Quality, Risk and Patient Safety Report
Fiscal Year 2016-17, Third Quarter

Submitted to: Board of Directors
March 3, 2017

Analysis and Ideas for Improvement
Contributed by Staff of the North East CCAC

Date of Report: February 17, 2017
# TABLE OF CONTENTS

HIGHLIGHTS

1. INTRODUCTION

2. ENTERPRISE-WIDE QUALITY AND RISK MANAGEMENT UPDATE
   a. Patient Safety Plan
   b. Quality Improvement Plan (QIP)
   c. Centre of Operational Excellence
   d. Accreditation
   e. Risk Events and Feedback (REF)

3. ACCESSIBLE: Wait time for CCAC services

4. ACCESSIBLE: Access to long-term care home

5. EFFECTIVE: Keeping people healthy in home care

6. SAFE: Avoiding harm in home care and the community

7. PATIENT-CENTRED: Meeting patients’ needs and preferences

8. APPROPRIATELY RESOURCED: Healthy work environment


12. Quality Improvement Plan (QIP) Progress Report

APPENDIX A: ENTERPRISE-WIDE QUALITY AND RISK MANAGEMENT STRATEGIES

APPENDIX B: DEFINITIONS

APPENDIX C: INDICATORS, TRENDS, ANALYSIS AND IDEAS FOR IMPROVEMENT

APPENDIX D: DATA SOURCES
HIGHLIGHTS

The Quality, Risk and Patient Safety Report is presented on a quarterly basis to the Board of Directors. It provides an overview of various performance and quality improvement indicators and measures along with brief analysis from the M-SAA, Balanced Scorecard, Quality Improvement Plan (QIP) and Patient Safety Plan. Refer to Appendix B for definitions of key terms and to Appendix C for an explanation of indicators, trends, analysis and ideas from improvement.

- Wait Times (pages 7-9)

The wait time metric for patients referred from a community setting to community home care increased from 41 days to 43 days this quarter but continues to meet and exceed the target of 48 days. There is a continued focus on reducing patient wait times for therapy services.

We have met targets for five-day wait times for nursing and personal support services: 98.1% of nursing patients receive their first nursing visit within five days from the patient availability date. For personal support, 96.2% of patients received their first visit within five days of the patient availability date. The use of patient availability date has been endorsed by the Ministry and the NELHIN. Please note that the metrics used in this Quality, Risk and Patient Safety Report do not reflect patient availability date.

- Placement (pages 10-11, 13)

As of December 31st, there were 2739 individuals waiting for Long-Term Care Home placement. This number includes 14 patients in LTC homes waiting to transfer to their 1st choice. Crisis patients waiting for admission include 91 waiting from community and 26 waiting from hospitals across the North East.

Between January and December 2016, an average of 57.2% of patients were admitted to their first choice of LTC Home.

- ALC-Acute Rate (page 14)

The ALC-Acute rate for the 4 Hub Hospitals averaged 22.1% in Q2, above the M-SAA target of ≤18%. Note that results are one quarter behind. Improvement work with individual hospitals continues, with a focus on the specific improvements with each hospital. Four HUB hospitals, in collaboration with NE CCAC, will be completing their respective acute and CCAC ALC framework inventories and identifying key priorities by the end of February, 2017. These strategies will become priorities on the local ALC Committee work plans for 2017-18.

- Prevalence of Falls for Adult Long-Stay Home Care Patients (page 18, 33)

Q3 result of 35.86% continues to meet and exceed the QIP target of 37.0% (lower is better). The completion rate of the Home Safety Risk Assessment, a QIP improvement initiative, continues to surpass the target of 85% with a Q2 result of 87.91%. Medication reconciliation completion rate has improved again at 95.23% exceeding the target of 80%.

- Patient Complaints (page 19)

A significant number of complaints involve provision of medical equipment. Opportunities for improvement to address these complaints are discussed with equipment providers by the Performance and Relations department, supported by Quality and Risk. The complaint management process is also discussed, clarifying the need to respond to the complainant and offer an explanation and/or an apology, as appropriate. This is an important part of the communication loop with patients to improve patient relations.

- Healthy Workplace Environment (page 26)

The turnover rate was 5.88% continuing the downward trend since Q1 2015-16 when it was 10.64%. All positions are being filled in a timely way with no staff vacancies exceeding 60 days as of December 31st.
1. INTRODUCTION

Home care is an important foundation for supporting an integrated health care system. Home care has a unique function as a key linkage point between various settings of care, such as acute hospitals, emergency departments, long-term care homes and various clinical services. Home care services are intended to meet patients’ needs in an individualized and comprehensive manner, and go beyond physical and mental health care to engage social supports as well.1

To ensure that the NE CCAC is monitoring indicators across the quality spectrum, the report has been organized to link indicators to the applicable attribute of quality. The nine attributes of quality that reflect a high performing health system include: accessible, effective, safe, patient-centered, equitable, efficient, appropriately resourced, integrated and focused on population health. The report also incorporates results from the Quality Improvement Plan and the Patient Safety Plan.

The report includes data to December 31, 2016, the end of third quarter for fiscal year 2016-17. Status reports and quality improvement strategy updates are current as of the date of the report.

1. **Keep me safe**
2. **Heal me**
3. **Be nice to me**
   ... in this order

©2006 Healthcare Performance improvement, LLC.
ALL RIGHTS RESERVED.
2. ENTERPRISE-WIDE QUALITY AND RISK MANAGEMENT UPDATE

Appendix A provides a description of all the NE CCAC’s enterprise-wide quality and risk management strategies. This section provides an overview of updates in the 3rd quarter.

a. Patient Safety Plan

Refer to Section 11 for the 2016-2017 Patient Safety Plan Quarterly Progress Report. Of the 12 key initiatives/activities, 5 are completed, 5 are in progress and 2 are not started.

Development of the 2017-18 Patient Safety Plan has started.

b. Quality Improvement Plan (QIP)

Sessions were provided by HQO as well guidance documents for preparation of the 2017-18 QIP. QIP indicators will remain the same for the CCAC sector to ease transition. Two “additional” indicators (preferred place of death and Health Links) are optional. A focus on equity is to be included in the narrative part of the QIP. CCACs and LHINs are encouraged to develop the QIP collaboratively.

An engagement session occurred in early January with NE CCAC Leadership and the LHIN Quality Lead Officer to review background information and brainstorm new change ideas for 2017/18 QIP. A draft QIP is currently in progress.

NE CCAC QIP status updates on the priority indicators are incorporated into this report. (Click on the following links to jump directly to each section.)

- 5-Day Wait Time – Nursing; Personal Support Complex Patients
- Unplanned, Less Urgent Emergency Department Visits
- Unplanned Hospital Readmissions
- Falls
- Patient Experience

The Progress Report on QIP improvement initiatives (change ideas) for each indicator is located in Section 12 of this report.

c. Centre of Operational Excellence

The Centre of Operational Excellence continues process improvement/LEAN work on the following initiatives:

- Purchasing of CCAC-owned medical equipment (minor equipment): This initiative is on hold pending completion of an inventory of current equipment and supplies by the Contracts team.
- Resume Process for patients – streamline and develop a standardized process for resume patients on hold less than 72 hours via access team: A pilot project in Timmins is testing the new process.
- Palliative Nurse Practitioner referral process – streamline and develop a consistent Palliative Nurse Practitioner referral process to be applied in all regions: Testing of the new process will take place in the Sudbury branch.
- Care Coordination Operations Task Analysis – streamline resources in order to create efficiencies for Care Coordinators and Team Assistants to increase their direct patient time for assessments and service planning: the planning phase is in progress.

The Centre of Operational Excellence is providing support to the development of the current and future state process map of the HSP 360 NE LHIN System Performance.

Staff involved in the process improvement initiatives were invited to participate in an evaluation survey of the Centre of Operational Excellence in January. Analysis is under way.

d. Accreditation

A request for a 12-month postponement was granted by Accreditation Canada, bringing our next survey to May 2019.
a. Quality and Risk Newsletter

The Quality and Risk Newsletter is a communication tool to inform all NE CCAC staff about quality and risk issues affecting the organization. The newsletter provides updates on issues related to current systems such as Policy and Procedure Manager, the Risk Event and Feedback System, Patient Safety topics and Accreditation.

- October issue: Infection Prevention and Control Week, Patient Safety Week
- November issue: influenza clinics, Centre of Operational Excellence, disclosure training, patient falls prevention
- December issue: quality tools on Portal, QIP, update about accreditation postponement

e. Risk Events and Feedback (REF)

In Q3, users of the system submitted 323 records about patient safety events, complaints and compliments. User support was offered by Patient Relations and Quality Specialist staff as needed. The training module was updated to incorporate improvements suggested by users as well as the policy and procedure to be released in the 4th quarter. Guidelines on the investigation process are in development.
3. ACCESSIBLE: Wait time for CCAC services

<table>
<thead>
<tr>
<th>What we want</th>
<th>Consequences if we don’t get it</th>
<th>To whom does this matter?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Short wait times and efficient care processes for CCAC services.</td>
<td>Long wait lists represent a barrier to accessibility for patients. In some cases a delay in providing care could result in a crisis and the need for more intensive forms of care.</td>
<td>Patients seeking accessibility to CCAC services in north eastern Ontario.</td>
</tr>
</tbody>
</table>

### Indicators and Trends for Wait Time for CCAC Services

![Wait Time for Patients Referred from Community Settings to Community Home Care](chart1)

- **Q3 Value:** 43 days
  - **2015-16 Target:** ≤48 days
  - **2014-15 Performance Standard:** <60 days

**Analysis:**
The metric is at 43 days which meets and exceeds the target. Each month data analysis is completed at a patient level to identify opportunities for further improvements.

**Quality Improvement Strategy:**
- A multi-prong tactical plan is being implemented with a continued focus on reducing patient wait times for therapy services
- We have been informed by the NE LHIN that the target will be less 21 days by March 31, 2018.

**Data Source:** Business Intelligence
- Business Intelligence > NE Reports > Indicators > Wait Time - 90th Percentile Community Referral to 1st Service
- M-SAA Quarterly Progress Report

### Q3 result: 55 days

**Quality Improvement Strategy:**
The “Access to Care Strategy for Therapy Services” aims to provide patients and children with quick access to high quality care. We are implementing solutions to reduce the wait time for therapy services.

Some of the quality improvement ideas include:
- Maximizing the use of OHIP funded physiotherapy clinics which are becoming operational across the NE (for patients who have the strength and mobility to access the clinics) as well as other sources of therapy such as Veterans Affairs Canada, WSIB, private insurance, Arthritis Society.
- Reducing travel time through geographic assignment of therapy staff
- Documenting in CHRIS and using integrated eform templates to speed up documentation
## Indicators and Trends for Wait Time for CCAC Services

### Therapy (SRC 92) Waitlist

<table>
<thead>
<tr>
<th>Month, Year</th>
<th>OT</th>
<th>PT</th>
<th>SW</th>
<th>SLP</th>
<th>Nutrition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jan '16</td>
<td>700</td>
<td>600</td>
<td>500</td>
<td>400</td>
<td>300</td>
</tr>
<tr>
<td>Feb '16</td>
<td>650</td>
<td>550</td>
<td>450</td>
<td>350</td>
<td>250</td>
</tr>
<tr>
<td>Mar '16</td>
<td>600</td>
<td>500</td>
<td>400</td>
<td>300</td>
<td>200</td>
</tr>
<tr>
<td>Apr '16</td>
<td>550</td>
<td>450</td>
<td>350</td>
<td>250</td>
<td>150</td>
</tr>
<tr>
<td>May '16</td>
<td>500</td>
<td>400</td>
<td>300</td>
<td>200</td>
<td>100</td>
</tr>
<tr>
<td>Jun '16</td>
<td>450</td>
<td>350</td>
<td>250</td>
<td>150</td>
<td>50</td>
</tr>
<tr>
<td>Jul '16</td>
<td>400</td>
<td>300</td>
<td>200</td>
<td>100</td>
<td>0</td>
</tr>
<tr>
<td>Aug '16</td>
<td>350</td>
<td>250</td>
<td>150</td>
<td>50</td>
<td>0</td>
</tr>
<tr>
<td>Sep '16</td>
<td>300</td>
<td>200</td>
<td>100</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Oct '16</td>
<td>250</td>
<td>150</td>
<td>50</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Nov '16</td>
<td>200</td>
<td>100</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Dec '16</td>
<td>150</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

### Data Source:
Business Intelligence

### Analysis and Ideas for Improvement

- Implementing a small “short stay” rehabilitation team of care coordinators to reduce the patient waiting time

### Wait Time (Days) from Hospital Discharge to Service Initiation

<table>
<thead>
<tr>
<th>Quarter, Fiscal Year</th>
<th># of Days</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1 14-15</td>
<td>8</td>
</tr>
<tr>
<td>Q2 14-15</td>
<td>6</td>
</tr>
<tr>
<td>Q3 14-15</td>
<td>4</td>
</tr>
<tr>
<td>Q4 14-15</td>
<td>2</td>
</tr>
<tr>
<td>Q1 15-16</td>
<td>10</td>
</tr>
<tr>
<td>Q2 15-16</td>
<td>8</td>
</tr>
<tr>
<td>Q3 15-16</td>
<td>6</td>
</tr>
<tr>
<td>Q4 15-16</td>
<td>4</td>
</tr>
<tr>
<td>Q1 16-17</td>
<td>2</td>
</tr>
</tbody>
</table>

### Data Source:
Ministry of Health and Long-Term Care, MSAA Indicators, MSAA 1.1.access_wt1

This M-SAA indicator defined by the LHIN measures the number of days from the hospital discharge date to the first non-case management service for patients whose referral source was the hospital.

### Analysis:
This result does not meet the established target and performance standard for Q1, 2016-17, the most recent data available. Further analysis is not possible without access to the actual data sources.

### Note:
The CCAC sector is dependent on the Ministry of Health and Long-Term Care for this data. CCAC is not able to replicate baseline numbers and identifies a large variance in referral to counts. Six month or more delay in data availability impacts reporting abilities.


<table>
<thead>
<tr>
<th>Indicators and Trends for Wait Time for CCAC Services</th>
<th>Analysis and Ideas for Improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>5 Day Wait Time - Nursing Visits</td>
<td>🌟 Quality Improvement Plan</td>
</tr>
<tr>
<td>Percentage of Patients Served Within 5 Days of</td>
<td><strong>Objective:</strong> To reduce service wait times</td>
</tr>
<tr>
<td>Service Authorization</td>
<td><strong>Outcome measure/indicator:</strong> 5-day wait time for Home Care service measured from Initial Authorization Date by Care Coordinator as start time to First Service Date as the end time.</td>
</tr>
<tr>
<td></td>
<td><strong>Note:</strong> these QIP indicators are defined by HQO and differ from the 5-day wait time indicators in the Balance Scorecard.</td>
</tr>
<tr>
<td></td>
<td><strong>Nursing Service:</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Q3 Result:</strong> 93.72%</td>
</tr>
<tr>
<td></td>
<td><strong>2016-17 Target:</strong> ≥ 95.0%</td>
</tr>
<tr>
<td></td>
<td><strong>2016-17 Performance Standard:</strong> ≥ 90.25%</td>
</tr>
<tr>
<td></td>
<td><strong>Personal Support – Complex Patient Only</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Q3 Result:</strong> 80.67%</td>
</tr>
<tr>
<td></td>
<td><strong>2016-17 Target:</strong> ≥ 95.0%</td>
</tr>
<tr>
<td></td>
<td><strong>2016-17 Performance Standard:</strong> ≥ 90.25%</td>
</tr>
<tr>
<td></td>
<td><strong>Analysis:</strong></td>
</tr>
<tr>
<td></td>
<td>The result for Nursing is within the performance standard though slightly below the target. The result for Personal Support does not meet the target and is not within the performance standard.</td>
</tr>
<tr>
<td></td>
<td>A contributing factor relates to each patient being available for care. Patients with complex needs often require pre-hospital discharge planning and advanced care planning before PSW services begin in the home. This proactive planning enables safe transitions from hospital to home. We have completed education sessions for care coordination teams to ensure the use of the “patient availability date” field in CHRIS and are tracking this performance indicator as well. Additionally we have been informed that the MOHLTC is considering changing this data definition next year to be measured to the patient availability date as the end time.</td>
</tr>
<tr>
<td></td>
<td>Refer to <a href="#">section 12</a> for a progress report on Q1 Quality Improvement plan change ideas.</td>
</tr>
<tr>
<td></td>
<td><strong>Data Source:</strong></td>
</tr>
<tr>
<td></td>
<td>Business Intelligence&gt;Indicators&gt;5 Day Wait Times</td>
</tr>
</tbody>
</table>

![5 Day Wait Time - Nursing Visits](image1)

100%
95%
90%
85%
80%
75%
70%
65%
60%
55%
50%
45%
40%
35%
30%
25%
20%
15%
10%
0%

Quarter, Year
Q4 14-15
Q1 15-16
Q2 15-16
Q3 15-16
Q4 15-16
Q1 16-17
Q2 16-17
Q3 16-17

![5 Day Wait Time - Personal Support for Complex Patients](image2)

100%
95%
90%
85%
80%
75%
70%
65%
60%
55%
50%
45%
40%
35%
30%
25%
20%
15%
10%
0%

Quarter, Year
Q4 14-15
Q1 15-16
Q2 15-16
Q3 15-16
Q4 15-16
Q1 16-17
Q2 16-17
Q3 16-17

Refer to [section 12](#) for a progress report on Q1 Quality Improvement plan change ideas.
4. ACCESSIBLE: Access to long-term care home

<table>
<thead>
<tr>
<th>What we want</th>
<th>Consequences if we don’t get it</th>
<th>To whom does this matter?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Short wait times to get into a long-term care home.</td>
<td>If the person is waiting at home, a heavy burden could be placed on loved ones who are caring for the individual. If the person is waiting in hospital, the hospital bed is used unnecessarily, which can lead to emergency department overcrowding and wasted resources.</td>
<td>Patients in north eastern Ontario who are currently on the wait list for placement into a long-term care home, along with their families and caregivers.</td>
</tr>
<tr>
<td>People get their first choice of long-term care home.</td>
<td>Being placed in a second or third choice home may mean being placed further away from loved ones or in a home that does not specialize in meeting one’s ethnic, cultural or medical needs. Residents can move to a higher-ranked choice later, but that can be inconvenient and disruptive to the residents’ continuity of care.</td>
<td></td>
</tr>
</tbody>
</table>

### Indicators and Trends for Access to Long-Term Care Home

As of December 31, 2016, patients on wait list including transfers: 2739

The number of individuals making application and waiting for initial placement has steadily increased since January 2014 and continues to exceed the number of available beds in Long-Term Care Homes (LTCH). Fluctuations of the wait list are based on the number of applications pending for placement and the number of available LTCH beds at any point in time. This metric also includes patients admitted to a LTCH and waiting for transfer to their first choice.

Across the North East, there are currently 91 crisis patients waiting from community, 14 waiting from LTCHs for their 1st choice and 26 waiting from hospitals.

**Data Source:** Business Intelligence > NE Reports > Care Coordination > Placement > Placement Waitlist
### Indicators and Trends for Access to Long-Term Care Home

<table>
<thead>
<tr>
<th>Month, Year</th>
<th>% Placed to 1st Choice of LTC Home</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jan '16</td>
<td></td>
</tr>
<tr>
<td>Feb '16</td>
<td></td>
</tr>
<tr>
<td>Mar '16</td>
<td></td>
</tr>
<tr>
<td>Apr '16</td>
<td></td>
</tr>
<tr>
<td>May '16</td>
<td></td>
</tr>
<tr>
<td>Jun '16</td>
<td></td>
</tr>
<tr>
<td>Jul '16</td>
<td></td>
</tr>
<tr>
<td>Aug '16</td>
<td></td>
</tr>
<tr>
<td>Sep '16</td>
<td></td>
</tr>
<tr>
<td>Oct '16</td>
<td></td>
</tr>
<tr>
<td>Nov '16</td>
<td></td>
</tr>
<tr>
<td>Dec '16</td>
<td></td>
</tr>
</tbody>
</table>

#### Analysis and Ideas for Improvement

Jan 2016 to Dec 2016 Average for placement in 1st choice LTC Home: 57.2%

The percentage of patients placed into their 1st choice of LTC home remained consistent and within normal variation in the 12-month period from January 2016 to December 2016.

**Data Source:** Business Intelligence > SSRS Report List > Indicators > Other Misc. Indicators > LT Placements by Ranking
### 5. EFFECTIVE: Keeping people healthy in home care

<table>
<thead>
<tr>
<th>What we want</th>
<th>How to get it</th>
<th>Consequences if we don’t get it</th>
<th>To whom does this matter?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients receive effective home care to improve their</td>
<td>Promote activities to maintain health and independence (e.g. preserving bladder function and</td>
<td>Patients experience loss of independence, reduced quality of life through admissions and/or</td>
<td>All CCAC patients</td>
</tr>
<tr>
<td>health, maintain it or prevent deterioration to avoid</td>
<td>mobility, controlling pain, preserving communication ability, memory and thinking abilities and</td>
<td>readmissions to hospital and/or admission to long-term care home.</td>
<td></td>
</tr>
<tr>
<td>hospitalization and/or admission to long-term care</td>
<td>avoiding depression and weight loss).</td>
<td></td>
<td></td>
</tr>
<tr>
<td>homes.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Analysis and Ideas for Improvement

Q3 Value (as of December 31, 2016): 69.80%*  
Target: ≥ 60%  
Performance Standard: < 60%

The percentage of complex patients who are maintained in their home exceeded the target and performance standard in December 2016.

With the support of enhanced personal support services and more intensive care coordination, complex patients are able to remain in their homes for longer, following discharge from hospital.

*Note: the data source for this metric changed as of April 2015. The graph has been updated to reflect the results based on the new Business Intelligence report. The metric for this report is being reviewed by Business Intelligence.

**Data Source:** Business Intelligence>BSC and MSAA Reporting>M-SAA and LHIN Reporting>M-SAA 2014-17>Percentage of Complex Clients Remaining in the Community for 60 Days Post Hospital Discharge (using ED Notification data)
**EFFECTIVE**

**Indicators and Trends for Keeping People Healthy in Home Care**

### Patients placed in LTC Home with MAPLe SCORES High or Very High (i.e. appropriately)

- **Q3 Value:** 81%
  - This is now an explanatory indicator on the 2016-17 M-SAA. There is no longer a target or performance standard.

- **Analysis:**
  - The percentage of patients placed in LTC Homes with MAPLe scores High or Very High in Q3 has remained the same as in Q2.
  - Most people placed into a LTC home have very heavy needs that require them to be in that type of setting; however, one in five people placed in LTC have relatively lighter needs.

- **Ideas for Improvement:**
  - The community crisis escalation process assists with ensuring that the most appropriate patients are placed into LTC. Ongoing monitoring of MAPLe scores continues.

**Data Sources:**
- Business Intelligence > NE Reports > Indicators > MSAA 2014-2017 > Patients Placed in LTC with MAPLe High or Very High as Portion of Total Patients Placed

### Patients with MAPLe scores high and very high living in the community supported by CCAC

- **Q3 Value:** 4301 patients
  - This is now an explanatory indicator on the 2016-17 M-SAA. There is no longer a target or performance standard.

- **Analysis:**
  - The number of patients with high and very high MAPLe scores living at home with CCAC support continues to grow.
  - Our complex patients typically have high to very high maple scores. As the overall number of complex patients increases, so does the number that we are able to maintain in the community with enhanced services and intensive care coordination supports.

**Data Source:** M-SAA Quarterly Progress Report to the NE LHIN: (2014-2017)
EFFECTIVE

<table>
<thead>
<tr>
<th>Indicators and Trends for Keeping People Healthy in Home Care</th>
<th>Analysis and Ideas for Improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>NE LHIN ALC Acute Rate</strong></td>
<td>Q3 report of Q2 result: average: 22.1% (report is for previous quarter)</td>
</tr>
<tr>
<td>4 Hub Hospitals</td>
<td>Target: ≤18%</td>
</tr>
<tr>
<td></td>
<td>Performance Standard: &lt;19.8%</td>
</tr>
<tr>
<td><img src="chart1.png" alt="" /></td>
<td>Analysis:</td>
</tr>
<tr>
<td></td>
<td>The Q2 average ALC-Acute rate for the 4 Hub Hospitals does not meet the target and is outside the performance standard for 2016-17.</td>
</tr>
<tr>
<td></td>
<td>Ideas for Improvement:</td>
</tr>
<tr>
<td></td>
<td>• The NELHIN has coordinated an ALC strategy framework education session with Toronto Central CCAC/LHIN which took place in November, 2016. Four HUB hospitals, in collaboration with NECCAC, will be completing their respective acute and CCAC ALC framework inventories and identifying key priorities by the end of February, 2017. These strategies will become priorities on the local ALC Committee work plans for 2017-18.</td>
</tr>
<tr>
<td></td>
<td>• Local ALC Steering Committees continue to meet regularly to identify opportunities for addressing system gaps.</td>
</tr>
</tbody>
</table>

**Data Source:** M-SAA Quarterly Progress Report to the NE LHIN (H1) (2014-2017)

**Quality Improvement Plan**

<table>
<thead>
<tr>
<th>Unplanned, Less Urgent Emergency Department Visits Within 30 Days of Discharge from Hospital</th>
<th>Q3 2016-17 Result: not available</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Last Available Result: 12.5% (Q1 2016-17)*</td>
</tr>
<tr>
<td></td>
<td>Target: ≤ 12.5%</td>
</tr>
</tbody>
</table>

**Analysis:**

The Q1 result meets the target for 2016-17. The 4-quarter total result for Q2 2015-16 to Q1 2016-17 remains at 13.7%, same as the previous 4-quarter result. Local results for Q3 indicate that 22.5% of patients visited the Emergency Department within 30 Days of discharge from hospital. Some of these may have been planned visits.

**Ideas for Improvement:**

The NECCAC is working with a rural and HUB hospital to review, analyze and identify root causes of emergency room visits by CCAC patients. The hospitals are Timmins and District Hospital and MICs Group of Health Services.

Another change idea is to ensure that wound care patients are on the appropriate clinical pathway to avoid unnecessary ED visits. Refer to section 12 for
### Indicators and Trends for Keeping People Healthy in Home Care

<table>
<thead>
<tr>
<th>Quarter, Year</th>
<th>Unplanned Hospital Readmissions Within 30 Days of Hospital Discharge</th>
</tr>
</thead>
<tbody>
<tr>
<td>1Q 15-16</td>
<td>Percentage of Home Care Patients</td>
</tr>
<tr>
<td>10%</td>
<td>12%</td>
</tr>
</tbody>
</table>

#### Analysis and Ideas for Improvement

A progress report on Q3 Quality Improvement plan change ideas.

**Data Source:**
- OACCAC Reporting Site: CCAC Metrics for Quality Improvement Plan
- NE CCAC Business Intelligence reports

Note: The CCAC sector is dependent on the Ministry of Health and Long-Term Care for this data. Delay in data availability will impact reporting abilities.

#### Quality Improvement Plan

**Q3 2016-17 Result:** not available  
**Last Available Result:** 17.8% (Q1 2016-17)*  
**Target:** ≤ 17.2%

**Analysis:**

The Q1 result is slightly over the target. The result for the four-quarter period from Q2 2015-16 to Q1 2016-17 is 17.8%, slightly above the 2016-17 target. Local results for Q3 indicate that 14.27% of patients were readmitted to hospital 30 Days of hospital discharge.

**Ideas for Improvement:**

The NECCAC is working with a rural and HUB hospital to review, analyze and identify root causes of hospital readmissions of CCAC patients within 30 days of discharge from hospital. The hospitals are Timmins and District Hospital and MICs Group of Health Services.

Other Quality Improvement Plan change ideas, along with a progress report for Q3, are noted in section 12 and include:

- Telehomecare,
- Rapid Response Nursing
- Hospital to Home program.

**Data Source:**
- OACCAC Reporting Site: CCAC Metrics for Quality Improvement Plan
- NE CCAC Business Intelligence reports

Note: The CCAC sector is dependent on the Ministry of Health and Long-Term Care for this data. Delay in data availability will impact reporting abilities.
### SAFE: Avoiding harm in home care and the community

<table>
<thead>
<tr>
<th>What we want</th>
<th>How to get it</th>
<th>Consequences if we don’t get it</th>
<th>To whom does this matter?</th>
</tr>
</thead>
<tbody>
<tr>
<td>No risk events and complete patient records to identify high risk patients</td>
<td>Implement preventative measures to minimize risk events to the extent possible. Monitor completeness of patient records.</td>
<td>Risk of temporary or permanent disability and death; more emergency department visits and hospitalizations. High risk patients may not get the help they need in an emergency/disaster situation</td>
<td>All patients, caregivers and family members. Those identified as long-stay home care patients are at particular risk.</td>
</tr>
</tbody>
</table>

#### Indicators and Trends for Avoiding Harm in Home Care and the Community

**Total Number of Patient Risk Events per 1000 Patients R12 Jan-16 to Dec-16**

- **Analysis and Ideas for Improvement**
  - **Q3 Result:** 3.54 risk events per 1000 patients (average)
  - **Analysis:** The number of risk events reported per 1000 patients rose consistently throughout the quarter with a spike in December. This is slightly higher than normal activity. The rise cannot be attributed to any one element.
  - **Ideas for Improvement:** The training for the new REFS system was rereleased with improvements based upon suggestions received from users. Also, the Policy & Procedure Guide has been updated to reflect the updates (to be released 4th quarter).
  - **Data Source:** Risk Event and Feedback System (Legacy REFS Report 10-005; New 00179)

- **Top 5 Patient Risk Events by Specific Event Type Jan-16 to Dec-16**
  - **Analysis:** The top 5 reported categories remain the same while the overall reporting has increased slightly over last quarter. Quality and consistency of Service/Care Delivery remains the top reported event type.
  - **Ideas for Improvement:** The infusion committee released the independent double check process and documentation for high risk medications in the 3rd quarter. Plans to create a monitoring system for that process are in place. Also, consistency in training for nurses in the community regarding infusion is being examined.
  - **Data Source:** Risk Event and Feedback System (Legacy REFS Report 06-003, New 00161)
SAFE

Indicators and Trends for Avoiding Harm in Home Care and the Community

<table>
<thead>
<tr>
<th>Risk Level</th>
<th>Definitions</th>
</tr>
</thead>
</table>
| Very High  | • There is significant uncontrolled risk to the patient or organization.  
|            | • The situation requires the immediate attention of senior leaders for comprehensive corrective action and resolution.  
|            | • Escalation to at least the Senior Director level is mandatory for resolution. |
| High       | • There is significant risk to the patient or organization that requires corrective action to prevent recurrence in the future.  
|            | • Escalation to at least the Director level is required for resolution. |
| Medium     | • There is unresolved risk to the patient or organization that requires attention.  
|            | • Formal corrective actions are not mandatory but highly recommended to prevent recurrence in the future.  
|            | • Escalation to the Manager level is required for resolution. |
| Low        | • There is some risk to the patient or organization but the situation can be resolved through normal existing procedures.  
|            | • Corrective action is not required but may be developed if deemed necessary.  
|            | • Authority for resolution remains at the front line level and escalation may be required if deemed necessary. |
| Very Low   | • There is little risk to the patient or organization with no specific corrective action required.  
|            | • Correction of the issue is within authority of the front line staff involved and does not necessarily require escalation. |

Analysis and Ideas for Improvement

**Analysis:**
Of the 177 patient risk events reported in Q3, 9 were reported as “high” (5.0%), 49 were reported as “medium” (27.6%) and 91 were reported as “low” (51.4%). The remaining 28 reports were reported as being “very low” and “very low” (15.8%). Although the breakdown by percentage was relatively consistent, there was an overall rise in reports for the quarter.

The 9 reported as “high” were categorized as follows:
- Medication/Fluid Errors - 6
- Clinical Administration - 1
- Access - 1
- Safety/Security - 1

**Note:** Missed visits causing patient harm are documented in the Risk Event and Feedback System (REFS) whereas missed visits where there is no patient harm are captured in CHRIS.

**Ideas for Improvement:**
Medication management continues to present significant challenges in the community. The Infusion work group continues to work toward solutions and improvements related to independent double checks of high risk medications and consistency in training among nurses in the community.

**Data Source:**
- Risk Event and Feedback System (Legacy REFS Reports 10-007/10-023, New 00164/00181)
### Quality Improvement Plan

**Objective:** The incidence of falls in adult long-stay home care patients will be reduced.

**Outcome Measure/Indicator:** Percentage of long-stay patients who record a fall on follow-up RAI HC assessment.

**Target:** 37.0%

**Q3 Result:** 35.86%

**Analysis:**

The current rate of 35.86% meets and exceeds the QIP target. The patient population that is included in this metric has seen a significant increase in the average RAI score. It is not unreasonable that these increasingly complex patients will have a higher rate of falls even with the success of the falls prevention program.

**Improvement Initiatives:**

- Care Coordination staff are completing home safety assessments as part of their home visit.
- Medication review for high risk patients is also being done.

Patients are referred to therapy for mobility and assistive devices, as appropriate.

**Data Source:**

- OACCAC Members Portal, Reporting Site, MSAA Indicators 2011-2014 Reports
- Business Intelligence: Home Safety Risk Assessment Report

---

### Indicators and Trends for Avoiding Harm in Home Care and the Community

#### Prevalence of Falls for Adult Long-Stay Home Care Clients

![Graph showing prevalence of falls for adult long-stay home care clients]

<table>
<thead>
<tr>
<th>Quarter, Year</th>
<th>Percentage of Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q4 14-15</td>
<td>25%</td>
</tr>
<tr>
<td>Q1 15-16</td>
<td>30%</td>
</tr>
<tr>
<td>Q2 15-16</td>
<td>35%</td>
</tr>
<tr>
<td>Q3 15-16</td>
<td>40%</td>
</tr>
<tr>
<td>Q4 15-16</td>
<td>45%</td>
</tr>
<tr>
<td>Q1 16-17</td>
<td>50%</td>
</tr>
<tr>
<td>Q2 16-17</td>
<td>40%</td>
</tr>
<tr>
<td>Q3 16-17</td>
<td>35%</td>
</tr>
</tbody>
</table>

**Analysis:**

BETTER
7. PATIENT-CENTRED: Meeting patients’ needs and preferences

<table>
<thead>
<tr>
<th>What we want</th>
<th>Consequences if we don’t get it</th>
<th>To whom does this matter?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients who are satisfied with the services that they receive from the NE CCAC and our service providers.</td>
<td>Dissatisfied patients. Potential for internal and external appeals, legal proceedings, and loss of reputation.</td>
<td>Patients, caregivers, family members, NE CCAC staff and service providers.</td>
</tr>
</tbody>
</table>

**Patient-Centered Indicators and Trends**

**Analysis and Ideas for Improvement**

**Q3 Result:** 2.44 complaints per 1000 patients (average)

**Analysis:**
The overall rate of complaints documented per 1000 patients in Q3 was higher than previous reporting periods.

**Ideas for Improvement:**
A significant number of complaints involve provision of medical equipment. Quality and Risk is working more closely with equipment providers through the Performance Relations department to address complaints specific to equipment.

**Data Source:** Risk Event and Feedback System (Legacy REFS Report 01-001, New 00160)

**Analysis:**
The top 5 types of complaints in Q3 reflect report submissions to the new risk event and feedback system since October 2015.

**Ideas for Improvement:**
Quality and Risk attended Service Provider Quarterly meetings arranged via the Performance Management Department to discuss and clarify the need to respond to the complainant and offer an explanation and/or an apology, as appropriate. This is an important part of the communication loop with patients to improve patient relations.

**Data Source:** Risk Event and Feedback System (Legacy REFS Report 01-002, New 00192)

Note: The data source for this metric has changed as of October 1, 2015. The graph has been updated to reflect the results based on the new risk event and feedback system (Intelex) and only includes data from the last quarter.
## Patient-Centered Indicators and Trends

### Analysis and Ideas for Improvement

**Analysis:**
In Q3, there were a total of 126 complaints of which 26 (20.6%) were medium, 82 (65.1%) were low and 18 (14.3%) were very low in nature.

Although the volume for this quarter was slightly higher, the overall percentage of complaints by risk level remained fairly consistent. There were no complaints with a high or very high risk level.

**Data Source:** Risk Event and Feedback System (Legacy REFS Report 01-001/10-024, New 00160/00180)
The data source for this metric has changed as of October 1, 2015. The graph has been updated to reflect the results based on the new risk event and feedback system (Intelex).

### Patient-Centered Indicators and Trends

<table>
<thead>
<tr>
<th>Risk Level</th>
<th>Definitions</th>
</tr>
</thead>
</table>
| Very High    | • There is significant uncontrolled risk to the patient or organization.  
• The situation requires the immediate attention of senior leaders for comprehensive corrective action and resolution.  
• Escalation to at least the Senior Director level is mandatory for resolution. |
| High         | • There is significant risk to the patient or organization that requires corrective action to prevent recurrence in the future.  
• Escalation to at least the Director level is required for resolution.       |
| Medium       | • There is unresolved risk to the patient or organization that requires attention.  
• Formal corrective actions are not mandatory but highly recommended to prevent recurrence in the future.  
• Escalation to the Manager level is required for resolution.                  |
| Low          | • There is some risk to the patient or organization but the situation can be resolved through normal existing procedures.  
• Corrective action is not required but may be developed if deemed necessary.  
• Authority for resolution remains at the front line level and escalation may be required if deemed necessary. |
| Very Low     | • There is little risk to the patient or organization with no specific corrective action required.  
• Correction of the issue is within authority of the front line staff involved and does not necessarily require escalation. |
Patient-Centered Indicators and Trends

French-Language Services Complaints Reported in Risk Event and Feedback System

Analysis and Ideas for Improvement

Q3 Value: 0, Year-to-date: 0

Analysis:
The number of complaints about the provision of services in French remains very low with 0 patient complaints reported in the Risk Event and Feedback System in Q3. The chair of the French Language Services Operational Committee has sent a reminder to staff to document complaints from patients about not receiving services in French when that is their preferred language.

CCEE results are reported to the French-Language Services Operational Committee, as available.

Data Source:
• Risk Event and Feedback System

Number of Internal Appeals by Type Internal Appeals Committee

Q3 Value: 0, Year-to-date: 1

One request for Internal Appeal was received in the 1st quarter and it was later withdrawn.

<table>
<thead>
<tr>
<th>16/17 Fiscal Quarter</th>
<th>Number</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>In-Process</td>
</tr>
<tr>
<td>1st</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>2nd</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>3rd</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>4th</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>1</td>
<td>0</td>
</tr>
</tbody>
</table>

Data Source: Complaint Log (Action Line, MPP and Appeals)
Patient-Centered Indicators and Trends

Analysis and Ideas for Improvement

### Q3 Value: 0, Year-to-date: 0

<table>
<thead>
<tr>
<th>16/17 Fiscal Quarter</th>
<th>Number</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>In-Process</td>
</tr>
<tr>
<td>1st Quarter</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>2nd Quarter</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>3rd Quarter</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>4th Quarter</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

**Data Source:** Complaint Log (Action Line, MPP and Appeals)

In the 3rd quarter, there were 2 complaints from patients/families that were referred to the North East CCAC by the Long-Term Care Action Line.

**Data Source:** Complaint Log (Action Line, MPP and Appeals)

In Q3, there were 5 complaints/inquiries referred by MPP offices throughout the North East CCAC region and none from the NE LHIN.

**Analysis:**

The topics of the referred complaints or inquiries include:
- Placement (4)
- Other (1)

The Senior Director, Strategic Engagement followed up on all complaints/inquiries from MPPs.

**Data Source:** Complaint Log (Action Line, MPP and Appeals)
PATIENT CENTRED

Quality Improvement Plan

Objective: To improve client experience
Outcome Measure/Indicator: Percent of home care patients who responded “Good”, “Very Good”, or “Excellent” on a five-point scale to any of the patient experience survey questions:
   i) Overall rating of CCAC services
   ii) Overall rating of management/handling of care by Care Coordinator
   iii) Overall rating of service provided by service provider

Target: ≥ 90%
Performance Standard: > 85.0%
Annual Result (Apr 2015 to Mar 2016): 93.0%

Analysis:
The annual 2015-16 result meets and surpasses the target and is above the provincial overall result.
The 2016-17 semi-annual report covering the April to September 2016 time period is expected in early 2017.

Improvement Initiatives:
Refer to section 12 for a progress report on the following planned improvement initiatives:
   • Crucial Conversations staff training
   • Reception/Information & Referral

Client and-Caregiver Experience Evaluation (CCEE) Survey
KPI 1 - Overall Experience Annual Results

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>NE CCAC</td>
<td>93.8%</td>
<td>92.4%</td>
<td>92.1%</td>
<td>93.0%</td>
</tr>
<tr>
<td>Provincial Overall</td>
<td>92.9%</td>
<td>92.4%</td>
<td>92.2%</td>
<td>91.8%</td>
</tr>
</tbody>
</table>
8. **APPROPRIATELY RESOURCED: Healthy work environment**

<table>
<thead>
<tr>
<th>What we want</th>
<th>Consequences if we don’t get it</th>
<th>To whom does this matter?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Injury rates for healthcare workers as low as possible through proper safety training, inspections and organizational commitment to safety.</td>
<td>When workers are off work due to injury, both workload and stress increase for those who cover for injured workers. Workplace Safety and Insurance Board (WSIB) claims increase and premiums may rise. Injuries may result in staff turnover, which disrupts continuity of care and adds to recruitment expenses.</td>
<td>This directly affects all NE CCAC staff. It indirectly impacts all patients of the NE CCAC, due to possible disruption in continuity of care.</td>
</tr>
<tr>
<td>Higher job satisfaction for healthcare providers – by reducing stress, keeping workload reasonable and enabling good teamwork and leadership.</td>
<td>Dissatisfied workers may leave their jobs, leading to the problems associated with turnover noted above. Dissatisfied workers may also have more absenteeism and provide lower quality of care or less courteous care if they are feeling stressed or overworked.</td>
<td></td>
</tr>
</tbody>
</table>

### Indicators and Trends for Healthy Work Environment

#### Staff Safety
(Frequency of Occupational Health and Safety Incidents)

- **Rate of OH&S Incidents (%):**
  - Q4 14-15: 6.0%
  - Q1 15-16: 5.0%
  - Q2 15-16: 4.0%
  - Q3 15-16: 3.0%
  - Q4 15-16: 2.0%
  - Q1 16-17: 1.0%
  - Q2 16-17: 0.5%
  - Q3 16-17: 0.2%

- **Analysis and Ideas for Improvement:**
  - The **Staff Safety Indicator** is calculated as the percentage rate of occupational health and safety incidents reported per full-time equivalent in a given year - annualized and cumulative.
  - **Q3 Result:** 5.45%
  - **Target:** ≤ 8.0%
  - **Performance Standard:** < 10.0%

  - **Analysis:**
    - The Q3 Staff Safety Indicator result (annualized and cumulative) met and exceeded the target. There were 7 employee incidents including the following types:
      - Fall (3)
      - Motor Vehicle Accident: (2)
      - Slip/Trip (1)
      - Other (1)

  - **Prevention notes:**
    - Development of the prevention program to reduce slips, trips and falls, continues.
    - Three monthly Health and Safety Agenda items dealing with the following topics were published in Q3 for managers to share at their staff meetings:
      - October: 2016 On-Site Influenza Immunization Clinics
      - November: Slips, Trips and Falls
      - December: Safe Winter Driving

- **Data Source:** Health and Safety Report
### Indicators and Trends for Healthy Work Environment

#### Total Number WSIB Claims Compared to the Total Number of Incidents

<table>
<thead>
<tr>
<th>Fiscal Year, Quarter</th>
<th>Total # WSIB Claims</th>
<th>Total # Incidents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q4 2016</td>
<td>14</td>
<td>12</td>
</tr>
<tr>
<td>Q1 2017</td>
<td>10</td>
<td>8</td>
</tr>
<tr>
<td>Q2 2017</td>
<td>6</td>
<td>4</td>
</tr>
<tr>
<td>Q3 2017</td>
<td>10</td>
<td>8</td>
</tr>
<tr>
<td>Q4 2017</td>
<td>6</td>
<td>4</td>
</tr>
<tr>
<td>Q1 2018</td>
<td>10</td>
<td>8</td>
</tr>
<tr>
<td>Q2 2018</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>Q3 2018</td>
<td>10</td>
<td>8</td>
</tr>
<tr>
<td>Q4 2018</td>
<td>6</td>
<td>4</td>
</tr>
</tbody>
</table>

**Q3 Value:** 2 claims submitted to WSIB

**Analysis:**
There were 2 claims submitted of which both were accepted by WSIB. The # of WSIB claims in this period is the same as Q2.

**Ideas for Improvement:**
Human Resources staff are increasing their knowledge of WSIB claims management practices.

**Data Source:** Health and Safety Report

### Absenteeism, Number of Days per Eligible Employee (annualized)

<table>
<thead>
<tr>
<th>Quarter, Fiscal Year</th>
<th>Number of Days</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q4 2014</td>
<td>14</td>
</tr>
<tr>
<td>Q1 2015</td>
<td>10</td>
</tr>
<tr>
<td>Q2 2015</td>
<td>8</td>
</tr>
<tr>
<td>Q3 2015</td>
<td>12</td>
</tr>
<tr>
<td>Q4 2015</td>
<td>10</td>
</tr>
<tr>
<td>Q1 2016</td>
<td>8</td>
</tr>
<tr>
<td>Q2 2016</td>
<td>6</td>
</tr>
<tr>
<td>Q3 2016</td>
<td>10</td>
</tr>
<tr>
<td>Q4 2016</td>
<td>8</td>
</tr>
<tr>
<td>Q1 2017</td>
<td>6</td>
</tr>
<tr>
<td>Q2 2017</td>
<td>4</td>
</tr>
<tr>
<td>Q3 2017</td>
<td>10</td>
</tr>
<tr>
<td>Q4 2017</td>
<td>8</td>
</tr>
<tr>
<td>Q1 2018</td>
<td>6</td>
</tr>
<tr>
<td>Q2 2018</td>
<td>4</td>
</tr>
<tr>
<td>Q3 2018</td>
<td>10</td>
</tr>
<tr>
<td>Q4 2018</td>
<td>8</td>
</tr>
</tbody>
</table>

**Q3 Annualized Value:** 9.29 days

**Target:** 9 days

**Performance Standard:** 11 days

**Analysis:**
The Q3 result is slightly higher than the Q2 result.

**Ideas for Improvement:**
Continue guiding managers through pro-active sick leave, accommodation and attendance practices. A new disability management provider is now part of the program.

**Data Source:** HR Indicators
**Indicators and Trends for Healthy Work Environment**

**Turnover Rate (annualized)**

- Q3 Annualized Value: 5.88%
- Target: 9.6%
- Performance Standard: 12%

The Q3 turnover rate is slightly lower than the Q2 turnover rate.

**Notes:**
- Employee turnover excludes employees leaving at the end of an assignment period, casual employees and previous retirees.

**Data Source:** HR Indicators

---

**Staff Vacancies Exceeding 60 Days**

**Analysis:**
As of December 31, 2016, there were no vacant staff positions exceeding 60 days.

**Ideas for Improvement:**
Other staffing models are being considered for difficult to fill therapy positions.

**Data Source:** Staff Vacancy Report

**Goals:** To create a culture of safety within the organization.

<table>
<thead>
<tr>
<th>Objective</th>
<th>Key Initiatives / Activities</th>
<th>Measure / Indicator</th>
<th>Performance Target</th>
<th>Responsibility</th>
<th>Planned Start / End Date</th>
<th>Comments and Quarterly Report as of:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strengthen and reinforce the process of event investigation and disclosure within the NE CCAC to provide safer care to patients.</td>
<td>A documented and coordinated approach to investigating risk events is implemented.</td>
<td>Approved P&amp;P</td>
<td>Complete Y/N</td>
<td>C. Barnhart (Director, Quality &amp; Risk)</td>
<td>April 2016 - March 2017</td>
<td>December 31, 2016</td>
</tr>
<tr>
<td>An education module is developed to support and guide Care Coordination and Clinical Managers and Directors on conducting an effective investigation and analysis of risk events.</td>
<td>An educational strategy is developed.</td>
<td>Complete Y/N</td>
<td>C. Barnhart (Director, Quality &amp; Risk)</td>
<td>Apr 2016 - Mar 2017</td>
<td>Not started. Dependent on completion of key initiative noted above.</td>
<td></td>
</tr>
<tr>
<td>Disclosure education is updated and disseminated to Care Coordination and Clinical Services staff and management.</td>
<td>Disclosure education is updated</td>
<td>Complete Y/N</td>
<td>C. Barnhart (Director, Quality &amp; Risk)</td>
<td>Apr 2016 - Mar 2017</td>
<td>The disclosure policy and procedure has been updated. LMS training modules have been revised to align. A briefing note has been submitted to Senior Leadership to inform of mandatory training. Training has been assigned to clinical and care coordination staff and managers for completion by March 31, 2017.</td>
<td></td>
</tr>
<tr>
<td>At least one patient safety-related prospective analysis is carried out and appropriate improvements</td>
<td>A prospective analysis is carried out with respect to Patients at Risk of IV and Medication Errors.</td>
<td>Analysis complete</td>
<td>Complete Y/N</td>
<td>M. Musicco (Director, Clinical Services)</td>
<td>Apr 2016 - Mar 2017</td>
<td>Not started.</td>
</tr>
</tbody>
</table>

**Legend:**
- Green – Completed
- Yellow – Work started, not completed
- White – Planned, but not started
## PATIENT SAFETY PLAN PROGRESS REPORT

<table>
<thead>
<tr>
<th>Objective</th>
<th>Key Initiatives / Activities</th>
<th>Measure / Indicator</th>
<th>Performance Target</th>
<th>Responsibility</th>
<th>Planned Start / End Date</th>
<th>Comments and Quarterly Report as of: December 31, 2016</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Goal: To ensure the safe use of high risk medications.</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The NE CCAC ensures that high-alert medications are managed safely.</td>
<td>A documented and coordinated approach to safely manage high-alert medications is implemented. (ROP Medication Management 1.7)</td>
<td>Approved P&amp;P</td>
<td>Complete Y/N</td>
<td>M. Musicco (Director, Clinical Services)</td>
<td>April 2016-March 2017</td>
<td>The review of the medication management framework was conducted. Work plan has been created for the balance of the year to address findings. Medication Management Framework being updated.</td>
</tr>
<tr>
<td>The availability of certain medications as identified by Accreditation Canada, are evaluated and limited to ensure that formats with the potential to cause patient safety incidents are not stocked in patient service areas. (ROP Medication Management 2.7, 2.6, 2.8)</td>
<td>An audit of the medication management framework is completed for at least one branch. The audit will include inspecting patient service areas for concentrated electrolytes, heparin and narcotics.</td>
<td>Audit complete and findings documented</td>
<td>Complete Y/N</td>
<td>C. Barnhart (Director, Quality &amp; Risk)</td>
<td>April 2016-March 2017</td>
<td>Review complete and summary of findings submitted to Director of Clinical Services Sept. 12 2016.</td>
</tr>
<tr>
<td>The NE CCAC ensures a continuous quality improvement approach to IV medication safety.</td>
<td>Establish an SPO-CCAC IV Quality Improvement Sub-Committee to monitor and improve the safety of IV medication to CCAC patients.</td>
<td>Committee Terms of Reference and work plan developed</td>
<td>Complete Y/N</td>
<td>M. Musicco (Director, Clinical Services)</td>
<td>April 2016-March 2017</td>
<td>An Infusion sub group of the NECCAC/SPO CQI committee has been in operation looking at ways to mitigate risks. Terms of reference and a work plan are in place. There are 4 projects. The committee meets monthly. Work plan items all under way. Work group is on Clinical Services top priorities list for next fiscal.</td>
</tr>
<tr>
<td>Objective</td>
<td>Key Initiatives / Activities</td>
<td>Measure / Indicator</td>
<td>Performance Target</td>
<td>Responsibility</td>
<td>Planned Start / End Date</td>
<td>Comments and Quarterly Report as of: December 31, 2016</td>
</tr>
<tr>
<td>-----------</td>
<td>------------------------------</td>
<td>---------------------</td>
<td>--------------------</td>
<td>---------------</td>
<td>-------------------------</td>
<td>--------------------------------------------------</td>
</tr>
<tr>
<td>Goal: To create a worklife and physical environment that supports the safe delivery of care and service.</td>
<td>Patient safety training and education that addresses specific patient safety focus areas are provided at least annually to leaders, team members and volunteers. (ROP Leadership 10.9)</td>
<td>Crucial Conversations Training for Staff and Managers.</td>
<td># of staff and managers who complete the training</td>
<td>50</td>
<td>T. McDonald (Manager, Training and Development)</td>
<td>April 2016-March 2017</td>
</tr>
<tr>
<td>Goal: To reduce the risk of health-care associated infections and their impact across the continuum of care.</td>
<td>Compliance with accepted hand hygiene practices is measured and Hand Hygiene Education is provided to staff. (ROP IPAC-CB 8.1, 8.4)</td>
<td>Compliance with accepted hand-hygiene (HH) practices is measured through audits (home visit checklist) and results are shared with staff.</td>
<td># of home visit checklists completed</td>
<td>50</td>
<td>C. Barnhart (Director, Quality &amp; Risk)</td>
<td>April 2016-March 2017</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Hand hygiene refresher education is provided through the re-issue of the hand hygiene education module through the LMS.</td>
<td>Hand Hygiene Education Module re-issued to all staff and completion rate tracked</td>
<td>Complete Y/N</td>
<td>C. Barnhart (Director, Quality &amp; Risk)</td>
<td>April 2016-March 2017</td>
</tr>
</tbody>
</table>
### Objective

**Goal:** To identify and mitigate safety risks inherent in the patient population.

<table>
<thead>
<tr>
<th>Key Initiatives / Activities</th>
<th>Measure / Indicator</th>
<th>Performance Target</th>
<th>Responsibility</th>
<th>Planned Start / End Date</th>
<th>Comments and Quarterly Report as of: December 31, 2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>The NE CCAC is prepared for disasters and emergencies. <strong>(Leadership 14.0)</strong></td>
<td>Plan tested and findings documented</td>
<td>4 tests complete (Y/N)</td>
<td>C. Barnhart (Director, Quality &amp; Risk)</td>
<td>April 2016-March 2017</td>
<td>One test was completed involving the Voiceshot system. Minor findings of the system were identified and corrected.</td>
</tr>
<tr>
<td>One type of emergency or one element of the emergency preparedness plan is tested at least quarterly. <strong>(Leadership 14.5)</strong></td>
<td>Evacuations conducted and findings documented</td>
<td>Complete Y/N</td>
<td>C. Cacciotti (Director, Human Resources)</td>
<td>April 2016-March 2017</td>
<td>A detailed assessment has been completed and staff mobilized to support evacuation drills. Evacuation drills will be planned for Q4.</td>
</tr>
<tr>
<td>Annual evacuation drills are held for each branch. <strong>(Leadership 14.5)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Reference to Accreditation Canada standard and/or Required Organization Practice (ROP) noted in red font as applicable.
## 12. Quality Improvement Plan (QIP) Progress Report

<table>
<thead>
<tr>
<th>Objective</th>
<th>Planned improvement initiatives (Change Ideas)</th>
<th>Methods</th>
<th>Process measures</th>
<th>Goal for change ideas</th>
<th>Q3 Progress Report</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>To reduce avoidable hospital admissions among home care clients</strong></td>
<td>1) Telehomecare Program - Chronic Obstructive Pulmonary Disease/Chronic Heart Failure patients use equipment to monitor their vitals at home which is monitored remotely by a nurse. Patients are set with parameters for vital signs. Action is taken by the nurse when the patient’s vitals are outside of their parameters. Each care plan is individualized by patient needs and health coaching is provided to ensure patients are able to understand their disease and recognize and prevent exacerbations.</td>
<td>OTN produces and provides Program Leads with a monthly report from the THC database. The report details the # of patient’s in program who have received their first visit. This data is reviewed regularly by program leads and shared as needed. Further indicators are pulled from CHRIS as needed.</td>
<td># of patients enrolled in the Telehomecare Program</td>
<td>550 patients supported in this program (budgeted level)</td>
<td>441 patients enrolled from April 1 to December 31, 2016 (80% of target). On track to meet target. Working with OTN to trial new software vendor.</td>
</tr>
<tr>
<td></td>
<td>2) Rapid Response Nursing (RRN) - facilitate a smooth transition from hospital to home, prevent readmissions/admissions to hospital/Emergency Department of frail elderly patients with brittle support and diagnoses of Chronic Obstructive Pulmonary Disease/Chronic Heart Failure/Diabetes/Dementia/ Asthma/ Pneumonia</td>
<td>Through Business Intelligence, a CHRIS report is produced to show the average days to first visit from service assignment. The manager of this program reviews these reports regularly and data is available to all internal staff.</td>
<td>% of referred hospital patients served by a Rapid Response Nurse within 24 hours of hospital discharge</td>
<td>90% of referred hospital patients are served by a Rapid Response Nurse within 24 hours of hospital discharge</td>
<td>In Q3, 93% of patients received an RRN visit within 24 hours of hospital discharge.</td>
</tr>
<tr>
<td></td>
<td>3) Hospital to Home (H2H): facilitating a smooth transition from hospital to community for complex patients.</td>
<td>Through Business intelligence, a monthly report is produced to show LOS post hospital discharge.</td>
<td>% of complex patients who remained/remain in community for 30 days or more following hospital discharge</td>
<td>60% complex patients remain in community for 30 days or more (LOS ≥ 30 days)</td>
<td>Target met for all Chronic &amp; Complex patient populations: HSN = 88.89% SAH = 79.82% NBRHC = 68.81% TADH = 64.15%</td>
</tr>
<tr>
<td>Objective</td>
<td>Planned improvement initiatives (Change Ideas)</td>
<td>Methods</td>
<td>Process measures</td>
<td>Goal for change ideas</td>
<td>Q3 Progress Report</td>
</tr>
<tr>
<td>-----------</td>
<td>-----------------------------------------------</td>
<td>---------</td>
<td>-----------------</td>
<td>----------------------</td>
<td>-------------------</td>
</tr>
<tr>
<td>4) Continue to collaborate with one hub hospital (TADH) and one small hospital (MICs) to <strong>identify root causes of avoidable hospital readmissions</strong> by NE CCAC patients and to develop strategies that support hospital admission avoidance in the community.</td>
<td>Over a 3 to 6 month period (to be determined by the work group), unplanned hospital readmissions reports will be analyzed and reviewed by the designated work group (hospital and CCAC) for root cause trends and admission avoidance strategies.</td>
<td>Number of joint strategies identified to support hospital admission avoidance from community.</td>
<td>Completed analysis outlining root cause factors contributing to hospital readmissions during the designated time period with development of preliminary ideas for improvement; By Q3-4, potentially identified joint improvement ideas vetted for pilot implementation within communities engaged.</td>
<td>Meetings scheduled Feb 22/17. TADH &amp; MICs to bring data to this meeting for review and discussion (meetings prior to this have included NE CCAC data only).</td>
<td></td>
</tr>
<tr>
<td>To reduce the number of unplanned ED visits among home care clients</td>
<td>1) <strong>Wound Care Program</strong> - ensure patients receive leading practices in wound care using clinical pathways</td>
<td>A monthly report is generated from CHRIS to show patients on a clinical pathway. These reports are shared with service provider organizations and reviewed regularly as part of their performance metrics.</td>
<td>% of wound care patients on a clinical pathway</td>
<td>80% of wound care patients will be on a clinical pathway by Sep 30 2016</td>
<td>As of December 31, 2016, 89% of wound care patients are on a clinical pathway, exceeding the target.</td>
</tr>
<tr>
<td>2) Continue to collaborate with one hub hospital and one small hospital to understand the <strong>underlying causes</strong> of unplanned ED visits by CCAC patients and to develop strategies that support patient’s care needs in the home.</td>
<td>Monthly ED Notification Reports will be analyzed and reviewed by the designated work group (hospital and CCAC) for accuracy and to discover cause(s) of unplanned ED visits over a period of 3 to 6 months (to be determined by the work group).</td>
<td>Number of joint strategies identified to support ED avoidance from community.</td>
<td>Completed analysis outlining root cause(s) of patients returning to the ED during the designated period with preliminary ideas for improvement; By Q3-4, potentially identified joint improvement ideas vetted for pilot implementation within communities engaged.</td>
<td>Meetings scheduled Feb 22/17. TADH &amp; MICs to bring data to this meeting for review and discussion (meetings prior to this have included NE CCAC data only).</td>
<td></td>
</tr>
<tr>
<td>To improve client experience</td>
<td>1) <strong>Patient and Family Engagement Strategy</strong> development that will function into the future as CCAC’s transition to a new entity.</td>
<td>Patient and Family Engagement Strategy is developed in accordance with best practice and vetted with stakeholders for review.</td>
<td>Strategy document is developed and shared with the new entity for feedback; Implementation workplan developed collaboratively with the new entity.</td>
<td>Strategy developed and vetted by March 31 2017; Implementation plan developed by new entity the following year (future goal).</td>
<td>ON HOLD: Strategy &amp; Implementation plan will be developed by the new entity. Any further work on this topic will be led by the new entity at a timeline that they will determine.</td>
</tr>
<tr>
<td>Objective</td>
<td>Planned improvement initiatives [Change Ideas]</td>
<td>Methods</td>
<td>Process measures</td>
<td>Goal for change ideas</td>
<td>Q3 Progress Report</td>
</tr>
<tr>
<td>--------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>2) Crucial Conversations Training - support staff in effectively conducting difficult conversations with patients and families.</td>
<td>Roll-out and progress with this training program will be tracked and monitored regularly by Training and Development.</td>
<td># of staff who participated in the training.</td>
<td>50 staff are trained by December 31 2016.</td>
<td>At January 1, 2017, we have trained 121 staff in Crucial Conversations. We do not have any additional classes scheduled at this time in order to concentrate on transition activities.</td>
<td></td>
</tr>
<tr>
<td>3) Reception/Information and Referral - improve the patient journey by reducing unnecessary telephone hand-offs when contacting NECCAC; reducing the repetition of patient story and maximizing use of resources</td>
<td>Data will be pulled from CHRIS, Elevate, CCM Server and Prairie Fire. A monthly report will be produced. Care Coordination will review and analyze the data. Results will be shared with staff accordingly.</td>
<td>% of patients able to speak to a live voice when calling (no VM); % of staff trained in AIRS (American Information and Referral Standards)</td>
<td>85% Live Answer rate; 75% of staff AIRS trained by March 31, 2017</td>
<td>97% Answer Rate</td>
<td>100% of Staff trained in AIRS</td>
</tr>
</tbody>
</table>

To reduce falls among long-stay home care clients

1) Home Safety Risk Assessments - increase use of risk assessment as a teaching tool with patients about safety of the home environment.

2) Medication Reconciliation - ensure med rec completed for population identified as at risk of falls

To reduce service wait times

1) Understand the impact of patient and caregiver choice and availability for Patients receiving their first nursing service visit.

Conduct monthly data analysis for patients whose first visit is greater than 5 days. Use evidence to guide implementation of improvements.

% of patients who received their first visit within 5 days of their availability date

95% of patients received their first visit within 5 days of their availability date.

Data analysis is completed each month to identify reasons for delays in first service beyond 5 days. This includes a review of the patient record.

Q3 Result based on patient availability date:
Nursing Service: 98.1%
It is evident that patient and caregiver choice have a
<table>
<thead>
<tr>
<th>Objective</th>
<th>Planned improvement initiatives (Change Ideas)</th>
<th>Methods</th>
<th>Process measures</th>
<th>Goal for change ideas</th>
<th>Q3 Progress Report</th>
</tr>
</thead>
</table>
| 2) Understand the impact of patient and caregiver choice and availability for complex patients receiving their first personal support service visit. | Conduct monthly data analysis for patients whose first visit is greater than 5 days. Use evidence to guide implementation of improvements. | % of patients who received their first visit within 5 days of their availability date | 95% of patients received their first visit within 5 days of their availability date. | Q3 Result based on patient availability date:  
• Personal Support Service by complex patients: 96.2%  
It is evident that patient and caregiver choice have a significant influence on the number of days to first visit. Exceeding provincial target of 95%. Will continue to monitor monthly. |
b. Quality Framework and Enterprise Risk Management Framework

The Quality Framework outlines the NE CCAC’s commitment to quality improvement in the provision of patient services and a safe, productive workplace. The Framework is aligned with the NE CCAC’s vision, mission, strategic plan and operational plan as well as Accreditation Canada standards. It provides a strategic overview of the key principles and practices necessary for the effective planning, management, delivery and improvement of NE CCAC services.

The NE CCAC Enterprise Risk Management Framework (ERM) supports the identification, assessment, and mitigation of risks through a standardized and documented method.

c. Quality, Risk and Patient Safety Committee (Operational)

The Quality, Risk and Patient Safety Committee provides a mechanism to align enterprise-wide quality improvement, risk management and patient safety efforts occurring at an operational level with the organization’s strategic priorities. The Committee includes representation from a broad range of backgrounds and geographic regions to obtain regional views and perspectives, is chaired by the Director, Quality and Risk, and is accountable to the CEO.

The purpose of the Quality, Risk and Patient Safety Committee (operational) is to:

- Support a culture of quality, risk management, and patient safety at an operational level.
- Identify and remove barriers to patient safety and quality of care.
- Analyze organizational performance data and translate this data into meaningful opportunities for improvement.
- Support quality improvement initiatives.
- Identify strategies to mitigate enterprise-wide risks.

d. Patient Services and Quality Committee of the Board of Directors

This Committee provides governance oversight related to risk management in the areas of patient services, patient safety, human resources, ethics and health system partnerships. The Committee provides input into the development of the annual Quality Improvement Plan.

e. Patient Safety Plan

The Patient Safety Plan outlines the North East CCAC’s commitment to Patient Safety and supports the mission and vision through the practice of developing and implementing a culture of safety. The Patient Safety Plan details specific objectives, activities, indicators, responsibilities, and target dates to facilitate meeting the organization’s goals and objectives related to patient safety.

f. Quality Improvement Plan (QIP)

The Quality Improvement Plan (QIP) is an annual plan required under the Excellent Care for All Act. This legislation currently applies to hospitals and to the primary health care sector. A Ministry of Health and Long-term Care directive requires that every CCAC shall develop, make publicly available, and submit to Health Quality Ontario their first annual QIP by April 1, 2014 for the fiscal year 2014-2015 using standardized templates and guidance material. As recommended by the CCAC CEOs, the CCAC-specific QIP priority indicators are:

- Patient Experience – Percentage of “Good”, “Very Good” and “Excellent” Client Experience Survey responses on a 5 point scale (poor to excellent) to the three patient experience KP 1 survey questions:
  - Overall rating of CCAC Services;
APPENDIX A: ENTERPRISE-WIDE QUALITY AND RISK MANAGEMENT STRATEGIES

- Overall rating of management/handling of care by Care Coordinator;
- Overall rating of service provided by service provider. (Key Performance Indicator 1 – CM Services)

- 5 Day Wait Times for Nursing Services and PSW Services for Complex Patients
- Falls – Percentage of adult long-stay home care patients who record a fall on follow-up RAI-HC assessment.
- Hospital Readmissions – Percentage of home care patients who experienced an unplanned readmission to hospital within 30 days of discharge from hospital.
- Unplanned Emergency Department (ED) Visits – Percentage of home care patients with an unplanned, less-urgent ED visit within the first 30 days of discharge from hospital.

The NE CCAC QIP is approved by the Board of Directors and submitted to Health Quality Ontario by April 1st of each year.

g. Centre of Operational Excellence

A Centre of Operation Excellence is “A small team of...process improvement experts...who provide support to the business unit champions, process improvement initiative sponsors and leaders.” It is intended to provide the organization with:
1) Process improvement/LEAN curriculum;
2) Access to experts;
3) A repository of process improvement initiatives; and
4) A forum for Lean champions within portfolios.

In June 2016, to support the concept of a Centre of Operational Excellence and continue developing our culture of continuous quality improvement, a Process Improvement Advisor position was approved by the Executive Team on a temporary basis. This additional expertise builds capacity to develop and sustain a methodical approach to quality improvement using the Lean philosophy.

h. Insurance

The NE CCAC carries insurance protection through the Healthcare Insurance Reciprocal of Canada (HIROC).

i. NE LHIN Risk Reporting

Risks or opportunities that may influence achievement of objectives are identified during regular joint meetings with the NE LHIN.

j. Disaster/Emergency Response Planning

The NE CCAC Emergency Management Plan provides a systemic response to any emergency.

k. Pandemic Influenza Planning

The NE CCAC Pandemic Plan provides a systemic response in the case of a pandemic.

l. Document Control (Policies, Procedures and Forms)

The Policy and Procedure Manager software is used to manage policies, procedures and related documents developed to standardize processes within the NE CCAC. Each Senior Director of the Executive Team is accountable for the Table of Contents of their respective portfolio manual and is responsible for delegating, writing and/or editing policies, procedures and related documents to their Managers.
Forms are managed and housed on a SharePoint site. Using SharePoint allows for using electronic forms to their fullest capabilities, including fillable Word forms and InfoPath forms. The Forms Management Committee reviews all forms.

m. Risk Events and Feedback

The Risk Event and Feedback System (REFS) is a database that captures patient risk events and feedback (compliments and complaints), risk events affecting employees, service providers and other third parties, general feedback, health and safety hazards, non-conformances, as well as enterprise-wide risks. A REFS e-learning intranet site ensures that training materials are available to staff throughout the NE CCAC 24/7.

Risk event and complaint reporting is a challenge for many health care organizations with documented reports reflecting only the tip of the iceberg. Maximizing the overall value of the reporting system as a source of actionable data could be a helpful tool to improve patient safety and patient experience.

n. Quality and Risk Newsletter

The Quality and Risk Newsletter is a communication tool to inform all NE CCAC staff about quality and risk issues affecting the organization. The newsletter provides updates on issues related to current systems such as Policy and Procedure Manager, the Risk Event and Feedback System, Patient Safety topics and Accreditation.

o. Accreditation

The NE CCAC participated in the Accreditation Qmentum Survey from May 4-8, 2014 was Accredited with Commendation.

p. Internal Audit/Tracer Strategy

“An audit is a systematic, independent and documented process for obtaining audit evidence and evaluating it objectively to determine the extent to which audit criteria are fulfilled.” – ASQ Auditing Handbook

The NE CCAC supports internal auditing as an independent and objective assurance and consulting activity designed to add value and improve the NE CCAC’s operations. It assists the NE CCAC in accomplishing its objectives by bringing a systematic and disciplined approach to evaluate and improve the effectiveness of the NE CCAC’s risk management, control, leadership processes and delivery of client services.

q. Client and Caregiver Experience Evaluation (CCEE)

The provincial Client and Caregiver Experience Evaluation (CCEE) Provincial Committee oversees a coordinated approach of ongoing patient surveys to gather comparable information across and within individual CCACs about the satisfaction and experience of their patients, for the purpose of improving service and reporting to funders and the public. The surveys are currently completed by National Research Corporation Canada (NRCC) using a continuous sampling approach spread over four waves during a one year period. The survey tool has been revised and streamlined to reduce the number of questions and amount of time required for patients or caregivers to respond to the telephone survey.

Other survey components have also been developed by the provincial committee to evaluate services that are not in scope in the existing core survey, including the Caregiver Voice Survey of family members/caregivers of palliative/end of life patients following their death; Clinic Only patients; Patients Referred from Hospital Discharge; and Mental Health and Addictions Nursing program clients. These new surveys are optional for CCACs. The North East CCAC is not participating at this time.
APPENDIX B: DEFINITIONS

Healthcare Quality Improvement: “A broad range of activities of varying degrees of complexity and methodological and statistical rigour through which healthcare providers develop, implement and assess small-scale interventions, identify those that work well and implement them more broadly in order to improve clinical practice.”

MAPle Score: The MAPle score was developed to prioritize patients for access to CCAC services. Patients who have been assessed and have MAPle scores of high and very high represent the CCAC patients most in need of long term care placement.

Performance Indicator: A measurement that is linked to a strategic direction. It demonstrates progress towards a stated goal and identifies areas for improvement.

Performance Standard: A corridor or range around a performance target. It is established for variance reporting purposes. It takes into account expected variations such as statistical and seasonal fluctuations in performance. The Performance Standard is indicated by dashed red lines on the graphs.

Performance Target: Sets a goal to achieve. It is measurable and used to demonstrate progress towards a stated goal. The Performance Target is indicated by a solid red line on the graphs.

Quality in Healthcare: The nine attributes of a high-quality health system, as defined by Health Quality Ontario (HQO), are:

<table>
<thead>
<tr>
<th>ATTRIBUTES OF QUALITY</th>
<th>OUTCOMES</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACCESSIBLE</td>
<td>People should be able to get timely and appropriate healthcare services to achieve the best possible health outcomes.</td>
</tr>
<tr>
<td>EFFECTIVE</td>
<td>People should receive care that works and is based on the best available scientific information.</td>
</tr>
<tr>
<td>SAFE</td>
<td>People should not be harmed by an accident or mistake when they receive care.</td>
</tr>
<tr>
<td>PATIENT-CENTERED</td>
<td>Healthcare providers should offer services in a way that is sensitive to an individual’s needs and preferences.</td>
</tr>
<tr>
<td>EQUITABLE</td>
<td>People should get the same quality of care regardless of who they are and where they live.</td>
</tr>
<tr>
<td>EFFICIENT</td>
<td>The health system should continually look for ways to reduce waste, including waste of supplies, equipment, time, ideas and information.</td>
</tr>
<tr>
<td>APPROPRIATELY RESOUCED</td>
<td>The health system should have enough qualified providers, funding, information, equipment, supplies and facilities to look after people’s health needs.</td>
</tr>
<tr>
<td>INTEGRATED</td>
<td>All parts of the health system should be organized, connected and work with one another to provide high-quality care.</td>
</tr>
<tr>
<td>FOCUSED ON POPULATION HEALTH</td>
<td>The health system should work to prevent sickness and improve the health of the people of Ontario.</td>
</tr>
</tbody>
</table>

Risk: Anything of variable uncertainty and significance that interferes with the achievement of business strategies and objectives. Something goes wrong detracting from the organization’s purpose and the quality of its programs and services.

Risk Management: Risk Management is a systematic approach to identify, analyze and respond to risks. Most risks can be managed so that impact to the organization is minimized, mitigated or prevented entirely.

Root Cause: The underlying or original cause of an incident or problem.

---

The nine attributes that reflect a high performing health system are:

1. Accessible
2. Effective
3. Safe
4. Patient-centered
5. Equitable
6. Efficient
7. Appropriately resourced
8. Integrated
9. Focused on population health

To ensure that the NE CCAC is monitoring indicators across the spectrum of the definition of quality, the following section of the report has been organized to link indicators to the applicable attribute of quality.

For each attribute, from a NE CCAC perspective, there is a definition of “What we want”, “Consequences if we don’t get it” and “To whom does this matter?”.

For each indicator there is a mini-graph to indicate progress or lack of improvement over time. The actual indicator, performance corridor (range) and target are displayed on the graphs as shown in the example below:

As applicable, to the right of each graph there is an arrow indicating which direction is “better” for that particular indicator. As well, there is a brief summary of the current status of the indicator along with a brief analysis and ideas for improvement.
APPENDIX D: DATA SOURCES

The following data sources were used to compile the Quality, Risk and Patient Safety Report:

NE CCAC Business Intelligence
- 90th Percentile Wait Time for Patients Referred from Community Settings to Community Home Care
- Service Waitlist Analysis Report
- 5 Day Wait Time
- Total Long Stay Wait List, with Transfers (Placement Waitlist)
- % of Patients Placed to 1st Choice of LTC Home (LT Placements by Ranking)
- Hospital Readmissions and ED Visits
- Patients Placed in LTC with MAPLe High or Very High as Portion of Total Patients Placed
- Patients with MAPLe Scores High and Very High Living in the Community Supported by CCAC
- French-Language Related Complaints
- Balanced Scorecard
- Home Safety Risk Assessment Report


Ministry of Health and Long-Term Care,
- Wait Time (Days) from Hospital Discharge to Service Initiation (MSAA Indicators, MSAA 1.1.access_wt1)

Risk Event and Feedback System (REFS)
- Total Number of Risk events per 1000 Patients (denominator is based on monthly Caseload Snapshot)
- Number of Patient Risk Events by Specific Event Type (Top 5)
- Number of Patient Risk Events by Risk Level
- Total Number of Complaints per 1000 Patients
- Complaints by Risk Level
- Number of Complaints by Specific Type (Top 5)

Complaint Log (Action Line, MPP, NE LHIN and Appeals)
- Number of Internal and External Appeals
- Number of Internal Appeals by Type
- Number of External Appeals by Type (Health Services Appeal and Review Board)
- Number of Complaints Referred to the CCAC by the LTC Action Line
- Complaints/Inquiries Referred to NE CCAC by MPP Offices and NE LHIN

Occupational Health and Safety Incident Reports
- Total Number of Employee Incidents by Type
- Total Number of WSIB Claims Compared to the Total Number of Incidents

Human Resources Quarterly Reports
- Absenteeism, Number of Days per Eligible Employee (annualized)
- Turnover Rate (annualized)
- Staff Vacancies Over 60 Days

Evaluations
- National Research Corporation (NRC), Client and Caregiver Experience Evaluation (CCEE) Annual Results Year 4 (2015-16)