2015/2016 Quality Improvement Plan for CW CCAC

PART B: Improvement Targets and Initiatives

Central West CCAC

AIM		Measure				Change				
Quality dimension	**Objective**	**Measure/Indicator**	**Current performance**	**Target**	**Target justification**	**Planned improvement initiatives (Change Ideas)**	**Methods**	**Process measures**	**Goal for change ideas**	**Comments**
Safety	To reduce falls among long-stay home care clients	Percentage of adult long-stay home care clients that have a fall on their follow-up RAI-HC Assessment	40.9% Q3 13/14 - Q2 14/15	≤ 35%	Provincial average for the same time period is 35.3%. There is opportunity to reduce this percentage and improve overall safety of our patients. A reduction in falls to 35% would place us below the provincial average and is appropriate for our organization.	Increase completion rate of RAI-HCs to capture accurate falls rate amongst long stay patients (SRC 93 & 94)	Collected through RAI HC assessments in CHRIS.	% of initial RAI-HCs completed within specified timeframe each month	100% of initial RAI-HCs completed within specified timeframe each month by February 2016	Consistent completion of RAI-HCs will ensure valid data to measure the rate of falls
						Improve communication of falls risk assessments between WOHS/HHCC and CW CCAC through a standardized communication tool.	Collected through standard monthly reports generated in CHRIS.	Standardized process for communicating falls risk assessments between hospitals and CCAC in place Central location for falls related information in CHRIS created	Standardized process in place by September 2015 Central location for falls related information in CHRIS completed by September 2015	Sharing fall risk information between hospitals and CCAC allows for enhanced risk and safety planning in the community setting

						Improve communication of falls risk assessments between CW CCAC and Nursing and Rehabilitation Service Providers (SPOs) through submission of falls risk assessments and implementation of fall prevention/injury reduction strategies by SPOs.	Collected through standard report generated in CHRIS.	Expectation of Nursing and Rehabilitation SPOs to complete falls risk assessment on all new patients embedded in contracts % of completed falls risk assessment tools on new patients provided to CW CCAC within 48 hours of first visit by Nursing and Rehabilitation Service Providers each quarter % of identified at risk for fall patients who have a documented fall prevention/injury reduction plan in CHRIS	Expectation for completion and submission of falls risk assessment on all new patients by Nursing and Rehabilitation SPOs to CW CCAC within 48 hours of first visit included in contracts by April 2015 90% of new admissions to Nursing and Rehabilitation SPOs have a fall risk assessment completed and submitted to CW CCAC within the first 48 hours of first visit 100% of patients identified at risk for a fall have a documented fall prevention/injury reduction plan in CHRIS by December 2015	Matching the identification of a patient at risk for a fall with an appropriate fall prevention or injury reduction plan has demonstrated to be more successful in reducing falls.
						Improve differentiation between falls resulting in injury and falls resulting in no injury	Collected and reported through CW CCAC event tracking system.	A standard nomenclature is developed that assesses falls and differentiates the levels of harm caused by a fall.	A standard nomenclature is developed and implemented as part of CW CCACs incident reporting system by January 2016.	Reducing falls that result in harm are critical to ensuring patient safety. The current categorization of falls within the CW CCAC incident reporting system does not provide levels of harm to differentiate the impact of a fall on a patient. This information will assist in further refining the injury reduction strategies.
Effectiveness	To reduce the number of unplanned ED visits among home care clients	Percentage of home care clients with an unplanned, less-urgent ED visit within the first 30 days of discharge from hospital	3.8% Q2 FY 13/14 - Q1 FY 14/15	≤ 3.8% Maintain	CW CCAC has the lowest unplanned, less urgent ED visits within 30 days of discharge from hospital in the province. We will continue to monitor this indicator and work with our local health system partners to mitigate unplanned ED visits.	The target for this indicator is to maintain. Therefore change ideas are not required.				

	To reduce avoidable hospital admissions among home care clients	Percentage of home care clients who experienced an unplanned readmission to hospital within 30 days of discharge from hospital	19.2% Q2 13/14-Q1 14/15	≤ 18%	CW CCAC is currently performing higher than the provincial average of 18.2%. A reduction in readmissions to 18% would be an appropriate improvement for our organization and would be below the provincial benchmark.	Explore feasibility of implementing the Hospital Admission Risk Prediction (HARP) tool to measure risk of readmission amongst Health Links and Chronic/Complex Patient populations	Feasibility of implementing HARP tool tracked internally.	Feasibility of implementing the HARP tool for all Health Links and Chronic/Complex patient populations completed.	Feasibility of implementing the HARP tool for all Health Links and Chronic/Complex patient populations completed by October 2015.	Identification of patients at risk for readmission is considered a best practice in better management of chronic diseases in the community and reduction in readmissions.
						Ensure all Health Links and Chronic/Complex patients are connected with a primary care physician	Collected through CHRIS documentation system.	% of Health Links and Chronic/Complex patients who are connected with a primary care physician	100% of Health Links and Chronic/Complex patients are connected with a primary care physician by March 2016.	Wrapping an interprofessional care team around Health Links and Chronic/Complex patients provides a higher level of support for disease management reduces likelihood of readmission.
						All Care Coordinators are linked to a primary care physician	Collected through CHRIS documentation system.	% of Care Coordinators linked to a primary care physician	95% of Care Coordinators are linked to a primary care physician by March 2016	Wrapping an interprofessional care team around Health Links and Chronic/Complex patients provides a higher level of support for disease management reduces likelihood of readmission.
						Service Providers and CW CCAC complete case reviews of all CW CCAC patients readmitted within 30 days of discharge from hospital	Collected through internal case review documentation	% of case reviews completed by CW CCAC and SPOs on patients readmitted to hospital within 30 days of discharge	100% of case reviews completed by CW CCAC and SPOs on patients readmitted to hospital within 30 days of discharge by March 2016	Proactively identifying contributing factors to readmissions informs further quality improvement strategies aimed at reducing readmissions.
Access	To reduce service wait times	5 Day Wait Time - Personal Support for Complex Patients: % of complex patients who received their first personal support service within 5 days of the service authorization date.	91.8% Q3 13/14-Q2 14/15	≥ 91.8% Maintain	We are performing well above the provincial average. We will continue to monitor our progress and take necessary steps to course correct as appropriate.	The target for this indicator is to maintain. Therefore change ideas are not required.				
	To reduce service wait times	5 Day Wait Time - Nursing Visits: % of patients who received their first nursing visit within 5 days of the service authorization date.	97.1% Q3 13/14-Q2 14/15	≥ 97.1% Maintain	We are the top performer in the province. We will continue to monitor our progress and take necessary steps to course correct as appropriate.	The target for this indicator is to maintain. Therefore change ideas are not required.				

Client Experience	To improve client experience	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 CCAC services ii) Overall rating of management/handling of care by Care Coordinator iii) Overall rating of service provided by service provider	91.3% FY 13/14	≥92.4%	CW CCAC is performing below the provincial average of 92.4 %. This target matches the provincial average and is appropriate for our organization.	Conduct patient satisfaction surveys by telephone with planned total hip and knee replacement patients with a focus on transitions in care between hospital and CCAC.	Collected through Call Centre database.	% of patients discharged from William Osler Health Sciences Centre post planned total hip/knee replacement who are contacted and complete a telephone patient experience survey	90% of patients discharged from William Osler Health Sciences Centre post planned total hip/knee replacement are contacted and complete a telephone patient experience survey by January 2016	Seeking timely feedback from patients on their experience with transitions in care further ensures the voice of the patient informs patient experience improvement initiatives.
						Conduct patient satisfaction surveys by telephone with Headwaters Health Care Centre Oncology Clinic patients receiving CW CCAC services with a focus on transitions in care.	Collected through Call Centre database.	% of patients receiving care from HHCC and CW CCAC who are contacted and complete a telephone patient experience survey	90% of patients receiving care from HHCC and CW CCAC are contacted and complete a telephone patient experience survey by March 2016.	
						Set expectations with SPOs to develop strategies to improve overall patient experience within their individual QIPs	Collected through SPO annual reports submitted to CW CCAC	% of SPOs who document in their annual plan a formal patient experience improvement strategy	100% of SPOs document in their annual plan a formal patient experience improvement strategy by June 2015.	CW CCAC is instrumental in navigating patients through the health care system and connecting patients to appropriate care and services. A significant amount of direct patient care is provided through third party providers (SPOs) therefore a joint effort on the part of CW CCAC and our SPOs is required to truly impact the entire patient experience
						Implement an organization wide Patient/Caregiver Advisory program.	Implementation of a CW CCAC Patient/Caregiver Advisor program	CW CCAC Patient/Caregiver Advisor program is implemented.	CW CCAC Patient/Caregiver Advisor program is operational by January 2016	A formal Patient/Caregiver Program is considered best practice in enhancing patient/caregiver engagement and ensuring the voice of both patients and caregivers informs continuous patient experience improvement strategies