THE CHANGE FOUNDATION
HEALTH CARE DESERVES OUR FINEST THOUGHT

The Change Foundation

Quality Improvement in Home and Community Care
Research Agenda

Revised June 2009

Introduction

This paper describes The Change Foundation's research agenda in support of quality improvement in home and community care -- one of several areas of concentration committed to in the Foundation's strategic plan for 2007-2010.

In Ontario, recent quality improvement initiatives include: reports from the Ontario Health Quality Council monitoring the quality of health care in the province; hospital accountability agreements designed to support long-term planning and promote quality; and Cancer Care Ontario reports on cancer care quality. These represent a good beginning in the performance management aspect of quality improvement; however, there is a long way to go, and great opportunity, particularly in community care.

The Foundation zeroed in on quality improvement in home and community care in Ontario as an area needing attention, analysis, and action for several reasons. Successful health services and system integration – the Foundation's underlying focus – demands a better knowledge of the processes, performance and outcomes derived from services in the community and a clearer picture of how to link them to other services in a sensible way that works for the people who need them. In addition, the relative lack of data and information in this field means the Foundation is serving a real need, contributing to filling the many research gaps that exist.

To formulate this research agenda, the Foundation consulted experts, organized a roundtable discussion with stakeholders in May 2007, and conducted a literature review. Fragmentation of community and home-care services emerged as a recurrent theme during these discussions. In fact, this sector has suffered from fragmentation since its inception. Whether it is the lack of national policy, or standardized care, or communication between and among care providers, disconnects are apparent.

The Foundation will continue focusing its quality improvement initiatives around strengthening continuity of care between health-care sectors and contributing to building the evidence needed for better decision-making in home and community care. This agenda creates a synergy between the Foundation's two strategic themes – integration and quality improvement.

In July of 2008, the Foundation's quality improvement agenda got an enormous infusion of expertise and energy as the Ministry of Health and Long-Term Care's Ontario Health Performance Initiative chose to join The Change Foundation to create **The Centre for HealthCare Quality Improvement (CHQI) at The Change Foundation**. Operating arms-length from government, CHQI's commitment to improving the quality of health care through on-the-ground projects across the province aligns perfectly with the Foundation's new strategic directions focused on supporting the integration of health services and improving the quality of health services in the community. The partnership is a felicitous fit with a shared focus on accelerating the pace and widening the scope of quality improvement in health care in Ontario.

1. Improving the continuity of health care

A system ceases to be a system if it lacks or loses continuity. And despite much focus on the importance of providing Ontarians with an integrated health-care system, where "the right people get the right treatment in the right place at the right time", many patients still fall between the cracks. One of the causes of this disconnect is the lack of good transition planning from one health-care sector to another. With the demand for home-care/community services on the rise and hospital cost constraints, the need for good discharge planning from acute care hospital to home/community setting is more pressing than ever.

Every year over 1 million patients are discharged from acute care hospitals in Ontario. Effective transition processes would help ensure that patients are transferred to the most appropriate subsequent care destination in a timely manner. There is compelling evidence that in some parts of the province that is not always happening today:

- Patients often stay in hospitals long after their acute-care requirements have been met (ALC -Alternative Levels of Care).
- In 2007/8, Ontario had 2,500 hospital-bed equivalents used for alternative level of care (ALC) (CIHI, 2008).
- 58% of ALC days are spent preparing to return home or relocate to a Long-Term Care Home (Provincial Health Planning Database, 2005).

Delays are often caused by slow processes, complex or inadequate communication, and lack of timely information. The challenge of effective communication is that it involves a great number of stakeholders – for instance, patients, family and caregivers, clinicians, administration, long-term care homes, hospitals, and Community Care Access Centres (CCACs). But without solid methods of collaboration among the players, the transition process will not improve.

- Quality Improvement in Community Care through Integration Related Initiatives

The Foundation's first project under the quality improvement theme focused on one of the aspects of transition from acute care hospital to home/community care setting: decision-making around the subsequent destination of care.

In January 2008, the Foundation launched a project in partnership with the Ontario Association of Community Care Access Centres (OACCAC) to map out and identify the myriad interactions and decisions that patients and their families have to make after leaving the hospital. The project, "Having Their Say and Choosing Their Way", was implemented in two sites: Quinte Health Care and South East CCAC; and Toronto Western Hospital and Toronto Central CCAC. We heard from patients who no longer required acute care and were seeking care or accommodation either in long-term care facilities (both sites) or at home with home-care services (Toronto Western site). We learned about their placement circumstances, preferences, needs, and perspectives. An **interim report** is posted on our website**,** and final reports and related materials will be available on-line late summer 2009.

Building on this learning exercise the Foundation will now focus on building capacity for quality improvement in the community to improve integration of services for the elderly with chronic diseases. The project will map the current interaction between providers as well as clients/ caregivers, and will identify deficiencies and opportunities for improvement. Training in quality improvement strategies will enable providers to implement process improvements in their existing practice.

The project will be developed and implemented in partnership with the OACCAC, Community Provider Associations Committee, and the Centre for Healthcare Quality Improvement at The Change Foundation, and will be launched in the Fall of 2009.

- Implementing a Patient/Caregiver Navigation Tool

Whether they like it or not, clients and their informal caregivers are charged with the responsibility to navigate the system and manage their own care. We have learned from literature that this can be a daunting task since services are disconnected across providers and care systems (Howell, 2008). The Foundation will support testing a navigation tool specifically designed for clients and their informal caregivers with potential provincial application. The project will guide them through the appropriate home and community services.

2. Contributing to evidence-based decision-making in home/community care

In every sector of the health-care system, efforts are underway to improve the quality of care. A number of studies are in progress looking at quality indicators by assessing the structure, process, and outcomes of health care. Most of these initiatives aim to identify data gaps, and/or develop a common platform for communicating to different audiences. With the *Local Health System Integration Act*, performance measurement is instrumental in shaping priorities for providers and developing accountability agreements between LHINs and CCACs. The need for data on the quality of home care is long recognized, but reliable data is still not available for evidence-informed decision-making. Inconsistency of data makes home-care service evaluation difficult.

Establishing quality indicators for home-care services is a starting point for improving quality of services. Ontario started collecting information using the InterRAI tool (International Resident Assessment Indicators) for home care in 2001, capturing patient data at the point of admission to home-care programs or at hospitals prior to discharge. This tool captures data on care planning, eligibility screening, case mix, outcome measurement, and quality indicators. However, this wealth of information is underutilized in Ontario.

- **Understanding home-care utilization**

To build on this resource, the Foundation has commissioned a report on home-care services that will provide information to decision-makers on the trends and utilization of home-care services based on InterRAI –Home Care data analysis**.** A focus will be placed on data such as home-care service utilization trends by clients with Congestive Heart Failure (CHF) and re-admission rates after the patient is discharged from hospital

to community setting. (For preliminary results see **"Using interRAI Instruments to Understand Chronic Disease Management and ALC Patients"**. The findings of this project will be posted on our website.

- **Supporting informal caregivers**

The contribution of informal caregivers – an organic but undervalued part of the home-care workforce -- is not fully recognized and their needs as care providers are inadequately met. Studies suggest that 75-90% of home care is provided by this group (Health Canada, 2005). Higher acuity patients are discharged to informal caregivers without the skills to provide higher complexity care (Health Canada, 2004). Consistent and adequate quality of care for patients is one concern; the health of family members and caregivers is another; and there are many others.

Informal caregivers are with the clients in the centre of the healthcare system. Informal caregivers' multiple roles include nursing, physiotherapy, occupational therapy, navigation, psychosocial support and many more. Their role in ensuring continuity of services for elderly is tremendous. We need to understand the pressures, needs, and requirements of informal caregivers and provide them the necessary support if we want to ensure that they continue providing quality care to their loved ones and maintain their own health. To this end, the Foundation is planning to announce a number of initiatives:

a) Analysis of InterRAI data will help understand the informal caregiving arrangements of elderly who use home care, mental health or palliative services in order to determine whether the existence or lack of informal caregiving contributed to hospital admission and discharge. A report will be released in June 2010.

b) A policy synthesis will look at the current policy environment in which the informal caregivers provide care for their loved ones and will provide advice on the role of informal caregiving in supporting quality care and whether further supports are required in Ontario.

c) Finally, a competition for small grants to fill in knowledge gaps about the contribution of informal caregiving to quality will be announced early 2010**.** This program will focus on whether there are existing models of informal caregiver support that work and if so, whether they could be applied to Ontario.

d) Reporting on adverse events in home care

The Foundation has identified safety – a prerequisite to quality care -- as another area of its quality improvement direction. Although a number of seminal studies described adverse events (AEs) in acute hospitals, there is paucity of data on AEs after discharge. The increased demand on home-care services and increased complexity of care provided at home suggest an increased risk of adverse events in home/community care. More research is needed to understand the incidence of AEs in the home and design safeguards to prevent them.

The Change Foundation saw this as an opportunity to contribute to the discussion around safety in home and community care. We commissioned the Centre for Health Services and Policy Research at Queen's University to develop research priorities for patient safety initiatives in the community setting based on a workshop consultation of

over 40 researchers, policy makers and practitioners**.** Findings of this workshop were published in **Longwoods** in January 2009.

Building on this work the Foundation is in a process of building a partnership with the Canadian Patient Safety Institute (CPSI) to support an adverse event study in the home-care sector. Details about the progress of this initiative will be posted on our website in the Fall of 2009.

e) Communities of Practice for End-of-Life Care

In an effort to contribute to evidence-based decision making in the community sector and further our thinking about coordination of care, the Foundation will support a Community of Practice (CoP) for end-of-life care. This partnership with the Seniors Health Research Transfer Network (SHRTN) will enable palliative care providers across Ontario to share evidence-based best practice to coordinate and improve care for seniors in their final journey and develop common evaluative tools and processes.

Concluding Comments

The above projects mark the beginning of The Change Foundation's commitment to quality improvement in home and community care. The Foundation will continue to consult stakeholders and build partnerships to improve quality of care in the community. This is an evolutionary process dedicated not only to identifying quality improvement initiatives, but also to creating forums for discussion and exchanges of ideas.