

Having Their Say and Choosing Their Way Project

“I Don’t Know”

Report 1: People’s experience receiving home care after being hospitalized.



THE CHANGE FOUNDATION
HEALTH CARE DESERVES OUR FINEST THOUGHT



Executive Summary:

More and more Ontarians are struggling with the stress, confusion, and uncertainty of deciding on and finding the right care for themselves - or a loved one - when leaving hospital. People going home with home care lack clear and complete information so they can understand what is available to help them when they get home.

Value from the Patient/ Family Caregiver Perspective

Community Care Access Centres serve a range of client types. They provide home care to people with Alzheimer's and other dementia, children and families, palliative and end of life care, short term treatment and services to people with serious, often life-changing, medical conditions. Within this latter group, nine elderly patients discharged from medicine units of University Health Network (UHN)- Toronto Western, with home care, told investigators what helped and what was lacking in this journey. People have a common idea of what is important:

"The right care in my home starts by understanding me, and then delivers personal help to me and my family. With my changing situation, I need the information about my care and care options to be easy to find, understandable, accurate, and comprehensive."

People felt positive about the help they received that got them home from hospital, when they felt cared about, when the 'little things' were looked after, and when they received service in their language of choice.

Applying this value statement rigorously and throughout the entire process exposes four areas where deficiencies occur.

Deficiency # 1 :Clients and families are confused about home care

Deficiency # 2 :The care arranged didn't help

Deficiency # 3 :Impersonal approach

Deficiency # 4 :Little help with navigating system

The investigators conclude there are two main actions that would improve the experience of clients. Designing in more meaningful time with patients and, enhancing the information sharing methods for point-of-care information for *the entire community care team*.

We can see what the 'system' says is important by noting where time is spent in the current process. The process is highly oriented to collection and processing of information, and on maintaining a very complex approach to delivering services that is confusing to clients and their families.

Walking the 'shop floor' of the whole intake process tells us that at least ten minutes of time is spent processing information for every minute with the client. The processing system spans at least 35 forms, ten people, and nine databases.

A process redesigned to deliver personal help to the client and their family would include:

- **A more comprehensive understanding of the client at the beginning of the process**, to ensure that the client receives the most appropriate services, and that the family is being involved as per their abilities and desires. This takes time, and requires an orientation on delivering a *personal and*

helpful client experience, not just conducting assessments.

This will require a rethink of the tasks Care Coordinators, and others, are currently performing.

- **A sharing of clear information with the client about what they can expect.** This will require new information resources and knowledge for those *at the point of care*.
- **Strong intentional transfers of knowledge between care providers across the community care sector** that would include not only the clinical details of the client, but personal needs as well. It also would involve less paper and more social means (conversations) and real time tools (mobile technology). This would extend from hospital to the front line providers and back to hospital.

Health care providers are excellent at optimizing activities directly related to their scope of work. However, the limited focus of each player in the hospital-to-home care process disables activities from being easily enmeshed with those occurring later or at other locations. The result is the most common statement of interviewees being - ‘I don’t know’ - the title of the report. It is a direct result of front-line personnel who are ill equipped with information.

Many companies in other industries have had great success in reducing cost and driving up quality by more visibly and tightly coupling processes, even those that are highly complex and idiosyncratic. This can be done in the community care sector as well.

Report Organization

We studied two processes at two separate sites in Ontario. Each process has its own report:

Sites Involved	Report 1 'Hospital to Home Care' Transition	Report 2 'Hospital to LTCH' transition
<u>Toronto Central Region</u> Toronto Western Hospital + Toronto Central CCAC	√	√
<u>South East Region</u> Trenton Memorial Hospital + South East CCAC	X	√

In this document, Report 1, we examine the ‘hospital to home care’ transition.

Site Acknowledgements

The leadership of Toronto Western Hospital (TWH) and Toronto Central Community Care Access Center (TCCCAC) are to be congratulated. By opening their doors, and sharing access to the people they serve, and their staff, they are demonstrating leadership in quality improvement. This is not easy. However, this kind of courage will be what fuels the ongoing changes needed to transform and integrate health care in Ontario.

The project involved front line staff, management, and technical advisors at each site, from all related organizations, with project management provided by Doleweerd Consulting.

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1. Introduction

Having Their Say and Choosing Their Way is a project funded by The Change Foundation in partnership with the Ontario Association of Community Care Access Centers (OACCAC).

Purpose of the project

The purpose of 'Having Their Say and Choosing Their Way' project is to help funders and providers of care more deeply understand the experience of the client during the 'hospital to home care' transition. This transition takes place thousands of times each month in Ontario. If we understand the experience of some of these patients, we can think about the changes needed to make everyone's experience better.

The objective of this project is improvement. How people who are making the transition from 'hospital to home care' feel is a function of the design of the process, which spans many organizations. The CCAC Coordinators, Nurses, Personal Support Workers, Discharge Planners and Therapists working within each individual organization are what make the process bearable for those going through it.

Two principal client experiences are explored: the transition from hospital to long-term care home and from hospital back to home, with home care. We interviewed patients who had left specific hospital inpatient units in Toronto and South East Ontario. Jeff Doleweerd and Tim Berezny are the authors of this report, having been involved in all stages of the initiative.

This report presents its findings using the following structure:

- Specifying what 'value' means to the client
- Identifying deficiencies in the process that were experienced by the client and family
- Determining how *capable* the process is of providing value
- Providing observations and suggestions for improvement for the hospital, CCAC, service provider agencies, vendors, Local Health Integration Network (LHIN) and Ministry of Health and Long-Term Care (MOHLTC). We call these 'Change Concepts'.

Scope of services being examined

The scope of the 'hospital to home care' process begins with the patient going to the hospital, and then follows them through a variety of other stages. This includes admission to the hospital, hospital discharge, and then receiving services at home. Our emphasis is the client's *transition* to home and the client's experience receiving services at home in the first few weeks post hospitalization. This spans the work done by the CCAC Care Coordinator, Hospital Social Worker, CCAC office staff, and home care personnel.

The 'hospital to home care' process involves people typically leaving units 8A or 8B of Toronto Western Hospital of the University Health Network. Subsequently, Toronto Central CCAC and its subcontracted agencies become involved as care at home is arranged and delivered.

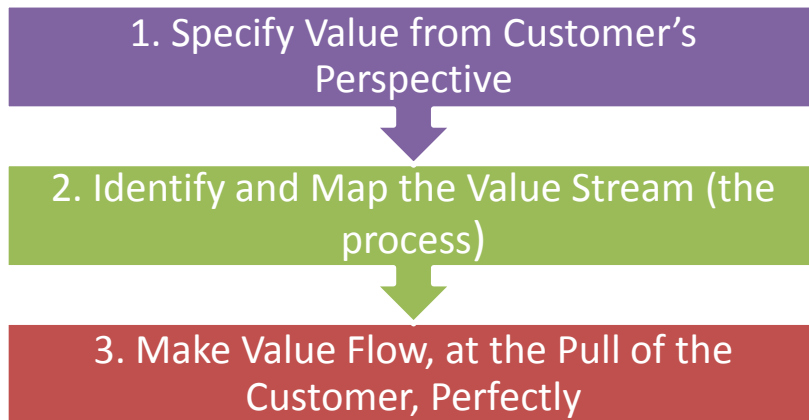
This report discusses the 'hospital to home care' process. An accompanying report discusses the 'hospital to LTCH' process, which begins with the patient identifying the need to go to the hospital, admission to the hospital, making long-term care home selections,

usually includes an ALC phase, and ends with the arrival at the long-term care home.

Methodology

The investigation is guided by quality improvement theory. The basic concepts popularized as 'Lean' quality improvement are relied upon to guide the investigation. The core idea central to this report is to understand what clients and patients prefer (Value), map how Value is provided, and find ways to make Value flow from beginning to end, by eliminating waste.

Figure 1 Lean Steps in Brief



We begin to understand the experience of the client by seeking them out and listening to their story. We gather their views- not for research - but rather as 'expert advisors' with opinions that matter. Then the process is examined to see how it works. Is the process designed to deliver what people want and value? We can then start to examine what parts of the process add value, what parts of the

process represent waste, and what can be done to create a better client experience.

Action 1 - Specify Value from the Client's Perspective

The local CCAC recruited a sample of people recently discharged from hospital for one-to-one interviews. This helped us understand the process from the patient's perspective. We contacted caregivers or power of attorneys listed in the patient record for consent if the patient had dementia or cognitive challenges and difficulty recounting their experience fully. Our interviews were conducted in the caregiver's home with the actual client present if possible. Occasionally, we held interviews over the phone. The majority of people who we interviewed in the 'hospital to home care' category required interpreters. All interviews were recorded (where the client consented) and then transcribed professionally. The transcripts were subjected to a variety of qualitative analyses by the investigators. We arrived upon the main themes after multiple iterations and reviews of the transcripts.

The clients' and caregivers' insights were the primary source for generating the client value statement. Clients' comments also helped to illustrate the shortcomings of the process. The defects or 'deficiencies' listed in the report are process problems that do not get reversed before they get experienced by the client.

All participants were provided with a small monetary reward as a 'thank you' for their participation.

Action 2 - Identify and Map the Value Stream (The Process)

Detailed process maps were created after directly observing the clinical and administrative staff activity. We observed and collected

information articles – brochures, forms, letters, checklists, and screenshots of applications- from start to finish. We created and validated a ‘Ben Graham Workflow’ map which shows task-level information. This detailed process map was then used to generate a modified value stream map - a more conceptual or abstracted diagram showing only key operations involved.

We overlaid the map with the issues identified through the client interview process. We also gathered ‘Change Concepts’ or improvement ideas informally suggested by staff, clients and families. We include in this report the change concepts which could improve the performance of the process, based on our preliminary analysis.

Action 3 – Make Value Flow, at the Pull of the Client, Perfectly

The investigators analyzed the process maps to determine if, in its design, the process is *capable* of delivering value to the client. In so doing, we were able to better understand the root causes of both the positive and negative issues identified by the clients.

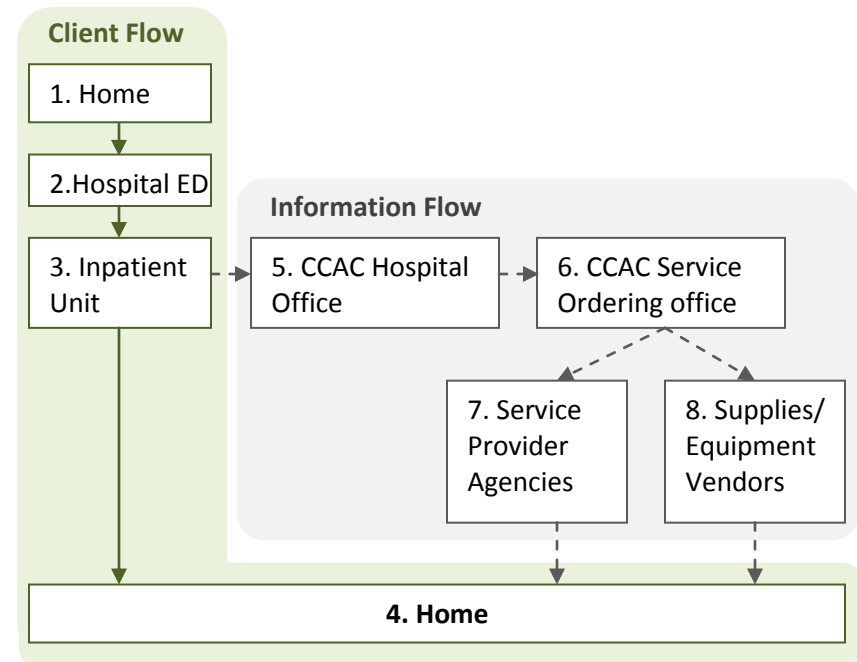
A note about language – ‘patient’ vs. ‘client’ vs. ‘customer’. For simplicity, we have chosen to describe people admitted to hospital as ‘patients’ and those in community as ‘clients’. ‘Customer’ is only used when discussing general quality improvement theory. ‘Caregivers’ refers to family or others who are informally caring for a patient or client

Process Overview

The high-level **client flow** steps for the ‘Hospital to Home Care’ process are as follows: From 1) home, the client travels to the 2) hospital Emergency Department (ED) and eventually gets admitted

to the 3) hospital inpatient unit. Here, hospital and CCAC staff work with the client to plan home care services before the client travels 4) home.

The **information flow** portion of the process begins with hospital unit (unit clerk, resident, or Social Worker) completing a medical referral to the Hospital Care Coordinator (CC). The CC assesses the client while in the 3) inpatient unit. The CC travels back to the 5) CCAC hospital office to process the file and send the referral package to 6) CCAC service ordering office. This office selects the 7) home care service provider and the 8) supplies vendor.



Summary of Findings – ‘Hospital to Home Care’

What is Value?

Through interviews with clients and caregivers who experienced the ‘hospital to home care’ process, common themes emerged that were used to define what ‘value’ is, as desired by the client:

“The right care in my home starts by understanding me, and then delivers personal help to me and my family. With my changing situation, I need the information about my care and care options to be easy to find, understandable, accurate, and comprehensive.”

This ‘Value Statement’ represents what is important to the client and families experiencing this transition.

The investigators found positive aspects to what people experienced. Most commonly, clients said they were grateful to get home care service so they could get home from hospital. On occasion, they felt positive about how individuals cared about them, took care of the little things, and offered service in the client’s mother tongue.

The *design* of the ‘hospital to home care’ process, however, yielded deficiencies identified by the clients. Most commonly, clients and families told us about the following deficiencies:

Deficiency # 1 : Clients and families are confused about home care

Deficiency # 2 : The care arranged didn’t help

Deficiency # 3 : Impersonal approach

Deficiency # 4 : Little help with navigating system

What is the Process for Delivering Value?

The detailed process investigation revealed many of the root causes of process deficiencies. From this investigation, 37 Change Concepts were generated. All of these change concepts are centered on the concept of *delivering better value to the client*. The client’s experience crosses a network of organizations, thus change faces every organization involved in this process; the hospital, CCAC, service provider agencies, vendors, LHIN, and MOHLTC.

The change concepts are not intended as definitive recommendations, rather they are meant to provoke further reflection and feasibility investigation.

How Capable Is the Process?

The process was examined in relation to the value statement with the following question: “How capable is the process of providing value, as defined by the client?”

The review found that several system and process design failures exist. The following document will describe the immediate sources of problems. These problems can be grouped into two fundamental issues:

1. Need to design-in meaningful time with client:

CCAC Hospital Care Coordinators are spending most of their time on administrative tasks away from the client. Care Coordinators need time with the client to get a personal understanding of them. They also need time to share what they know in a way that can help the client. Without this effective knowledge exchange, care cannot be made personal, and

service plans may not be helpful to clients. The process requires redesign to ensure the encounters with patients are personal, informative and both parties gain relevant knowledge.

The vast majority of intake process handling time observed, including all agencies and departments, is in documenting, organizing, searching for, and transmitting information. In particular, the steps that follow the Care Coordinator do not contribute meaningfully to the client experience. To the extent they prevent information flow to the client, they may detract value.

These handling steps are done to address organizational and policy requirements within a process that has a myriad of operational owners, each optimizing their component of the process. Transformational process improvement will require a rethink of such policies to ensure limited resources are directed to positively impacting the client experience.

2. Need to enable information sharing across 'care team':

Information is dynamic, with the client health status and related plans changing frequently. Community care is delivered by staff who are distributed across many settings.

Information about current care or other care options does not flow as a 'finger tip resource' to home care providers and CCAC Coordinators *at the point of care*. This causes a lack of confidence in care by clients. It causes personnel to make extraordinary efforts to find and provide what should be simple

and straightforward information. (e.g., start times, end times, who is coming, health status trends, etc.)

The investigators believe information technology solutions are required that are designed to optimize the workers encounters with clients, support knowledge exchange, and drive care and caring.

2. Background

Basic Sample Statistics

Nine interviews were conducted with a semi-structured interview format. Candidates were identified by Toronto Central CCAC.

The sample population of nine interviewees had the following characteristics:

- Average Age: 77 (min 70, max 84)
- Three previously received home care, and resumed with service changes after hospitalization
- One had LTCH application completed subsequent to home care admission
- 78% lived with a family member prior to and after hospitalization
- 66% female

9 total interviews	Length of Hospitalization 1-10 days	Length of Hospitalization 11- 30 days	Length of Hospitalization +30 days
# interviewed	3	3	3
Unit 8B	2	0	1
Unit 8A	1	3	2
CCAC diagnosis	Abscess, pneumonia (2)	UTI, Stroke (2)	Disease of Circ. Syst.; Dis of Genitourinary Syst. COPD
First Language	Italian (2), Portuguese	Chinese, Russian, Ukrainian	Russian, English, Italian

3. Specify Value from the Client/ Caregivers' Perspective

Many patients leave Toronto Western Hospital for their own residence, with the addition of home care, every month. We interviewed nine of these individuals in their home and found the following positive themes.

Positive Experiences

Positive Attribute # 1. Helped me get home, out of hospital

The investigators heard a common sentiment that people were anxious to leave the hospital and that they needed help leaving.

"Because I was for a month, shut in...on that same bed, in the same room. I wanted, I was busting, you know, I couldn't take it anymore. But on the other hand, I couldn't walk. "

Clients are determined to go home, but realize some limitations. Eight of nine people indicated they were ready to leave when they actually left hospital. Of the nine people interviewed, five indicated that the home care service helped them, to some degree, to get home.

"At the family meeting we knew that they [both parents] couldn't take care of themselves so we needed to bring someone in and I would be here to assist them in the evening."

"There was no way that she could have taken care of herself".

"[The Occupational Therapist] taught me few things, [...] I was laughing because before I never think about these things, you know."

I can't undress or dress. I can't shower by myself, because I'm not steady on my legs. So it's very important."

Many people expressed gratitude that *any* home care services were available, and that the sheer availability was enough to delight.

"We were grateful, because we needed laundry done and stuff [for Mom]. And you know I work full time, my sister works full time"

Positive Attribute # 2. Cared About Me

Home care personnel are challenged to manage the tension between being professionally detached and emotionally sensitive to the client. On three of nine occasions, the interviewers found clients elated by service because of the humanizing approach that was taken.

"Oh my mom just loves this person that comes. She just adores her. Like I said they're almost like family. I mean she's really caring, compassionate, she really helps my mom."

"She is very affectionate and caring to my Dad. She [the Nurse] hugs him and that's what he wants. I said 'Dad, you are a lucky man. He's like yeah yeah yeah. "

Are health care providers supported in managing this tension? How might we ensure jobs are designed to support 'caring for' and 'about' people?

Positive Attribute # 3. Took Care of the Little Things

Health is a personal issue. When families express delight, it is often with the 'little things' that get delivered in a **personal** way. Sometimes this personalization was in the nursing care delivery, and sometimes in the way personal support is offered, as follows:

"She took it, she folded nice. Even I don't have to iron. She do it so nicely you know."

"I have one girl, she's fantastic. She's very good. She's like...it's her apartment. She knows where everything is. You know she washes a cup, she knows where to put it back, and so on".

Positive Attribute # 4. Service in language of choice

Most of the clients did not speak English as a first language (eight of nine). On four occasions, family members acted as an interpreter for the investigators. The interpreters were spouses or daughters. Eight of nine clients were post-war European immigrants with first language Italian, Portuguese, and Russian in most cases.

Three of nine people interviewed directly spoke of the importance of language. In particular, we heard how important it is for home support workers to share a common language with the client.

"If you didn't have no Portuguese speaking this program to me wouldn't be working for me.

"Language, language, language. Because if you get somebody that speaks the same language that makes everything so much easier."

"We need to get more folks in there that speaks the language because if you have the language intact the communication is so much easier."

The investigators found **no observed deficiencies** in how community care was delivered that directly contributed to the hospitalization of people in this sample.

The Deficiencies

The investigators categorized the problems observed by clients and families into four categories: 1) Confusion; 2) the care provided not helping; 3) impersonal service; and 4) a lack of navigation assistance.

Deficiency # 1 : Clients and families are confused about home care

Clients wanted to understand information about their services. Some information needs they discussed included knowing when their services are starting or stopping, their visit schedules, what to do if they have a problem, who is coming to the home, and how their health status is changing. All interviewees repeated the phrase "I don't know..." in relation to many aspects of home care.

Simply put by one client:

"I confused about everything"

It is vital that information is provided as the client's situation changes. It also must be context-specific to be effective, taking into account the person's condition, location, and language, for example.

Brochures and paper documents are a central medium used to communicate home care service plans with patients leaving hospital. To be helpful, they must be well-designed in order to be easily understood.

The **quantity of brochures** created confusion. These may be distributed by the hospital Social Worker, CCAC Care Coordinator and subcontracted agencies. The investigators consistently found 20 to 40 pages of brochures and loose-leaf pages from several agencies in the clients' homes.

Q: "What did they tell you about homecare while you were still in the hospital?"

A: "They just give it to me brochure. So many you know. So many I have".

We observed most interviewees rummaging through paperwork to locate basic information.

"They gave me this at the hospital I think. Yeah they give me this from the hospital. Oh... I think this is my mom's ... I think that's hers. Sorry I've got papers for both my parents and it's really hard to keep track."

The **design and writing on the brochures** creates confusion.

Seven of nine clients produced a brochure for the investigator entitled "Bringing Healthcare Home". Within the brochure, the Care Coordinator handwrites a page that describes services to be received, and provides this to the patient while in hospital. Care Coordinators write this at the hospital patient's bedside, often without the details available of start date, time, or agency.

One brochure, as an example, indicated service frequency would be twice weekly for two weeks is as follows:

E/S, OT/Physio, 2XWX2WKS

Interviewer Q: "Did you know by reading this, what you would be getting?"

A: "No, they say three times a week, for one hour. That's how I understood."

Thus, people did not understand what was said because the syntax is challenging and the message is not obvious.

Accordingly, clients **do not know who is organizing their post-hospital care**. The investigators did not find any interviewees who could name or provide a title of any CCAC personnel who arranged their care while in hospital. Only two of nine clients knew of the existence of a Community Care Coordinator, both of whom had already been receiving home care prior to hospitalization. Other typical comments were as follows:

Q: Do you know who your Care Coordinator is?

A: Care Coordinator?

Q: You have a community care access center that arranges your services, do you know of them?

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A: What community?

Q: Do you know of the Community Care Access Centre?

A: No.

When asked “when you were in the hospital, was it clear whose job it was to do arrange your home care?” the following client responded:

“Not really no. [...], they didn't do anything.”

Another client stated:

“The hospital was great. They actually emailed and made all the arrangements for home care”

When asked if they ever talked to the Care Coordinator, another client said:

“Well occasionally a lady came and said if you needed any help here and she put some notes in her paper and then she walk away...”

Another said:

“My understanding is that everything [in the hospital] is coordinated through the [Hospital's] Social Worker. We never saw anybody in the hospital from CCAC...”

While discussing how care was organized, another client showed his complete bewilderment, thinking that hospital personnel came to the home:

*“They said in hospital, when you go home **the Nurse go home too** [and would visit at 10 o'clock]. Nobody come at night and nobody come in the morning.*

People frequently state **they do not know what to do when or if there is a problem with their care**. The spouse of one client says:

The phone number I have is for the Nurse. Is that. It is for if don't come or something happen you call this number. Or this number. I don't know. I don't if that is for everything I need maybe this is different business because I am in hospital. I don't know. I have no idea.

Others think they know, but are unclear:

Q. Who would you call if there was a problem?

A. The coordinator.

Q. And what's the company the coordinator is with?

A. It's the.... CCCSRT or something like that.

We observed how all clients new to home care were **uncertain about the time of the first visit**, and who this would be at the visit:

*“A Nurse in the hospital said [...] you go home tonight at **six o'clock**, then at **ten o'clock** they will have a Nurse in there. Then the [Nurse] comes at **eight o'clock**. [...] That's when I found out that] the Nurse [only works] until **eight o'clock**. There is something wrong. I said no, [my wife] had the medicine already at **6 o'clock**, and if you put other medicine on top of that that is too much, the Nurse is supposed to come at **ten o'clock**.”*

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Three clients perceived that there were **too many people involved in arranging home care**. One gentleman commented:

"Lots of complicated. Too much people talk. The woman come in and talk. The Nurse come in and talk. Personal Support Worker [come in and talk]."

We observed that the extent of paperwork and individuals involved caused confusion for people. The following caregiver expressed bewilderment about how hours for home care services are increased after hospitalization:

"It's sort of like a black hole you know. You call the Care Coordinator and she says 'I forwarded the paper'. You call CCAC, and CCAC says 'We haven't received the paper'. [...] I'm not sure how the paper flows. This is important because my mother became incontinent [...]. Three hours [of service] wasn't enough when she came home from hospital. It took about three weeks from leaving the hospital for [the paperwork] to go through!"

Clients receiving home care were **confused by the inconsistent messages being provided** to them. The following client was near the end date of her service schedule, but had many supplies left over. She had multiple nurses looking after her who provided various opinions on how to deal with the leftover IV medication supplies:

"The Nurse said if you don't need it anymore ... don't throw in the garbage, it is not good for the garbage'. The second Nurse says break it and dump it in sink or

throw outside. I don't want that stuff anymore. So I threw it outside. I didn't throw in drain, I threw it in the grass."

We found that clients **struggled to comprehend the status of their care**, or that of their loved one. This was often a struggle.

"I would like to know if the infection is getting better or worse. Better, stay the same, or something like that. I like someone to call us, but nobody calls us. I have to go somewhere to find out."

On three occasions, the investigator encountered clients with frustration about their plan status. This caused the family strain. For example, another client's "Bringing Healthcare Home" brochure indicated nursing services were ending the following day. This client said:

"I have six boxes [of supplies] here. I don't know if we continue to the [IV] bags is finished, or can stop tomorrow. I have no idea. Nobody told me nothing. [...] I have no idea if they stop tomorrow. Maybe the Nurse they know. Tomorrow maybe I going to find out from Nurse, is up to them. I have no idea of that stuff."

Clients also **do not understand the CCAC**. At the conclusion of the interview, we asked clients who they would recommend if a friend needed help in their home. One client indicated CCAC, while others mentioned Service Provider Agency (3 clients), Family and Friends (3), Community Centre (2), Work (1), Meals on Wheels (1), Hospital (1), Friend (1).

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"You don't really know who to call... And what number to call? Because that information is not even available in the yellow pages. My cousin also has gone through it [...] so I guess family is a great tool to have and to ask and get information.

Several people had an *incorrect understanding about how CCACs services were paid for and accessed*, believing that they would be charged for services delivered to their home. The following interviewees incorrectly believed that they had to pay for CCAC services:

"They don't need to come here three times a day. How much it cost me three times a day"

"I think the cost is a lot to consider. [...] If you're looking at an elderly person they're making just pension I mean it's a lot of money just to you know to pay somebody."

The investigators found three of nine people who incorrectly believed that CCAC services could be accessed only through a physician referral:

"They would need that [Physician] referral. You can't just call them and say I need home care because then they'd say 'why?' You know if you don't have referral from the doctor ...most definitely [you need a referral]"

Another client believed that home care services were reserved for those who did not live close to a hospital:

"I guess we were concerned that, you know, being close to the hospital that we would go back down the waiting list for service."

Deficiency # 2 : The care arranged didn't help

Four of nine clients interviewed indicated the home care service that was delivered was not helpful. Two of the four involved were getting care after being ill with pneumonia.

"Well I don't think I need anything. As soon as I come out of the hospital I was doing my own. I didn't need help."

Many people interviewed seemed to be unclear about what they would be getting, and how it could help. There was a feeling of reluctant conformity with these clients, a willingness to try something that was being offered. They discovered soon after being home that service wasn't a fit for their situation. One client said:

"Well we said we'd try it see what, you know.... But she found that she really didn't need it and they didn't really do that much for her."

Another respondent said:

"[The first person], the Nurse, just took her pulse and listened to her heart and that was it. [...] Was it helpful? No. [The second person] went through the house and said "you need a railing", which we already had and loose carpet or rug that she could trip over or and that was about it. [The third person] didn't come. My wife

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said she didn't want her to come in. [...] She found that she really didn't need it and they didn't really do that much for her. [...] Her family doctor comes in once a month and checks them out anyway. [...] The family, we want to continue to look after things."

Similarly, another client commented on receiving services that she did not want and discontinued shortly after getting home:

"Adding physiotherapy, that is what they wanted in hospital. We didn't want any changes. That's more comfortable for her - [...] not change is better for her because we get used to that. I can take care of whatever she needs immediately."

Says another daughter, who is accustomed to caring for her parents:

"It was confusing.... And it's also for people of European background. I think it's kind of they feel that the independence is some sort of taking away in a sense. ... They are used to having working really hard...It is sort of like a put down.... We are used to having to do for themselves."

Service provider shortages are sometimes unknown before a patient leaves hospital. No clients report knowing who was coming to their home before leaving the hospital. One caregiver reported that their arranged home care worker did not come arrive as scheduled, and only after calling the hospital discovered that there was no nurse available due to a shortage over a long weekend. The client returned to hospital for the full Thanksgiving weekend.

"The Hospital Nurse says] 'oh I am sorry, I have no nurse for the weekend [...] She said my wife have to come into the hospital again [for 3 days]."

Shortages and lengthy referral processing times contributed to **home care starting too late to be helpful**. Two interviewees fell into this category.

"They didn't [...] help me, if they want to help me they should have called me before I came out from the hospital. When [the home care worker] came I was already feeling strong."

Another client demonstrates the importance of timing, while also indicating her lack of knowledge of when service would start:

"Thursday I come home. ... Monday she come right away and give [the shower] to me. I was surprised so fast, you know."

Deficiency # 3 : Impersonal approach

As often as clients said they felt cared about, others reported the opposite feeling from more dehumanized interactions. When people were asked what they would most like improved about the service received, three people responded with sentiments such as:

"[I want somebody to] pay more attention to me"

"[Some of the workers are] are too tired to do the work, and they stay there, or they sit down and they just look at you... I want [people] with enthusiasm".

Having Their Say and Choosing Their Way Project: Report 1: People's experience getting home care after being hospitalized

"I would like someone who is pleasant, polite, and knows a joke. Because some of them, they just don't have a clue."

Clients express frustration when perceived insensitivity leads to providers *missing the 'little personal things'*.

"For instance, making the bed in the morning. They don't make it the way you want it. So you show them the first time, the second time, the third time. It still doesn't sink in. You get fed up".

The interviewers validated the importance of the emotional connection. We found that people were generally happier with their service when this personal connection was in place. Two quotes as follows support this:

"We're just so happy that we have this person that comes in. She is energetic and upbeat. ... She called me at work once and said you'd better come right away and take your mom to the hospital,[which I did] ... I feel that my parents are getting the home care that they need with this woman. "

"She goes the extra mile. There was one time that my dad had a doctor's appointment and she was actually here for my dad and she said "I'll drive you to the hospital".

Another client similarly expressed....

"I have one girl, she's fantastic. She's very good. She's like...it's her apartment. She knows where everything is. You know she washes a cup, she knows where to put it back, and so on.

Deficiency # 4 : Little help with navigating system

People living in their own homes can often benefit from other services beyond those paid for by CCAC. Care Coordinators or hospital Social Workers could play a role in organizing these. Each interviewee was asked if other non-CCAC services had been arranged for them. The interviewers found three instances where clients used other services that had helped them and that clients found on their own:

"Meals on wheels [...is working] very good. [We arranged] it ourselves. One of the neighbours' mother has it and she told us about it. [The Social Worker didn't help with that], she never mentioned anything."

"We just rented a walker. [...] The pharmacist [got] a prescription done. [I arranged that myself]"

"Well I don't know what [the CCAC's] goal is to tell you the truth so I mean if my mother needs Wheel-Trans I call them [...]. I'm going to speak the language, it's probably easier for me to do as opposed to just giving her all the information. [...] What they can provide again I don't know."

Having Their Say and Choosing Their Way Project: Report 1: People's experience getting home care after being hospitalized

Caregivers feel that they are on their own when it comes to finding care, or finding the information that they needed to help their parent. Families would express feelings of desperation:

"I would say, keep pushing with anybody who is inputting into this, to get them to give you information."

"When they say something in hospital, make sure it is going to happen. Make sure so you don't have to go back to hospital again."

"Carry on doing what you can, if you can. If you don't get satisfaction, try and find out the cause it, you know, and take care of yourself, because no one else will"

"[If you want] something you pretty well have to do yourself"

"So many brochures... I don't know."

The clients were all of the post-war demographic. Some of these *clients are unwilling to ask for help if they need it*, making it more difficult to reach them. Several interviewees expressed that they were happy to receive anything at all, and didn't want to complain. For these people, even the idea of asking for help was out of the question:

"If I needed more, I don't call to bother people.... I am really happy they are coming... It is enough for me... I am quite happy with this. I think they have given so

much to me, what can I ask for more? My goodness. I am lucky I live in Canada. If I am in Ukraine I will be dead a long time ago. You maybe don't understand. You did not see Communism. I saw. You didn't see people die. I saw when 10 years old. ... What can I ask for better?... I am okay. I am not like that, because I see worse. I never forget that....So what can I ask more? Oh no, sorry."

The investigators suggest that this post-war demographic may be more easily satisfied by service compared to subsequent generations. It is also common for consumer expectations to evolve such that what causes delight today may simply be expected tomorrow.

Several clients interviewed felt they could make no claim for anything more than they were receiving.

Creating a Client Value Statement

The investigators developed a draft 'value statement' after conducting and analyzing all the interviews. This value statement is our best attempt to assemble the words of the clients together in a succinct manner, explaining what they desired in the process of going from hospital to home and getting home care. It was validated with interviewees and successively modified.

Clients said they liked feeling cared about and when 'little things' were taken care of. They were upset with impersonal care and, cautiously, raised issues about care that wasn't helpful.

Consequently, the first part of the value statement addresses the *nature* of encounters and service that people want:

*“The right care in my home starts by understanding me,
and then delivers personal help to me and my family.*

The client's situation is dynamic, which was poorly addressed with the tools and divided roles across multiple organizations. Clients said they didn't understand how to navigate community care services. Consequently, the second part is about *information*.

*With my changing situation, I need the information
about my care and care options to be easy to find,
understandable, accurate, and comprehensive.”*

Each component of this statement is a dimension of service value that may, or may not, be offered in the care process. In Lean theory, any step in the hospital-home care process that does not contribute to what the client desires is waste.

It is against this statement that the process (in the next section) is assessed.

4. Identify and Map the Value Stream (The Process)

The consultants created a *workflow level* process map by observing the process step by step. The detailed map tracked most databases, forms, hand-offs, inspections, persons, and steps in the process, from end to end. This is done assuming a client arrives in hospital at emergency department (ED), is admitted (unit 8a or 8b of TWH) is discharged to home care with one service and supplies (supplies not done to detail level). Through this approach the investigators gained a deep and detailed understanding of the process, which was used as the foundation for the process analysis.

At a size 14 font, this map spans 35 feet by 3 feet. Consequently the map is too large and complex to include in this report. We instead include a *high level* process map (see next page) describing the overall process, broken into eight process blocks. The following section discusses the relevant activities observed in these eight process blocks.

Blocks 1 – 4 represent the 'client pathway'. This is the process as the client experiences it. It is the interactions within these steps that the client experiences value.

Blocks 5 – 8 represent the 'data processing pathway'. These steps are largely invisible to the client, and involve information collection, documentation, and sharing between individuals in the various organizations involved.

We present ideas, or 'Change Concepts' to reduce waste and create more value for the client. The change concepts are not specific action plans or definitive recommendations, rather they are meant

to provoke further reflection and investigation. These concepts are targeted at making value flow to the client.

The group that may be most interested in the change concept, from an implementation perspective, is also noted alongside each of the 37 change concepts.

Client Journey Path

1-Home
a. Living in Community
who: Client

2-Hospital Emergency (s)
a. Present in Emergency Dept.
who: client

3-Hospital IP Medicine Unit (s)
a. Stay on IP Medicine Unit (s)
who: Client
b. Client Discharge Counseling
who: Social worker
c. Create Assessment + HC Plan
who: Hospital CC
d. Discharge to Home
who: Client

4 - Home
a. Arrive Home
who: Client

Process: Hospital to Home Care

(High Level)

Abbreviations:
CC: Care Coordinator
CCAC: Community Care Access Center
HC: Home Care
IP: Inpatient
SPA: Service Provider Agency

Information Processing Path

5-Hospital CCAC Office
a. Place order for HC Services/ Supplies
who: Hospital CC

6-CCAC Main Office
a. Process order for HC services
who: Central Service Ordering
b. Process order for Supplies
who: Central Service Ordering
b. Move to Community Caseload
who: Central Service Ordering

7-Supply Vendor Office (s)
Process order for Supplies
who: Vendor Staff

8-SPA Office(s)
a. Accept/ Reject HC service order
who: SPA clerk
b. Process service order
who: SPA Booking

c. Deliver Supplies/ equip.
who: Supplies/equip. Vendor

d. Schedule 1st visit
who: SPA scheduler + client
e. Client receives 1st visit
who: SPA nurse

Process Metrics	
Overall process measures (‘hospital to home care’, not including home visit)	Observed estimate
(a) Total Touch Time (does not include wait times between steps)	200 minutes
(b) Component of Time with Client	20 minutes
(c) Component of time with client- value added	15 minutes
Value add proportion of time spent (c/a)	7.5%
Number of unique information collection forms observed to be used	35
Number of instances of forms observed	84
Number of databases/ applications - unique	9
Total lead time to bring client onto service	Variable
Number of unique staff involved in process (not including home visiting personnel)	10
Total number of handoffs/ waits in process	11
Total observed of steps in process (not including those within supplies delivery process) includes 27 inspection steps , 20 transport steps	247

At a glance description of process:

A patient presents to the emergency department with an acute issue, and is then admitted to an inpatient unit. The CCAC Care Coordinators are notified by hospital personnel, who may be the Resident, unit Social Worker or Unit Clerk. CCAC Hospital Care Coordinators (~six for hospital) distribute the referrals among themselves (within CCAC hospital office) and triage priority.

The Hospital Care Coordinators gather background information from their CCAC systems, information from hospital chart, then from the patient on the unit and other personnel. They complete the assessment paperwork and provide the client with the “Bringing Healthcare Home” brochure. The Care Coordinator forwards the paperwork by fax to CCAC main office.

The service-ordering personnel inside CCAC open all referral packages as an email, and triage the client who is then registered in the CCAC information system. CCAC staff select service provider agencies based on market share calculations (e.g., nursing visits are allocated by CCAC in accordance with contracts across multiple agencies), who in turn accept or reject the referral, cycling through providers until the service is arranged. Once accepted, the service provider(s) is transferred the referral package. This is done through portal technology. The CCAC assigns the client to a Community Care Coordinator.

The service provider agencies each register the client in their own information system and assign the individual staff (may be acceptance/rejection steps at this stage). The patient is discharged from hospital. The service provider agency contacts the client to

select appropriate visit time preferences. The Nurse/ Personal Support Worker/ Therapist takes receipt of referral from corporate agency and notes location, directions, etc.

The providers each contact the client prior to their visit to ensure the client is home. Supply vendors receive their orders, enter data into their information systems, pick the order, and deliver or arrange pick up. Home 'visits' are then made by authorized providers and Community Care Coordinators.

1 – Home

1a – Home: Living in the Community- description

- Three of nine clients were receiving community care before hospitalization. This was primarily personal support service.
- Several clients had previous hospital encounters and all reported having a family doctor.
- One client began the long-term care application process.
- Clients are unclear as to who, or if, they should contact someone within CCAC should they become hospitalized. (Should they contact the CCAC, the agency, a community organization, family, etc..?).

Databases: (many)

Change Concepts

- # 1. **CCACs** - Consider the opportunity of a clearer community care client identifier, province wide. This would be something clients carry/ produce as a visible sign for the health system of their home care status, and also who they should notify *within* CCAC about changes or problems.

- # 2. **CCACs** - Develop a clear communications protocol to clients and the community care team for events where the client will not be present for home visit, or where medical status changes.

2 - Hospital Emergency

2a. Present to Emergency Department- description

- All people interviewed experienced acute illnesses or acute exacerbations of chronic conditions.
- Clients may sacrifice timeliness of arrival to ED to get to a hospital that has their history. That is, they avoid calling ambulance so they can get to the 'right' hospital that understands their history and preferences.
- ED Notification Portal identifies previous, current, and potential CCAC clients at the point of entry into the ED, and communicates this to hospital CCAC staff.
- The home care status of clients from out of the LHIN region is not known by the IT systems. (large numbers of clients from out of area).
- The ED visit history is not known in cases where the client visited other hospital networks.
- Agency care providers or supplies deliveries may arrive at the client home, not knowing that client is at hospital. This triggers an onerous search process to track down the client. (known as the 'client not seen, not found' process).

Databases: 3

Change Concepts

- # 3. **LHIN** - Integrate hospital records across a region, so clients will be sure all EDs have relevant medical history.
- # 4. **CCAC** - If not already done, extend the ED notification portal to notify care provider agencies, and supplies and equipment providers. This would resolve some 'not seen, not found' issues for clients missing from their homes during home care visits or deliveries.
- # 5. **CCAC** - Identify client groups already on CCAC services that are at high risk of admission to ED. Create pre-emptive contingency plan to keep them out of the ED. Partner with their Family Health Team.
- # 6. **MOHLTC** - Extend the ED notification Portal across the province to other CCACs where clients are on service. This would resolve confusion around 'out of region' clients.

3 - Hospital Inpatient Unit

3a. Stay on IP medicine Unit- description

- Three clients were hospitalized less than one week; five were 21- 40 days; and one was upwards of 100 days.
- Interviewees were not queried in-depth on the quality of their care. Some frustrations with access to nurses and quality of food were voiced.
- While generally happy with their care, eight of nine felt strongly of the need to go home, and that they had spent enough time in hospital.
- The hospital organizes daily rounds to review patient status.
- Patient status may be listed on a white board on unit.

- The CCAC Hospital Care Coordinator may attend rounds, but most often is notified by voicemail or page of a potential client.
- Hospital approaches to notification of CCAC vary by unit.
- CCAC may be notified multiple times of same patient.
- Patient referral to CCAC may be omitted.

3b. Client Discharge Counseling

- At this site, the client interacts primarily with the hospital Social Worker (SW) to plan the transition out of hospital.
- SW communication materials are oriented towards long-term care home admission.
- There is no systematic way of ensuring full post-acute care options are presented in a way that is relevant and understood by the client.

Change concepts:

- # 7. **CCAC** - Create supportive tools that guide the person doing discharge planning towards exploring all viable services available in the client's region (such as meals on wheels, home support, retirement homes, personal security) in the course of planning for home care and long term care. Should include private and public services.
- # 8. **Hospital** - Create a standard mistake-proof method of notifying CCAC of patient for follow-up.

3c. Create Assessment + Home Care plan- description

- After SW or other hospital referral, all interviewees were seen by Hospital Care Coordinators, as evidenced by tracking tool in place.

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- Care Coordinators triage all hospital referrals as group up to two times per day.
- Coordinator gathers background information from CCAC care portal and/or TRCCD database and/or other CCAC.
- Go to patient unit to collect referrals and review hardcopy chart at nursing station
- Complete part of client assessment form (CAF) package.
- Care Coordinator goes to see patient, collect consent (verbal), assess, complete "Bringing Healthcare Home" brochure, provide to client and complete more of CAF package. Emergency contact information collected.
- CCAC Care Coordinators spend 10 – 20 minutes with each patient.
- Return to nursing station, disassemble CAF and gather more background from hospital, and walk back to CCAC office.

Forms: 6

Databases: 4

Change concepts:

- # 9. **CCAC** - Purposely design the Care Coordinator's encounters with patients as they are intended to occur. Goal should be to become more engaging of clients, making them feel informed and confident about care.
- # 10. **CCAC** - Increase the face time of Care Coordinators with clients in hospital.
- # 11. **CCAC** - Create a concise, *understandable* package describing what to expect next, and what to do next, when getting home care etc. Include services and name of service provider agency. Ideally, first visit time and name of home care worker would also be provided. Have the Care

Coordinator and home care personnel review the package directly with the client, in the hospital, and in the home. This may involve redesigning the "Bringing Healthcare Home" brochure.

- # 12. **CCAC** - Ask the client specific questions that may reduce subsequent calls from agencies required at this step to locate optimal staff and schedule first visit.
- # 13. **HOSPITAL + CCAC** - Re-evaluate the division of activity between Social Worker, Hospital Care Coordinator and admin support. Ensure that skills are being used optimally and that the client is communicating with the person most able to provide them with complete information.
- # 14. **CCAC** - Redesign Client Assessment Form package to reduce over-processing of information.
- # 15. **CCAC** - Provide more mobile tools that allow access and automated collection of information closer to the patient (with form factor that works for a mobile worker).

3d. Discharge to Home

- Eight of nine clients report being ready for discharge (one said 'he could have stayed a little longer').
- All returned home with family or friends providing transportation.
- All clients had home care services arranged. (Seven of nine with apparent more than one service; all but two with professional services).
- The CCAC is not routinely notified when patient exits the hospital, and therefore, trigger of first visit may not get sent to partner organizations. (I.e. CCAC, Service Provider, supplies vendor).

- Service Provider and supplies agency are expected to call before visit/sending supplies to ensure the client has been discharged.
- Medical supplies required for the first visit are usually handed to the client.
- Very difficult for Care Coordinator to know availability of home care service, particularly for out of region CCACs which have varying rules and waitlists in place.

Change concepts:

- # 16. **HOSPITAL** - Make discharge and hospital exit process more robust to *trigger* notification to CCAC and relevant agencies (home care and supply agencies).
- # 17. **HOSPITAL + CCAC** - Make scheduling the first home care visit with confirmation an essential element of hospital discharge.

4 – Home with home care

4a. Arrive home

- Client brings supplies home as appropriate.
- Client waits for next event to happen such as a) call from agency for scheduling visit, b) call from supplier regarding arrival time.

Change concepts:

- # 18. **LHIN + CCAC** - provide access to web portal view of visit schedule (+) to client. Allow patient to share with family members as necessary.
- # 19. **CCAC + Vendors** - clarify / standardize the supplies catalogue and pick up/delivery approach across CCACs, as

well as approach to payment for these, so it is easier to communicate what clients can expect.

4b. Manage changes to service

- Changes made are not easily visible across agencies (i.e. Agency A does not know that there were changes to services if performed by Agency B) – especially not to field staff level.
- Clients call a variety of sources if they want changes or want to know information about their services.
- We found it unclear whether the Community Care Coordinator was supposed to get involved, or not, in the updates of clients admitted to hospital.

Databases/ forms: not observed

Change concepts:

- # 20. **CCAC + Service Providers** - Provide a single contact/ phone number for the client to get information about *any aspect of their care*, problems and care options. Use modern technology (e.g., VOIP) to move calls from CCAC to service provider for *full disposition* of issues.
- # 21. **CCAC + Service Providers** - Redesign all communication vehicles and tools for clients, so that they, together, are easy to understand for client (e.g., currently there exists a myriad of brochures, messages regarding who to call if there is a problem, name tags, ways of identifying oneself to client, etc.).
- # 22. **CCAC + Service Providers** - Create a *community care record* that is shareable and updated by all agencies involved in community care. With appropriate technology, this would

inform decisions at the point of care in the community (e.g., health status, visit authorization, risk issues).

4c. Deliver supplies/ equipment

- Supplies are delivered to client home with first order made by Hospital Care Coordinator.
- Subsequent supply deliveries are arranged by Nurses in field.
- Apparent over-delivery of supplies was observed on two occasions.
- Manual method of ordering, which can result in duplicate orders.
- Cross boundary supplies issues- ensuring client from out of region gets supplies from local vendor, with local catalogue.
- Clients don't know how to dispose of excess supplies.
- Phone calls to clients from Nurses to identify if supplies present are adequate for upcoming visit.
- Vendor may not be notified in time of when client leaves hospital causing client to not get adequate supplies, or client leaves without supplies in hand.

Forms: 1 (not fully observed)

Change concepts:

- # 23. **CCAC + Supplies Vendor** - Make supplies order status visible to client and/or Nurse. Also make the delivery status available to Care Coordinators. Consider using a mobile device for supplies ordering.
- # 24. **CCAC + Hospital** - On discharge from hospital (*step 3d*) confirm the destination of the client and arrival date back in

home (i.e. are they going home, to relatives, out of town?, etc).

- # 25. **CCAC + Agency** - On last home care visit, consider having home care worker dispose of unused supplies properly for the client.
- # 26. **CCAC** - If delivery timing is difficult to align with client availability, give the client the option to pick up their supplies at a depot site at a time that is convenient for them.

4d. Client confirms visit time (with agency)

- Information that is required but was not collected in the hospital is discussed over the phone such as 1) language requirements, 2) preferred visit times, 3) access codes to the apartment, 4) hazards in the home (e.g., dogs, smoking), etc.
- Visit times are set and confirmed over the phone between the Service Provider(s) scheduler and the client.
- There are various reasons why timely confirmation may be difficult such as 1) client is out, 2) illness, 3) sleeping, 4) re-admitted to hospital, etc.

4e. Client receives First visit

- The person delivering the care may have all or little of the hospital assessment package (CAF) depending on the corporate procedures of the agency for which they work.
- First visit may be from occupational therapy, physical therapy, nursing, and personal support worker (PSW) agency. Each performs own scheduling effort.
- Many people coming in at different times.

- No effective way to communicate subtleties of client preferences across workers and agencies.

Change concepts:

- # 27. **CCAC + Service Providers** - Provide contractor schedule information to Care Coordinator so she can provide first visit schedule, before client leaves hospital.
- # 28. **CCAC + Service Providers** - Reduce number of agencies involved, if possible, so as to reduce complexity.
- # 29. **CCAC + Service Provider** - Consider methods to organize services around client types, so that information and service is more likely to be customized to a client group. (e.g., dementia).

5 - Hospital CCAC Office – Information Processing Path

The following steps outline the information collection and handoff pathways once the Care Coordinator returns to the hospital's CCAC office.

5a. Place order for HC services & supplies

- The referral package, comprised of ~seven page CCAC forms, plus incidentals is faxed to CCAC main office (one of several fax queues depending on priority).
- Originals are then couriered to CCAC office.
- Out-of-region clients have their referral package then sent to corresponding CCAC.
- Tracking forms are used to ensure faxes are not lost.
- Local copy of the referral package is then made and kept for hospital office for up to one month.

Databases: 3

Forms: 4

Tracking Sheets: 5

Change concepts

- # 30. **CCAC** - Extend the CCAC portal workflow from the central office into the hospital offices to eliminate wasteful faxing and couriering. This would also make visible the status of the intake package to the Hospital Care Coordinators, and make new referrals visible to CCAC corporately.
- # 31. **CCAC/ LHIN** - Create an online tracking tool to replace the ALC tracking tool + TWH CCAC list of patients + CMAL + various whiteboard who may need home care into one unified electronic patient tracking. Have the tracking approach arise directly from the workflow of the staff, versus a manual, separate tracking system.
- # 32. **MOHLTC** - Add a 'submit an error' function to the postal code lookup website so that found mistakes can be quickly fixed.

6 - CCAC Main Office- Information Processing

6a. Process order for home care services

- Central Service Ordering department is dedicated to receiving service orders and supply orders (via fax) and entering them into the CCAC IT systems (TRCCD + CCAC Portal + CARE).
- Referral package is triaged twice upon receipt by service ordering department.
- IT system automated to determine next service provider to assign the client (this is done to meet contractual

obligations with service provider agencies). Minimal information is first sent to agency electronically via CCAC Portal. Agency has 30 minutes to accept before the client is assigned to the next agency.

- After acceptance, full package is sent to the agency via fax.
- Delays at this stage impact timeliness of service.
- Hospital Care Coordinator and patient do not have visibility into the status of these documents in the main CCAC office.

Databases: 5

Forms: 3

Communication Systems: 2

Change concepts:

- # 33. **CCAC+ SERVICE PROVIDERS** - provide data view of service provider personnel available for home visiting, thereby creating 'pull' into available capacity. (Versus blind push today.)
- # 34. **CCAC + SERVICE PROVIDERS** - Reduce number of competing agencies in given area to better enable a clear view of availability. Also has benefit of reducing traveling time.

6b. Process order for Supplies & Equipment

- (Not observed in detail within this project.)

6c. Move to Community Caseload

- (Not observed in detail within this project.)
- Clients interviewed had no discernible involvement of Community Care Coordinator.

7 - Supply Vendor Offices (s) – Information Processing

7a. Process order for supplies/ equipment

- The vendor accepts the supply order electronically, picks the order, and delivers the supplies and equipment to the client home.
- Note: the vendor processing of supplies orders sub-process was not studied in-depth for this investigation.

8 - Service Provider Office (s) – Information Processing

Note: The CCAC region has numerous service provider agencies and the process may vary between them. This is a generalized outline of the process at one agency.

8a. Accept/ Reject service order

- Service agency has 30 minutes to respond to offer, limited information provided by CCAC (privacy concerns). Agency reception either a) knows availability or b) verbally asks other internal coordinators if they have capacity to accept the client, within their team.

8b. Process service order

- After acceptance, client data pre-registered into client management system, log book(s) filled out, and an intake consent form is created.
- Referral package is received from CCAC approximately 30 minutes later via care portal. Further information is then

put into client information system. Region is looked up on MapQuest or other mapping tool.

8c. Schedule 1st visit and subsequent visits

- Call the client to collect information required for visit (see process block 4d).
- Schedule assigned to staff based on 1) schedule information in client information system, 2) coordinators knowledge of staff and client preferences.
- Schedules and changes are communicated to field staff via voicemail or by other methods which staff must check several times per day. Urgent changes are communicated via cell phone/pager or other devices as available. Very low use of modern communications technology among most provider agencies.
- Staff from various agencies have no reliable method of knowing each others' schedules regarding the same client (e.g., three agencies may service the client for different purposes). Each agency will be contacting the client to schedule.

Databases: 3

Tracking Sheets: 1

Forms: 2

Communication Methods: 3

Change concepts:

- # 35. **CCAC + SERVICE PROVIDER** - Share information about all services being provided to the client, including schedules, with each agency – Devise an approach that lets the client

schedule all of their home care visits through one phone call.

- # 36. **CCAC + Service Provider** - Use mobile devices to communicate schedules and changes in real time, eliminating the need for voicemail-based communication.
- # 37. **CCAC + Service Provider** - Send electronic client information to service provider in such a way that it can be automatically input into service provider agency's client information system, rather than through re-entry.

5. Conclusion: Is the Process *Capable* of delivering value to the client?

Thus far, this report has asked the following questions:

- What does the client define as value?
- What is the process used to deliver value to the client?

Recall the value statement:

“The right care in my home starts by understanding me, and then delivers personal help to me and my family. With my changing situation, I need the information about my care and care options to be easy to find, understandable, accurate, and comprehensive.”

Now, we can ask ‘*How capable* is the process of delivering value?’

The right care in my home starts by understanding me then delivers personal help to me and my family ...

Developing an understanding of a patient in hospital takes time. People need personal care in their home, which means creating a personal understanding of them. The Care Coordinator *lacks adequate time* with the patient, as designed in the current process. For every minute the coordinator spends delivering on value with the patient, thirteen minutes or more are spent locating and documenting and transferring information along the process.

The paper-based documentation methods of moving information from hospital to field staff (and back), several hand-offs away, fails to transfer the knowledge necessary for either party to provide personal care. The result is care that sometimes doesn't help, can

be impersonal, and families who are left to navigate the system on their own.

Is the process capable of delivering *personal* help the clients and their families?

Interviewees provided a mixed response on this issue. However, it was clear that the fact of clients being happy with the personal nature of their care was due to the dedication and determination of the home care worker assigned to them, rather than the result of intentional process design.

With my changing situation, I need the information about my care and care options to be easy to find, understandable, accurate, and comprehensive

Is the process capable of providing information that is easy to find, understandable, accurate, and comprehensive? The words of the client heard most often in this process were: “I don't know”, indicating that the process is not delivering the information needed by the client, in the way that they need it.

The problem lies in the complexity. In the Hospital-to-home care process, this investigation observed nine separate databases, 35 forms/tracking sheets/brochures, across multiple hospitals, used in 84 observed instances across 11 handoffs and close to 250 steps across several agencies using communication methods centered on fax, voicemail, and some electronic communication.

This complexity results in excessive recopying of information onto forms and re-entry into databases. This is a significant source of process waste, and the result is information that is hard to find, not

understandable, inaccurate, and not comprehensive in any one place.

As a result, the process evolves to fit the systems and forms that exist, instead of designing the systems and forms to fit the process.

For example, consider the information that the client needs when leaving the hospital. From the client's perspective, the process would provide the client with the following as the client is being discharged:

- 1) The name of the agencies working with them
- 2) The time of the first visit
- 3) The name of the person to be working with them
- 4) What to clearly do if they have a problem.

However, the system exists such that the assignment of agency is not done until the intake package has been sent to the main CCAC office, where offers are made to different agencies based on contractual obligations. Since the process design is centered on a departmental level business requirement rather than on the client, the process is incapable of delivering value as per the client's needs. Furthermore, a patient with service arranged could have his/her discharge date changed, even further complicating matters.

Overall Process Redesign Requirements

A process redesigned to deliver valued information about the client's care and care options that is easy to find, understandable, accurate and comprehensive would be able to deliver on the following principles:

- # 1. All information related to the client's first visit for all services that they would be on is available near to the time they are leaving (e.g., which agency, scheduled visit time, name of home care providers).
- # 2. Information presented to the client would be tailored such that it is understandable for them. First, this means purposefully spending face to face time with the client and their caregivers until all of their questions have been answered, and providing a reliable medium for follow up. Some standard information to communicate with all clients should be agreed upon, such as how to introduce the role of the CCAC. Second, design all of the information material that is handed to the client to be easily understandable by the client, concise, and absent of jargon. Test with users and focus groups before deploying.
- # 3. The question of "who do I contact" for inquiries regarding care and care options would be completely unambiguous for both the client and caregiver. If a call was placed to the incorrect place, there would be a seamless transition to the right place.
- # 4. Whoever the client may interact with (Care Coordinator, Nurse, PSW, etc...) would be able to provide up-to-date key information to the client such as visit schedule, care plan, status of delivery for supplies orders, etc.
- # 5. All computer system interactions for the Care Coordinators and other staff would be elegantly streamlined according to

their workflow, not divided into arbitrary system blocks. It should be simple to use, making the process faster, easier, and more accurate.

- # 6. An IT system designed around the process, starting from the hospital (and community) referral through the CCAC and connected to the service provider agencies and vendor. (Note that TCCCAC has the beginnings of this with the CCAC portal which links some limited information between the CCAC, agencies and vendors).
- # 7. Elimination of faxes and courier bags wherever possible, replace with electronic methods of transmission such as e-forms or database (after the forms have been redesigned and simplified).
- # 8. All organizations involved in the continuum of care would know when a client is admitted to the hospital (CCAC, Service providers, vendor).

6. Moving forward

Challenging the way we think about Home Care Access

A number of questions were generated about access to home care and delivery processes thereafter:

1. How does one minimize complexity for patients in light of a brokerage model?
2. What should integration look like in community care?
3. Is it possible to collect only that information required for an optimal client experience?
4. How do we create more value from assessment information? When is assessment information irrelevant?
5. How do we ensure all community care staff are oriented to delivering care versus excessive travel and reporting?
6. How do we invest in health information technology enablement for processes that span a myriad of organizations?
7. How does one create a lasting community care Information Technology infrastructure in an environment where contracts begin and end?
8. How do services of a CCAC better mesh with the other community services (e.g., home support)? How can this broader system of care become less confusing to the public and clients?
9. If a client wants more home care services than what they are eligible for (e.g., personal support), is it appropriate to present them with for-pay options?
10. How do we develop quality measures and targets for improvement that are based in the client's experience?

11. The client's experience is the sum of interactions of many disciplines in care processes spanning many organizations. How can the current discipline-based approach to managing CCAC contracts lead to an improved client experience?

These are not easily answered and may challenge some of the working assumptions underlying today's system design.

Future areas of inquiry

The following list of questions could be explored in future process/value investigations.

1. How does what's valuable to the client/ caregiver differ between regions of the province (i.e. rural/small town vs. urban)?
2. Approximately 50% of people access home care from their home setting (not hospital). What is important to people in this community intake process? How well is the process performing?
3. What does community care 'value' look like to people requiring short term acute, cancer care, palliative care, care in school, etc.?
4. What is the best division of labour between the Social Worker and CCAC Care Coordinator, so as to be most effective at delivering value?

Current status of improvement actions

Toronto Central

During the past year, Toronto Central CCAC has initiated a redesign of its current service delivery model. The focus of change is on improving value to clients, more effectively supporting transitions, and helping hospitals address short and long term wait time and capacity issues.

This project has had a significant influence on CCAC planning and has helped to set priorities for transformation. Key building blocks of the approach are outlined below.

A Population Focused Model of Care Coordination

TCCCAC is transitioning from a geographic focus to a population focused case management model, where case managers specialize in caring for certain client types. This will enable case managers to gain a better understanding of client and caregivers, tailor processes and communications to meet their needs, and strengthen partnerships with stakeholders including physicians, hospitals, psycho geriatric resources and others. Given their vulnerability and the results of this project, frail seniors at risk of losing independence will be the first in a series of population-focused teams in the future.

Intensive, Continuum-Focused Case Management for Targeted High Risk Populations

The population-based model will introduce a more intensive case management model for targeted high-risk populations. Intensive case management has the potential to reduce avoidable admissions

to hospital, improve pre-planning and more proactively identify and respond to issues of caregiver fatigue. In this model, care coordinators will follow their clients through the continuum of care. Seniors receiving home care who are admitted to hospital will be followed by their existing community care coordinator, who can help them prepare to return to the community and support them make decisions about their next care destination.

Organizational Focus on the Client Experience

Toronto Central CCAC has committed to deepening its understanding of the experience of clients. Promises of care and service commitments are being established across all areas of client service. Specialized training and orientation has been developed and the provincial client satisfaction survey has been adjusted to capture more feedback from clients. Other client experience initiatives underway include:

- **Introduction of Client Quality Check Points** – Toronto Central CCAC now performs check-in calls to all newly admitted clients 1-2 days post-discharge from the hospital. This is intended to provide support to the client in their transition and to proactively address any issues or concerns that they may have with their service.
- **Communication Redesign** - Toronto Central CCAC has redesigned all client brochures based on feedback from this report and client focus groups and input. The message is simple – Help is a phone call away. Call centre staff have been retrained to provide a warm embracing experience for all callers and further work is underway to take the call centre response to a new level.

Waiting at Home & Seniors Independence Project

These two projects have allowed Toronto Central CCAC to test very different approaches to supporting seniors and their caregivers. One is community based, with a goal to help seniors remain independent in the community safely with more integrated support. The other is a hospital 'in-reach' program where community care coordinators work with CCAC staff in hospitals to support clients to get back home. TCCCAC has seen significant diversions from long-term care as well as vastly improved results in measures of client experience and satisfaction. Evaluations of these programs are available from Toronto Central CCAC.

Together We Care

In March 2009, Toronto Central CCAC co-authored "Together We Care", a white paper exploring innovative ways to support patient flow across the continuum during times of growing demand and reduced capacity. The focus is on transforming system culture and behaviours related to clients – particularly when it comes to traditional assumptions about long term care. The mantra is keeping people home and getting people back home. This paper was tabled at the hospital leadership (CEOs) in the Toronto Central LHIN, who recognized that we need a change in approach across the continuum at every level of the organizations that serve clients. The next step includes a round table on the subject and research into an integrated model of care for seniors.

Hospital Transformation

Toronto Central CCAC has committed to transforming how it works in hospitals with a goal to improve the value that it brings to clients, rethinking key processes, and building stronger relationships with hospital partners at all levels of the organization. A number of

significant changes are planned for the coming year, including a new approach to working in the emergency department, redesigned processes and workflows, and improved information and support for clients as they transition home or to other care destinations.

Other initiatives include:

- **Home First** – The "Home First" approach is about creating an environment where life-altering decisions are not made in an acute care bed. It has the potential to transform the current referral process to long term care by refocusing everyone, including discharge planners, physicians and the CCAC, on the idea that patients should go home first if they are able. Patients are assessed for their ability to go home with CCAC support; decisions about long term care are made once a client has returned to the community. *Home First* has shown dramatic improvement in other jurisdictions, both in terms of client experience and in reduced ALC to long term care. Toronto Central CCAC is planning to phase in a Home First approach with all of its hospital teams beginning in Summer 2009.
- **Early Notification and Involvement of CCAC in Hospital** - A new automated referral system is being implemented in the Toronto Central LHIN. Fundamental to this system is an early notification to the CCAC of a hospitalization to improve the timeliness and opportunity for their involvement. In early tests, this has been critical to getting people back home (as opposed to long term care) and providing improved support to clients and families.

Crisis Placements

1A crisis placement designation gives priority to hospital patients in the LTC Home placement processes, causing a ripple effect across the system that has real impact on the client experience. This report verifies that 1A Crisis Placement (Hospital Priority Access) causes confusion and may cause further hospitalizations. Toronto Central CCAC and Toronto Central LHIN have a steadfast commitment to avoiding the assignment of 1A status to hospitals. However, Toronto Central CCAC continues to feel the impact of other LHIN areas when they use this priority method, and has therefore escalated this issue to a provincial review table.

Commitment and Focus from Board to Front Line

Toronto Central CCAC has committed to three major aims for 2009/10 that demonstrate wide spread commitment to transformational change. Overall transformation will occur over two to three years as we fundamentally drive a 'client experience' focused culture through the new organization. These aims included

- Transforming Our Clients Experience;
- Transforming Our Work and Role in the Hospital;
- Building Our Quality and Safety Capacity Across the Organization.

"This project, combined with others... was pivotal for the Toronto Central CCAC in challenging our thinking and behaviours. It significantly informed our path forward. We have chosen to radically change the way we are structured, organized as well as how we approach care for our clients as a result."

Appendix A : Staffing Structure Toronto Western Hospital (TWH)/ CCAC Site

Patients and caregivers come in contact with two primary roles at TWH who facilitate their transfer from 'hospital to home care'. Other members of the health care team are involved in providing care and may assist by providing information to these personnel. They are not described here because arranging home care and/or long-term care is not their main responsibility – for example, the General Practitioner, internist, or the unit Team Leader.

Social Worker (SW)

At TWH, the patient's main contact for discharge issues is the Social Worker (SW). The SW is a hospital employee. The SW uses a number of approaches to identify clients who may be at high risk of exceeding the hospital's expected length of stay due to their more complicated situation (e.g. frailty, co-morbidities, living arrangements, etc), or who may need home care services.

Once the patient has been identified, the SW works with the patient, family and care team to locate post-acute care options. A 'continuum of care planning intake' tool is hand completed by the SW which outlines the key dates and events within the patient's hospital stay. The SW implements the discharge plan. Clients in this study had been referred by the SW to CCAC for home care service. A SW *may* also make a linkage to other community resources to maintain the patient's independence in the community (e.g. retirement homes, Hospice, Meals on Wheels, Alzheimer Day Programs, etc.).

Hospital Care Coordinator (HCC)

This Hospital Care Coordinator is a CCAC employee and is responsible for arranging home care services (e.g. personal support service, rehab, nursing, etc). The HCC sees the patient in their hospital room and completes an assessment to identify services and equipment required to facilitate a safe discharge back to their personal residence.

Community Care Coordinator (CCC)

The Community Care Coordinator is a CCAC employee who is responsible for managing changes to the client's care plan and quality of service after they have arrived back at home. The Community Care Coordinator revises the care plan of clients as needs change, and manages the quality of care delivered.

Appendix B : Acronyms

- ALC** – Alternate Level of Care
- CCAC** – Community Care Access Centre
- ED** – Emergency Department
- CCC** – Community Care Coordinator
- CM** – Case Manager
- HCC** – Hospital Care Coordinator
- HC** – Home Care
- LHIN** – Local Health Integration Network
- LTCH** – Long Term Care Home
- SPA** – Service Provider Agency
- SW** – Social Worker