

Hospital Report



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COMPLEX CONTINUING CARE

HOSPITAL REPORT
HRRC
RESEARCH COLLABORATIVE

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This report is brought to you by the Government of Ontario in partnership with the Ontario Hospital Association.



ABOUT THIS REPORT

Quality improvement has become an integral part of health care, and hospitals are no exception. In recent years there has been increasing interest in health-system performance measurement in order to provide the information that is required for the effective management of hospitals across Ontario.

Hospitals are faced with many challenges in order to offer the best possible care. This means ensuring that high quality care is provided when and where it is needed, while at the same time effectively managing resources. Measuring quality and efficiency in health care facilities is critical for managing them. Providing comparable information on performance benefits providers of care as well as the public interested in understanding the issues facing Ontario hospitals.

Better information allows hospitals to identify areas where there may be a need for improvement and monitor progress. Sharing this information allows users of the health care system to know which questions to ask, and gives health care providers and decision-makers the evidence that is needed to further improve the quality of health care.

Hospital Report 2007: Complex Continuing Care is a hospital-specific report that uses a balanced scorecard approach to provide information on the performance of hospitals that provide complex continuing care (CCC) in Ontario. The objectives of this series of reports are to facilitate local quality improvement programs, encourage openness and transparency in reporting and to support hospitals' accountability to the communities they serve.

WHO SHOULD USE THIS REPORT?

This report is designed for health care providers, managers, as well as others interested in the performance of hospitals in Ontario. The primary audiences for this report series are hospital boards of directors and senior managers, and local health integration networks (LHINs). Results should also be shared broadly among hospital staff, patients, families and the public at large.

To ensure optimal use of the scorecard results, board members and senior managers can use the information in this report for strategic planning and priority-setting within their hospitals. By identifying indicators for which their hospital's performance is lower than average they can direct resources and refine/develop corporate policies to facilitate quality improvement in these areas. Within an environment of competing demands, boards need to ensure that the organization's culture supports an enduring commitment to quality improvement.

Hospitals can use these indicators to describe, evaluate, and compare their performance. The results can be used to monitor improvements and outcomes related to specific quality improvement initiatives within hospitals. By comparing hospital-specific results to the provincial average and to peer hospitals' performance, individual hospitals can evaluate their progress in their quality improvement initiatives. These high-level comparisons can also be a first step for hospitals to identify opportunities for improving quality of care. The next step for hospitals would be to examine their own data that support the indicators, to understand the underlying factors contributing to their hospitals' results. Finally, hospitals can also use this report to identify other hospitals from which they might seek opportunities to learn.

Members of the public can use this report to better understand some of the issues facing the health care system. Public reporting of hospital performance can help to promote a culture of transparency so that Ontarians know that quality care will be available when they need it.

i. A free-standing complex continuing care hospital, as defined in this report, generally meets the following criteria: (a) does not have acute care patients; (b) reports statistical, clinical and financial data separately (from other hospitals or facilities) to the Ontario Ministry of Health and Long-Term Care; (c) has its own chief executive officer (CEO) and board; and (d) is a physically separate building.

This report focuses only on publicly funded chronic care beds. These beds can be found in i) free-standing complex continuing care and rehabilitation hospitals; or ii) acute care hospitals as stand-alone designated beds or within designated units. These facilities provide continuing and specialized services to medically complex patients, who usually have multiple health problems and/or functional impairments. There is variety in the types of services provided, which includes active rehabilitation of these medically complex patients; palliative and end-of-life care; and also support to families with respite care needs.

This report classifies hospitals that provide complex continuing care services into two groups: free-standing complex continuing care hospitals,ⁱ and acute care hospitals with complex continuing care programs. The former are hospitals with a primary mission related to servicing complex continuing care and rehabilitation populations. The latter are hospitals that also serve other populations (most commonly by providing acute care services) in addition to their complex continuing care role.

Concepts

In this report the term **hospital** refers to both single-site organizations and multi-site organizations that provide CCC services. The term **facility** refers to specific sites within a hospital corporation (that is, hospitals can have more than one facility).

A SNAPSHOT OF HOSPITAL ACTIVITY IN ONTARIO'S LHINS

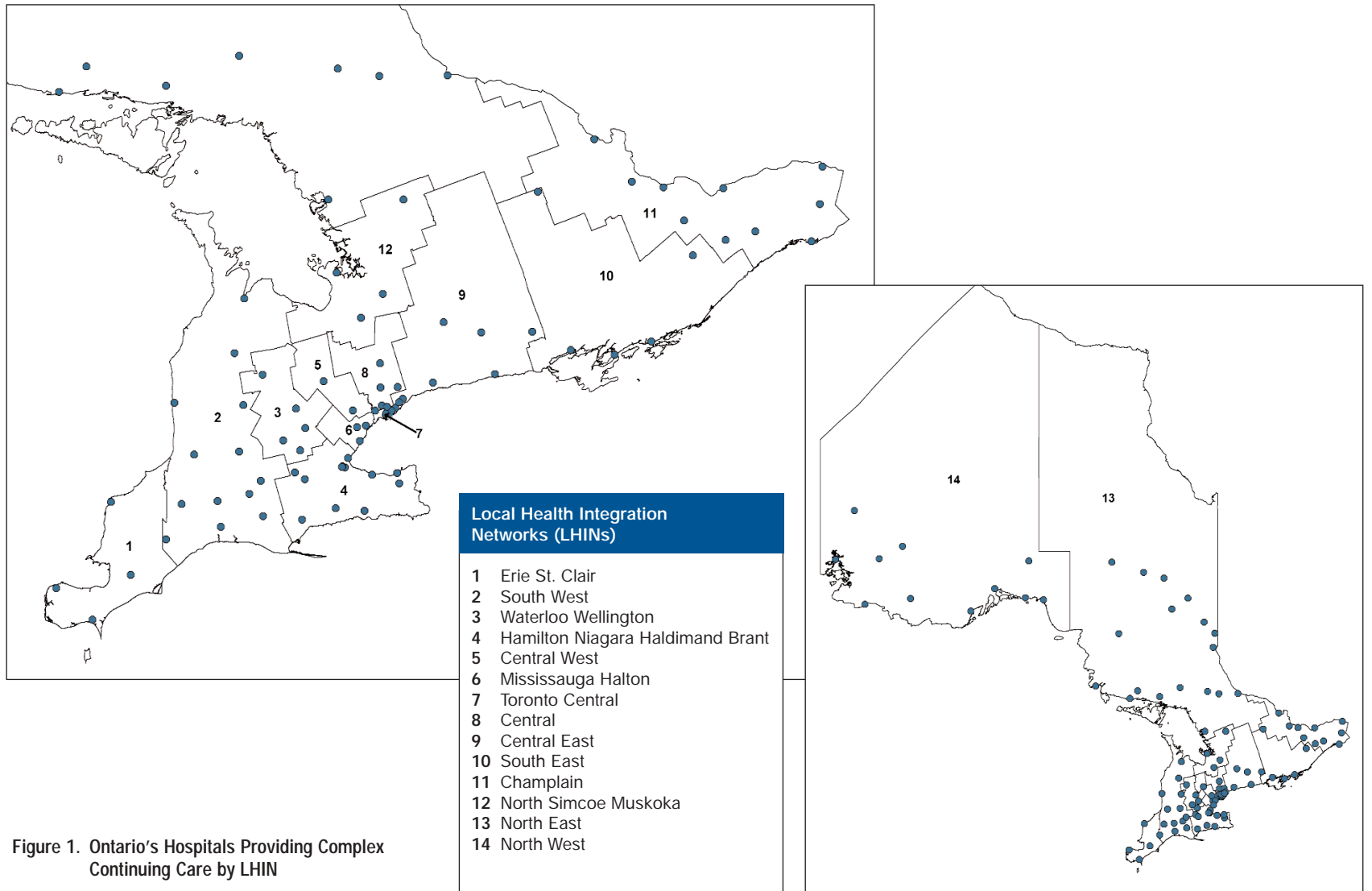


Figure 1. Ontario's Hospitals Providing Complex Continuing Care by LHIN

This section highlights selected characteristics of local health integration networks (LHINs), providing context for interpretation of the complex continuing care (CCC) indicator results.

Table 1 shows the proportion of Ontario CCC population served by LHIN and lists the number of CCC hospitals in each LHIN by size (based on the total number of patient days in 2005–2006) and whether they were free-standing or associated with an acute care hospital. While all LHINs provided CCC services, the number of hospitals within the LHINs varied from 2 to 18. The 12 large free-standing hospitals tended to be located in the large urban centres; in particular, the Toronto Central LHIN had seven of these hospitals. In contrast, the numerous CCC units associated with small acute care hospitals were more likely to be located in rural areas.

The Central West LHIN, which has one medium and one small hospital, served only 1% of the CCC population. Toronto Central and Hamilton Niagara Haldimand Brant LHINs served, by far, the largest proportion of the CCC population; 20% and 15%, respectively.



Table 1. Hospitals Providing Complex Continuing Care in Ontario

LHIN	Percent of Ontario CCC Patients	Free-Standing Hospitals		Acute Care Hospitals With CCC Units/Beds			Total	
		Large	Small/Medium	Large	Medium	Small		
1	Erie St. Clair	7	0	0	1	2	1	4
2	South West	9	0	0	1	3	9	13
3	Waterloo Wellington	7	0	1	1	1	2	5
4	Hamilton Niagara Haldimand Brant	15	2	0	1	3	6	12
5	Central West	1	0	0	0	1	1	2
6	Mississauga Halton	8	0	0	1	2	0	3
7	Toronto Central	20	7	0	1	1	0	9
8	Central	3	0	1	0	1	2	4
9	Central East	8	0	0	1	1	5	7
10	South East	5	1	0	0	1	2	4
11	Champlain	5	1	1	0	0	9	11
12	North Simcoe Muskoka	4	0	1	0	2	1	4
13	North East	3	0	0	0	2	16	18
14	North West	6	1	0	0	0	10	11
Ontario		100	12	4	7	20	64	107

Notes: The Percent of Ontario CCC Patients adds to 101% due to rounding.

Small: less than or equal to 10,000 patient days in 2005–2006.

Medium: between 10,001 and 30,000 patient days in 2005–2006.

Large: over 30,000 patient days in 2005–2006.

Source: Continuing Care Reporting System, 2005–2006, CIHI.

In total, there are 107 hospitals in Ontario with CCC services and 134 facilities.

The LHINs also served different patient populations, as seen in Table 2. Overall, a quarter (26%) of CCC patients were defined as being chronic. The percentage of chronic patients ranged from 4% to 50% across LHINs. To be defined as chronic, a patient must stay in the CCC facility long enough to have two Resident Assessment Instrument Minimum Data Set (RAI-MDS) assessments (usually around 100 days). Therefore, LHINs with a higher proportion of chronic clients tended to have a longer median length of stay.

The percentage of patients who died in CCC also varied by LHIN, ranging from 13% in the North East LHIN to over half (53%) in the Mississauga Halton LHIN. There was similar variability across LHINs in the percentage of CCC patients who were discharged home. These data suggest that there are important differences in the patient populations across the LHINs.

Overall, LHINs vary considerably in the number of facilities within their boundaries, the populations they serve and the services they provide. For example, more than half of the patients of CCC facilities in the Mississauga Halton LHIN died in the facility, and only 10% were discharged home, suggesting that a large proportion of the patients in this LHIN received end-of-life care during their stay. In contrast, facilities in the Central East LHIN had a smaller proportion who died in the facility (19%) and a much larger proportion (31%) who were discharged home.

Readers should be cautious and take into consideration these differences when interpreting the indicator results at the LHIN level. However, these differences do not necessarily explain the findings and all the variation that may be observed, as other factors need to be considered at the hospital level within each LHIN (including variations in clinical processes and resources that may affect the patients' quality of care and their outcomes). Where variation in indicator results is observed, further investigation is warranted to explore the opportunities for shared learning and process improvement.

Table 2. Selected Complex Continuing Care Characteristics by LHIN

	LHIN	Chronic Patients	Median Length of Stay (days)	Died in CCC	Discharged Home
1	Erie St. Clair	22%	23	32%	18%
2	South West	19%	19	28%	23%
3	Waterloo Wellington	12%	24	32%	30%
4	Hamilton Niagara Haldimand Brant	21%	25	32%	24%
5	Central West	4%	27	19%	41%
6	Mississauga Halton	20%	14	53%	10%
7	Toronto Central	49%	42	25%	14%
8	Central	7%	19	37%	21%
9	Central East	15%	27	19%	31%
10	South East	19%	23	35%	23%
11	Champlain	50%	34	22%	20%
12	North Simcoe Muskoka	14%	26	30%	19%
13	North East	37%	36	13%	12%
14	North West	21%	26	25%	42%
Ontario		26%	25	29%	22%

Source: Continuing Care Reporting System, 2005–2006, CIHI.

A BALANCED SCORECARD



WHAT IS A BALANCED SCORECARD?

Providing care in a health care facility is a complex activity involving a multitude of skills, experiences and technologies. No single aspect of the system causes poor or excellent hospital performance. For this reason, performance-measurement activities must include measures that provide insights into multiple dimensions of a hospital's performance. The balanced scorecard approach describes performance across four dimensions or quadrants critical to the strategic success of any health care organization. These quadrants include: System Integration and Change, Patient and Family Satisfaction, Clinical Utilization and Outcomes and Financial Performance and Condition.

Performance measures for each of the four quadrants are provided at the hospital-specific level, along with average scores by local health integration network (LHIN) and the province as a whole.

While all hospitals values are used in calculating average results by LHIN, hospital type and the province, hospital-specific values are shown for hospitals that had sufficient data and agreed to have their results published for quality improvement purposes. This year, 81 out of 107 (76%) hospitals with designated CCC beds participated in at least one quadrant and 20 (19%) hospitals participated in all four quadrants of the report.

Using a balanced scorecard format, this report provides a summary of performance scores for 39 indicators across four areas of performance.



System Integration and Change

This quadrant measures efforts made by Ontario hospitals with complex continuing care programs to increase collaboration with other providers, improve coordination of care and invest in better information for decision-making. [7 indicators]

Patient and Family Satisfaction

In participating hospitals, trained staff interviewed patients who consented and were able to respond to an interview. As well, the person who visited the patient most frequently (generally a family member) was mailed a questionnaire to complete to reflect family satisfaction with the program. In complex continuing care, family members of patients are considered to be clients and "recipients of care" as well. [13 indicators]

Clinical Utilization and Outcomes

This quadrant presents indicators of processes and outcomes important to evaluating the quality of clinical care provided in complex continuing care programs. Twelve of the 13 indicators reflect care provided to "chronic" patients (admitted to a CCC bed for a minimum of 100 days); the remaining indicator reflects care provided to shorter-stay patients (with stays typically under 100 days). The indicators describe changes in physical functioning, cognitive and psychosocial functioning, continence, care complexity and medication use. [13 indicators]

Financial Performance and Condition

This quadrant describes the efficiency, productivity and sustainability of complex continuing care programs. The comparative results reflect financial performance and condition for free-standing hospitals only. These are hospitals that provide only complex continuing care and/or rehabilitation services, and do not provide acute care services. [6 indicators]

“HIGH-PERFORMING” HOSPITALS



HIGH-PERFORMING HOSPITALS WITHIN QUADRANTS

System Integration and Change

Criteria

Hospitals that scored above average on at least 4 of 7 indicators and did not score below average on any of the indicators.

Hospitals

No hospitals met the high-performing hospital criteria this year.

Patient and Family Satisfaction

Criteria and Hospitals:

As a good proportion of the participating hospitals did not have sufficient numbers of respondents to be assigned a performance allocation, Patient and Family Satisfaction indicators were not included in the process of identifying high-performing hospitals.

Clinical Utilization and Outcomes

Criteria

Above-average on 7 out of 13 indicators and no below-average rating on any indicator.

Hospitals

- Almonte General Hospital
- Bridgepoint Health

Financial Performance and Condition

Criteria and Hospitals:

There are no high-performing criteria for the Financial Performance and Condition quadrant.

For quality improvement purposes, methodologies are available to identify “high-performing” hospitals within two of the quadrants in complex continuing care.

It is useful to highlight hospitals that performed well in particular quadrants when compared to their peers, because these hospitals may be able to share useful ideas and best practices with other hospitals within the specific areas of focus. It is interesting to note that no hospitals were identified as high performing across both quadrants. This illustrates the importance of using a variety of measures, such as a balanced scorecard approach, when looking at hospital performance. Good performance in one quadrant does not necessarily translate into good performance in another quadrant.

In addition, high performance in a given year relates only to how hospitals perform based on the indicators calculated for that particular year. High performance is not necessarily a predictor of high-performing status in future years.

High-performing hospitals are listed in alphabetical order.



INTERPRETING THE RESULTS



Where Can You Find More Information?

Further information is available in the technical summaries, which can be accessed through the Hospital Report website at www.hospitalreport.ca. The technical summaries provide more detailed definitions of the indicators and the statistical methods used to calculate the results.

As there can be competing interests and incentives in the management of hospitals to maximize both quality and efficiency and maintain a balance of resources in the context of limited resources, no single indicator or quadrant should be used to assess a hospital. All aspects of performance are important. One quadrant, or one indicator, on its own will provide an incomplete picture of overall performance. The indicator results in this report should be viewed as screening tests that can identify potential opportunities for quality improvement. In medicine, screening tests do not provide a definitive diagnosis, but can help to identify patients that require follow-up. Similarly, comparisons of indicator results may not offer a definitive assessment of a hospital's performance. Further investigative work is required by hospitals to better understand the factors underlying their results and identify specific strategies or areas for improvement.

There are many factors that can cause indicator values to vary from hospital to hospital. Some of these factors, such as the diversity in patient characteristics and the populations served, are beyond a hospital's control. To reflect this, adjustment factors have been applied, as appropriate, in order to ensure meaningful comparisons within the balanced scorecard quadrants. Adjustment factors are described in more detail in the technical summaries available on the Hospital Report website (www.hospitalreport.ca).

While commonly accepted risk-adjustment techniques were used to reduce the effect of factors that are beyond hospitals' control (for example, age of patients) on indicator results, it is not possible to adjust for every factor. For this reason, comparisons of indicator scores among hospitals, hospital types and LHINs should be made with caution. It is also important to exercise caution when examining year-to-year changes in indicator values. This is because the methodology used to calculate indicators is reviewed annually, and in some cases, changes are made to improve the methodology over time.

INTERPRETATION OF BOX PLOTS AND PERFORMANCE ALLOCATION TABLES

Interpreting Box Plots

For each quadrant, a summary of the distribution of the hospital values for the indicators is presented graphically using a box plot. Hospitals can use these graphs to determine where their indicator value falls relative to other hospitals, the median value and the provincial average.

Figure 2 is a sample box plot.

The **vertical line** in the shaded box represents the **median value**; this is the value at which half of hospitals values are higher and half are lower.

The **shaded box** represents the **interquartile range (IQ)**; the middle 50% of hospital values will be contained in this range.

The **whiskers** or lines beyond the shaded box extend to the **largest and smallest values**, excluding outliers. That is, they contain approximately the top 25% and bottom 25% of hospital values.

Outliers, hospital values that are considerably different from the others, are identified by **circles** and **extreme outliers** are identified by **stars**.

The **provincial average** (38.3%) is displayed to the right of the graph.

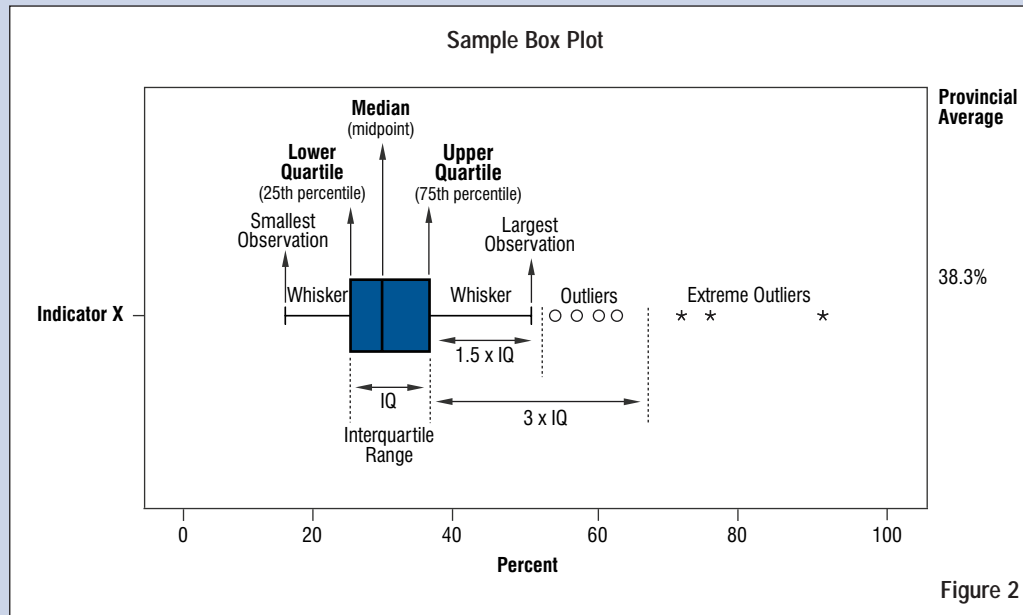


Figure 2

Interpreting Performance Allocation Tables

The performance allocation tables in this report show the indicator values for each hospital participating in that quadrant of the report. Also included is a shaded background that indicates whether the hospital's score on that indicator reflected above-average performance, average performance or below-average performance. For more detailed information on the methodologies used to assign hospital performance, please see the technical summaries provided on the Hospital Report website at www.hospitalreport.ca.

Coloured shading for performance is assigned as follows:

- The hospital's score reflected *above-average* performance.
 - The hospital's score reflected *average* performance.
 - The hospital's score reflected *below-average* performance.
- For some indicators, lower values suggest better performance. In these cases, lower values are labeled as *above average*.

Some results are not shown. This is explained by the following symbol.

- NR** NR means non-reportable—some results are not shown to protect patient or physician confidentiality, because the number of events was too low to obtain a reliable estimate or due to a data quality issue.

Performance Allocation

The method for assignment of performance allocation varies based on the quadrant. For Clinical Utilization and Outcomes, hospitals' indicator values were compared to the provincial average for all measures. For Patient and Family Satisfaction, classifications were assigned based on hospitals' scores compared to the provincial performance target. For System Integration and Change, performance classifications were assigned based on hospitals' scores compared to the provincial average. In the Financial Performance and Condition quadrant, performance benchmarks have been developed for two indicators (Total Margin and Current Ratio). For these indicators, a hospital's performance allocation is based on the relationship of its indicator score to the benchmarks. Scores that fall within the benchmark threshold represent good financial performance; scores that fall outside the threshold are considered to be poor financial performance and/or to require further investigation. Performance allocations are not calculated for the remaining indicators in the Financial Performance and Condition quadrant.

The System Integration and Change (SIC) quadrant describes a complex continuing care program's ability to adapt to a dynamic health care environment. It measures a hospital's focus on client-centred care, their use of information and information technology, as well as practices to ensure that complex continuing care staff have the skills needed to care for patients with increasingly complex needs.

Indicator Definitions

Evidence-Based Practice (Revised)

The extent to which hospitals use and integrate one of several specified practice guidelines, and the number of clinical issues for which hospitals have guidelines.

Evidence of Client-Centred Care

The extent to which hospitals are providing patient care in a client-centred manner, at the individual client level. Four main components form this indicator: patient/family education, family involvement in patient care, patient involvement in decision-making and emotional support for patients/families.

Integration of Care (Revised)

The extent to which CCC services are collaborating on a range of activities with other levels of care and other service providers. These activities include formal consultations on the development of standardized admission and discharge criteria, integrated development and application of practice guidelines and joint initiatives with other service providers.

Use of RAI-MDS in Quality Improvement and in Clinical and Utilization Management Applications (Revised)

The extent to which hospitals utilize RAI-MDS data with respect to level of reporting detail, dissemination of results and decision-making about clinical care and quality improvement.

Use of Information Technology

The extent to which CCC services are performing clinical functions "online" in real time, and the extent to which hospitals use electronic records/data as a primary source of information.

Use of Staff Skills/Competencies Descriptions Specific to Complex Continuing Care (Revised)

The extent to which staff skills/competencies descriptions have been (a) developed and address various categories of patient care needs within CCC services and (b) applied to staff development and training, performance appraisals and hiring processes.

Healthy Work Environment (Revised)

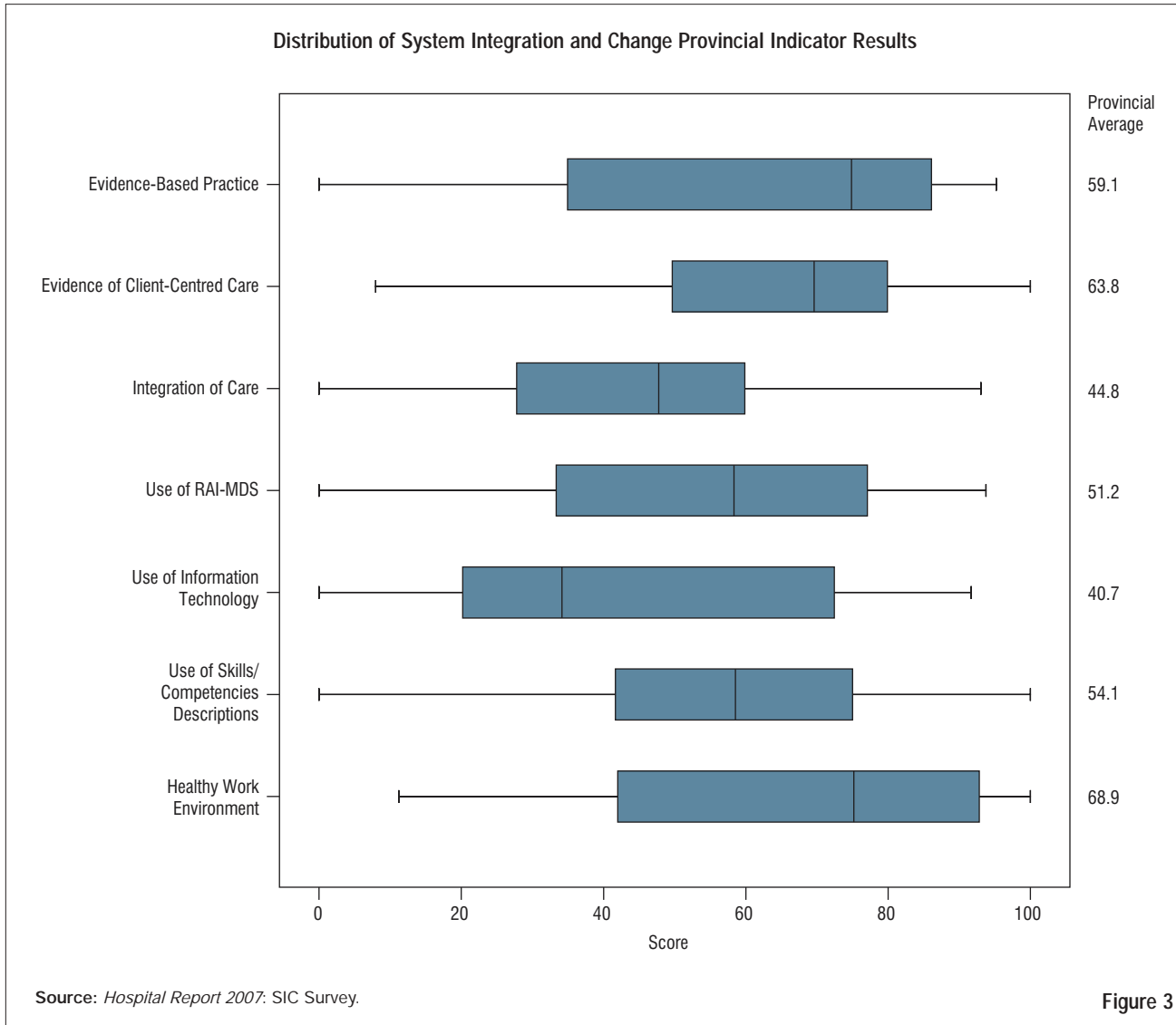
The extent to which hospitals have mechanisms in place to support and promote a healthy work environment, thereby contributing to employees' physical, social, mental and emotional well-being.

Data presented are based on results from a survey completed on a voluntary basis by hospital managers in February 2007. In total, 80 hospitals with complex continuing care services completed the survey.

The introduction of a web-based SIC survey allowed for a more streamlined process for hospitals to submit their responses. Please note that this year there have also been significant changes in the indicator weights and methodologies and performance allocation methods. Caution should be taken when trending indicator results from previous years. For a complete listing of all the changes introduced this year, please refer to this year's technical summary (available at www.hospitalreport.ca).

This year, the Healthy Work Environment indicator has been included in all sectors (that is, Emergency Department Care, Complex Continuing Care, Rehabilitation and Acute Care). Hospitals that participated in multiple sectors have the same Healthy Work Environment score across all sectors. However, the provincial average and performance allocation for this indicator is not consistent because it includes only participating hospitals within that sector.

SUMMARY OF RESULTS



For more information on the interpretation of box plots, please refer to the Interpreting the Results section in this report.

Figure 3 depicts the distribution of scores and the provincial average (mean) for each of the indicators. There is considerable variation in scores for the majority of the indicators. Hospitals can use this figure to see where their scores (found in the performance allocation tables) for each of the indicators fall relative to other hospitals' scores in the province. This figure is not meant to facilitate comparison between indicators.

SUMMARY OF RESULTS (CONT'D)

Hospitals are beginning to implement electronic records and data within their CCC services. This year, over 70% of hospitals are using electronic records as a primary source of information, 66.3% are using electronic records for patient registration and Admitting Discharge Transfer (ADT) systems, 61.3% are using electronic records for diagnostic imaging results, 58.8% are using electronic records for diagnostic laboratory results and 52.5% are using electronic records for the Resident Assessment Instrument Minimum Data Set (RAI-MDS). Although many hospitals are improving access to information through electronic means, there are opportunities for improvement. Approximately one-fifth of CCC hospitals used electronic nursing flow sheets and/or electronic recording of patients' progress relative to care plans or care maps.

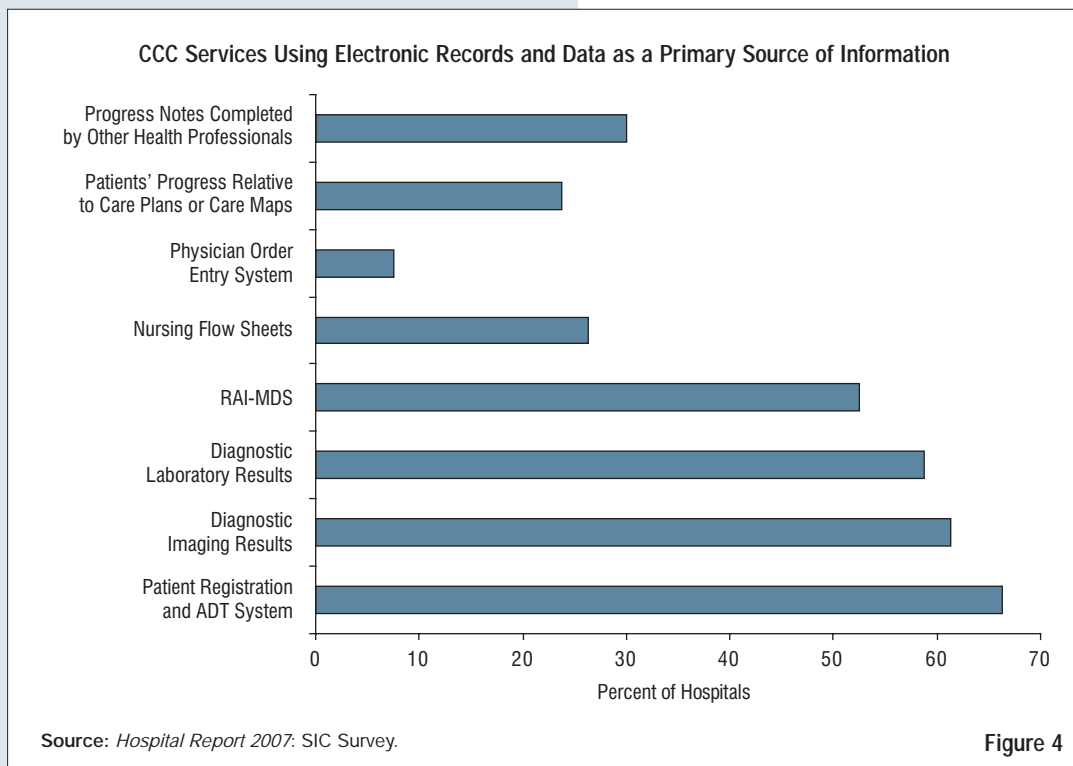


Figure 4

SUMMARY OF RESULTS (CONT'D)

There is also a wide range of clinical areas and conditions for which practice guidelines are available, which should be used in the care of all eligible patients. This year, most (90%) hospitals had a practice guideline in place for the use of physical restraints; 80% of hospitals had and used a practice guideline for wound, ulcer and skin care; and 73.8% of hospitals had and used practice guidelines for falls (Figure 5). However, fewer hospitals reported the availability and use of practice guidelines for depression (23.8%), urinary tract infection (25.0%) and incontinence (37.5%).

Sharing information with patients and incorporating them into the decision-making process are important steps for improving the quality and goals of patient care and treatment plans. Approximately three-quarters of hospitals (73.8%) incorporated formal processes to establish meetings between professionals and patients in order to involve patients in decisions regarding their care, treatment and discharge. Just over half (53.8%) of hospitals implemented a formal process of employing a designated contact person to address patients' questions, concerns and goals. Hospitals can continue to improve in these areas of patient goal-setting and decision-making.

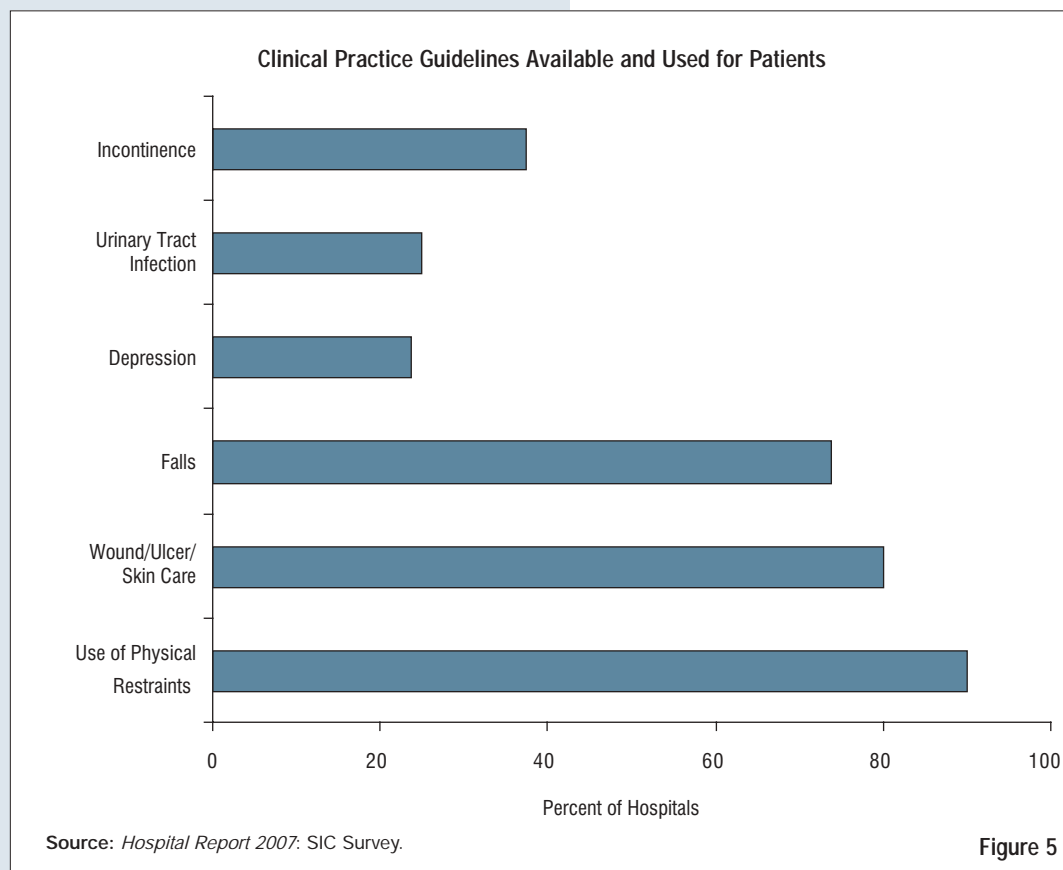


Figure 5

PERFORMANCE ALLOCATION TABLE

The performance allocation table shows results for 78ⁱⁱ hospitals that completed the CCC SIC survey and are participating in this report.

For each indicator, a higher score and above-average performance classification is interpreted as a better result. The maximum score for each indicator is 100. As in the previous report, a three-point scale (above average, average, below average) was used to determine performance.

Methodology Changes

In *Hospital Report 2005*, the method of assigning performance allocation was based on the interval of the mean ± 1.645 standard deviations. The end-points of this interval are the upper and lower cut-points for "above" and "below" average classification. With an assumption that the indicator values are approximately normal, this interval should capture roughly 90% of the indicator values.

However, this year, the high degree of variability in indicator scores caused the upper cut-point to exceed 100 for several indicators. This made it impossible for hospitals to achieve the "above-average" status.

To resolve this issue, a new performance allocation method was applied to all *Hospital Report 2007* SIC indicators. This new method sets the upper and lower cut-points at the 95th percentile and the 5th percentile, respectively. Like the original method, this interval should capture roughly 90% of the indicator values.

-
- ii. While 80 hospitals with complex continuing care services completed the CCC SIC survey and are included in the provincial and LHIN averages, hospital-specific results are shown only for those hospitals participating in this report. Two hospitals are not participating in this year's report, as they had no clinical assessment data for 2005–2006.

Hospital	Community Served	LHIN	Healthy Work Environment	Evidence-Based Practice	Evidence of Client-Centred Care	Integration of Care	Use of RAI-MDS	Use of Information Technology	Use of Staff Skills/ Competencies Descriptions
PROVINCIAL AVERAGE			68.9	59.1	63.8	44.8	51.2	40.7	54.1

FREE-STANDING CCC HOSPITALS

Baycrest Centre for Geriatric Care	Toronto	7	59.7	41.9	68.6	48.9	85.4	87.5	80.7
Bridgepoint Health	Toronto	7	94.5	83.0	100.0	66.7	83.3	36.9	70.5
Penetanguishene General Hospital Inc. (The)—North Simcoe Hospital Alliance	Penetanguishene	12	97.1	88.5	80.2	76.0	91.7	84.0	73.9
Providence Continuing Care Centre	Kingston	10	96.6	94.2	90.5	88.5	66.7	20.2	98.9
Providence Healthcare	Toronto	7	74.7	24.7	79.2	52.2	83.3	31.7	72.7
Sisters of Charity of Ottawa (SCO) Health Service	Ottawa	11	11.2	88.0	83.5	54.4	77.1	32.4	53.4
St. Joseph's Care Group	Thunder Bay	14	39.2	78.2	64.6	62.4	33.3	83.7	56.8
St. Joseph's Health Centre, Guelph	Guelph	3	83.8	34.9	73.6	50.3	50.0	32.4	41.7
St. Peter's Hospital	Hamilton	4	92.2	40.3	88.2	80.4	79.2	36.2	86.4
Toronto Grace Hospital	Toronto	7	91.1	74.6	74.8	37.5	85.4	20.8	75.0
Toronto Rehabilitation Institute	Toronto	7	93.8	81.3	72.4	66.7	87.5	25.0	100.0
West Park Healthcare Centre	Toronto	7	86.2	46.8	55.9	71.1	83.3	28.5	100.0

ACUTE CARE HOSPITALS

Alexandra Hospital	Ingersoll	2	91.1	38.0	55.7	92.1	64.6	30.8	65.9
Alexandra Marine and General Hospital	Goderich	2	20.2	79.5	38.9	22.5	6.3	88.1	0.0
Almonte General Hospital	Almonte	11	85.6	58.8	81.4	37.2	79.2	0.0	71.6
Atikokan General Hospital	Atikokan	14	70.6	0.0	8.0	0.0	0.0	0.0	0.0
Bluewater Health	Sarnia	1	87.9	24.2	62.0	28.8	18.8	83.7	0.0
Cambridge Memorial Hospital	Cambridge	3	42.0	86.1	77.8	61.9	37.5	64.1	40.2
Chatham-Kent Health Alliance	Chatham	1	75.6	41.3	40.8	84.9	85.4	80.1	62.5
Dryden Regional Health Centre	Dryden	14	94.3	39.4	67.5	20.0	0.0	20.8	48.5
Glengarry Memorial Hospital	Alexandria	11	72.8	22.2	57.3	10.3	20.8	0.0	0.0
Grand River Hospital	Kitchener	3	44.9	87.0	72.3	93.1	83.3	79.5	93.2

Hospital	Community Served	LHIN	Healthy Work Environment	Evidence-Based Practice	Evidence of Client-Centred Care	Integration of Care	Use of RAI-MDS	Use of Information Technology	Use of Staff Skills/ Competencies Descriptions
Groves Memorial Community Hospital	Fergus	3	92.9	29.5	79.9	50.0	70.8	0.0	73.1
Halton Healthcare	Oakville	6	100.0	87.8	81.2	51.0	43.8	84.0	84.1
Headwaters Health Care Centre	Orangeville	5	93.7	93.3	63.6	74.3	85.4	80.1	86.4
Hôpital Général de Hawkesbury and District General Hospital Inc.	Hawkesbury	11	89.0	18.9	54.2	27.8	47.9	23.1	50.0
Hôpital régional de Sudbury Regional Hospital	Sudbury	13	38.2	79.7	73.1	51.8	39.6	72.4	72.7
Huron Perth Healthcare Alliance	Stratford	2	53.5	81.0	83.0	43.0	56.3	88.1	41.7
Joseph Brant Memorial Hospital	Burlington	4	64.3	88.5	66.8	37.5	91.7	40.1	59.1
Kemptville District Hospital	Kemptville	11	92.8	35.6	42.3	14.7	0.0	0.0	17.4
Kirkland and District Hospital	Kirkland Lake	13	93.1	77.9	41.6	59.9	62.5	38.5	41.7
Lakeridge Health	Oshawa	9	36.4	90.7	89.1	56.0	77.1	91.7	64.8
Leamington District Memorial Hospital	Leamington	1	62.3	79.1	28.5	27.8	41.7	11.9	43.6
Lennox and Addington County General Hospital	Napanee	10	40.8	83.3	49.7	46.3	18.8	71.8	56.8
Listowel and Wingham Hospitals Alliance	Listowel	2	33.5	87.0	63.9	57.5	58.3	25.0	0.0
Markham Stouffville Hospital	Markham	8	83.2	80.8	70.4	32.5	47.9	84.0	50.0
Mattawa General Hospital	Mattawa	13	74.7	24.7	95.5	4.7	0.0	0.0	0.0
McCausland Hospital	Terrace Bay	14	50.0	76.3	44.5	24.4	25.0	12.5	12.9
MICs Group of Health Services	Cochrane	13	51.1	23.4	24.0	43.8	12.5	0.0	0.0
Muskoka Algonquin Healthcare	Huntsville	12	34.0	28.2	34.3	16.6	12.5	12.5	41.7
Niagara Health System	Niagara Falls	4	94.0	72.3	76.1	32.5	62.5	56.1	8.3
Nipigon District Memorial Hospital	Nipigon	14	33.5	25.3	64.4	16.3	0.0	0.0	0.0
Norfolk General Hospital	Simcoe	4	84.2	75.1	76.1	51.2	72.9	79.8	78.4
North Bay General Hospital	North Bay	13	18.0	19.9	39.9	41.0	0.0	0.0	50.0
Northumberland Hills Hospital	Cobourg	9	95.9	44.2	84.0	46.9	85.4	87.8	67.0
Orillia Soldiers' Memorial Hospital	Orillia	12	87.3	35.8	68.7	69.3	79.2	52.2	70.8
Pembroke Regional Hospital	Pembroke	11	89.3	42.8	76.0	52.2	37.5	20.2	41.7
Peterborough Regional Health Centre	Peterborough	9	68.9	14.1	68.9	52.4	62.5	48.1	87.5
Quinte Health Care	Belleville	10	35.6	79.9	38.9	38.8	50.0	76.0	68.2
Renfrew Victoria Hospital	Renfrew	11	94.4	91.2	78.4	68.6	39.6	35.9	86.4
Ross Memorial Hospital	Lindsay	9	54.4	90.5	76.0	80.8	85.4	28.2	70.5

Hospital	Community Served	LHIN	Healthy Work Environment	Evidence-Based Practice	Evidence of Client-Centred Care	Integration of Care	Use of RAI-MDS	Use of Information Technology	Use of Staff Skills/ Competencies Descriptions
Rouge Valley Health System	Scarborough	9	70.4	85.8	72.9	46.3	52.1	31.4	50.0
Royal Victoria Hospital	Barrie	12	97.2	84.5	61.1	62.9	45.8	75.6	65.9
Sault Area Hospital	Sault Ste. Marie	13	38.3	34.6	56.3	15.6	47.9	19.2	59.1
Sensenbrenner Hospital	Kapuskasing	13	55.9	34.9	55.6	27.5	56.3	30.8	42.0
Sioux Lookout Meno-Ya-Win Health Centre	Sioux Lookout	14	36.5	26.3	28.5	21.3	0.0	16.7	0.0
Smooth Rock Falls Hospital	Smooth Rock Falls	13	60.8	15.1	40.7	12.5	0.0	23.1	0.0
South Huron Hospital	Exeter	2	24.7	22.4	30.4	0.0	8.3	26.9	0.0
Southlake Regional Health Centre	Newmarket	8	34.8	78.8	70.3	63.7	70.8	47.8	41.7
St. Francis Memorial Hospital	Barry's Bay	11	49.0	79.2	31.6	27.5	83.3	19.2	41.7
St. Joseph's Health Care London	London	2	97.2	42.2	91.1	52.4	93.8	52.2	93.2
St. Joseph's Healthcare Hamilton	Hamilton	4	98.5	40.5	83.4	57.0	64.6	64.4	68.2
St. Thomas-Elgin General Hospital	St. Thomas	2	83.9	89.3	78.7	56.7	75.0	51.9	83.0
Strathroy Middlesex General Hospital	Strathroy	2	28.4	82.5	96.4	42.4	58.3	55.8	50.0
Sunnybrook and Women's College Health Sciences Centre	Toronto	7	88.6	92.1	72.2	56.6	70.8	20.8	93.2
Temiskaming Hospital	New Liskeard	13	84.6	56.0	32.4	5.0	37.5	0.0	0.0
The Brantford General Hospital	Brantford	4	91.9	37.1	71.2	48.6	70.8	26.9	55.7
The Credit Valley Hospital	Mississauga	6	86.7	89.4	82.2	81.8	70.8	72.8	88.6
Timmins and District Hospital	Timmins	13	50.8	40.3	30.1	31.9	31.3	59.9	56.8
Toronto East General Hospital	Toronto	7	98.0	95.2	74.0	58.1	56.3	60.3	93.2
Trillium Health Centre	Mississauga	6	94.3	87.5	100.0	43.0	62.5	72.4	98.9
West Lincoln Memorial Hospital	Grimsby	4	93.4	2.9	49.8	11.9	0.0	12.5	54.5
William Osler Health Centre	Brampton	5	24.8	86.5	90.6	69.3	62.5	87.8	95.5
Wilson Memorial General Hospital	Marathon	14	38.3	17.0	38.0	21.3	29.2	0.0	58.0
Winchester District Memorial Hospital	Winchester	11	52.4	41.9	40.0	26.9	66.7	0.0	65.9
Windsor Regional Hospital	Windsor	1	100.0	82.1	82.2	39.9	47.9	51.9	40.2
Woodstock General Hospital	Woodstock	2	83.4	90.5	92.0	46.3	75.0	40.1	100.0
York Central Hospital	Richmond Hill	8	18.0	92.4	51.1	50.5	91.7	25.0	65.9

LHIN	Healthy Work Environment	Evidence-Based Practice	Evidence of Client-Centred Care	Integration of Care	Use of RAI-MDS	Use of Information Technology	Use of Staff Skills/Competencies Descriptions
RESULTS BY LOCAL HEALTH INTEGRATION NETWORK							
LHIN 1 (Erie St. Clair)	81.5	56.7	53.4	45.4	48.4	56.9	36.6
LHIN 2 (South West)	57.3	68.0	70.0	45.9	55.1	51.0	48.2
LHIN 3 (Waterloo Wellington)	70.5	55.3	62.7	51.0	48.3	35.2	49.6
LHIN 4 (Hamilton Niagara Haldimand Brant)	88.4	50.9	73.1	45.6	63.1	45.1	58.7
LHIN 5 (Central West)	59.3	89.9	77.1	71.8	74.0	84.0	90.9
LHIN 6 (Mississauga Halton)	93.7	88.2	87.8	58.6	59.0	76.4	90.5
LHIN 7 (Toronto Central)	85.8	67.4	74.6	57.2	79.4	38.9	85.7
LHIN 8 (Central)	45.3	84.0	63.9	48.9	70.1	52.2	52.5
LHIN 9 (Central East)	70.4	63.1	75.5	52.2	60.4	51.7	65.0
LHIN 10 (South East)	57.6	85.8	59.7	57.8	45.1	56.0	74.6
LHIN 11 (Champlain)	70.7	53.2	60.5	35.5	50.2	14.5	47.6
LHIN 12 (North Simcoe Muskoka)	78.9	59.2	61.1	56.2	57.3	56.1	63.1
LHIN 13 (North East)	56.6	40.6	48.9	29.4	28.8	24.4	32.2
LHIN 14 (North West)	51.8	37.5	45.1	23.6	12.5	19.1	25.2

When loved ones are in a CCC setting for any length of time, their families often play an integral role in the care and care planning processes. Directly measuring patient and family perspectives on the care they receive in CCC is fundamental to hospitals' understanding of how well they care for the chronically ill patient population.

Twenty (20) hospitals participated in the CCC Patient and Family Satisfaction surveys. This is a small decrease in hospital participation in the Patient and Family Satisfaction surveys compared to *Hospital Report 2005: CCC* when 24 hospitals participated, and a large decrease in participation compared to *Hospital Report 2003: CCC* when 42 hospitals participated.

The Patient and Family Satisfaction quadrant reflects findings from interviews of 1,088 CCC patients (42.1% of potential participants) and responses to a mail survey from 1,086 of their family members (47.9% of mailed questionnaires).

Participation in the Patient and Family Satisfaction Survey is not consistent across LHINs. Four LHINs have no participating hospitals and another four have only one. Meanwhile, the Toronto Central LHIN has six participating hospitals. LHIN-level results are not provided due to the small number of participating hospitals and to insufficient coverage of LHINs.

The patient interviews were conducted between October 2006 and January 2007 (with the exception of one hospital that conducted its interviews during April 2007). Family questionnaires were mailed between the months of December 2006 and February 2007, the most recent of which were returned during March 2007.

For each of the indicators, a higher score is desirable, as is an above-average performance classification. The maximum score for each indicator is 100.

Indicator Definitions

Family Indicators

Global Quality

This indicator reflects family members' responses to questions pertaining to the overall quality of care and services provided and whether they would recommend the hospital to a family member or friend.

Living Environment

This indicator reflects family members' responses to questions relating to whether the patient's personal space and hospital space met the patient's and family's needs.

Communication

This indicator reflects family members' responses to questions relating to the adequacy of information provided to family members, the involvement of family in the care process and the relationship developed between family members and staff.

Care and Services

This indicator reflects family members' responses to questions about the quality of the physical and psychosocial care received by the patient, the extent to which the patient is treated with dignity and the cleanliness of the hospital.

NRC + Picker

The patient and family satisfaction results in this report are based on data collected by NRC + Picker Canada. NRC + Picker Canada is a Canadian research company specializing in promoting patient-centred care in the Canadian health care setting. NRC + Picker Canada has over 13 years' experience nationally, and over 26 years internationally, conducting survey research designed to uncover what is most important to patients.

Results for the 20 hospitals that voluntarily participated in the complex continuing care patient and family satisfaction survey process in 2006–2007 are included in the analysis and illustrated in the performance allocation tables.

Activities

This indicator reflects family members' responses to questions regarding the amount of activities and entertainment available to the patient (such as entertainment, trips/outings, programs and personal activities such as reading watching television, writing and visiting).

Patient Indicators

Patient Living Environment

This indicator reflects patients' responses to questions about the level of comfort, privacy, safety of personal belonging and room in general in the unit or hospital.

Food and Food Services

This indicator reflects patients' satisfaction with variety, availability, taste and temperature of foods provided, with the amount of time available to eat and with required assistance provided.

Patient Activities

This indicator reflects patients' responses to questions relating to activities, including awareness of and participation in available activities and opportunity to take part in personal activities. Only patients who participate at least "sometimes" in activities at the hospital are included in the calculation of this indicator.

Staff

This indicator reflects patients' responses to questions about staff demonstrating they care, demonstrating respect, making an effort to understand, offering assistance when it is needed, staff skill, response time and tendency to involve the patient in care-related decisions.

Dignity

This indicator reflects patients' responses to questions regarding dignity, including whether the staff call them by name, whether their privacy is respected and whether they are treated as they would like.

Autonomy

This indicator reflects patients' responses to questions such as whether they are encouraged to participate in decisions about their care, whether they had a say in their care and in what they were going to do each day, whether they felt free to express their feelings and opinions or were free to come and go as they pleased.

Medical Care and Treatment

This indicator reflects patients' responses to questions regarding obtaining assistance when in pain or uncomfortable, ability to have access to and converse with a doctor, obtaining necessary treatments and medication, receiving appropriate medical assistance when not feeling well and receiving therapy.

All Domains

This indicator reflects patients' responses to all the questions in the above patient satisfaction domains.

Questionnaire items included in each of the indicators are detailed in the technical summary on the Hospital Report website at www.hospitalreport.ca.

SUMMARY OF RESULTS

Figure 6 depicts the distribution of indicator scores for all hospitals and the provincial average (mean) for each of the indicators. Hospitals can use this figure to determine where their indicator scores fit in relation to the overall distribution of scores.

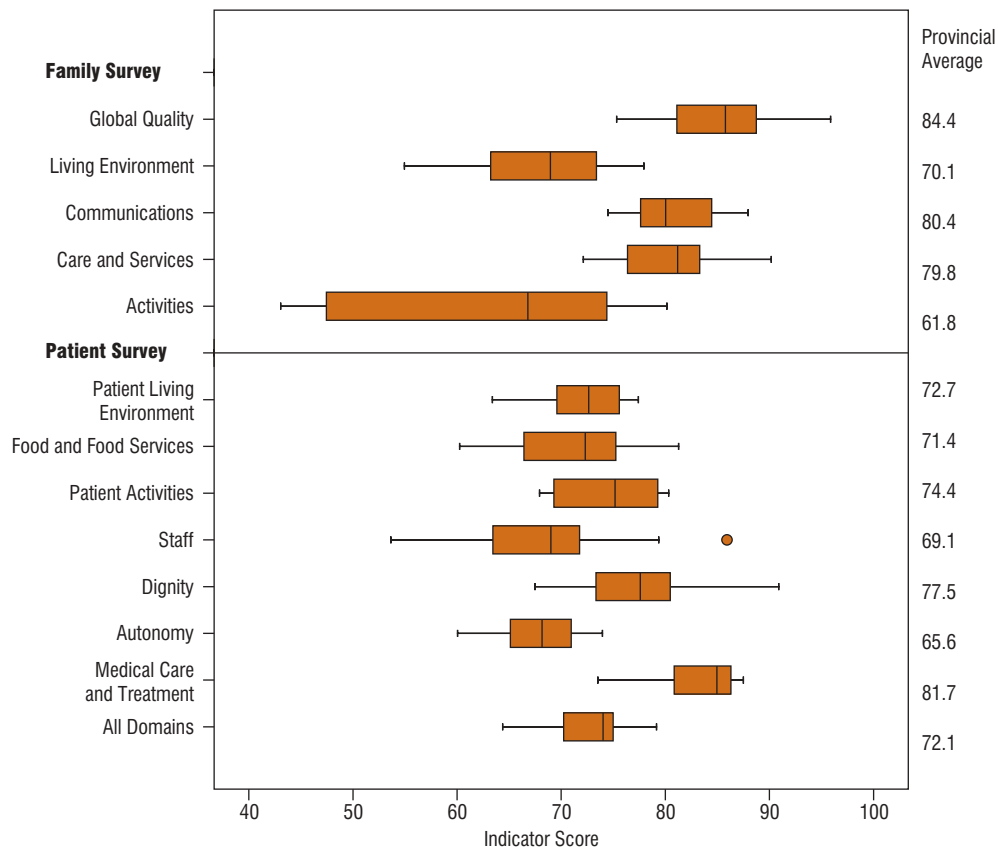
As in previous years, family members are least satisfied with the amount of activities and entertainment available to their loved ones. While both hospital types have room to improve in this domain, the CCC acute care hospital (that is, CCC unit beds within acute care hospitals) results are noticeably lower (by 8 points) than those of the free-standing CCC sites. Family member scores are highest for the overall (global) quality.

Patient scores are highest for medical care and treatment, suggesting that patients are most satisfied with their ability to obtain assistance when in pain or uncomfortable, to have access to and converse with a doctor and in obtaining necessary treatments, medication and therapy.

Patients are least satisfied with their perceived level of autonomy, suggesting that hospitals have room to improve in encouraging patients to participate in decisions relating to their care and what they are going to do each day, and in cultivating an atmosphere in which patients feel free to express their feelings and opinions and to come and go as they please.

For more information on the interpretation of box plots, please refer to the Interpreting the Results section in this report.

Distribution of Patient and Family Satisfaction Indicator Results for Participating Hospitals



Note: The box plots display the distribution of the hospital-level scores. The provincial averages (means) are calculated using weighted data.

Source: NRC + Picker CCC Patient and Family Satisfaction Survey, 2006–2007.

Figure 6

SUMMARY OF RESULTS (CONT'D)

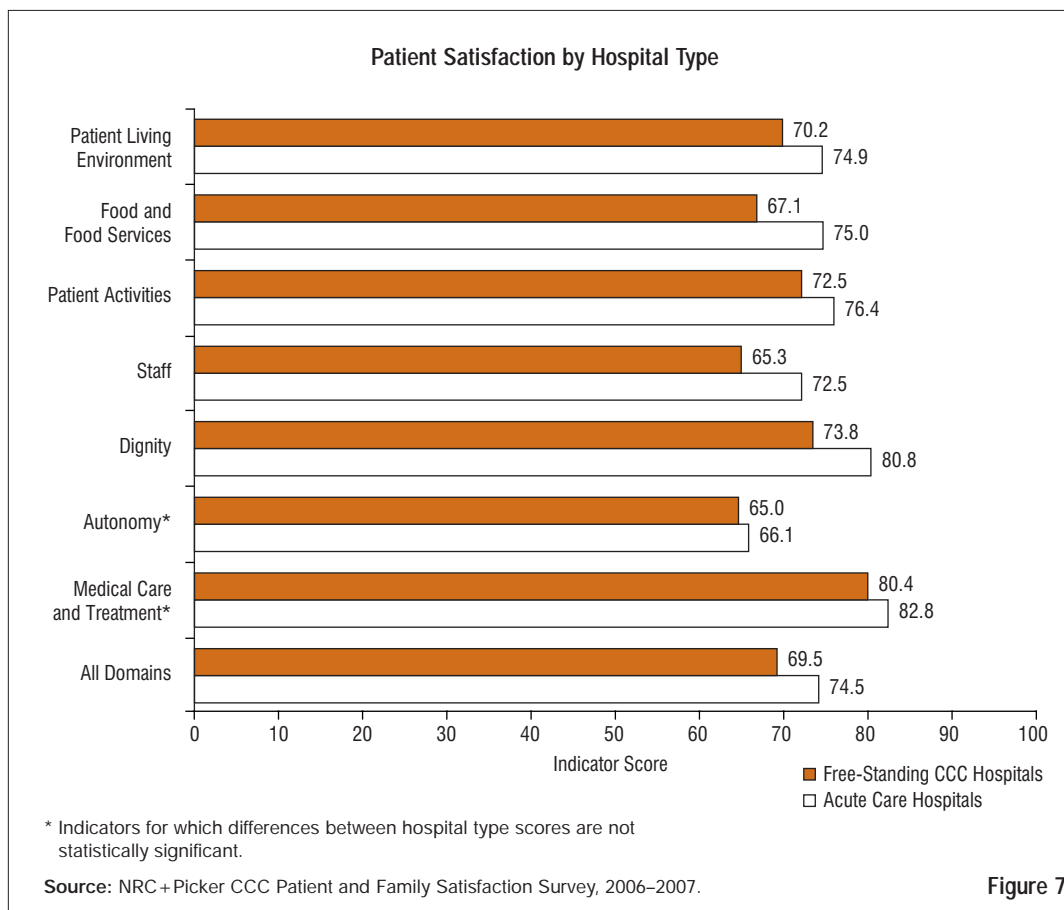


Figure 7 presents the patient satisfaction indicator results by hospital type. Acute care hospitals seem to be reporting higher levels of satisfaction across all dimensions of patient satisfaction. While the differences are minimal and statistically insignificant in the dimensions of Autonomy and Medical Care and Treatment, the rest of the patient indicators have statistically significant differences between hospital type average scores.

Indicator results for the hospitals that participated in the patient and family satisfaction surveys are shown in the performance allocation tables. Hospital results are only shown for those indicators where the hospital passed a volume screen of 30 valid responses.

PERFORMANCE ALLOCATION TABLE

Hospital	Community Served	LHIN	Family					Patient							
			Global Quality	Living Environment	Communications	Care and Services	Activities	Patient Living Environment	Food and Food Services	Patient Activities	Staff	Dignity	Autonomy	Medical Care and Treatment	All Domains
PROVINCIAL AVERAGE			84.4	70.1	80.4	79.8	61.8	72.7	71.4	74.4	69.1	77.5	65.6	81.7	72.1
PROVINCIAL PERFORMANCE TARGET*			85.1	67.6	80.9	80.2	62.0	72.3	71.5	75.1	68.8	77.3	66.3	82.9	72.7
FREE-STANDING CCC HOSPITALS AVERAGE			82.0	70.7	79.8	77.6	65.9	70.2	67.1	72.5	65.3	73.8	65.0	80.4	69.5
Baycrest Centre for Geriatric Care	Toronto	7	83.3	77.8	84.0	79.0	74.6	67.6	NR	NR	NR	73.6	NR	NR	NR
Penetanguishene General Hospital Inc. (The)—North Simcoe Hospital Alliance	Penetanguishene	12	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
Providence Continuing Care Centre	Kingston	10	92.0	64.6	84.9	83.8	NR	66.4	71.9	NR	64.3	73.3	67.9	85.1	70.2
Providence Healthcare	Toronto	7	86.4	71.5	79.4	81.9	64.0	74.7	73.1	76.3	70.5	78.8	67.9	84.8	74.5
Sisters of Charity of Ottawa (SCO) Health Service	Ottawa	11	77.5	77.9	77.5	73.7	72.4	69.3	61.1	68.7	55.3	67.5	59.6	74.0	64.4
Toronto Rehabilitation Institute	Toronto	7	77.3	58.5	75.0	72.5	48.2	67.2	69.7	73.0	60.6	74.5	64.8	80.0	68.0
West Park Healthcare Centre	Toronto	7	88.1	67.2	85.9	82.0	74.4	69.4	64.2	67.9	66.5	72.3	68.9	87.1	70.8

ACUTE CARE HOSPITALS AVERAGE			86.7	69.5	80.9	81.9	57.8	74.9	75.0	76.4	72.5	80.8	66.1	82.8	74.5
Chatham-Kent Health Alliance	Chatham	1	NR	54.9	77.2	72.9	NR	77.0	NR	NR	NR	NR	NR	NR	NR
Halton Healthcare	Oakville	6	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
Lakeridge Health	Oshawa	9	85.8	64.5	77.7	82.5	50.0	75.9	70.0	NR	85.6	91.2	73.3	86.2	79.2
Niagara Health System	Niagara Falls	4	78.9	55.9	78.9	80.3	43.1	75.1	74.6	78.6	79.4	85.5	67.1	85.5	76.6
Norfolk General Hospital	Simcoe	4	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
Orillia Soldiers' Memorial Hospital	Orillia	12	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
St. Joseph's Health Care London	London	2	86.5	72.3	79.1	80.2	67.1	71.5	81.5	80.8	67.2	79.2	65.2	82.7	75.0
St. Thomas-Elgin General Hospital	St. Thomas	2	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
Sunnybrook and Women's College Health Sciences Centre	Toronto	7	95.9	74.4	88.0	90.2	80.1	77.9	77.2	78.8	69.0	76.7	64.3	78.9	74.2
Toronto East General Hospital	Toronto	7	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
Trillium Health Centre	Mississauga	6	84.5	71.6	83.0	82.8	46.1	75.1	71.7	76.3	70.0	77.6	64.2	85.3	73.9
Windsor Regional Hospital	Windsor	1	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
York Central Hospital	Richmond Hill	8	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR

Notes:

* The average of hospital scores. Used for performance allocations.

NR: participated in patient satisfaction surveying, but did not pass the volume screen to have data displayed.

Due to small numbers of participating hospitals with sufficient sample size and insufficient coverage of LHINS, the LHIN averages for Patient and Family Satisfaction have not been reported.

Hospitals are grouped according to whether the CCC program is in a free-standing CCC hospital or an acute care hospital; however, these groupings were not used in indicator or performance classification calculations.

■ Above-Average Performance ■ Average Performance ■ Below-Average Performance

As in other hospital sectors, the need to maintain and improve the quality of clinical outcomes in complex continuing care (CCC) is essential as hospitals continue to work to improve the care patients receive.

This section reports on clinical outcomes and care processes, based on 2005–2006 data from the Continuing Care Reporting System (CCRS). The CCRS uses the RAI-MDS 2.0[©], an internationally validated clinical assessment instrument, as its foundation data standard. All the indicators in this quadrant are based on the clinical information gathered from assessments of CCC patients.

Patient Populations

Throughout this report, patients in CCC are classified into two broad groups: “chronic” and “short-stay” patients. To be classified as chronic, CCC patients generally must have stayed in the CCC hospital for at least 100 days and had at least two RAI-MDS assessments. Short-stay patients were defined as non-chronic patients who had only received a single admission full RAI-MDS assessment or were not assessed (usually because the patients stayed under 14 days, when completion of a RAI-MDS assessment is optional). Also, short-stay patients must not have another stay in the same CCC program for the 90 days before or after their stay. (For further details, see the technical summary at www.hospitalreport.ca.)

Overall, there were 21,934 patients who received care in CCC during 2005–2006. Of these, 5,780 or just over a quarter (26.4%) were classified as chronic patients and 13,973 or just under two-thirds (63.7%) were classified as short-stay patients.ⁱⁱⁱ Among the short-stay patients, 10,472 had a RAI-MDS assessment and 3,501 had no assessment data. Although short-stay patients comprised the largest single group of CCC patients, they accounted for less than a quarter (22%) of the total number of patient days during 2005–2006.

All 13 of the clinical indicators are the same as those reported in 2005. Twelve of these apply to the chronic CCC population. The final indicator, short-stay patients with disruptive or severe pain, applies to the short-stay patients *with* a RAI-MDS assessment. Short-stay patients without a RAI-MDS assessment do not have any clinical information available and therefore cannot be included in any of the clinical indicators. A brief description of each indicator is provided below. Full details, including the individual inclusion and exclusion criteria for each indicator, are available in the technical summary.

Indicator Definitions

Improvement in Performance of Activities of Daily Living (ADL)

This outcome indicator measures the proportion of chronic CCC patients considered to have rehabilitation potential, who improved in functional independence over a typical 90-day period during the fiscal year. The set of ADL included in this indicator are ones for which chronically ill people tend to lose independence at early, mid and later stages of functional decline. Higher values are generally considered to reflect better performance.

iii. The remaining 9.9% of patients present at some time during 2005–2006 were mostly patients who were admitted prior to the fiscal year and only stayed for a few days at the beginning of 2005–2006 or those who were admitted in the final few days of 2005–2006. These patients could not be classified as chronic or short-stay using the definitions used here, since there was too little information about the patients during 2005–2006 to make a definitive classification.

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The hospital-specific tables include data for 81 (about three-quarters) of the 107 hospitals that deliver CCC services in Ontario. Many of the hospitals have very small CCC programs, consisting of a few CCC patients, for which calculation of statistically stable hospital-specific indicator values for a fiscal year is not feasible. However, the provincial and LHIN results are based on data from all CCC hospitals that had assessed patients who met the indicator inclusion criteria.

Decline in Ability to Walk or Wheel Self

This outcome indicator measures the proportion of chronic CCC patients who experienced a decline in their level of independence in walking or wheeling (in a wheelchair) in and near their room over a typical 90-day period during the fiscal year. Lower values are generally considered to reflect better performance.

Increase in Depression or Anxiety

This outcome indicator measures the proportion of chronic CCC patients who showed increased signs of depressed mood or anxiety over a typical 90-day period during the fiscal year. It is important to note that this indicator is not based on a diagnosis of depression or anxiety disorder and many of the items used as signs of depression are also behaviors manifested due to dementia, which is a common diagnosis in the CCC population. Lower values on this indicator are generally considered to reflect better performance.

Communication Decline

This outcome indicator measures the proportion of chronic CCC patients who experienced a decline in their ability to communicate over a typical 90-day period during the fiscal year. Lower values on this indicator are generally considered to reflect better performance.

Presence of Indwelling Catheter

This process indicator measures the proportion of chronic CCC patients who had an indwelling urinary catheter in place during at least part of a typical 90-day period in the fiscal year. Lower values on this indicator are generally considered to reflect better performance.

Decrease in Bladder Continence

This outcome indicator measures the proportion of chronic CCC patients who declined in urinary continence over a typical 90-day period during the fiscal year. Lower values on this indicator are generally considered to reflect better performance.

Patients With New Falls

This outcome indicator measures the proportion of chronic CCC patients without a recent prior history of falling who fell during a typical 90-day period during the fiscal year. Lower values on this indicator are generally considered to reflect better performance.

Presence of Disruptive or Severe Pain

This outcome indicator measures the proportion of chronic CCC patients who, in a typical 90-day period, had moderate pain on a daily basis or severe/excruciating pain at any time, during the 7-day RAI-MDS assessment period. Moderate pain is defined as a level of pain that is sufficiently severe to significantly limit a patient's participation in desired activities and daily routines. Lower values on this indicator are generally considered to reflect better performance.

Presence of Pressure Sores

This outcome indicator measures the proportion of chronic CCC patients in a typical 90-day period who had a pressure ulcer at any stage of development. Lower values on this indicator are generally considered to reflect better performance.

New Stage 2 or Greater Skin Ulcers

This outcome indicator measures the proportion of ulcer-free chronic CCC patients who developed stage 2 or greater skin ulcers (of any kind) over a typical 90-day period. Lower values on this indicator are generally considered to reflect better performance.

Presence of Patients in Daily Physical Restraints

This process indicator measures the proportion of chronic CCC patients who were physically restrained, according to the RAI-MDS definition, on a daily basis during a typical 90-day period. Lower values on this indicator are generally considered to reflect better performance.

Use of Antipsychotic Medication Without a Diagnosis of Psychosis

This process indicator measures the proportion of chronic CCC patients who received antipsychotic medication, in a typical 90-day period, who did not have a diagnosis of a psychotic condition indicated on the RAI-MDS. Lower values on this indicator are generally considered to reflect better performance.

Short-Stay Patients With Disruptive or Severe Pain

This outcome indicator measures the proportion of assessed short-stay CCC patients in a typical 90-day period who had moderate pain on a daily basis or severe/excruciating pain at any time, during the 7-day RAI-MDS assessment period. Lower values on this indicator are generally considered to reflect better performance.

All but two of the indicators (daily use of physical restraints; increase in depression or anxiety) are risk-adjusted to account for differences among hospital populations. Certain patients have clinical conditions that contribute to their risk of the indicator conditions and for which that risk may not be mitigated by modifying care practices. As some hospitals will have more of the higher-risk patients than others, risk adjustment enables hospitals to appropriately compare their quality of care with one another. The physical restraints indicator and the depression/anxiety indicator were not risk-adjusted because these care issues should be addressed regardless of patient characteristics. Lack of risk-adjustment for these two indicators conforms with practice in other jurisdictions where these indicators have been investigated and/or reported. (For example, the national reports of nursing home quality in the United States on the NHCompare website at www.cms.hhs.gov/NursingHomeQualityInits/downloads/NHQIOverview.pdf)

SUMMARY OF RESULTS

At the provincial level, the Presence of Patients in Daily Physical Restraints indicator has shown considerable improvement. Over the five-year period from 2001–2002 to 2005–2006, the provincial average dropped by half (from 29.1% to 14.3%). A number of factors may explain this decrease. The use of physical restraints in hospitals, including CCC, was the subject of legislation in 2001. As a result, the *Ontario Patient Restraint Minimization Act* came into effect, which may have been a contributing factor to the change in care practices and policies around restraint use. Over the same time period, the use of clinical practice guidelines across hospitals related to restraints increased from 76% in 2001–2002 to 90% in 2005–2006 (see the System Integration and Change section for more information).

Hospitals should continue to pursue least restraint as a goal in their CCC programs. The reductions in physical restraints seen to date demonstrate the ability of hospitals to successfully modify this practice.

Three indicators have shown a decline in performance at the provincial level since 2001–2002: use of antipsychotic medication without a diagnosis of psychosis, improvement in ADL performance and the presence of pressure sores.

Overall, the proportion of chronic CCC patients with antipsychotic medication use without a diagnosis of psychosis in Ontario increased from 18.3% in 2001–2002 to 22.6% in 2005–2006. While antipsychotic drugs can be used as chemical restraints, among individual hospitals with five years of data, there was no significant relationship found between their change in use of physical restraints and any change in their use of antipsychotics. In fact, many hospitals showed improvements in both indicators.

The ADL improvement indicator (the proportion of chronic CCC patients considered to have rehabilitation potential who improved their functional independence) is a positive measure of performance that decreased from 30.3% in 2001–2002 to 27.6% in 2005–2006.

The proportion of chronic CCC patients with a pressure ulcer at any stage of development increased from 21.0% in 2001–2002 to 24.1% in 2005–2006. In addition, the proportion of ulcer-free chronic patients who developed new stage 2 or greater skin ulcers remained relatively stable over the years at 6%.

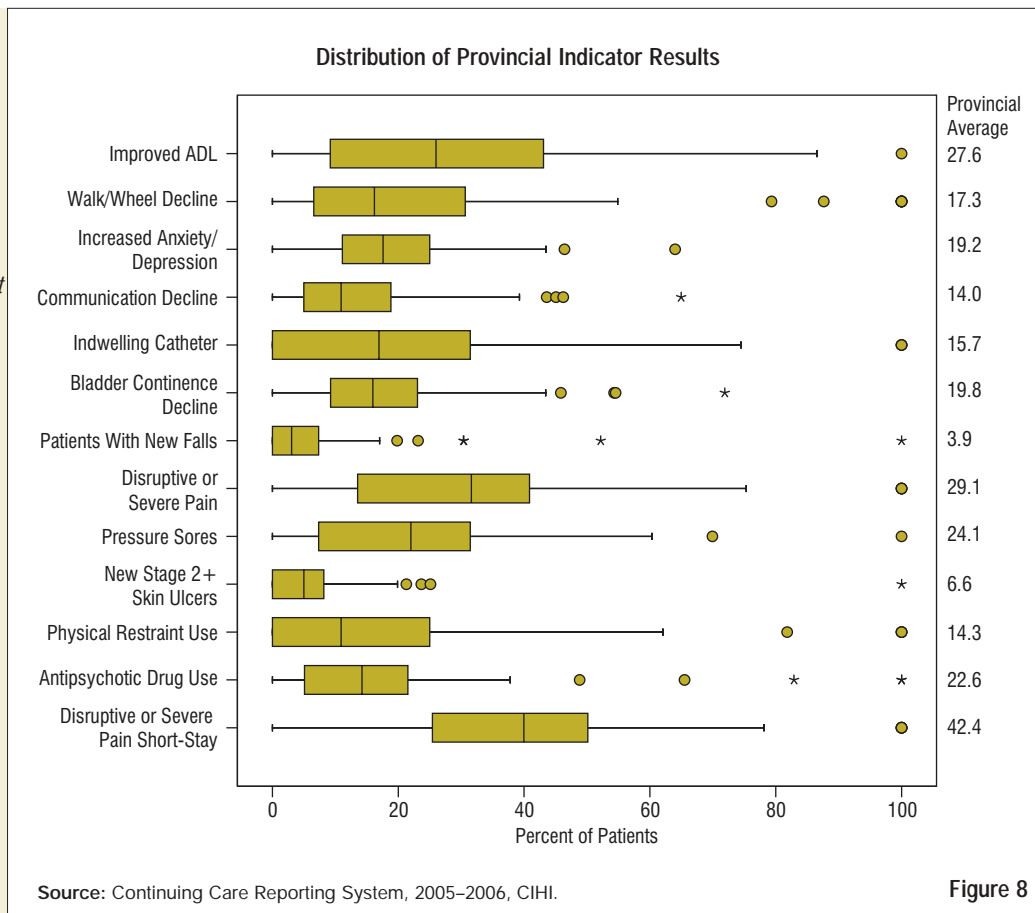


Figure 8

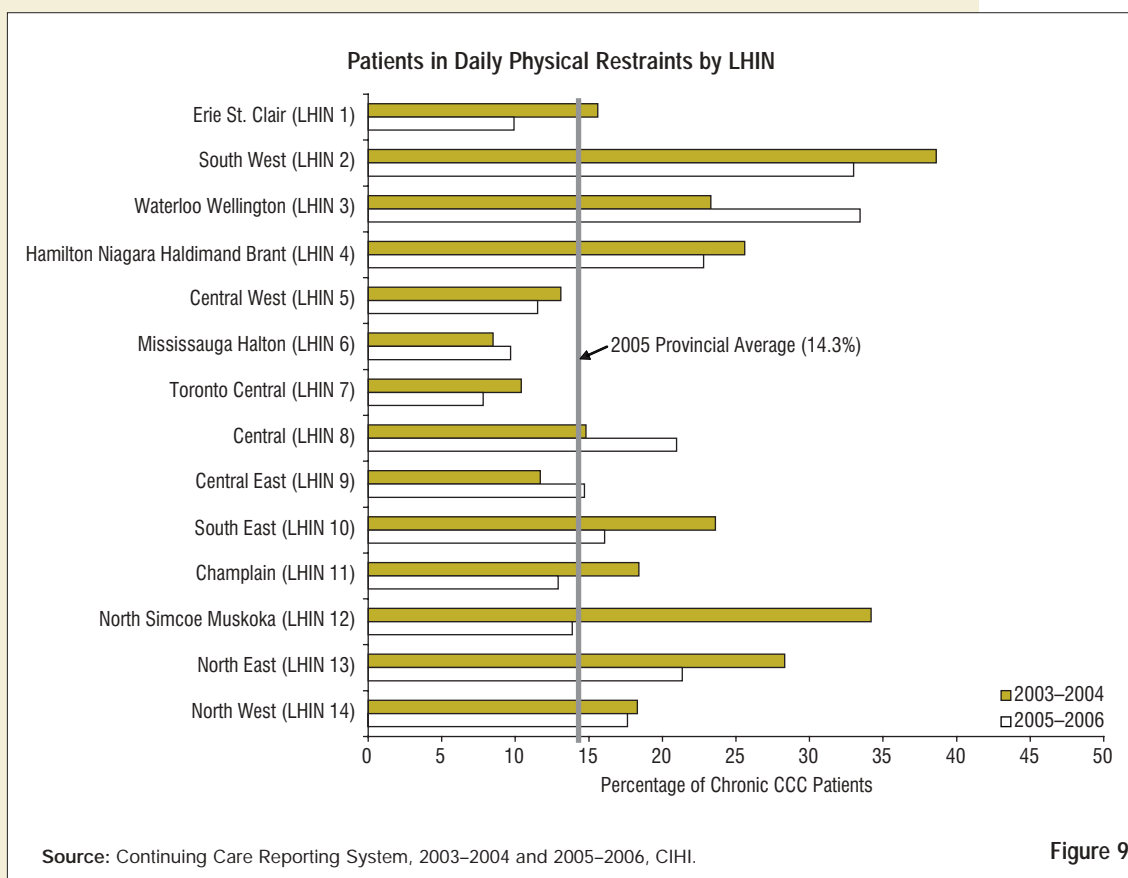
For more information on the interpretation of box plots, please refer to the Interpreting the Results section in this report.

SUMMARY OF RESULTS (CONT'D)

Sharing information across the sector could shed light on the potential reasons for these negative trends and identify opportunities for improvement.

LHIN Results

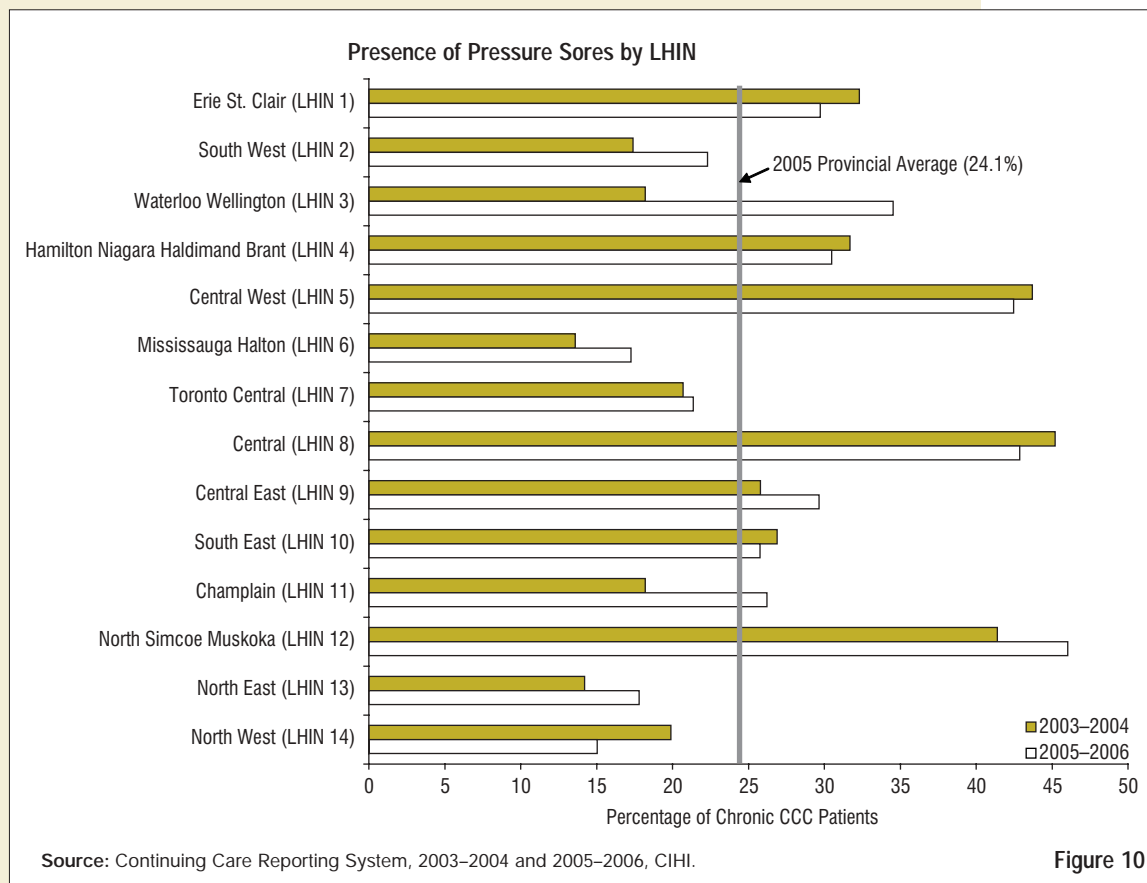
While the overall provincial proportion of chronic patients in daily physical restraints decreased from 2003–2004 to 2005–2006 by approximately 19%, Figure 9 illustrates that there is wide variation in the use of restraints across the LHINs. In 2005–2006, the Waterloo Wellington LHIN had the highest proportion of chronic patients in daily physical restraints (33.4%), while the smallest proportion was found in the Toronto Central LHIN (7.8%).



SUMMARY OF RESULTS (CONT'D)

Two CCC clinical indicators measure different aspects of the quality of care related to pressure sores and skin ulcers. The presence of pressure sores indicator measures performance related to the management and treatment of existing sores and ulcers at any stage of development among chronic CCC patients (irrespective of when the sore/ulcer developed); while the new stage 2 or greater skin ulcers indicator relates to managing the prevention of new ulcers while in the CCC hospital. As figures 10 and 11 show, both indicators showed wide variation across LHINs.

Figure 10 shows the proportion of chronic CCC patients who had pressure sores in 2003–2004 and 2005–2006 by LHIN. In 2005–2006, the North Simcoe Muskoka LHIN had the highest presence of patients with pressure sores (46.0%) and the North West LHIN had the smallest (15.0%).



Between 2003–2004 and 2005–2006, the proportion of ulcer-free chronic CCC patients who developed a new stage 2 or greater ulcer increased marginally from 5.8% to 6.6%. Figure 11 shows that in 2005–2006, Central LHIN had the highest proportion (15.7%) of patients with a new stage 2 or greater ulcer, over double the provincial average.

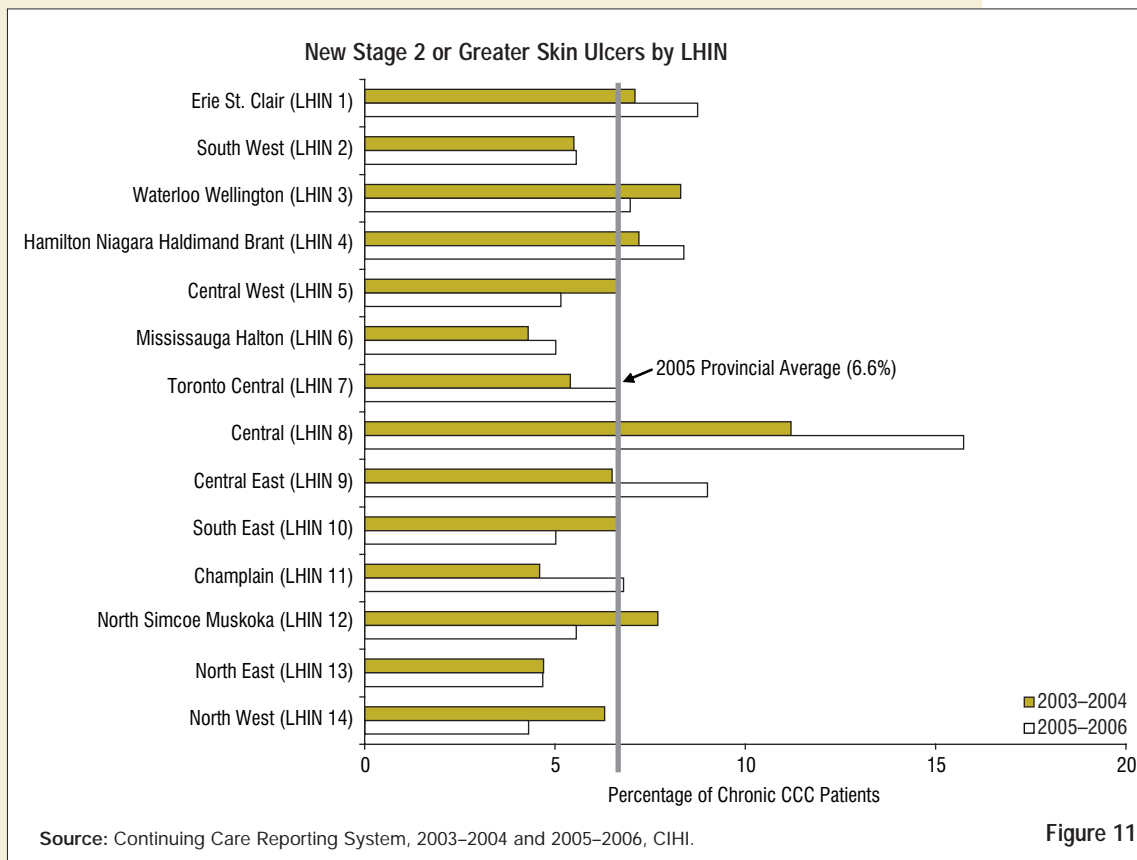


Figure 11

The variation in results for these indicators across individual hospitals and LHINs suggests potential for improvement. The significant improvements observed in the physical restraints indicator show that focused attention on an indicator can result in change. Further exploration of the potential differences in patient populations and processes of care is warranted to shed light on the reasons for these variations and to seek out best practices.

PERFORMANCE ALLOCATION TABLE

Hospital	Community Served	LHIN	Improved ADL	Walk/Wheel Decline	Increased Anxiety/Depression	Communication Decline	Indwelling Catheter	Bladder Continence Decline	Patients With New Falls	Disruptive or Severe Pain	Pressure Sores	New Stage 2+ Skin Ulcers	Physical Restraint Use	Anti-psychotic Drug Use	Disruptive or Severe Pain, Short-Stay
PROVINCIAL AVERAGE			27.6	17.3	19.2	14.0	15.7	19.8	3.9	29.1	24.1	6.6	14.3	22.6	42.4

FREE-STANDING CCC HOSPITALS

Baycrest Centre for Geriatric Care	Toronto	7	14.3	23.5	17.4	12.0	14.9	15.4	1.7	29.2	19.0	6.9	5.0	14.4	41.1
Bridgepoint Health	Toronto	7	28.8	6.9	5.0	1.7	11.7	10.0	1.3	16.9	18.0	3.1	2.2	14.7	36.6
Penetanguishene General Hospital Inc. (The)—North Simcoe Hospital Alliance	Penetanguishene	12	NR	11.3	12.3	7.0	16.9	16.2	9.6	53.6	69.9	1.0	11.8	7.6	55.4
Providence Continuing Care Centre	Kingston	10	25.8	22.5	30.6	19.4	20.9	17.2	3.8	47.5	25.8	5.2	16.3	16.9	53.0
Providence Healthcare	Toronto	7	47.3	30.9	32.6	28.7	10.5	35.9	4.2	37.6	22.9	6.0	18.2	11.2	44.7
Sisters of Charity of Ottawa (SCO) Health Service	Ottawa	11	19.2	14.2	20.4	9.5	19.4	13.7	2.9	24.7	28.9	8.2	5.5	18.6	52.3
St. Joseph's Care Group	Thunder Bay	14	40.4	9.7	16.4	5.0	16.1	17.2	5.8	38.2	19.7	6.9	11.6	21.1	46.4
St. Joseph's Continuing Care Centre (Cornwall)	Cornwall	11	4.7	18.9	16.8	11.3	29.3	10.9	6.1	57.1	17.2	5.5	53.9	33.3	NR
St. Joseph's Health Centre, Guelph	Guelph	3	13.9	22.3	22.1	15.0	24.0	22.0	4.4	47.5	44.8	5.3	49.3	17.4	NR
St. Peter's Hospital	Hamilton	4	25.0	18.6	17.7	9.2	7.8	14.1	6.3	19.7	28.4	8.2	29.1	21.5	23.5
Toronto Grace Hospital	Toronto	7	24.3	9.8	13.4	8.7	8.3	20.3	5.4	22.7	14.9	7.9	13.8	12.6	NR
Toronto Rehabilitation Institute	Toronto	7	26.1	7.6	12.9	8.1	9.6	30.9	1.7	17.1	21.4	5.0	8.6	12.4	59.6
West Park Healthcare Centre	Toronto	7	30.6	6.6	18.2	19.6	17.0	10.2	2.1	31.7	17.2	12.9	13.7	15.2	52.5

ACUTE CARE HOSPITALS

Alexandra Hospital	Ingersoll	2	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	NR
Alexandra Marine and General Hospital	Goderich	2	N/A	N/A	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
Almonte General Hospital	Almonte	11	NR	8.0	1.2	1.1	25.0	4.1	0.0	18.9	0.0	1.7	0.0	NR	NR
Atikokan General Hospital	Atikokan	14	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
Bluewater Health	Petrolia	1	30.3	25.6	20.3	16.3	25.3	14.2	11.1	44.8	22.1	5.9	9.5	13.5	57.9
Cambridge Memorial Hospital	Cambridge	3	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	48.7
Chatham-Kent Health Alliance	Chatham	1	33.0	33.6	26.4	17.4	43.3	16.3	6.1	6.7	40.6	14.0	12.1	21.9	7.8
Dryden Regional Health Centre	Dryden	14	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
Glengarry Memorial Hospital	Alexandria	11	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
Grand River Hospital	Kitchener	3	48.1	25.4	20.4	22.2	16.6	38.1	4.3	32.9	12.0	9.6	11.3	8.7	40.7
Groves Memorial Community Hospital	Fergus	3	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	47.4
Halton Healthcare	Milton	6	NR	NR	5.7	10.3	NR	NR	NR	40.0	27.4	5.0	3.7	NR	46.7
Headwaters Health Care Centre	Shelburne	5	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	11.7

NR: Insufficient sample size.

N/A: Denominator of "0."

■ Above-Average Performance ■ Average Performance ■ Below-Average Performance

Hospital	Community Served	LHIN	Improved ADL	Walk/Wheel Decline	Increased Anxiety/Depression	Communication Decline	Indwelling Catheter	Bladder Continence Decline	Patients With New Falls	Disruptive or Severe Pain	Pressure Sores	New Stage 2+ Skin Ulcers	Physical Restraint Use	Anti-psychoptic Drug Use	Disruptive or Severe Pain, Short-Stay
Huron Perth Healthcare Alliance	Clinton	2	NR	NR	36.4	NR	NR	NR	NR	NR	NR	NR	NR	NR	58.4
Hôpital Général de Hawkesbury and District General Hospital Inc.	Hawkesbury	11	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	44.5
Hôpital régional de Sudbury Regional Hospital	Sudbury	13	31.5	5.9	16.3	11.4	31.5	9.2	1.1	42.4	27.6	5.0	20.7	25.9	NR
Joseph Brant Memorial Hospital	Burlington	4	NR	NR	20.8	5.0	15.6	20.6	7.9	35.0	29.6	6.8	7.1	NR	39.4
Kemptville District Hospital	Kemptville	11	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	N/A
Kirkland and District Hospital	Kirkland Lake	13	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
Lakeridge Health	Bowmanville	9	22.4	32.7	19.9	15.9	15.6	34.2	3.0	29.6	14.5	9.1	16.9	16.4	39.7
Leamington District Memorial Hospital	Leamington	1	NR	NR	NR	NR	NR	NR	NR	NR	NR	11.2	NR	NR	31.4
Lennox and Addington County General Hospital	Napanee	10	NR	NR	NR	NR	NR	NR	N/A	NR	NR	NR	NR	NR	NR
Listowel and Wingham Hospitals Alliance	Listowel	2	NR	NR	16.1	6.7	NR	NR	4.7	35.4	25.1	0.6	33.3	NR	39.7
MICs Group of Health Services	Iroquois Falls	13	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
Markham Stouffville Hospital	Markham	8	NR	NR	31.7	NR	NR	NR	19.8	NR	NR	6.2	NR	NR	34.6
Mattawa General Hospital	Mattawa	13	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	NR
McCausland Hospital	Terrace Bay	14	NR	NR	17.5	20.1	NR	NR	1.4	NR	NR	NR	NR	NR	N/A
Muskoka Algonquin Healthcare	Huntsville	12	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	38.2
Niagara Health System	Fort Erie	4	23.9	20.8	19.1	12.9	31.8	18.6	6.1	35.7	38.9	8.2	14.0	14.0	40.3
Nipigon District Memorial Hospital	Nipigon	14	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	N/A
Norfolk General Hospital	Simcoe	4	NR	NR	23.8	11.6	NR	NR	NR	NR	NR	9.4	NR	NR	NR
North Bay General Hospital	North Bay	13	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	44.2
Northumberland Hills Hospital	Cobourg	9	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	40.2
Orillia Soldiers' Memorial Hospital	Orillia	12	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	41.0
Pembroke Regional Hospital	Pembroke	11	NR	NR	15.7	5.9	NR	NR	NR	NR	NR	4.1	NR	NR	75.7
Peterborough Regional Health Centre	Peterborough	9	NR	NR	12.9	6.0	NR	NR	2.2	NR	NR	5.2	NR	NR	42.4
Quinte Health Care	Belleville	10	53.3	36.1	28.2	29.8	54.4	27.8	9.6	33.3	18.1	6.6	11.5	5.4	47.5
Renfrew Victoria Hospital	Renfrew	11	NR	NR	38.9	38.8	NR	NR	16.5	NR	NR	NR	NR	NR	NR
Riverside Health Care Facilities Inc.	Fort Frances	14	NR	10.6	22.4	12.7	NR	16.8	8.0	NR	NR	5.3	NR	NR	37.4
Ross Memorial Hospital	Lindsay	9	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	63.9
Rouge Valley Health System	Scarborough	9	NR	NR	27.8	46.2	36.3	12.8	3.6	45.7	30.7	10.2	6.5	13.5	39.0
Royal Victoria Hospital	Barrie	12	NR	NR	21.4	9.9	37.8	12.1	7.3	22.1	32.8	5.2	15.2	30.7	36.5
Sault Area Hospital	Sault Ste. Marie	13	41.6	34.3	14.2	31.5	39.4	25.5	6.2	31.6	23.8	11.5	28.3	28.7	34.8
Sensenbrenner Hospital	Kapuskasing	13	NR	3.2	23.5	15.8	NR	NR	1.5	NR	NR	NR	NR	NR	NR

NR: Insufficient sample size.

N/A: Denominator of "0."

■ Above-Average Performance

■ Average Performance

■ Below-Average Performance

Hospital	Community Served	LHIN	Improved ADL	Walk/Wheel Decline	Increased Anxiety/Depression	Communication Decline	Indwelling Catheter	Bladder Continence Decline	Patients With New Falls	Disruptive or Severe Pain	Pressure Sores	New Stage 2+ Skin Ulcers	Physical Restraint Use	Anti-psychotic Drug Use	Disruptive or Severe Pain, Short-Stay
Sioux Lookout Meno-Ya-Win Health Centre	Sioux Lookout	14	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
Smooth Rock Falls Hospital	Smooth Rock Falls	13	N/A	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	N/A
South Huron Hospital	Exeter	2	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
Southlake Regional Health Centre	Newmarket	8	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	51.5
St. Francis Memorial Hospital	Barry's Bay	11	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
St. Joseph's Health Care London	London	2	7.6	8.2	11.1	9.3	19.6	13.2	1.9	32.4	23.8	5.0	37.2	16.5	44.1
St. Joseph's Healthcare Hamilton	Hamilton	4	6.1	NR	11.0	5.7	13.6	NR	1.9	36.5	60.3	5.7	15.0	15.5	NR
St. Thomas-Elgin General Hospital	St. Thomas	2	NR	18.4	35.6	19.0	26.2	21.3	8.7	41.9	29.5	9.4	3.4	36.2	47.3
Strathroy Middlesex General Hospital	Strathroy	2	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	27.2
Sunnybrook Health Sciences Centre	Toronto	7	26.0	31.7	30.6	27.8	19.1	30.2	4.1	10.9	27.0	7.2	4.9	17.8	32.3
Temiskaming Hospital	New Liskeard	13	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
The Brantford General Hospital	Brantford	4	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	44.6
The Credit Valley Hospital	Mississauga	6	NR	NR	21.2	7.4	14.2	20.9	0.0	44.7	9.2	1.8	9.6	11.8	NR
Timmins and District Hospital	Timmins	13	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Toronto East General Hospital	Toronto	7	31.6	16.7	18.6	16.6	24.7	34.4	6.1	19.9	30.3	11.8	5.0	23.1	56.2
Trillium Health Centre	Toronto	6	21.5	11.6	17.6	10.2	15.0	18.7	1.8	32.8	15.6	6.2	10.3	22.8	37.6
West Lincoln Memorial Hospital	Grimsby	4	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	37.0
West Parry Sound Health Centre	West Parry Sound	13	NR	15.9	21.7	15.4	19.7	20.9	4.8	35.6	24.4	4.2	15.9	9.6	40.8
William Osler Health Centre	Brampton	5	NR	NR	17.6	1.4	10.9	18.3	6.2	26.3	37.1	3.8	11.4	20.1	51.9
Wilson Memorial General Hospital	Marathon	14	NR	NR	13.3	5.7	NR	NR	NR	NR	NR	NR	NR	NR	N/A
Winchester District Memorial Hospital	Winchester	11	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	31.2
Windsor Regional Hospital	Windsor	1	31.3	20.0	20.7	14.1	19.6	28.4	5.2	37.9	30.5	6.8	10.3	17.6	50.1
Woodstock General Hospital	Woodstock	2	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	45.4
York Central Hospital	Richmond Hill	8	NR	NR	43.5	27.2	NR	NR	23.2	32.7	36.6	21.3	4.3	NR	44.0

NR: Insufficient sample size.

N/A: Denominator of "0."

■ Above-Average Performance

■ Average Performance

■ Below-Average Performance

LHIN	Improved ADL	Walk/Wheel Decline	Increased Anxiety/Depression	Communication Decline	Indwelling Catheter	Bladder Continence Decline	Patients With New Falls	Disruptive or Severe Pain	Pressure Sores	New Stage 2+ Skin Ulcers	Physical Restraint Use	Anti-psychotic Drug Use	Disruptive or Severe Pain, Short-Stay
RESULTS BY LOCAL HEALTH INTEGRATION NETWORK													
LHIN 1 (Erie St. Clair)	32.7	24.9	22.7	16.5	22.8	22.1	8.4	33.8	29.7	8.7	9.9	28.9	31.5
LHIN 2 (South West)	15.1	11.5	16.7	11.1	15.9	15.2	4.4	35.1	22.3	5.6	33.0	28.9	46.0
LHIN 3 (Waterloo Wellington)	34.7	22.8	21.2	15.3	21.0	25.2	4.4	45.0	34.5	7.0	33.4	18.5	45.3
LHIN 4 (Hamilton Niagara Haldimand Brant)	24.5	21.3	18.9	12.2	14.9	19.8	6.2	25.7	30.5	8.4	22.8	29.0	40.3
LHIN 5 (Central West)	34.4	25.0	20.0	2.9	18.4	13.0	4.3	23.0	42.5	5.2	11.5	22.3	36.1
LHIN 6 (Mississauga Halton)	23.8	13.7	17.2	10.1	12.9	20.6	1.0	34.2	17.3	5.0	9.7	27.5	40.3
LHIN 7 (Toronto Central)	29.5	16.9	18.3	16.3	11.7	23.8	2.9	21.6	21.4	6.7	7.8	18.5	42.9
LHIN 8 (Central)	36.0	21.4	36.9	22.5	33.3	28.6	14.7	32.4	42.9	15.7	21.0	11.8	47.6
LHIN 9 (Central East)	30.3	33.9	20.6	21.0	26.0	24.8	3.3	41.0	29.7	9.0	14.7	20.3	41.9
LHIN 10 (South East)	31.6	23.0	29.2	20.5	23.0	19.0	4.3	47.8	25.8	5.0	16.1	21.2	49.1
LHIN 11 (Champlain)	21.5	15.6	19.4	9.7	19.9	11.1	3.2	31.1	26.2	6.8	12.9	23.1	46.9
LHIN 12 (North Simcoe Muskoka)	36.5	19.0	22.6	11.5	28.2	20.3	6.8	35.6	46.0	5.6	13.9	21.9	42.2
LHIN 13 (North East)	32.2	17.2	17.1	15.2	19.3	16.5	4.4	37.7	17.8	4.7	21.4	26.9	38.7
LHIN 14 (North West)	34.8	10.7	17.2	7.3	9.6	15.9	5.8	34.9	15.0	4.3	17.6	26.0	46.2

This quadrant provides insights into the financial performance and condition of complex continuing care (CCC) hospitals. The indicators presented are based on data from the 2005–2006 fiscal year, which were the most recent financial data available. These data are submitted annually to the Ontario Ministry of Health and Long-Term Care using formats specified by the Ontario Healthcare Reporting Standards (OHRS).

This report divides hospitals that provide complex continuing care services into two groups: free-standing complex continuing care hospitals and acute care hospitals with complex continuing care programs. For CCC programs located in acute care hospitals, it is difficult to isolate inpatient revenues, assets and liabilities that relate solely to complex continuing care services in these settings. As a result, the only indicators that can be calculated for all hospitals that provide complex continuing care services are Total Cost per RUG-III Weighted Patient Day and Direct Cost per RUG-III Weighted Patient Day.

There are 16 free-standing complex continuing care hospitals in Ontario. For these hospitals, we report an additional four indicators at the corporate level. Additional corporate-level indicators published in previous editions of *Hospital Report: Complex Continuing Care* have been removed from this year's report to be consistent with a substantial redevelopment of financial performance and condition indicators used in *Hospital Report 2006: Acute Care*. This redevelopment was necessitated by changes in the hospital industry, the data collected and performance criteria.

Although the four corporate-level indicators in *Hospital Report 2007: Complex Continuing Care* can be found in *Hospital Report 2007: Acute Care*, readers are cautioned not to make direct comparisons between the financial performance indicators of free-standing complex continuing care hospitals and acute care hospitals. There are fundamental differences in funding and operational structures between these two groups that make this comparison inappropriate.

Indicator Definitions

Total Cost per RUG-III Weighted Patient Day^{iv}

This indicator measures the total cost of providing inpatient care to complex continuing care patients, and is stated on a weighted day basis. This indicator is a measure of efficiency. A lower value indicates less total cost per weighted patient day and a higher value indicates more total cost per weighted patient day. Currently, there are no standards or benchmarks for this indicator other than the provincial mean. Further development of a benchmark should be based on the lowest reasonable total cost per weighted patient day to achieve an acceptable quality of care and patient outcome. This indicator is not adjusted for differences between hospitals that can affect cost structures, such as size and teaching mandate. As a result, direct comparisons between hospitals using this indicator should be made with caution.

Data from all 107 hospitals in Ontario that provided complex continuing care services in 2005–2006 were used to calculate provincial and LHIN means for both the Total and Direct Cost per RUG-III Weighted Patient Day indicators. Hospital-specific data for these two indicators are shown for 81 hospitals that voluntarily agreed to participate in this quadrant of the report. Data from all 16 free-standing complex continuing care hospitals were used to calculate provincial and LHIN means for the remaining three corporate-level financial indicators. Hospital-specific data for these indicators are shown for 13 free-standing hospitals that voluntarily agreed to participate in this quadrant of the report.

iv. Patients in complex continuing care beds are classified into resource utilization groups (RUGs), which are clinically relevant and resource-homogeneous groups based on information captured by the Resident Assessment Instrument Minimum Data Set (RAI-MDS 2.0[©]). RUG-III is the current version of this classification system. A hospital's RUG-III weighted patient days adjusts for case mix differences in complex continuing care patients and allows comparison among hospitals.

Direct Cost per RUG-III Weighted Patient Day

This indicator measures the direct cost of providing inpatient care to complex continuing care patients, and is stated on a weighted day basis. This indicator is a measure of efficiency. A lower value indicates less direct cost per weighted patient day and a higher value indicates more direct cost per weighted patient day. Currently, there are no standards or benchmarks for this indicator other than the provincial mean. Further development of a benchmark should be based on the lowest reasonable direct cost per weighted patient day to achieve an acceptable quality of care and patient outcome. This indicator is not adjusted for differences between hospitals that can affect cost structures, such as size and teaching mandate. As a result, direct comparisons between hospitals using this indicator should be made with caution.

The following indicators are calculated for free-standing complex continuing care hospitals.

Total Margin

This indicator measures the percent by which a hospital's total revenues differs from its total expenses, excluding the impact of facility amortization (land, building and building service equipment). This indicator is a measure of financial viability. A positive value indicates total expenses are less than total revenues (a surplus). Very high positive values may indicate temporary cash inflows (such as the sale of an asset), relatively high levels of funding, relatively high efficiency or under-provision of service. A negative value indicates total expenses are greater than total revenues (a deficit). Very high negative values may indicate temporary cash outflows (such as the purchase of an asset), relatively low levels of funding, relatively low efficiency or over-provision of service and, as a consequence, financial difficulty. The ability to generate a surplus is influenced by government funding levels, patient need and volume, local prices, service mix and complexity, third-party payer rates, management strategies and other factors. A good Total Margin value is high enough to provide funds to acquire equipment, meet increases in patient need and volume and improve the quality of care, but not so high as to indicate that the mandate of a not-for-profit hospital is not being fulfilled. In 2005, Ontario hospitals were surveyed to create benchmark values for Total Margin. A hospital is demonstrating good financial management if Total Margin is between 0 and 5%. Variations in reporting non-recurring costs, such as pay-equity settlements and restructuring charges, and in the rate at which equipment purchases are expensed can affect this indicator.

Current Ratio

This indicator measures the number of times a hospital's short-term obligations can be paid using the hospital's short-term assets. It is a measure of liquidity and describes a hospital's ability to meet its short-term debts. A value greater than 1.0 indicates current assets are greater than current liabilities. Very high values may indicate under-investment in longer-term assets that usually yield higher returns. A value less than 1.0 indicates current assets are less than current liabilities. Very low values may indicate financial difficulty. The ability to manage current assets and liabilities and to meet day-to-day requirements for paying creditors is influenced by payer practices, payment policies, credit arrangements, investment policies, management strategies and other factors. A good Current Ratio value is high enough to meet creditor needs, but not so high as to forego the benefits of a long-term investment strategy. In 2005, Ontario hospitals were surveyed to create benchmark values for the Current Ratio. A hospital is demonstrating good financial management if the Current Ratio is between 1.0 and 2.0. Variations in the classification of assets and liabilities as either short-term or long-term can affect this indicator.

Unit Cost Performance

This indicator measures the extent to which a hospital's actual cost per equivalent weighted case differs from its expected cost. This indicator is a measure of efficiency. A negative value indicates actual cost is less than expected cost (unit cost efficiency). Very high negative values may indicate relatively high efficiency or under-spending. A positive value indicates actual cost is greater than expected cost (unit cost inefficiency). Very high positive values may indicate relatively high inefficiency or over-spending. The ability to achieve unit cost efficiency is influenced by staff mix, productivity, local prices of goods and services, community linkages, management practices and physician practice patterns and other factors. A good Unit Cost Performance value is low enough to indicate appropriate use of scarce resources but not so low as to indicate low quality of care, poor outcomes or patient needs that are not being met. The 2005–2006 Unit Cost Performance values were not available for the initial release of this report. See www.jppc.org for more information about this indicator.

% Corporate Services

This indicator measures how much a hospital spends in areas of administrative services relative to its total operating expenses. This indicator is a measure of efficiency. Higher-than-average values indicate more complex or a greater amount of corporate services. Very high values may indicate over-spending on corporate services. Lower-than-average values indicate less complex or a lesser amount of corporate services. Very low values may indicate under-spending on corporate services. The ability to appropriately manage corporate services is influenced by organizational size, service mix and complexity, information systems, management models and other factors. A good % Corporate Services value is low enough to indicate that the operations of the hospital are being supported at reasonable cost, but not so low as to indicate a lack of staff in leadership roles that would slow decisions and impair achievement of organizational goals and objectives. Variations in the allocation of corporate and support service staff costs between patient care and corporate areas can affect this indicator. For example, in some hospitals the cost of system support staff on nursing units is assigned to a nursing/program administration functional centre, while in other hospitals these employees are assigned to general administration or information system support services.

SUMMARY OF RESULTS

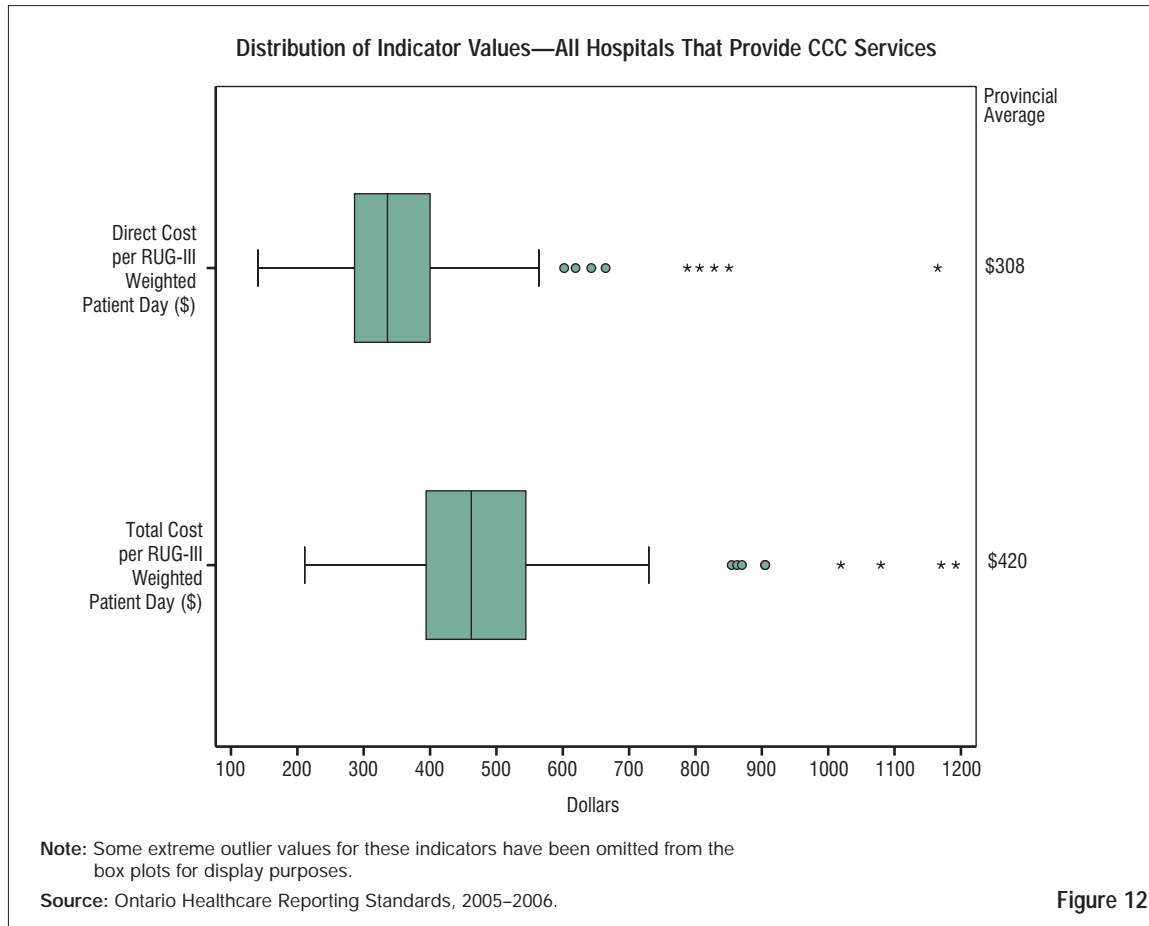
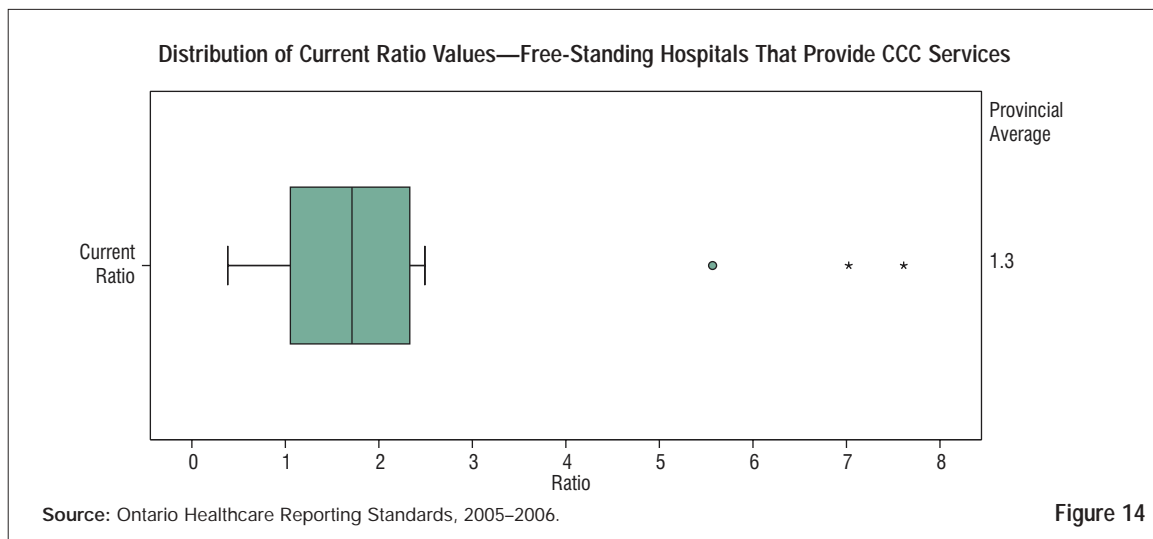
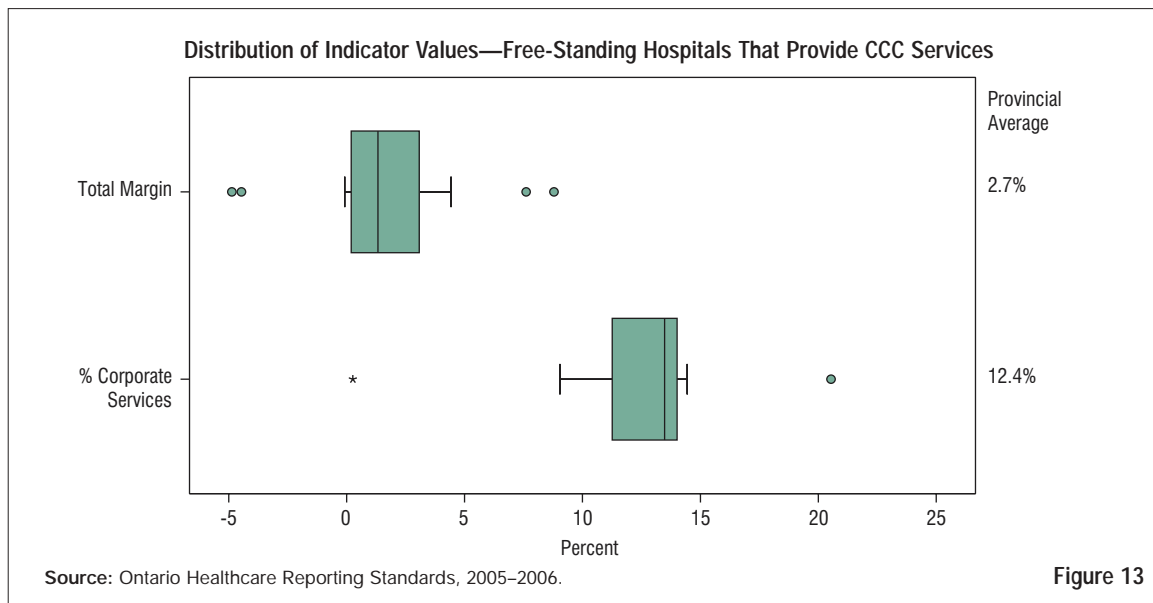


Figure 12

SUMMARY OF RESULTS (CONT'D)

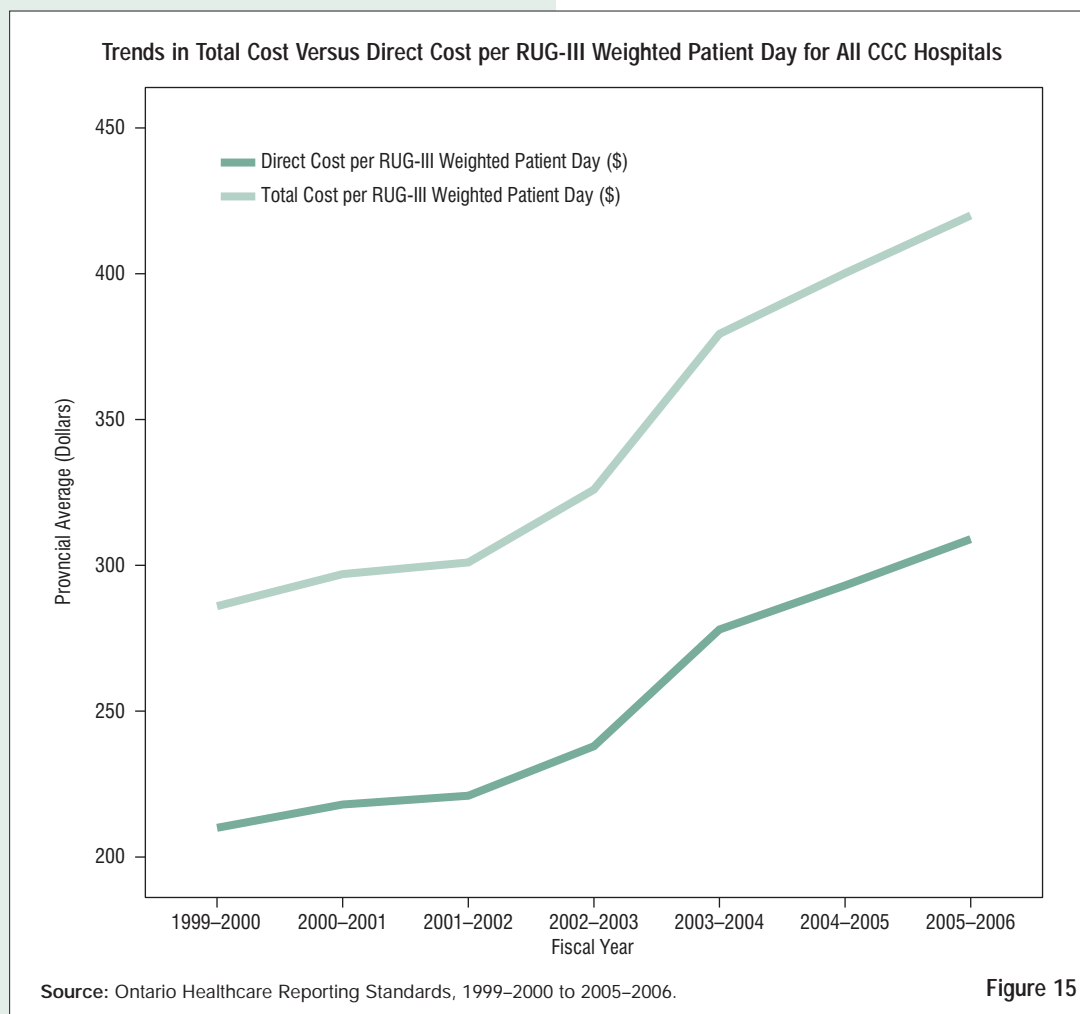


Figures 12–14 show the distribution of indicator scores for all hospitals and the provincial average (mean) for each of the indicators. For more information on the interpretation of box plots, please refer to the Interpreting the Results section in this report.

SUMMARY OF RESULTS (CONT'D)

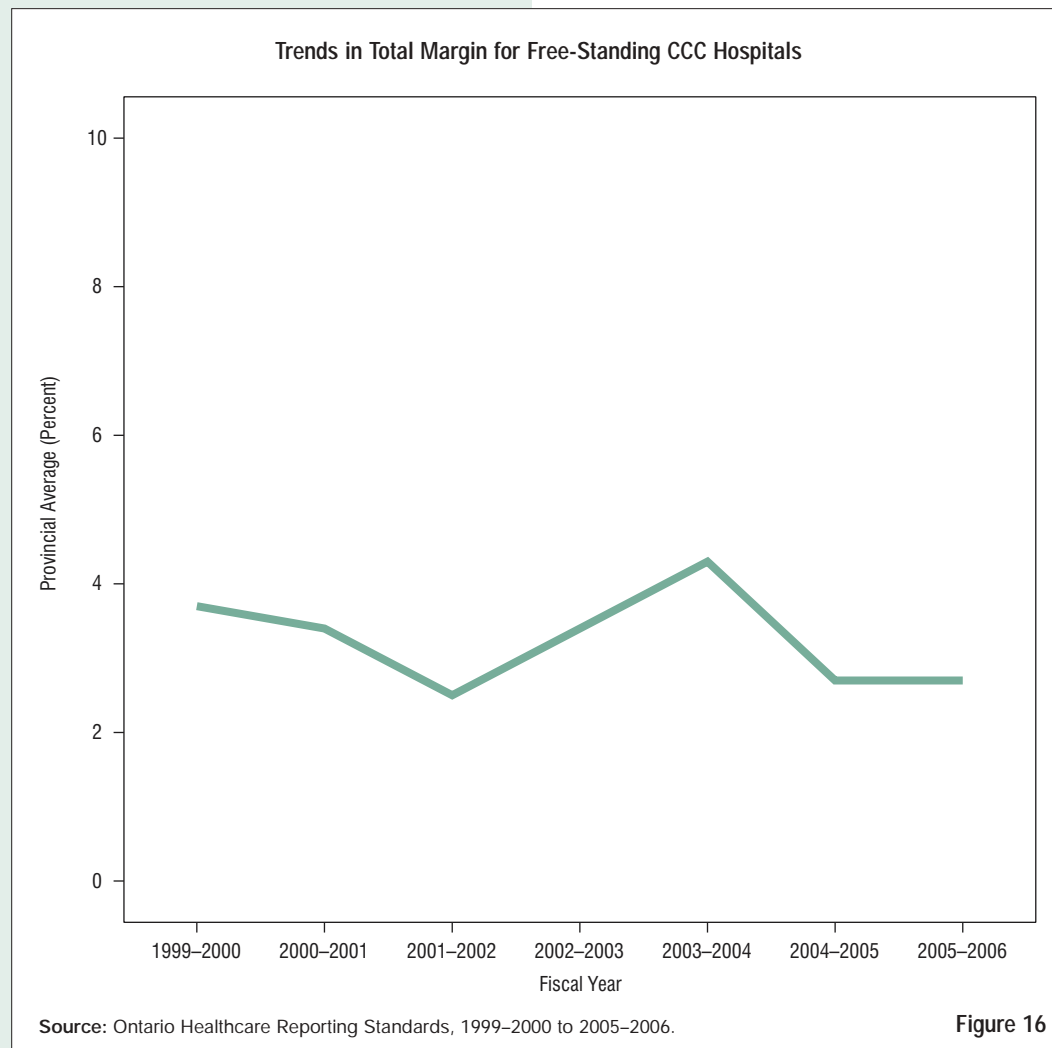
In 2005–2006, Ontario hospitals reported a total cost of \$826.4 million related to complex continuing care programs and reported approximately 2 million RUG-III weighted patient days, resulting in a provincial mean for total cost of \$420.10 per RUG-III Weighted Patient Day. Between 1999–2000 and 2005–2006, the provincial mean Total Cost per RUG-III Weighted Patient Day increased from \$286.17 to \$420.10 (Figure 15). During the same period, the lowest total RUG-III weighted patient days were reported in 2005–2006. The 2.3 million total RUG-III weighted patient days reported in 1999–2000 were the highest over that period.

In 2005–2006, hospitals reported total direct costs of \$605.4 million related to complex continuing care programs, resulting in a provincial mean of \$307.80 for Direct Cost per RUG-III Weighted Patient Day. Between 1999–2000 and 2005–2006, the provincial mean Direct Cost per RUG-III Weighted Patient Day increased from \$209.67 to \$307.80.



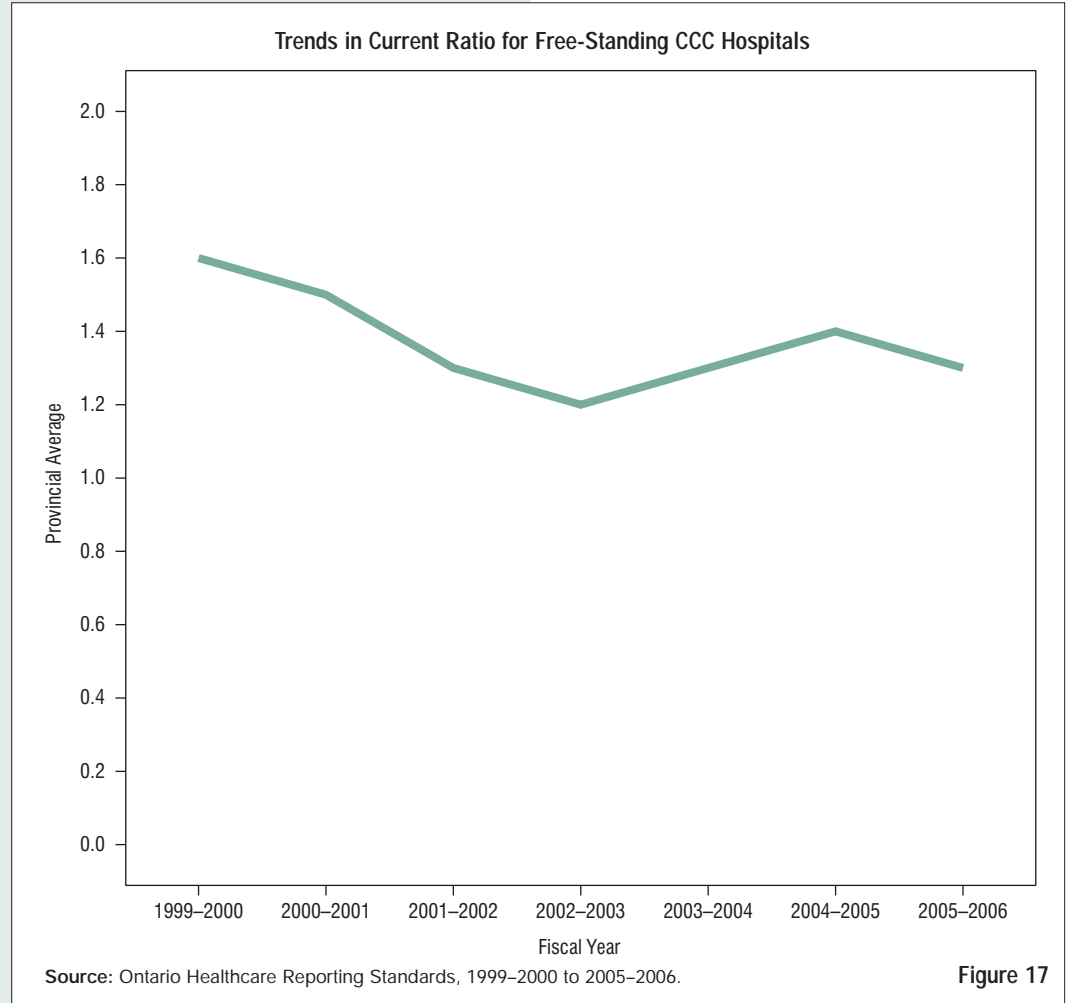
SUMMARY OF RESULTS (CONT'D)

The 16 free-standing CCC hospitals reported an aggregate net surplus of \$24.2 million and total revenues of \$901.4 million, resulting in a mean Total Margin of 2.7% in 2005–2006. Thirteen of the free-standing hospitals reported surpluses (for a total of \$26.9 million) and three reported a deficit of \$2.6 million. Two hospitals reported Total Margin values greater than 5%. Between 1999–2000 and 2005–2006, the Total Margin for free-standing complex continuing care hospitals decreased from 3.7% to 2.7% (Figure 16). The ability of a hospital to generate a surplus of revenues over expenses is influenced by government funding levels, patient need and volume, local prices, service mix and complexity, third-party payer rates, management strategies and other factors.



SUMMARY OF RESULTS (CONT'D)

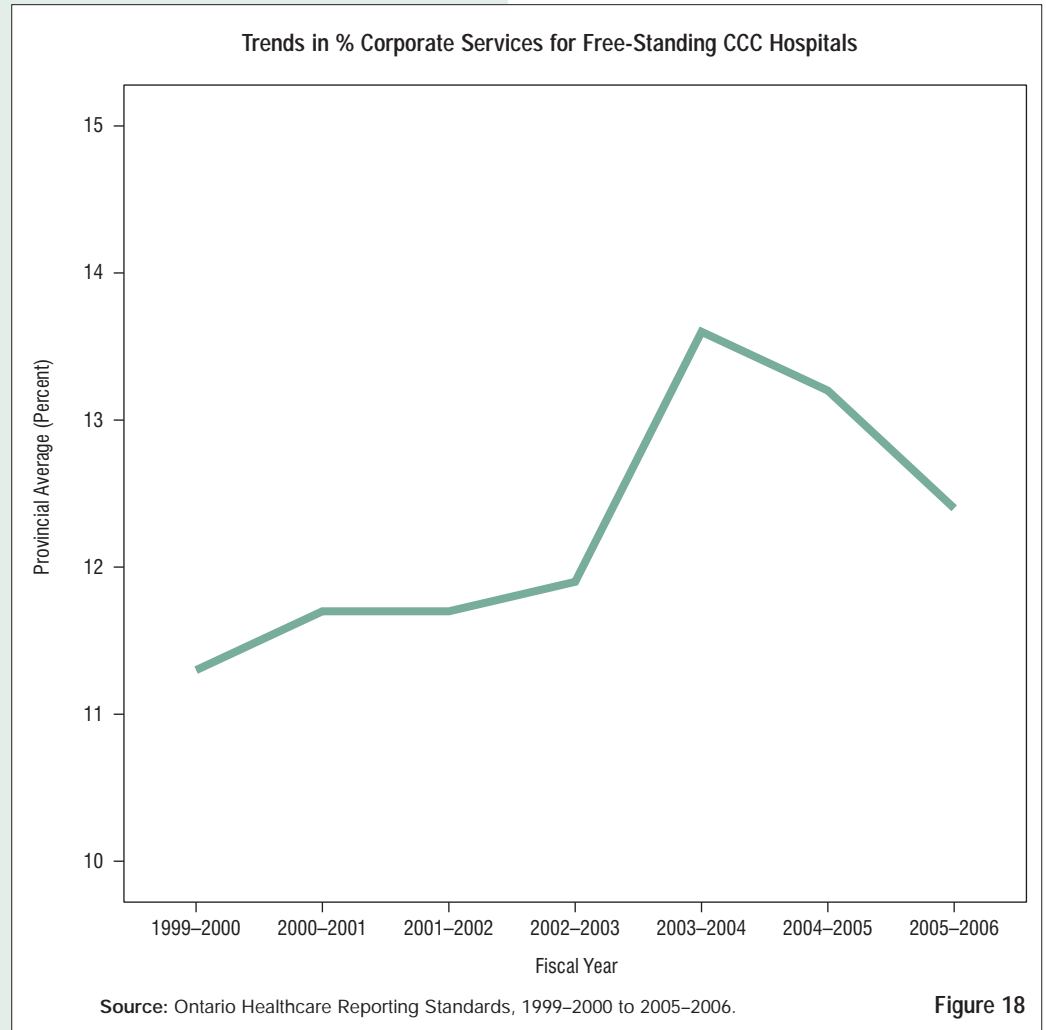
In 2005–2006, the 16 free-standing complex continuing care hospitals reported total current assets of \$270.7 million and total current liabilities of \$211.0 million, for a mean Current Ratio of 1.3. Seven of the free-standing hospitals reported a Current Ratio between 1.0 and 2.0, three reported a Current Ratio less than 1.0, and six were above 2.0. Between 1999–2000 and 2005–2006, the current ratio of free-standing complex continuing care hospitals declined from 1.6 to 1.3 (Figure 17). Over this period, the number of free-standing hospitals increased from 15 in 1999–2000 to 16 in 2005–2006, as some hospitals became specialized free-standing complex continuing care hospitals.



SUMMARY OF RESULTS (CONT'D)

This is the seventh year that expected cost per equivalent weighted case has been calculated for complex continuing care. In recent years, the methodology for calculating expected cost per weighted case in complex continuing care settings has been improved and now captures tertiary care activities provided in CCC settings, which results in a better measurement of the costs at the high end of the CCC care continuum. Please see the Joint Policy and Planning Committee website (www.jppc.org) for 2005–2006 Unit Cost Performance values, as they were not available at the time of the publication of this report.

In 2005–2006, the 16 free-standing complex continuing care hospitals reported total corporate expenses of \$100.6 million and total operating expenses of \$813.1 million, indicating that corporate expenses accounted for 12.4% of total operating costs in 2005–2006. Between 1999–2000 and 2005–2006, the corporate expense ratio for free-standing complex continuing care hospitals increased slightly from 11.3% to 12.4% (Figure 18). The ability of a hospital to appropriately manage corporate services is influenced by organizational size, service mix and complexity, information systems management models and other factors.



PERFORMANCE ALLOCATION TABLE

Hospital	Community Served	LHIN	Total Cost per RUG-III Weighted Patient Day (\$)	Direct Cost per RUG-III Weighted Patient Day (\$)	% Corporate Services	Total Margin (%)	Current Ratio
PROVINCIAL AVERAGE			420.1	307.8	12.4	2.7	1.3

FREE-STANDING COMPLEX CONTINUING CARE HOSPITALS							
Baycrest Centre for Geriatric Care	Toronto	7	462.2	312.0	14.2	2.3	0.4
Bridgepoint Health	Toronto	7	367.0	263.3	13.4	0.2	2.2
Penetanguishene General Hospital Inc. (The)—North Simcoe Hospital Alliance	Penetanguishene	12	441.6	318.7	13.8	4.4	2.5
Providence Continuing Care Centre	Kingston	10	544.3	391.0	11.1	-0.1	1.1
Providence Healthcare	Toronto	7	339.3	252.8	11.4	1.7	1.7
Sisters of Charity of Ottawa (SCO) Health Service	Ottawa	11	416.0	284.7	14.2	1.0	0.6
St. Joseph's Care Group	Thunder Bay	14	475.8	368.9	9.0	7.6	1.8
St. Joseph's Continuing Care Centre (Cornwall)	Cornwall	11	336.8	236.2	13.8	0.2	7.6
St. Joseph's Health Centre, Guelph	Guelph	3	478.3	312.3	0.3	2.9	1.7
St. Peter's Hospital	Hamilton	4	352.4	245.2	13.7	3.0	2.0
Toronto Grace Hospital	Toronto	7	370.9	265.5	13.5	0.5	7.0
Toronto Rehabilitation Institute	Toronto	7	326.0	233.7	12.4	8.8	1.4
West Park Healthcare Centre	Toronto	7	391.3	287.8	14.4	3.1	1.0

ACUTE CARE HOSPITALS WITH COMPLEX CONTINUING CARE				
Alexandra Hospital	Ingersoll	2	211.1	140.8
Alexandra Marine and General Hospital	Goderich	2	633.9	458.4
Almonte General Hospital	Almonte	11	272.6	185.3
Atikokan General Hospital	Atikokan	14	862.8	562.7
Bluewater Health	Sarnia	1	503.2	392.6
Cambridge Memorial Hospital	Cambridge	3	496.9	375.8
Chatham-Kent Health Alliance	Chatham	1	479.6	312.0
Dryden Regional Health Centre	Dryden	14	729.6	510.2
Glengarry Memorial Hospital	Alexandria	11	383.7	271.7
Grand River Hospital	Kitchener	3	381.5	293.5
Groves Memorial Community Hospital	Fergus	3	367.0	264.2
Halton Healthcare	Oakville	6	NR	NR
Headwaters Health Care Centre	Orangeville	5	360.7	269.7

NR = Non-reportable—results are not shown due to data quality issues.

■ Inside Range to Reflect Optimal Performance ■ Outside Range to Reflect Optimal Performance

Hospital	Community Served	LHIN	Total Cost per RUG-III Weighted Patient Day (\$)	Direct Cost per RUG-III Weighted Patient Day (\$)
Huron Perth Healthcare Alliance	Stratford	2	428.6	312.4
Hôpital Général de Hawkesbury and District General Hospital Inc.	Hawkesbury	11	464.0	330.6
Hôpital régional de Sudbury Regional Hospital	Sudbury	13	450.4	354.2
Joseph Brant Memorial Hospital	Burlington	4	373.9	296.6
Kemptville District Hospital	Kemptville	11	1,698.8	1,165.1
Kirkland and District Hospital	Kirkland Lake	13	586.2	423.8
Lakeridge Health	Oshawa	9	384.9	294.5
Leamington District Memorial Hospital	Leamington	1	453.1	327.3
Lennox and Addington County General Hospital	Napanee	10	439.4	306.6
Listowel and Wingham Hospitals Alliance	Listowel	2	347.7	255.5
MICs Group of Health Services	Cochrane	13	854.6	602.1
Markham Stouffville Hospital	Markham	8	386.1	299.1
Mattawa General Hospital	Mattawa	13	1,170.2	787.7
McCausland Hospital	Terrace Bay	14	544.6	350.9
Muskoka Algonquin Healthcare	Huntsville	12	590.1	454.2
Niagara Health System	Niagara Falls	4	244.1	185.6
Nipigon District Memorial Hospital	Nipigon	14	341.7	236.3
Norfolk General Hospital	Simcoe	4	655.4	461.6
North Bay General Hospital	North Bay	13	596.6	447.4
Northumberland Hills Hospital	Cobourg	9	471.8	363.0
Orillia Soldiers' Memorial Hospital	Orillia	12	503.5	399.3
Pembroke Regional Hospital	Pembroke	11	458.4	319.3
Peterborough Regional Health Centre	Peterborough	9	434.0	341.2
Quinte Health Care	Belleville	10	459.8	341.1
Renfrew Victoria Hospital	Renfrew	11	638.2	504.9
Riverside Health Care Facilities Inc.	Fort Frances	14	528.0	357.6
Ross Memorial Hospital	Lindsay	9	593.1	438.6
Rouge Valley Health System	Scarborough	9	415.3	318.2
Royal Victoria Hospital	Barrie	12	390.7	308.4
Sault Area Hospital	Sault Ste. Marie	13	443.0	357.9
Sensenbrenner Hospital	Kapuskasing	13	437.9	313.2
Sioux Lookout Meno-Ya-Win Health Centre	Sioux Lookout	14	1,079.4	664.5

Hospital	Community Served	LHIN	Total Cost per RUG-III Weighted Patient Day (\$)	Direct Cost per RUG-III Weighted Patient Day (\$)
Smooth Rock Falls Hospital	Smooth Rock Falls	13	473.3	316.1
South Huron Hospital	Exeter	2	522.6	345.7
Southlake Regional Health Centre	Newmarket	8	318.0	254.5
St. Francis Memorial Hospital	Barry's Bay	11	501.6	372.9
St. Joseph's Health Care London	London	2	499.8	386.4
St. Joseph's Healthcare Hamilton	Hamilton	4	356.9	276.9
St. Thomas-Elgin General Hospital	St. Thomas	2	529.2	373.7
Strathroy Middlesex General Hospital	Strathroy	2	496.1	368.4
Sunnybrook and Women's College Health Sciences Centre	Toronto	7	468.1	357.3
Temiskaming Hospital	New Liskeard	13	553.8	404.0
The Brantford General Hospital	Brantford	4	416.5	313.3
The Credit Valley Hospital	Mississauga	6	403.4	318.6
Timmins and District Hospital	Timmins	13	9,086.8	6,865.0
Toronto East General Hospital	Toronto	7	427.4	313.3
Trillium Health Centre	Mississauga	6	292.2	214.9
West Lincoln Memorial Hospital	Grimsby	4	335.6	255.4
West Parry Sound Health Centre	Parry Sound	13	481.0	338.1
William Osler Health Centre	Brampton	5	507.8	394.4
Wilson Memorial General Hospital	Marathon	14	420.6	272.0
Winchester District Memorial Hospital	Winchester	11	472.2	340.9
Windsor Regional Hospital	Windsor	1	462.5	361.8
Woodstock General Hospital	Woodstock	2	419.8	319.4
York Central Hospital	Richmond Hill	8	407.7	313.5

Note: Hospitals are grouped according to whether the CCC program is in a free-standing CCC hospital or an acute care hospital; however, these groupings were not used in indicator or performance classification calculations.

LHIN	Total Cost per RUG-III Weighted Patient Day (\$)	Direct Cost per RUG-III Weighted Patient Day (\$)
RESULTS BY LOCAL HEALTH INTEGRATION NETWORK		
LHIN 1 (Erie St. Clair)	476.9	357.1
LHIN 2 (South West)	484.9	362.8
LHIN 3 (Waterloo Wellington)	423.4	309.3
LHIN 4 (Hamilton Niagara Haldimand Brant)	356.7	261.5
LHIN 5 (Central West)	467.8	360.5
LHIN 6 (Mississauga Halton)	309.8	231.3
LHIN 7 (Toronto Central)	390.3	282.2
LHIN 8 (Central)	480.8	357.7
LHIN 9 (Central East)	431.0	330.0
LHIN 10 (South East)	510.4	370.8
LHIN 11 (Champlain)	418.4	290.7
LHIN 12 (North Simcoe Muskoka)	453.1	349.3
LHIN 13 (North East)	596.2	442.9
LHIN 14 (North West)	512.4	379.5

APPENDIX A: DATA SOURCES

The following table provides a list of the data sources used in each of the four sections of this report.

Quadrant	Data Source	Year*
System Integration and Change	System Integration and Change (SIC) Survey	2007
Patient and Family Satisfaction	NRC + Picker CCC Patient and Family Satisfaction Survey	2006–2007
Clinical Utilization and Outcomes	Continuing Care Reporting System (CCRS)	2005–2006
Financial Performance and Condition	Ontario Healthcare Reporting Standards (OHRS)	2005–2006

*Note: Previous years may also have been used in this report for trending purposes.



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