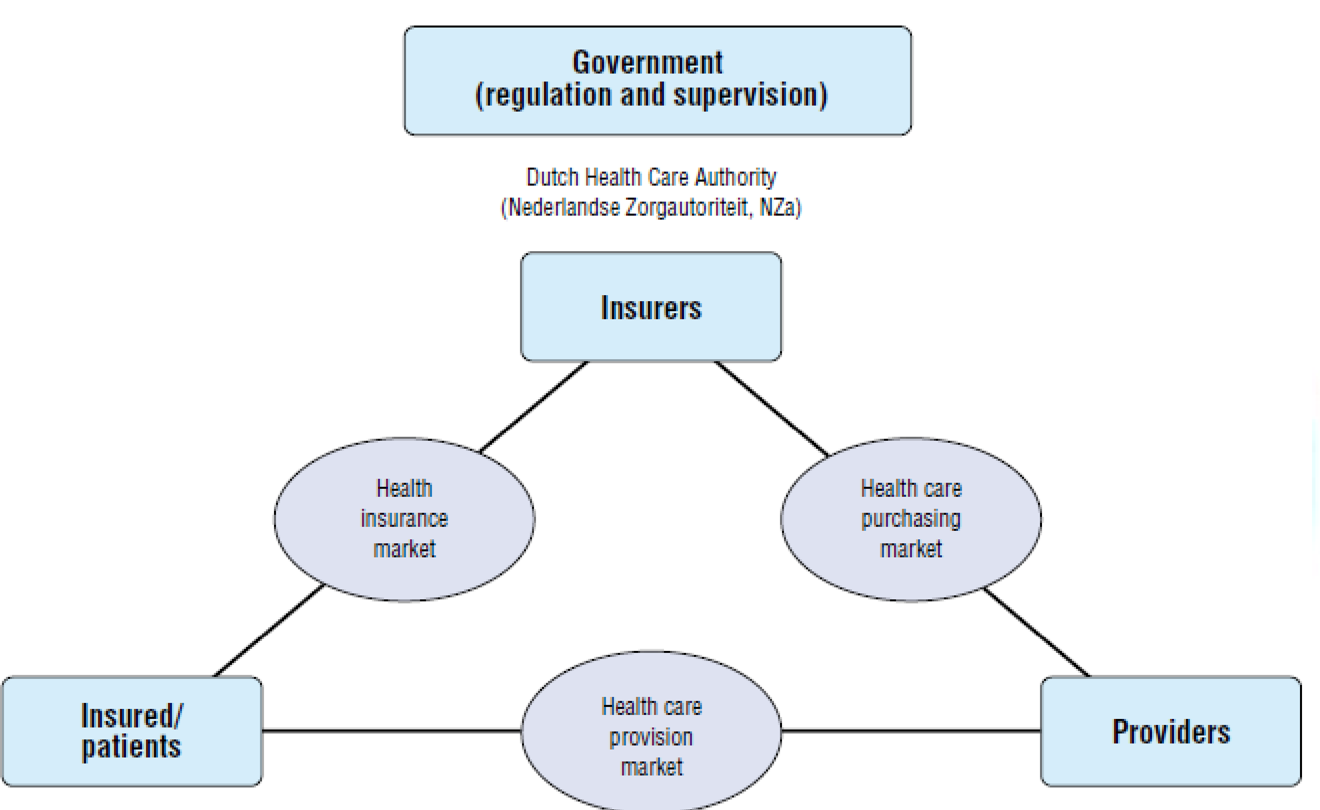
The Netherlands

- Support older people at home
- National level health system reform in 2006 – one aspect was to establish *Quality Framework Responsible Care*
- Market-led system focusing on patient requirements
- Single compulsory insurance scheme with multiple, competing private insurers and private service providers

Purpose of Quality Framework For Responsible Care: Choice and Safety

- Standards cover residential and home and community care sectors
- Independent regulatory bodies get info though mandatory annual reports filed by service providers
- Assure quality control by making info regarding standards publicly available, posted on-line to users, patient organizations, other providers and health insurers
- Clients use info to obtain services
- Insurance companies use info as leverage for service pricing and contracting activities
- Service providers can establish priorities for further performance improvements

Netherlands Health System



Schäfer et al. (2010). The Netherlands: Health system review. *Health Systems in Transition, 12(1).*

The Netherlands: Quality Framework Responsible Care

- 10 Indicator themes
  1. Care plan
  2. Communication and information
  3. Physical well-being
  4. Care relating to safety - nutrition, medication
  5. Domestic and living conditions
  6. Activities, independence/autonomy
  7. Mental well-being
  8. Safety living/residence
  9. Sufficient and capable staff
  10. Coherence in care

3 Kinds of Indicators

- Biannual client survey (Customer Quality Index)
- Organizational indicators
- Clinical indicators

Biannual Client Survey – CQ Index

- Completed by clients at home and in facilities
- Administered by external, independent, accredited market research organizations
  - Similar questions to get at the same issues to allow for comparability across sectors – common language for quality
- Satisfaction with:
  - Participation/control over care planning
  - Communication with service providers
  - Care provided at the right time/manner
  - Meal quality
  - Care quality
  - Living environment
  - Client independence/autonomy
  - Social participation
  - Mental well-being
  - Safety/home adaptation
  - Care coordination

3 Kinds of Indicators

- Biannual client survey (Customer Quality Index)
- Organizational indicators
- Clinical indicators

Organizational Indicators

- Based on government standards and regulations

- Measured by service provider
  - Staff vaccination
  - Whether there is a policy on when to use restraints
  - Onsite availability of nurses and doctors
    - 24/7 or can be on location within 10 min. (nurse) or 30 min. (doctor)
  - Competency of staff in restricted tasks
  - Proof that staff have been trained in transfer and lifting

3 Kinds of Indicators

- Biannual client survey (Customer Quality Index)
- Organizational indicators
- Clinical indicators

Clinical Indicators

- Relates to health conditions and care dependency
- Measured on clients by provider organization
  - Bedsores
  - Nutrition
  - Falls
  - Medication incidents
  - Use of psychiatric medications
  - Flu vaccination rates
  - Incontinence
  - Use of catheters
  - Behavioral issues
  - Use of restraints
  - Depression

Framework Assumptions and Focus

- Focuses on results; less on process

- Avoids specifying minimum standards
  - Don't want providers to reach for the "lowest hanging fruit"
  - E.g., what is the acceptable number of bed sores?

- Standards are based on client feedback, clinical indicators and selected organizational characteristics

- Client experience central to quality of care - literature

- Framework ties indicators to best practices and encourages working towards optimizing quality and not aiming at a corridor of acceptable practices

- Client surveys by external agency limits conflict of interest and workload of care organizations

Who Monitors Care Quality?

- Responsibility of IGZ (Health Inspectorate)
  - Independent from the Ministry of Health, Sport and Welfare
- Inspect sub-standard providers to order remedial actions
- Also inspect providers across the range of performances for learning and best practice opportunities

Work in Progress

- "Sound basis but not yet perfect!"
- "Rather done imperfectly than not done at all!"

Take Away Lessons from the Netherlands?

- Outcome focus in a market-led system
- Law requires service providers to implement quality monitoring system as a precondition to providing service
- Client experience is primary indicator of quality
- Annual self-evaluation by organizations - biannual client survey
- Results form basis for annual improvement cycle
- Results are publicly available at www.kiesbeter.nl and in annual social responsibility reports

Take Away Lessons From Both Systems?

- Two different systems with different quality assurance approaches
- Common goal = support older people at home
- Common language and framework for quality across home and community care sector
- Quality of care is not tied to priorities of the acute care sector

Take Away Lessons From Both Systems?

- Client centred care = asking the clients about the quality of their care -- independence, safety, social connectedness
- Measuring performance is about more than numbers
- Both systems avoid over-surveying clients

Take Away Lessons From Both Systems?

- Scheduled quality review process
- Build in continuous quality improvement mechanisms
  - Not simply a reaction to crises or deficits
  - Standards not based on minimum levels with acceptable corridors
  - Look at range of provider performances to identify best practices to be emulated through knowledge exchange

Quality of Care in Home and Community Care in Ontario

What does it look like?

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Source of Information

- CCAC Contracts
- LHIN Multi-Sector Service Agreements
- Interviews with stakeholders from LHINs and CCACs

Home and Community Care in Ontario

- Unlike Australia and Netherlands Home Care and Community Care services are separated in Ontario

Home Care Services	Community Care Services
Nursing Personal Care (bathing, dressing, feeding) PT, OT Speech-Language Therapy Social Work Dietetic services Respite Homemaking (light housekeeping)	Adult day programs Meals on Wheels Friendly visitor programs Security checks Transportation Home help (homemaking) Home maintenance (minor home repair, snow shovelling and lawn care) Meal prep Foot care
CCAC contracts	**LHIN MSAA's**

CCAC Contracts and Multi-Sector Service Agreements

- CCAC contracts
  - RFP process
  - General conditions
  - Service schedule
  - General Performance Standards

- LHIN Multi-Sector Service Agreements
  - General agreement

CCAC contracts: indicators

- General Performance Standards
  - Need to report quarterly, annually or on request

- CCAC indicators
  - # accepted referrals
  - # missed visits
  - # accepted urgent service referrals
  - # of clients receiving services (fixed period, hourly)
  - # of service providers/client
  - # services delivered in French (fixed period, hourly)
  - # of reports submitted by deadline (quarterly, risk events, discharge)

- Additional 10 indicators set by individual providers

LHIN Multi-Sector Service Agreements: Indicators

- 3 performance dimensions
  - Person Experience: Access, Effective, Safe, Person-Centered
  - Organizational Health: Efficient, Appropriately resourced, Employee Experience, Governance
  - System Perspective: Integration, Community Engagement, eHealth

- Three classifications:
  - Accountability Indicators
  - Explanatory Indicators
  - Developmental Indicators

- Designations:
  - Core Indicators
  - Sector specific indicators
  - LHIN specific indicators

LHIN Multi-Sector Service Agreements: Core Indicators

Person Experience
(Access, Effective, Safe, Person-Centered)

- Client Experience (Developmental)

Organizational Health
(Efficient, Appropriately Resourced, Employee Experience, Governance)

- Total Margin (Accountability)
- Balanced Budget (Accountability)
- Proportion of Budget Spent on Administration (Accountability)
- *Service Activity by Functional Centre (i.e. encounters by functional centre) (Accountability)
- *Variance Forecast to Actual Units of Service (Accountability)
- *Number of Individuals Served (Accountability)
- Variance Forecast to Actual Expenditures (Accountability)
- *Cost per Unit Service (by Functional Centre) (Explanatory)
- *Cost per Individual Served (by program/service) (Explanatory)
- Turnover Rate (Explanatory)

System Perspective
(Integration, Community Engagement, eHealth)

- Repeat Unplanned Emergency Visits within 30 Days for Mental Health Conditions (Explanatory)
- Repeat Unplanned Emergency Visits within 30 Days for Substance Abuse Conditions (Explanatory)
- Percentage of ALC Days (Explanatory)

* Note: CHC Sector "Developmental" until MIS compliant

LHIN Multi-Sector Service Agreements: CSS sector specific indicators

- NO CSS sector-specific Person Experience indicators
- NO CSS sector-specific System Perspective indicators
- NO CSS sector specific Volume/Output indicators
- Organizational health indicators
  - Average of days on waitlists (developing)
  - # of persons waiting for service

How do CCAC contracts and MSAAs compare: Performance review

	Performance review process
Australia	Continuous quality review process
Netherlands	Publicly available quality reports
CCAC contracts	Quality Management Program: Provider must develop program to monitor, record, evaluate and improve performance delivery
LHIN MSAA	Performance Improvement Process: in reaction to identified ongoing poor performance.

Most performance review for CCACs and MSAAs are in reaction to poor performance identified from ongoing performance reporting.

How do CCAC contracts and MSAAs compare?

Performance indicators	Australia	Netherlands	CCAC	MSAA
Access	✓	✓	✓	✓
Assessment	✓	✓	✓	✗
Care plan	✓	✓	✓	✗
Re-assessment	✓	✓	✗	✗
Referral	✓	✓	✗	✗
Independence / autonomy	✓	✓	—	✗
Living conditions	✓	✓	✗	✗

How do CCAC contracts and MSAAs compare?

Other indicators	Australia	Netherlands	CCAC	MSAA
Governance	✓	✓	✗	✓
Confidentiality	✓	✓	✓	✓
Complaints/ user feedback	✓	✓	✓	✓
Advocacy	✓	✓	✗	✗
HR	✓	✓	✓	✓
Continuity of care	✓	✓	–	✗
Risk management	✓	✓	✓	✓

SO, how does Ontario compare?

- Performance emphasizes access almost exclusively, and is mostly about the numbers
  - But they are working to develop additional indicators in both sectors
- Organizational indicators are well represented, mainly to support strong financial accountability and ensure efficiency.
- Performance improvement is done on an ad hoc basis rather than ongoing
- Client experience is important, but information is gathered internally by organizations, not by CCACs or LHINs.

Work in Progress

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Good Example of Work in Progress

SW –CSS Performance Measurement Project 2009

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