2019/20 Quality Improvement Plan for Home Care
"Improvement Targets and Initiatives"

Ontario
Hamilton Niagara Haldimand Brant Local Health Integration Network
Réseau local d'intégration des services de santé de Hamilton Niagara Haldimand Brant

Hamilton Niagara Haldimand Brant Local Health Integration Network

AIM		Measure									Change				
Issue	Quality dimension	Measure/Indicator	Type	Unit / Population	Source / Period	Organization Id	Current performance	Target	Target justification	External Collaborators	Planned improvement initiatives (Change Ideas)	Methods	Process measures	Target for process measure	Comments
M = Mandatory (all cells must be completed) P = Priority (complete ONLY the comments cell if you are not working on this indicator) C = custom (add any other indicators you are working on)															
Theme I: Timely and Efficient Transitions	**Efficient**	Percentage of home care clients with an unplanned, less-urgent ED visit within the first 30 days of discharge from hospital.	P	% / Home care clients discharged from hospital	HSSO HCD, CIHI DAD, CIHI NACRS / July 2017 – June 2018	92400*	5.34	5.23	Propose modest improvements of 2%; acknowledges potential changes in health system		1)Create mechanism to monitor Avoidable ED visits at the caseload level and service provider level	Work with Business Intelligence (BI) team and Patient Care Managers to report and monitor at the caseload level	% Patient Care Managers monitoring avoidable ED visits on a regular basis	100% of Patient Care Managers show evidence of monitoring avoidable ED visits by March 31, 2020.	
											2)Deep dive into the data for ED visits within 30 days of discharge from hospital	Decision Support to complete a deep dive into the patient demographics, admission diagnosis and further details to support development of future change ideas to prevent unplanned, less urgent ED visits.	% of the data analysis completed on patients with an unplanned, less urgent ED visit within the first 30 days of discharge from hospital.	100% completion of the data analysis and a minimum of one future change idea developed by September 1, 2019.	
	Timely	Median number of days residents waited to be placed in a LTCH from the date of long-term care home application or consent to the date of placement, whichever is longer. (community)	P	Days / Home care residents placed from community	CPRO / April 2017 – March 2018	92400*	112	109.76	LHIN has limited ability to impact this indicator. HNHB exceeding provincial average performance. Propose modest improvements of 2% reduction in days.	LTC Home Administrators in all Sub-Regions	1)Allocate resources to conduct timely patient assessments for eligibility for Long-Term Care and drive capacity building for Community teams	Develop processes that leverage existing non-regulated staff to match and fill Long-Term Care Home beds and regulated staff to conduct patient assessments.	% Completion of new processes to allocate resources to conduct patient assessments.	100% Completion of new processes to allocate resources to conduct patient assessments by March 31, 2020.	
											2)Address current challenges with LTCH bed matching and filling caused by process variation across sub-regions	Centralize (could be virtual) the work of matching and bed filling patients across all LHIN sub-regions	% Completion of centralization of matching and bed filling business processes across all LHIN sub-regions.	100% Completion of centralization of matching and bed filling business processes across all LHIN sub-regions by March 31, 2020.	
											3)Deploy a patient assessment process for Placement Coordinators that will optimize impact on capacity and patient experience	Phase in the assessment process leveraging existing regulated staff and test and validate best methods before scaling resources.	% Completion of patient assessment process for Placement Coordinators.	100% Completion of patient assessment process by March 31, 2020.	
											4)Improving relationships with hospitals and LTCH through ensuring efficient and effective placement processes, decreasing errors and increasing quality of assessments	Staff well-versed in placement process and legislation will be conducting the assessments	% Completion of education and coaching for regulated staff to complete patient assessments.	100% Completion of education and coaching by March 31, 2020.	

		Median number of days residents waited to be placed in a LTCH from the date of long-term care home application or consent to the date of placement, whichever is longer. (Hospital)	P	Days / Home care residents placed from AC hospitals	CPRO / April 2017 - March 2018	92400*	88	86.24	LHIN has limited ability to impact this indicator. HNHB exceeding provincial averages. Propose modest improvements of 2% reduction in days.	LTC Home Administrators in all Sub-Regions	1)Allocate resources to conduct timely patient assessments for eligibility for Long-Term Care and drive capacity building for Community teams	Develop processes that leverage existing non-regulated staff to match and fill Long-Term Care Home beds and regulated staff to conduct patient assessments.	% Completion of new processes to allocate resources to conduct patient assessments.	100% Completion of new processes to allocate resources to conduct patient assessments by March 31, 2020.	
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Theme II: Service Excellence	**Patient-centred**	Percent of home care clients who responded "Good", "Very Good", or "Excellent" on a five-point scale to any of the client experience survey questions: i) Overall rating of LHIN Home and community care services ii) Overall rating of management/handling of care by Care Coordinator iii) Overall rating of service provided by service provider	P	% / Home Care Clients	HSSO CCEE Survey / April 2017 - March 2018	92400*	91.9	93.00	Maintaining target from 2018-19 QIP acknowledges potential changes in health system	Able Living Services Inc., Participation House Brantford, Capability Support Services Inc., March of Dimes Canada, All Service Provider Organizations	1)Increase the number of patients receiving Coordinated Care Plans (CCP) through partnerships at the Sub-Region level.	Identify a minimum of 2 HealthLinks Partner Organizations that have a process to identify patients at risk and have these submitted to the Health Links team.	Number of Health Links Partner Organizations that have submitted their processes for identifying patients at risk.	100% of Sub Regions have submitted a minimum of 2 processes for identifying patients at risk by June 1, 2019	
											2)Increase the number of patients receiving Coordinated Care Plans (CCP) through partnerships at the Sub-Region level.	Each sub-region identifies collaborative partnerships to support patients along the continuum of care.	Each sub-region will identify a minimum of one formal and one informal collaborative partnership to support patients along the continuum of care.	100% of Sub Regions have identified a minimum of one formal and one informal collaborative partnership by September 30, 2019	
											3)Work with Contracted Service Providers to begin the alignment of home care services with sub-regions while also mapping all possible opportunities to cluster Personal Support Worker (PSW) care.	Review geographical alignment of service providers and adjust to achieve greater efficiency. Review opportunities for cluster care in Retirement Homes.	% Missed Care as reported by provider for each of the sub-regions and for each of the services	Missed Care equal to or less than provincial target of 0.05%	
											4)In partnership with contracted service providers and community support services, optimize Personal Support resources to better support the patients in HNHB LHIN.	Alignment of personal support and homemaking tasks across personal support contracted service providers and community support services. Implementing "Windows of Time" scheduling for patients.	% Missed Care as reported by provider for each of the sub-regions and for each of the services	Missed Care equal to or less than provincial target of 0.05%.	

		Percentage of complaints acknowledged to the individual who made a complaint within two business days	P	% / Home Care Clients	Local data collection / Most recent 12 month period	92400*	88.38	96.00	Maintaining target from 2018-19 QIP acknowledges potential changes in health system		1)Evolve our Home and Community Care complaints management process in alignment with Health Quality Ontario guidelines.	1. Consistent interpretation and application of the complaints definitions as defined by HQO 2. Re-design of the Event Monitoring System to ensure we can collect data for priority patient relations indicators	Alignment of the process to HQO and evaluation of system to meet needs of the organization and HQO.	Processes will be aligned with the HQO complaints management process and an evaluation of the process and data will occur by December 31, 2019.	
											2)Evolve our Home and Community Care complaints management process in alignment with Health Quality Ontario guidelines.	Update the Patient Relations Policy and Procedure to align with HQO complaints definitions and the updated Event Monitoring System.	% completion of policy and procedure and full launch of updated event monitoring system changes.	100% Completion of the updated policy and procedure and roll out of the changes to the event monitoring system by September 30, 2019.	
Theme III: Safe and Effective Care	**Effective**	Proportion of home care patients with a progressive, life-threatening illness who have had their palliative care needs identified early through a comprehensive and holistic assessment.	P	Proportion / at-risk cohort	Local data collection / Most recent 6-month period	92400*	CB	CB	Baseline Data Collection		1)Improving the identification of patients requiring a palliative approach to care	Implementation of a revised transfer of accountability process and related tools for patients transitioning to the palliative care team	% completion of implementation of process and tools to all care coordinators and service provider organizations	100% completion of implementation of process and tools by March 31, 2020	
											2)Improving the identification of patients requiring a palliative approach to care	Education to staff to assist with identifying patients that could benefit from palliative approach to care including assessment using the Clinical Indicators of less than 12 Months Prognosis in Advanced, Life-limiting Disease framework.	Number of staff that have completed the education on identifying patients that could benefit from a palliative approach to care.	100% of staff requiring education have completed the education on identifying patients that could benefit from a palliative approach to care.	
											3)Improving the identification of patients requiring a palliative approach to care	Continue to provide LEAP mini course to staff across the LHIN through the Regional Palliative Care Network to improve early identification and a palliative approach to care	Number of staff that have completed the LEAP mini course through the Regional Palliative Care Network	100% of staff required to complete the LEAP mini course have provided evidence of completion of course through the Regional Palliative Care Network	
	Safe	Falls With Injury - Percentage of adult long-stay home care clients who have a fall with injury reported in the HNHB LHIN internal Event Monitoring System.	C	Rate / Adult long stay home care clients	In house data collection / April 1 2019-March 31 2020	92400*	2.22	2.17	Propose modest improvement of 2%		1)Evolve our falls prevention strategies in alignment with best practices.	Develop a Falls Care Pathway and Policy & Procedure in collaboration with HNHB LHIN Service Provider Organizations and Community Support Services organizations.	% completion of policy and procedure and care pathway for Falls Prevention. % completion of education and roll out across HNHB LHIN staff, SPO staff and CSS staff.	100% completion of the updated policy and procedure, care pathway and roll our of education by October 31, 2019	
											2)Evolve our falls prevention strategies in alignment with best practices.	Update the Patient Falls Report located on the Care Coordinator's dashboard.	% completion of the Patient Falls Report and roll out to the Care Coordinator's dashboard.	100% completion of the Patient Falls Report and roll out to the Care Coordinator's dashboard by June 30, 2019.	

		Percentage of patients diagnosed with a healable diabetic foot ulcer (DFU), whose ulcer closed within 12 weeks	C	% / Home Care Clients	In house data collection / April 1 2019 to March 31 2020	92400*	67.85	69.21	Propose modest 2% improvement	All Service Provider Organizations	1)Wound Care Program Review	Continue to align wound care pathways to Health Quality Ontario wound care standards.	% Completion of alignment with health quality Ontario wound care standards.	100% alignment of wound care pathway to HQO wound care standards by March 31, 2020.	
											2)Wound Care Program Review	Review and/or delivery of education with Service Provider Organization nurses, LHIN wound care coordinators regarding DFU, assessment tools and offloading devices.	% completion of education review and delivery to SPO, LHIN wound care coordinators.	75% completion of education review and delivery by March 31, 2020	
											3)Wound Care Program Review	Development of patient education materials in collaboration with Service Provider Organizations	% completion of patient education materials related to DFU and treatment.	100% completion of patient education materials by March 31, 2020.	
											4)Enhanced clinical support for wound care patients	Patients with difficult to heal DFU will be seen by new Nurse Practitioner (NP) Clinical Wound Manager for more direct clinical support	Number of patients seen by NP Clinical Wound Manager % of patients seen by NP Clinical Wound Manager with a DFU that healed within 12 weeks after receiving care	Baseline Data Collection	