Notes on Accountability

- PM&A Accountability part of role. MOHLTC set up CCAC senior management teams in 2007 with the exact same positions for each of the 14. Changed over time, but intent was to have a separate role in org responsible for accountability. Similar role in LHINs. Noted that it was important enough to create a member of the senior team responsible for that oversight function.

- I don't believe anyone is going to dispute the need for appropriate accountability. As a taxpayer and a patient, I want to know that my needs will be looked after and I want it demonstrated to me. When things go wrong I want people to tell me that they went wrong, why they went wrong and what will be done to fix it. As someone who is a senior manager in the system, being able to demonstrate accountability and assure my stakeholders that I and my organization are accountable – this also affords me a measure of protection.

- Benefits of Accountability
  - Clear advantages for the recipients of the services
  - Better protection for those that operate in the system
- Challenges of Accountability
  - Making it very clear what you are held accountable for and why – simplicity & consistency of message, and alignment with measures
  - Ensuring that what you are measuring is directly correlated to what you want to achieve, and that there are no unintended negative consequences
  - Doing more than the minimum required

- Will talk about the 3 major challenges with accountability using examples from different levels including system, internal CCAC and between CCAC and contracted service providers

1) Making it very clear what you are held accountable for and why – simplicity & consistency of message, and alignment with measures

- CCAC Senior Team participation in CHQI LPE course. 16 month program designed to make quality the 'core business'. Based on IHI principles and one of the things it helped us do was identify clear, simple strategic goals for the whole organization and then align 3-6 'big dot measures'. Then everything cascades from there.

- 3 major aims – 5-6 big dot measures. Example: 'Keeping People Home, Getting People Home' strategies aligned with avoidable hospitalizations, ED/ALC getting people out of hospital and then once they're home, reducing # of people going to LTC before their time. Major activity is Home First. 2-3 measures about the rate at which we can get people home and then

determine whether or not they should go to LTC vs declaring them as headed for LTC and then they wait in an ALC bed. Acuity of people going into LTC making sure that we are only placing people in LTC who cannot be supported anywhere else in the system.

- We've reorganized our internal performance system to say we have a few major goals and a few major performance measures that we focus on, and this, according to IHI, is best practice for quality.

- The challenge for me is that the system I work in is not organized that way. CCACs have accountability measures set by the MOHLTC, LHINs and HQO. We are also have reports on our performance from ICES and the Auditor General. Each of these different stakeholders have different measures and tell us different areas to focus. I'm not telling you anything you don't know if I say there is no single set of agreed upon goals for what CCACs are supposed to do and no single set of measures that we held accountable to. The most recent QMonitor has 30 indicators for CCACs. The MSAA has 5 Core indicators- 8 accountability indicators – 12 explanatory indicators and 68 costing detail indicators, ICES yesterday released its Chartbook on Aging that has a bunch of indicators and the A-G report held us accountable for numerous other areas of improvement.

- What does the health care system want CCACs to focus on? If I were to recommend something, I would say to help Ontario achieve the lowest institutionalization rate (incl hospitals & LTC) for OECD countries. Period.

- I think the system should then measure the CCACs performance for the following:
    - Client experience
    - ALC for those people waiting for home care & LTC
    - Avoidable hospitalizations for CCAC clients, including readmissions and ED visits
    - Acuity of clients admitted to LTC
    - Having a sustainability strategy

- That's it. Pretty much any other indicator you measure us on is a contributing factor to one of these other measures.
- My strongest recommendation on system-level accountability, is simplicity , clarity and alignment.

2) Ensuring that what you are measuring is directly correlated to what you want to achieve, and that there are no unintended negative consequences

LHINs and HQO wanted the following measures for CCACs:
- wait times – referrals come from hospital & community.

- Time between referral and assessment & first service visit from hospital (1-3 days)
- Current practice is that we get referral & do assessment on day patient is going home and services start with 2 days. So performance is 1-2 days. The problem is this reflects poor practice. In fact, the time between referral and assessment should be growing in hospital. We want hospitals to refer patients to us as early as possible so we can plan well in advance for smooth discharge home
- Time to first nursing visit – 63% of nursing visits happen in 2 days of hospital discharge. Recent discussions with HQO have asked us to increase the number of nursing visits that happen within 2 days. No evidence for this. Work in the US on specific acute CMGs showed evidence that reduced admissions, but no reason to make this for all nursing clients. In fact, no need for lots of reasons, including new wound care products that require fewer visits, etc.

3) Doing more than the minimum required

relationship between CCAC and contracted providers
- Case management is ours vs most other services with other organizations
- complex relationship because it functions on 2 very different levels:
    - service providers are contracted providers to the CCAC and therefore held accountable for meeting the standards of care and quality in the contracts
    - they are also our most significant business partners. We could not do what we do without them.
    - Can get confusing

Contracts are an important tool in holding 2 or more parties accountable for upholding an agreement.
- The contracts are quite old (7 years), including the accountability measures. Multi-year moratorium on procurement.
- Haven't been able to update the performance expectations in the contracts
- In that time, huge shift in expectations around quality and client experience
- Need to shift entirely from contracts that incent transactions and volumes (fee for service) to new age contracts that incent outcomes, client experience and quality (pay for performance)
- We have 2 options
    - 1. Option 1 update the contracts, include performance incentives for higher quality, higher performance. Block funding to pay for outcomes not visits. Shift volume to agencies with higher performance, better client experience scores, etc. But can't do that yet. Desperately want to.
    - 2. Option 2, is Focusing on business partner vs contractor relationship. We want to drive improvement in client experience. Not going to happen via our contracts. Need to create a

common tsunami of change and reorientation around client experience. This means change at the front line – of the thousands of home care workers working in Toronto everyday, only 500 are our employees. Working with the senior teams and have got them on board to work with us co-leading a common strategy across all our organizations on improving client experience. Plan to publish the scores by provider so we are holding them accountable through an incentive for change.

Summary

1) first create goals, then create alignment of performance measures against those goals. Make sure the goals are at a system, not micro level. And make sure there are few of them (5-6, not 30). Ministry – LHIN – CCAC – SPO- HQO all lined up and moving in the same direction on a few key system level measures.

   Example of NHS where they had 1 of 5 NHS Strategic Goals, one of which was patient safety. A random interview with hospital staff showed one cleaner could identify how she was driving the NHS goal for increased patient safety because her job was to clean the patient rooms and reduce the chance of infection. Impressive. Clarity of direction can be achieved in Ontario, we just need the political will to make it happen.