This document is intended to provide health care organizations in Ontario with guidance as to how they can develop a Quality Improvement Plan. While much effort and care has gone into preparing this document, this document should not be relied on as legal advice and organizations should consult with their legal, governance and other relevant advisors as appropriate in preparing their quality improvement plans. Furthermore, organizations are free to design their own public quality improvement plans using alternative formats and contents, provided that they submit a version of their quality improvement plan to Health Quality Ontario (if required) in the format described herein.

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Overview

Mississauga Halton Local Health Integration Network (Mississauga Halton LHIN) is pleased to present our 2018/19 Home and Community Care Quality Improvement Plan (QIP). Through our new mandate to provide LHIN-delivered home care services, we continue to work towards improving access to quality health services in the community that are sustainable and delivered closer to home, ensuring our patients receive the care they need to live safely at home and, when necessary, supporting them in moving to long-term care.

Our 2018/19 QIP will be our fifth QIP and it continues to support provincial health system priorities as outlined by the Patients First Act - Action Plan for Healthcare, priorities that are designed to strengthen patient-centred care and deliver high-quality, consistent and integrated health services to all Ontarians, and local priorities as outlined in the Mississauga Halton LHIN 2016-2019 Integrated Health Service Plan – Partnering for a Healthy Community, and is closely aligned to our 2018-2019 Annual Business Plan submission to the Ministry of Health and Long-Term Care.

In developing the 2018/19 Home and Community Care QIP, efforts were made to address local system pressures related to acute care capacity challenges, personal support worker human resource challenges, as well as alternative level of care challenges affecting our patients. Also, in the spirit of continuing to build upon existing networks and relationships with our key stakeholders we will aim to identify opportunities for new partnerships and increase inter-sectorial collaboration for conceptualizing and making improvements. By working together, we can expand outreach efforts, learn from each other and build integrated system capacity to provide even better care to those who access LHIN-delivered home care services.

FOCUS OF OUR 2018/19 QIP

Nineteen change initiatives have been identified for action addressing six QIP indicators that we have decided to address for 2018/19.

1) Eight initiatives have been identified to reduce avoidable hospital re-admissions and unplanned Emergency Department visits among Home Care patients discharged from Hospital by:

   a. Focusing and rolling out an ALC Avoidance, Management and Flow strategy in three phases during the upcoming year.

      * ALC Avoidance, Management and Flow (Prevention) activities include:
        i) Incorporate DIVERT and TUGS scores from Inter-RAI
        ii) Bedded restorative programs
        iii) Test model of care attaching Nurse Practitioner/RN to those at high risk for readmission

      * ALC Avoidance, Management and Flow (Early ID) activities include:
        i) Test model of care for Quick Response Team (QRT) in Emergency Departments
        ii) Standardize ALC designation practices

      * ALC Avoidance, Management and Flow (Transition) activities include:
        i) Manage facility choice lists of patients awaiting LTC in hospital
        ii) Early patient identification for Bridges to Care, My Way Home programs
b. Implement Total Contact Cast for patients with intractable diabetic foot ulcers

2) Four initiatives have been identified to improve patient experience by:

   a. Evolving patient measuring and reporting mechanisms:
      i) Deeper data mining and root cause analysis to better understand the perspectives shared by patients and their care givers.
      ii) Standing agenda item for meetings with management, partners and Patient and Family Advisory Committee sharing patient experience results on a regular basis to inform key stakeholders.

   b. Home Care Assessment Modernization - implementing most up to date standardized assessment (Inter-RAI Home Care (CA) and the revitalized Clinical Assessment Protocols (CAPs) to better support care planning.

   c. Neighbourhood Care Conferencing - optimizing communication between care providers around the individual patient and collectively at the neighbourhood level.

3) Two initiatives have been identified to reduce falls among long-stay home care patients by:

   a. Incorporating timed up and go score (TUGS) from Inter-RAI to assist in better identifying patients that may be prone to falls.

   b. Creating an Intervention Plan based on patient risk factors to assist staff and that is aligned with the Mississauga Halton LHIN's Falls Prevention Strategy.

4) Two initiatives have been identified to reduce service wait times for personal support worker services for complex patients by:

   a. Doing a chart audit to ensure patient available date is being properly documented.

   b. Collaborating with existing community partners to increase capacity of PSW services within a shared model of care.

5) Three initiatives have been identified to improve on the number of palliative/end-of-life patients who have died in their preferred place by:

   a. Doing a chart audit to ensure identification of preferred place of death is being properly captured, documented and updated.

   b. Providing Wrap Around Care (24/7) during last month of life to ensure patient and family needs are addressed.

   c. Promoting and retaining a work force specialized in palliative care skills to ensure consistent practice and knowledge transfer for those at end of life.

We have chosen to continue to focus on these initiatives as they represent key areas where we have a role to play in supporting effective use of health system resources in our region or have room for improvement in relation to achieving established targets.
• Reduce service wait times for nursing services (all patients) – as Mississauga Halton's performance on this indicator has been consistently at or better than targets and has been better than the provincial average, we will maintain our current processes supporting initiation of these services, continue to monitor our performance regularly and initiate corrective action should our performance fall below our targets.

Describe your organization's greatest QI achievements from the past year

The Mississauga Halton LHIN continues to work to reduce barriers and improve timely access to an integrated and coordinated health care system that focuses on improving transitions between sectors, strengthening home and community care and supporting individuals, particularly those with complex needs to navigate the health care system so that they can receive the right kind of care when they need it.

1. ALC Avoidance Management and Flow: we have been working with partners in our region and the Ministry of Health and Long-Term Care (MOHLTC) to identify opportunities to best support patients and families in our community, while ensuring hospital care is available for patients who need it most and to address the high number of people who are appropriate for an alternative level of care (ALC) but remain in hospital beds designated for acute care patients. Our three pronged approach focuses on:

   * identifying at-risk patients in the community to prevent hospital admission and emergency department (ED) visits
   * identifying patients in the ED and during their early acute care stay at risk for ALC
   * transitioning existing ALC patients from hospital to the community or to long-term care.

The BRIDGES TO CARE PILOT targets patients in hospital who no longer require acute care, i.e., ALC patients. We provide short-term, enhanced community supports to patients for up to 60 days, including a dedicated care coordinator and placement care coordinator, after which time they will transition to a long-term care home or explore creative options for remaining in a personal dwelling or retirement home with in-home supports. The BRIDGES TO CARE PILOT provides 37 beds across several retirement homes and community support services. Within the first year of the program, Trillium Health Partners, our acute care partner reported that the Bridges to Care program had saved 18,557 patient days, the equivalent to freeing up one 50 bed unit for more than one year.

2. Neighbourhood Care Delivery Program of Work: we have identified new and innovative strategies to ensure the appropriate resources (funding, health human resources and infrastructure) are available and used efficiently to meet the needs of our growing and aging population, now and in the future. Building upon the recommendations in our Community Capacity Plan and work underway in hospital capital and program planning, we continue to quantify and address the pressures within our region and leverage our community resources to build a sustainable, person-centred health care system.
The Neighbourhood Care Delivery Program of Work includes:

* Coordinated Care Planning - The Health Links approach to care has been adopted and implemented for all home and community care patients with complex, chronic illness. That is, each of these patients has early in home assessment and development of integrated coordinated care planning, partnering beyond service provider organizations to include community support services, mental health and addiction services, primary care, and municipal supports.

**Patient/ resident engagement and relations**

Mississauga Halton engages its residents and patients in a number of improvement initiatives through collecting patient experience information (core survey through the National Research Council, and two additional surveys - one related to palliative care and another related to transitions from hospital to home), quality reviews, interactions with the Ombudsperson, and information from compliments or complaints. As well, patient stories (good and bad) are gathered and then used in a variety of settings, including incorporation into the Board of Director’s Quality Committee meetings, management and staff meetings. The themes and sentiments help directors and staff to understand the patient perspective, generate discussion and often point to opportunities for improvement, or to formally celebrate success.

The LHIN understands that having patients, caregivers and families involved in the development of programs and services, as well as decision making, is important in improving outcomes of personal experience within our health care system. The perspectives they share not only help guide our work, but their experiences, stories and insights also serve as an important measure when evaluating the success of our various projects and initiatives. To this end, patients and caregivers have been involved to advise on strategic matters e.g., committee members on the Strategic Planning Project team developing the Integrated Health Service Plan 2019-2025, and in process redesign, e.g., value stream analysis to optimize the Care Coordination Program of work. At the sub-region (care community) level, 30 Neighbourhood Forums have been held across the seven (7) sub-regions. These Forums are designed to build capacity for care coordination and necessarily involve patients, care providers, service providers and others (e.g., municipal housing). A key function of the Forums is resolution of service delivery issues optimizing the resources and problem solving skills of all partners in the neighbourhood.

As we continue to build our patient and family engagement strategy, learning how best to incorporate the voice of patients, caregivers and families into all aspects of our work, we have recently established a regional Patient and Family Advisory Committee (PFAC). The PFAC serves as an advisory committee to the LHIN and is comprised of individuals with lived-experiences with the health system, as well as being representative of the geographical and culturally diverse groups across our LHIN. In 2018-2019 the Patient and Family Advisory Committee will provide implementation guidance to a new Patient and Family Engagement Strategy, to be launched April 2018, which will provide a framework to strengthen the foundation of patient and family engagement that exists within the LHIN. Mississauga Halton LHIN efforts will build upon existing efforts to engage patients, families and individuals with lived experience, and complement existing forums.
Collaboration and Integration

Through our Integrated Health Services Plan, Partnering for a Healthy Community, the LHIN supports the local health care system to meet the needs of our region today and in the future focusing on three key priorities: access, capacity and quality. During the transition to the renewed LHIN, the priority was to preserve the continuity of patient care and experience.

Within the LHIN there are two public hospital corporations (six sites), 28 long-term care homes (4,231 beds), 32 community support service organizations, 10 mental health and addiction service providers and one community health centre. The LHIN has continued to integrate and build regional capacity to meet a range of health care needs though initiatives related to the opioid strategy, dementia care, regional palliative care and patient transitions.

Seven Health Links were established within the LHIN. As of December 2017, Health Links have served 3,512 individuals with complex needs within the LHIN. This represents 7% of the target population of 48,445 people with complex needs. Nearly 60 per cent of these individuals are managing mental health issues and 80 percent have coordination needs related to the social determinants of health. Through these seven sub-regions, Care Communities, we continue to plan care that leverages local resources. Optimizing home and community care coordination has enabled more consistent care through strengthening our Care Coordination Framework, Neighbourhood Realignment, Service Provider Realignment and Primary Care Integration.

The renewed LHIN included a refreshed focus on primary care integration including introduction of the Primary Care Network of Mississauga Halton, a collegial community of Primary Care Providers who come together to enhance health care system navigation and resource sharing to optimize quality of life for Primary Care Providers and their patients. The Primary Care Network of Mississauga Halton is: led by physicians and primary care providers; strengthening relationships between primary care colleagues in our region; provides a key communication source with the primary care sector in our region; and is the place for health care partners to engage and collaborate with primary care.

The network is designed on a hub and spoke model, where a core member is the lead for each geographical area of our region. Each core member then gathers input, organizes events and brings information out to the local chapters.

Supporting primary care integration in the LHIN is an innovative strategy: the primary care advisor (PCA) role. This role is unique to the Mississauga Halton region. Geographically assigned by care community boundaries, PCAs meet regularly with primary care physicians to keep them informed about LHIN-wide programs, services and initiatives across the continuum of care and within the health care system more broadly.

This one-on-one approach allows the Primary Care Advisors to gain an understanding of physicians’ interests and needs, in order to provide system-level support. Primary Care Advisors also engage primary care providers so they have a meaningful voice and contribution the development of the broader health care system. PCAs enter physician specific information on 1:1 visits into our engagement tracker, which helps us learn to support physicians more effectively.
Engagement of Clinicians, Leadership & Staff

The strategic direction, including priorities for patient care quality, is driven by the Board of Directors and the LHIN Executive Team. Leadership for the development of our QIP has been provided by input from leaders within the organization and region, particularly those for home and community care services and regional programs. These leaders, using management information systems and interactions with patients, caregivers and partners identified the improvement initiatives outlined in our QIP and provided input into our target setting process. Further refinement of our 2018/19 QIP improvement initiatives and targets occurred through our LHIN Executive Team and review by the Board of Directors.

On a day to day basis, each staff member at the Mississauga Halton LHIN plays a role in providing high quality, safe health care to patients - from patient facing staff members and organizational support staff to organizational leaders and board members. The Quality, Safety and Risk Framework provides a model to engage and include our staff members in our improvement work. Staff members from across the organization participate in our improvement work in various ways, including as members of the teams implementing and leading each improvement initiative, as participants in visioning exercises or focus groups, or as Champions (local experts) for our change initiatives.

Contracted service providers are an integral partner in the circle of care and the delivery of patient care. Where appropriate, change ideas outlined in the QIP have been developed in collaboration with services providers and primary care partners to collectively achieve improvements. As well, contracted service providers continue to develop their QIPs in alignment with the Mississauga Halton's plan, plans that are visited every 6 months during individual service provider quality review meetings.

Population Health and Equity Considerations

The Mississauga Halton Local Health Integration Network (LHIN) is home to over 1.2 million residents and continues to be one of the fastest growing LHINs in the province with the population growing by approximately 20,000 people each year. The Mississauga Halton LHIN has a wealth of culture due to its dynamic, diverse population demographic. Immigrants account for 44.3 per cent of residents. Nearly 41 per cent of residents are visible minorities, compared to 25.9 per cent for Ontario. The top five visible minorities are South Asian, Chinese, Black, Filipino and Arab. Not including English, the top five languages spoken at home are Urdu, Polish, Arabic, Spanish and Chinese. French is the mother tongue of 1.8 per cent of the population; 0.6 per cent of residents self-identify as Aboriginal. The proportion of residents in Mississauga Halton LHIN living in lower income is better compared to the provincial average, as is the unemployment rate for both adults and youth. However, there are areas, such as East Mississauga and South Etobicoke that are more economically disadvantaged.

Sixty-two percent of Mississauga Halton LHIN residents report very good or excellent health; residents are comparable or better in the areas of life expectancy, infant mortality, self-rated health and self-reported mental health when compared to others across the province. Historically, Mississauga Halton LHIN residents have had the lowest emergency department (ED) visit rate in the province (2015). Leading causes of death are ischemic heart disease, dementia and Alzheimer's disease, lung cancer and cerebrovascular disease. The potential years
of life lost rate is the second lowest in the province and has decreased by 9 per cent since 2007.

The LHIN is committed to ensuring awareness and understanding of health equity, the social determinants of health and the effect these determinants have on health outcomes. To ensure our planning, programs and services meet the distinct, unique characteristics of our residents, the LHIN applies a health equity lens as we strive to enable all people, regardless of income, age, education, gender, sexual orientation, ethnicity, religion or language to have timely access to the health care options they require. Ensuring the voices of the patient and family are at the heart of our work is essential to driving the delivery of culturally and linguistically appropriate services and patient centred care.

Consideration for the social determinants of health and the impact they play in building a sustainable, person-centred health care system is another opportunity that the LHIN factors into program planning and service delivery to neighbourhoods with enhancement opportunities. This includes continuing to advance socio-demographic data collection with health service providers and other partners to help assess and evaluate the impact of a person’s social determinants of health on outcomes. Socio-demographic data serves as a valuable resource to identify who is and who is not accessing services, the effects of social factors on health outcomes and increased awareness of potential barriers for underserved populations. Beyond providing a profile of health disparities, socio-demographic data are also a tool for aligning practices with unmet needs that enables health service providers to develop and track interventions, remove barriers and provide evidence-driven input.

This approach can be seen in the Care Navigation program in North Halton Care Community. The focus is on addressing the unmet needs of indigenous people, and those with mental health and addiction conditions. The approach specifically assists people with a high vulnerability index i.e., high needs related to the social determinants of health. Halton Community Legal Services is a partner in ensuring that this marginalized population receives the care that they need including ensuring a pathway to appropriate housing for indigenous people and those with mental health and addictions conditions.

Enhanced service responsiveness to the needs of marginalized populations, improved community collaboration and outreach to underserved populations helps to increase public awareness of services and allow for more discussions between providers, patients, families and caregivers to ensure their voices and needs are integrated into the care plan. As well, with indigenous leaders and the French language health planning entity, Reflet Salvéo, we will continue to leverage existing capacities and explore new opportunities to ensure equitable health care for all.
Alternate Level of Care (ALC)

Access to the right level of care, at the right time, is an important measure of health care quality. Mississauga Halton LHIN has a long-standing practice of being proactively and creatively engaged with health system partners to enable hospital patients to return home or transition to more appropriate care settings. With 25% fewer long term care home (LTC) beds per senior than the provincial average, this creates pressure across the system for resources and supports to safely support at risk adults and seniors in the community.

We will continue our strategic approach through initiatives launched in 2017-2018, including the Bridges to Care Program and the Alternate Level of Care (ALC) Avoidance, Management & Flow (Patient Access and Flow Steering Committee) initiatives. We will make further progress towards relieving system pressures and ensuring patients can transition seamlessly and safely through the health care system, creating capacity to ensure that patients are cared for in the most appropriate setting that meets their needs.

Through ALC Avoidance, Management & Flow (Patient Access and Flow Steering Committee) initiative we have been working with partners in our region and the Ministry of Health and Long-Term Care (MOHLTC) to identify opportunities to best support patients and families in our community, while ensuring hospital care is reserved for patients who need it most and addressing the high number of people who are appropriate for an Alternate Level of Care (ALC) but remain in hospital beds designated for acute care patients. This serves neither the patient nor the system well. We continue to implement a three-pronged approach focused on:

1. Identifying at-risk patients in the community to prevent hospital admission and emergency department (ED) visits
2. Identifying patients in the ED and during their early part of the acute care stay at risk for ALC
3. Transitioning existing ALC Patients from hospital to the community or to long-term care

Implementation of the 2018/19 deliverables of the ALC Avoidance, Management and Flow strategy will be a key organizational focus that is documented in the Quality Improvement Plan, and is a substantial contributing factor to maintaining access to acute care in a region that is constrained in this area.

Opioid Prescribing for the Treatment of Pain and Opioid Use Disorder

Opioid use has been identified as a major health issue in Ontario contributing to morbidity and mortality. Approximately one of every 170 deaths in Ontario is now related to opioid use. Among young adults 25-34 years old, one of every eight deaths is related to opioid use. In 2016 in the Mississauga Halton Region, 27.6% of the population or 348,034 individuals were 25-44 years old. In FY 2016 compared to FY 2013 there was a 3.1 death rate point increase for opioid related deaths in this age group. From 2003 to 2016 annual opioid-related emergency visits steadily trended upward. Addiction outreach and treatment service data for the Mississauga Halton Region indicate opioid use has been one of the top eight presenting problem substances at the time of admission for the last four years, ranging from 8% to 14%
from 2013-2017. A favorable decline in this statistic is being seen however more can be done to reinforce existing efforts and to ensure harm from opioid use is reduced and treatment efforts adequately support individuals attempting to recover from this addiction.

The capacity of LHIN funded addiction and mental health addiction agencies to provide appropriate treatment services and supports to individuals and their families affected by opioid use will be expanded through the Mississauga Halton LHIN Opioid Treatment Capacity Expansion Program. These agencies will also be engaged with the LHIN to review and design a coordinated model of care for opioid addiction. Regional partnerships and coordination mechanisms will be enhanced to the point that gains from this program can be handed off to the coordinating body to sustain a regional system of care and supports for individuals and their families impacted by opioid use. Health equity will be embedded regionally through a fulsome review and implementation. The program includes:

1. Managing 2017-18 Opioid Strategy funding allocations in the Mississauga Halton region
2. Increasing capacity within the agencies serving the Mississauga Halton region
3. Establishing a coordinating mechanism for addiction services in the Mississauga Halton region

Through the measures stated above we will continue to work closely with our partners as we increase access to treatment and supports for our residents.

Workplace Violence Prevention

Mississauga Halton has established a robust Occupational Health and Safety (OHS) Program that fully meets its statutory obligations and reflects its uncompromising approach to the safety and well-being of its employees, and embodies the concept implicit in the Act referred to as the Internal Responsibility System (IRS) whereby everyone in the workplace has a responsibility for health and safety.

Management’s commitment to the Program’s objectives and an accompanying accountability structure, beginning at the most senior levels, is critical to the success of the Mississauga Halton LHIN’s OHS Program. The Board of Directors has ultimate accountability in its exercise of due diligence to ensure that an effective OHS Program exists, and to monitor its performance. This is achieved through regular reports from the Chief Executive Officer (CEO). The CEO has operational accountability for the Program’s performance and its administration, the responsibility for which is delegated to the Vice President, Quality & People. Persons in supervisory roles have direct responsibility to take every reasonable precaution to ensure the safety and protection of their employees. This includes proper advisement to staff of potential safety hazards and providing education and training. Managers’ health and safety responsibilities are reflected in their job descriptions, and annual performance evaluations. All employees must comply with the OHSA and corporate health and safety policies. Properly using safety equipment and reporting of workplace safety hazards is a critical piece of legislation and training compliance.
The OHS Program establishes our commitment to maintain a safe workplace free from harassment and discrimination for all Mississauga Halton LHIN employees, consultants, volunteers and students. Within the OHS Program the following mitigation strategies are evidenced:

* Joint Health and Safety Committee (JHSC)
* Health and Safety Policy
* Workplace Harassment and Discrimination, and Workplace Violence
* Accident / Incident Reporting
* Workplace Safety and Insurance Board (WSIB)
* Ergonomic Safety
* Health and Safety Orientation and Education
* Infection Prevention and Control (IPAC) Program
* Emergency Management and Fire Safety
* First Aid
* Workplace Hazardous Material Information System (WHMIS)

Mississauga Halton continues to take the significant steps to reduce potential risk of workplace violence to staff at its various locations.
Sign-off

I have reviewed and approved the Mississauga Halton LHIN's 2018/2019 Home and Community Care Quality Improvement Plan.

Mary Davies  
Acting, Board Chair  
March 1, 2018  
Date

Gulzar Ladhani  
Chair, Quality Committee of the Board  
March 1, 2018  
Date

Bill MacLeod  
Chief Executive Officer  
March 1, 2018  
Date