

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



North East Local Health Integration Network

AIM	Measure	Current performance	Target	Change	Target for process	Comments									
Issue	Quality dimension	Measure/Indicator	Type	Unit / Population	Source / Period	Organization Id	Current performance	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	92409*	13.61	13.61	Move towards Provincial target 17/18 6.6%. Still a shortage of resources e.g. PSW capacity shortage and primary providers that will continue to impact need to access the ED.		1)To improve care coordination for individuals participating in the Health Link approach to care by increasing access to 2)To improve communication regarding HCC patient's medications at care transitions by offering patients a copy of 3)Explore ideas to reduce PSW demand, e.g.: Utilizing RPNs for first visit Ensure complex patients are correctly identified	Develop a work plan to allow partners' access to Coordinated Care Plans in HPG	# of targeted Health Service Providers (HSP's), who are Health Information Custodians, with access to HPG # of new Health Link Coordinated Care Plans created in CHRIS	To onboard and provide 25% of targeted HSP's who are Health Information	
		Median number of days residents waited to be placed in a LTCH from the date of long-term	P	Days / Home care residents placed from community	CPRD / April 2017 – March 2018	92409*	129	129.00	Sustain current performance. Working with the assumption that bed		1)Apply consistent, tighter crisis criteria across our region. Improve alignment with provincial legislation for crisis (when and where)	Weekly local (sub-region) meetings with Managers, Directors and Care Coordinators to reinforce crisis criteria and to identify and prevent crisis. Regularly review crisis list to determine which patients would benefit from review of crisis designation, and	Number of patients identified as crisis on wait list. Crisis risk level for patients on list Number of LTC homes have access to BSO.	100% of target patient population (i.e. 65 yrs. of age or greater; and 5 or more	Increase the % of complex patients who received a visit by PSW within 5 days by
	Median number of days residents waited to be placed in a LTCH from the date of long-term	P	Days / Home care residents placed from AC hospitals	CPRD / April 2017 - March 2018	92409*	89	89.00	Sustain current performance. Working with the assumption that bed		1)Apply consistent, tighter crisis criteria across our region. Improve alignment with provincial legislation for crisis (when and where)	Weekly local (sub-region) meetings with Managers, Directors and Care Coordinators to reinforce crisis criteria and to identify and prevent crisis. Regularly review crisis list to determine which patients would benefit from review of crisis designation, and	Number of patients identified as crisis on wait list. Crisis risk level for patients on list Number of LTC homes have access to BSO.	Reduced median wait time for LTC for 4As Year to year comparison of crisis levels		
	The time interval between the disposition date/time (as determined by the	C	Hours / All patients	CIHI NACRS / October 2018- December 2018	92409*	39.4	36.00	As per Health Sciences North	Health Sciences North	1)Refresh Home First initiatives in collaboration with Health Sciences North (HSN)	Collaborate in formal review upon request and where appropriate, of patient made ALC within 48 hours of admission to HSN Provide refresher education session to Access Coordinators working at HSN to encourage	Workload measurement specific to care conferences attended by Access Care Coordinators working at HSN # of Access Care Coordinators provided refresher education re Home First philosophy	Improved workload measurement related to attendance at		
Theme II: Service Excellence	Patient-centred	Percent of home care clients who responded "Good", "Very Good", or "Excellent" on a five-	P	% / Home Care Clients	HSSO CCEE Survey / April 2017 - March 2018	92409*	91.7	91.70	To sustain current performance. Existing PSW capacity		1)PFAC representation to be considered for any Quality Improvement project going through the Centre of LHIN Excellence	Will add field in project approval checklist to have project owners consider whether PFAC member representation is appropriate to specific project and whether involvement will be required during specific phases or for duration of project.	# of projects going through COLHE involving PFAC member(s)	PFAC member(s) will be involved in 10 Projects between April 1, 2019 and March	
		Percentage of complaints acknowledged to the individual who made a complaint within	P	% / Home Care Clients	Local data collection / Most recent 12 month period	92409*	91.69	95.00	Local process defined during last fiscal year. Continuing to improve timely		1)To increase the number of complaints received by Home and Community Care (HCC) that are acknowledged within 2	To analyze outlier complaints documented in the NE LHIN's Risk and Event Feedback System (REFS) to identify barriers/contributing factors to more timely acknowledgement Provide education to Managers/Directors re need to formally acknowledge	%complaints received by HCC acknowledged within 2 business days.	95% of complaints received by HCC will be acknowledged within 2 business	
Theme III: Safe and Effective Care	Effective	Proportion of home care patients with a progressive, life-threatening illness who have had their	P	Proportion / at-risk cohort	Local data collection / Most recent 6-month period	92409*	0.89	95.00	Target based on analysis of current performance over past 6		1)Ensure early identification and documentation of needs for palliative care patients	Identifying improvement opportunities by caseload Address contributing factors, including: Potential documentation gaps Education to Care Coordinators re: assessment frequency and type	% of SRC 95 patients with LOS over 7 days assessed using the RAI-PC, RAI-HC, Local Adult but not including RAI-CA	95% of SRC 95 patients with LOS over 7 days will be assessed using the RAI-PC, RAI-HC or	