Excellent Care for All

Quality Improvement Plans (QIP): Progress Report for 2018/19 QIP

The Progress Report is a tool that will help organizations make linkages between change ideas and improvement, and gain insight into how their change ideas might be refined in the future. The new Progress Report is mostly automated, so very little data entry is required, freeing up time for reflection and quality improvement activities.

Health Quality Ontario (HQO) will use the updated Progress Reports to share effective change initiatives, spread successful change ideas, and inform robust curriculum for future educational sessions.

ID	Measure/Indicator from 2018/19	Org Id	Current Performance as stated on QIP2018/19	Target as stated on QIP 2018/19	Current Performance 2019	Comments
1	5-day wait time for home care: Nursing Visits - % of home care patients who received their first nursing visit within 5 days of the patient available date (PAD) (%; Home Care Clients; October 2016 – September 2017; HSSO CHRIS, HSSO HCD)	92409	98.70	95.00	97.40	Current performance is reported as of Q3 of fiscal year 2018/19 .

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Change Ideas from Last Years QIP (QIP 2018/19)	Was this change idea implemented as intended? (Y/N button)	Lessons Learned: (Some Questions to Consider) What was your experience with this indicator? What were your key learnings? Did the change ideas make an impact? What advice would you give to others?
Implement the use of Elastomeric single-use, disposable infusion pumps: The introduction of these devices in the North will improve quality of care and reduce risk, delays and cost.	Yes	There is equitable access to elastomeric devices across the region to facilitate self-management of IV medications for appropriate patients. This initiative has increased patient's freedom and ability to mobilize and continue to monitor to determine if this will reduce the need for extra nursing visits.

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2	5-day wait time for home care: Personal support for complex patients - % of complex home care patients who received their first personal support service visit within five days of the patient available date (PAD) (%; Home Care Clients; October 2016 – September 2017; HSSO CHRIS, HSSO HCD)	92409	96.40	95.00	85.00	Current performance is reported as of Q3 fiscal year 2018/19.

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PSW Capacity: Establish a working group to develop and implement a plan to address contributing factors to PSW capacity concerns.	Yes	A PSW Capacity Task Force was formed and a project charter and workplan developed to identify recommendations to be considered that might improve PSW capacity and utilization in the North East. The Task Force identified three priority areas 1) Program Oversight and Coordination, 2) Collaboration and Innovation and 3) Working Conditions and Compensation Lessons Learned: PSW capacity planning is an issue impacting all HSP's and Service Provider Organizations across the North East. 1)Next steps will be to prioritize recommendations identified from the action plan. 2) There is a need to determine resource requirements 3) There is a need to create a Regional PSW Workforce Steering Committee (NE LHIN and H&CC will be a participant) 4) Execute as determined. Work will continue and be included in next fiscal year's QIP 2019/20.

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3	Number of patients identified as having a diabetic foot ulcer who are on a diabetic foot ulcer pathway. (Number; Home Care Clients; 2018-19; Local data collection)	92409	CB	CB	612.00	Current performance is reported as of Q3 fiscal year 2018/19.

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Implement HQO Wound Care Quality Standards: Establish a cross-functional working group to plan and roll out implementation of the HQO Wound Care Quality Standards. Including, update existing Integrated Clinical Pathways to ensure alignment with HQO.	Yes	An interdisciplinary working group was formed and reviewed and updated the NE LHIN's existing integrated clinical pathway for diabetic foot ulcers using Health Quality Ontario's Quality Standard. The NE LHIN has also developed a bilingual, North East LHIN. Helping You Heal. Your Guide to Wound Care. Diabetic Foot Ulcers. This is available as a booklet and as a patient handout and intended to help patients to manage their wounds at home, to improve and/or maintain their health and to prevent wounds. Education and dissemination of the updated evidence based practices has been provided to health care providers and to patients. This education continues.

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4	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 (%; Home Care Clients; April 2016 - March 2017; HSSO CCEE Survey)	92409	93.60	90.00	91.70	Current performance is reported as of year end of fiscal year 17/18.

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Expand the role of the recently established Patient Advisory Committee and continue to actively engage the Committee in initiatives throughout the organization.	Yes	The Patient and Family Advisory Committee (PFAC) members were involved in 25 initiatives during fiscal year 2018/19. These were as follows: 1) Provincial PFAC Leadership Table Quarterly Meeting. PFAC Co-Chairs 2) Dementia Strategy 3) Algoma Home and Community Care Network Meeting 4) Home and Community Care Manager's Meeting 5) Patient Stories at Board Meetings, Senior Leadership Meetings, and Community Collaborative Tables 6) Home and Community Care Forum 7) Cultural Competency Training 8) Sub-Committee to Establish PFAC Priorities and workplan 9) Ministry/LHIN Home and Community Care Experience Survey Expert Panel 10) Integrated Health Services Plan Steering Committee-PFAC Co-Chairs 11)Integrated Health Services Plan Focus Group- all PFAC members 12) NE LHIN Quality Committee (2 PFAC members) 13) PSW Taskforce-3 PFAC members 14)e-Referral and Musculoskeletal Steering Committee- 1 PFAC

		member 15)Sudbury Sub-Region Collaborative-1 PFAC member 16)PFAC speaking engagements: Seniors Health Fair in Elliot Lake 17)Algoma Home and Community Care Network Committee- 1 PFAC member 18)Discharge planning "passport" project with North Bay Regional Health Centre- 1 PFAC member 19) Provincial PFAC Leadership Table quarterly meetings- PFAC Co-Chairs 20) Short term subcommittee on 2019/20 Quality Improvement Plan 21) Rural ALC Avoidance Framework- 2 PFAC members 23) Regional Quality Committee- 5 PFAC members, each rotate attending meetings. 24)Speaking engagement: North East Family Health Councils Network Annual Conference-1 PFAC member 25) Input sought from PFAC re caller ID display for Client and Caregiver Experience Survey
Develop a strategy to increase utilization of CCEE results to ensure we are celebrating success and targeting areas of improvement related to patient experience.	Yes	Patient Relations and Quality Specialist, Director of Quality and Risk and Data Support Analyst participated in Catalyst training. Reports were run and shared from Catalyst with Managers and Directors of Home and Community Care. Aggregate reports were shared with all Management Team and posted to the Intranet and detailed action reports by Corporate, Service Provider and by Service were made available to Managers to discuss with their teams and to celebrate outcomes or to identify opportunities for improvement. Priority areas for improvement most highly correlated with the organization's overall rating were highlighted and "ease of contacting the LHIN" was further analyzed and change ideas for improvement generated for inclusion in next fiscal year's QIP.

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5	Percent palliative/end of life patients who died in their preferred place of death (%; Patients deemed palliative or end of life; October 2016 - September 2017; HSSO CHRIS)	92409	66.15	70.00	73.77	Current performance is reported as of Q3 of fiscal year 18/19.

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Data Integrity - Explore ways to increase the accuracy in which staff are reporting preferred place of death.	Yes	Preferred place of death is captured in CHRIS as disposition code. Did follow a sub category and audited Nurse Practioner's documentation. Monthly reports provided. When errors are detected,the client's file is reopened and discharge disposition description is corrected. It was found that the few clients who did not die in their preferred place of death, had been hospitalized prior to their death and thus, had passed away in hospital.

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6	Percentage of adult long-stay home care clients who have a fall on their follow-up of the international research network's Resident Assessment Instrument (interRAI) for home care. (%; Home Care Clients; October 2016 - September 2017; HSSO HCD)	92409	36.00	35.00	40.00	Current performance is reported as of year end of fiscal year 17/18.

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NE LHIN Stay on Your Feet Strategy: : Integrate best practices as outlined in the new RNAO Best Practices for Falls Prevention Guidelines (Sept 2017).	Yes	A working group was formed with interdisciplinary members of the NE LHIN and our Population Health Lead. There was collaboration with Public Health Unit and representation on this working group from therapists, dietician, care coordination, Accreditation Core Team, Managers. Service Provider Organizations shared their falls education materials with the NE LHIN in attempts to align key messaging to clients/families re falls prevention. The RNAO Best Practice Guidelines, Preventing Falls and Reducing Injury from Falls, 4th Edition was reviewed by the working group and a gap analysis completed to identify opportunities for improvement with our Falls Prevention Strategies. A workplan was developed and implemented and the NE LHIN's Falls Prevention Strategy document was updated to reflect best practices and new resources. The NE LHIN collaborated with Public Health Unit to give input and feedback as documents are being revised and updated. The NE LHIN's Patient Handouts Catalogue and Healthline was updated to include select materials from Public Health and to inform clients of both home exercises and

		exercise classes available in their communities. Work is ongoing to create an updated e-learn module re falls prevention. Lessons Learned: Using the gap analysis tool was very helpful and having a small team from different sections of the organization to review and discuss. Would highly recommend that others use the gap analysis as it helps to generate the necessary discussion and a relection on practice. Subject matter expertise is key.
Medication Reconciliation - ensure med rec completed for target population (65+ age, 5+ meds, 1+ chronic illness) as per best practice.	Yes	Monthly reports being sent to Managers to help identify clients in target population who did not have medication reconciliation recorded so that they are able to have their Care Coordinators follow up to ensure that a Best Possible Medication History and medication reconciliation has been completed. Exceeded target. Compliance Q3-93.5%
Home Safety Risk Assessments- increase use of risk assessment as a teaching tool with patients about safety of the home environment.	Yes	Managers were reminded to pull a compliance report semi monthly to reinforce adherence to documentation re the Home Safety Risk Assessment. Home Safety Risk Assessment form and Policy and Procedure were updated this fiscal year. Managers report compliance to Directors monthly. Exceeded target. Compliance- Q3 94.75%

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7	Percentage of complaints acknowledged to the individual who made a complaint within two business days (%; Home Care Clients; most recent 12 month period; Local data collection)	92409	CB	90.00	91.69	Current performance reported includes Q1-Q3 of fiscal year 18/19

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Establish a standard process for complaints management and build data requirements into Risk Event and Feedback System: Collect baseline data for time to acknowledgements and build acknowledgement into current processes.	Yes	All complaints are submitted into the risk event feedback system. We developed a report to capture time for acknowledgement. It was recognized that MPP and French-language service complaints are initially acknowledged by MPP or French-language commissioner and there is a time lag for us receiving these, so we should be counting from date of receipt of complaint by LHIN or removing these complaints from our denominator

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8	Percentage of home care clients who experienced an unplanned readmission to hospital within 30 days of discharge from hospital. (%; Home care clients discharged from hospital; July 2016 - June 2017; HSSO HCD, CIHI DAD, CIHI NACRS)	92409	17.98	17.00	18.00	Current performance is reported as of year end of fiscal year 2017/18.

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Rapid Response Nursing A nurse will visit the patient within 24 hours of hospital discharge to facilitate a smooth transition from hospital to home of frail elderly patients with brittle support and diagnosis of COPD, CHF, Diabetes, Dementia, Asthma, Pneumonia	Yes	A CHRIS report was produced to show the average days to first visit from service assignment. We did not meet our set target this fiscal year. Alternate methods were trialed to capture data and Rapid Response Nurses were directed to indicate on e-forms whether patient was seen within 24 hours of hospital discharge rather than provider authorization date. As a result, the number of patients seen within 24 hours of hospital discharge appeared to decline, however, this is a more accurate measurement of the indicator than previous. 18.7% of RRN patients were readmitted to hospital within 30 days during Quarter 3.
Virtual Care Through a secure connection, in-home nurses can upload a photo of the patient's wound and consult with an enterostomal therapy (ET) nurse about concerns and treatment recommendations on the spot, without scheduling a visit or incurring travel time.	Yes	Images are uploaded by both NE LHIN and SPO staff via a secure method to CHRIS. This has provided more timely consultation from the enterostomal therapy ET nurse and has decreased the need for travel for patients and for the ET nurse. Uploading of images to the ET nurse and to other

interdisplinary team members e.g. OT has been positive as it has eliminated

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9	Percentage of home care clients with an unplanned, less-urgent ED visit within the first 30 days of discharge from hospital. (%; Home care clients discharged from hospital; July 2016 - June 2017; HSSO HCD, CIHI DAD, CIHI NACRS)	92409	13.13	12.00	13.61	Current performance is reported as of year end of fiscal year 2017/18.

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Telehomecare COPD/CHF patients use equipment to monitor their vitals at home which is monitored remotely by a nurse. Patients are set with parameters for vital signs. Action is taken by the nurse when the patients vitals are outside of their parameters. Each care plan is individualized by patient needs and health coaching is provided to ensure patients are able to understand their disease and recognize and prevent exacerbations.	Yes	The NE LHIN has successfully piloted video visits and piloting transition program. During Quarter 3, there were an average of 29 alerts per patient and an average of 2.5 health coaching sessions per patient. We had initially been planning to compare the total number of patients on telehomecare with an ED visit to those patients who were not on telehomecare as a process measure, however, we recognized that we needed to account for when the patient had come on service so that we would be assured we were not counting them twice. Some patients might not have indicated a desire to be enrolled in telehomecare at the start of service, however, could be enrolled later and would then need to be excluded from the denominator.
Medical Supplies Drop off zone: One factor identified as contributing to ED visits was Supplies delivery in rural areas. Therefore partnering with hospital to establish a Supplies Drop Off Zone	Yes	All offices are now staffed. Cochrane District now has access to supplies 0830-0430 pm weekdays and nurses have access to after hours supplies. Hospitals were unable to partner with the NE LHIN on this initiative in some

that is staffed 24/7 to ensure supplies can always be delivered to someone.

communities due to a lack of capacity to store supplies.

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10	Percentage of patients meeting Health Link criteria (Nipissing Temiskaming and Sudbury Manitoulin) (%; Home Care Clients; 2018-19; Local data collection)	92409	CB	CB	1115.00	Number includes active patients between April 1, 2018 and December 31, 2018 who had Home Care Services and were SRC 93 or 94 and not Community Independent population.

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Internal education is provided to staff and leadership on the Health Links approach and philosophy to encourage utilization.	Yes	Training sessions held with internal and external stakeholders. Ongoing internal discussions are taking place to spread the Health Links approach within Home and Community Care. New staff are being recruited to lead change management activities. This has been impacted by the hiring freeze with the recent change in Government.