2019/20 Quality Improvement Plan HCC

Aim		Measure					Change Idea				
Theme	**Quality Dimension**	**Measure/Indicator**	**Data Source (Current Performance)**	**Current Performance (Baseline)**	**Target Performance for 2019/2020**	**Target Justification**	**Planned Improvement Initiatives (Change Ideas)**	**Methods**	**Process Measures**	**Target for Process Measure**	**Comments**
Timely & Efficient Transitions	**Efficient**	**Unplanned Emergency Department Visits:** % of Home Care patients with an unplanned, less-urgent ED visit within the first 30 days of discharge from hospital	HSSO Report Q2 2017/18 – Q1 2018/19	8.1%	7.6%	Maintain target selected in 2018/19 as not yet achieved (50% to the provincial average)	Information to be shared at hospital discharge relevant to the ongoing care of a patient is defined and standardized. (Accreditation Canada Required Organizational Practice)	Supported by the implementation of the Coordinated Care Plan (CCP) and in collaboration with our hospital partners: 1. Develop standard documentation and communications strategies within each hospital/unit to share relevant care information at time of hospital discharge 2. Develop standard process to ensure patients and families are given information at time of transition to support their own care 3. Report safety incidents related to information transfer at time of transition and identify opportunities for improvement 4. Spread to other hospital sites as able through out the remainder of the fiscal year	Standard documentation and communication strategies are developed and implemented at one hospital site	Implementation at one hospital site by September 30, 2019	
							Review and refresh of brochureware shared with patients and families at transition from hospital to home	Under the leadership of the Transition from Acute Care to Home Community of Practice: 1. Inventory all brochureware shared with patients and families across all hospital sites 2. Review and refresh all content to ensure consistency and accuracy (including French translation) 3. Standard process developed to ensure consistent sharing of brochureware by all Care Coordinators (CCs) as part of hospital discharge process 4. Re-orientation of Hospital CCs to update brochureware and process	1. Review and refresh of all identified patient and family brochureware used at all hospital sites 2. Re-orientation of all hospital CCs	1. By December 31, 2019, all identified patient/family brochureware will be reviewed and updated 2. 100% of all Hospital CCs will be re-oriented to the new materials and the process for sharing with patients and families	
							In collaboration with our health system partners within the Couchiching sub-region, develop a standard referral process from hospital to the Family Health Team Congestive Heart Failure (CHF) clinic and the Home and Community Care (HCC) Telehomecare program	1. As part of sub-region working group, analyze the barriers to referring to both programs (CHF clinic and Telehomecare) and identify opportunities to increase enrollment rates 2. Incorporate Telehomecare specific training into onboarding education for HCC staff and explore opportunities to add into regular education days with a focus on hospital CCs 3. Spread improvement opportunities to other sub-regions based on evaluation	% of patients enrolled in the HCC Telehomecare program over patients referred (Couchiching sub-region)	Increase in % of patients enrolled over patients referred quarter over quarter by March 31, 2020 in the Couchiching sub-region	

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							Development of a hypertension pathway to be included within the Telehomecare program	1. To be developed in partnership with Royal Victoria Regional Health Centre's (RVH) Chronic Disease Program or Stroke Rehabilitation Program and the Ontario Telemedicine Network (OTN) 2. Focus on patients that require support with their hypertension management and education 3. Developed and piloted within the Barrie and Area with plan to spread to other sub-regions	Hypertension pathway developed and added to the Telehomecare program for Barrie and Area (RVH)	Hypertension pathway developed and added to the Telehomecare program for Barrie and Area (RVH) by June 30, 2019	
							Implementation of the DIVERT algorithm as a tool to identify HCC patients at risk of Emergency Department (ED) visits	1. The DIVERT algorithm is an element of the Care Coordination (CC) Dashboard to be implemented within the 2019/20 fiscal year 2. Standards to be developed for use of the algorithm by all CCs to identify patients on their caseload who are at risk of ED visit(s)	1. Inclusion of the DIVERT algorithm on the CC Dashboard 2. Education of the CCs as to the DIVERT algorithm as a predictor of ED visits	1. Inclusion of the DIVERT algorithm on the CC Dashboard 2. 100% of all Community CCs received education by March 31, 2020	
	Timely	**Wait time to long-term care home placement (hospital and community):** Median number of days to long term care placement from the date of application or consent to the date of placement which ever is longer	FY 2017/18	From Hospital (Acute Care): 113 Days From Community: 190 Days	No target	Monitor internally while analysis is completed	Literature review and waitlist analysis to identify contributing factors which impact on long term care (LTC) wait time at a regional and sub-regional level	1. Literature review to identify key factors that impact on application and admission to LTC 2. Based on findings of literature review, analysis of current LTC waitlist including patient assessment information to confirm key factors that lead to LTC application and admission at the region and sub-region level	Completion of literature review, analysis and identification of contributing factors	Analysis completed by December 31, 2019. Based on findings, improvement initiatives identified for inclusion in the 2020/21 QIP	

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Service Excellence	**Patient-centered**	**Patient Satisfaction:** % of Home Care patients who responded "Good", "Very Good", or "Excellent" on a five-point scale to any of the following patient experience survey questions: • Overall rating of Home and Community Care services • Overall rating of management/handling of care by Care Coordinator • Overall rating of service provided by the service provider	CCEE Annual Results FY 2017/18	91.6%	92.9%	50% improvement to provincial best (94.2%) Provincial average is 90.9%. Range is 88.3% to 94.2% (NSM is 5th amongst all LHINs)	Coordinated Care Plan (CCP) initiated for all new complex patients	Project plan includes: 1. Process for collecting care plan information during patient assessments, reassessments or updates 2. Tool for sharing the CCP with patients and families developed with input from Patient Family Advisory Council (PFAC) 3. Identification of mandatory sections to be completed throughout the patient's care journey dependent on key factors 4. Method for documenting history of ongoing changes to the care plan 5. Training for NSM LHIN staff to access and complete CCPs in CHRIS with initial focus on complex patients 6. Evaluation spread across all sub-regions	1. % of complex patients who responded neutral, agree or strongly agree with question, "I felt involved in developing my care plan" (Client and Caregiver Experience Survey KPI 2 question) 2. # of new CCPs initiated per quarter	1. % increase over baseline by March 31, 2020 2. Increase in the number of new CCPs initiated quarter over quarter by March 31, 2020	Baseline CCEE 2017/18 annual results complex population Baseline - Q4 2018/19
							Evolve our organizational rewards and recognition program to include both formal and informal recognition opportunities	Under the leadership of the Employee Engagement Advisory Committee: 1. Staff engagement to guide understanding of what recognition means to staff 2. Evolution of the the program to include: - Ongoing leadership sessions (new and current leaders) with focus on reward and recognition - Formal annual recognition program in alignment with organization's values - Informal recognition opportunities (peer to peer and manager to staff) as part of daily work and staff events	% of staff who "agree or strongly agree" on the survey question "I receive recognition for good work" (Worklife Pulse Tool)	% increase over baseline by March 31, 2020	Baseline Worklife Pulse Tool February 2019 results
							Streamline the current processes for the Family Managed Care program to support management at the sub-region level	1. New program Family Managed Care implemented in Q4 2018/19 2. Evaluation of current processes by Project team and identification of opportunities to streamline current processes to ensure sustainability and management of the program at the sub-region level 3. Streamlining of processes and implementation within each sub-region	Processes streamlined to support management of the program at the sub-region level	Family Managed Care program managed at the sub-region level by September 30, 2019	
							Through Dementia Capacity planning, implementation of caregiver support strategies with focus on reducing caregiver burden	1. HCC is a member of the Dementia Capacity project team in partnership with the LHIN planning team and other health system partners 2. Analysis of data with focus on identifying strategies to reduce caregiver burden across the system	% of long-stay home care patients whose primary informal caregiver experienced continued distress, anger or depression in relation to their caregiving role at time of assessment (using the Inter-RAI assessment tool)	% decrease over baseline by March 31, 2020	Quality Outcomes data pulled from HSSO (runs monthly, HSSO compiles quarterly result) Reported quarterly on 15th of the month after previous quarter end - baseline 2018/19 data

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		Palliative Caregiver Satisfaction: % of caregivers of palliative patients who responded “Good”, “Very Good”, or “Excellent” on a five-point scale to the following question on the caregiver experience survey.: Overall, and taking all services, in all settings into account, how would you rate his/her care in the last 3 months of life?	Caregiver Voices Survey Annual Results FY 2017/18	92.0%	≥ 92.0%	Sustain or improve current performance. As Residential hospice now included within survey results for 2018-19 will be establishing new baseline Q1-Q2 2018/19 results are 91.1%	Coordinated Care Plan (CCP) initiated for all new palliative patients	Project plan includes: 1. Process for collecting care plan information during patient assessments, reassessments or updates by the Palliative Care Coordinators and the Palliative Nurse Practitioners (NPs) 2. Tool for sharing the CCP with patients and families developed with input from Patient Family Advisory Council (PFAC) 3. Identification of mandatory sections to be completed throughout the patient’s care journey 4. Method for documenting history of ongoing changes to the care plan 5. Training for NSM LHIN palliative care staff to access and complete CCPs in CHRIS for all palliative patients 6. Evaluation and spread to include both chronic and complex palliative patients	1. % of caregivers of palliative patients who responded "Yes" to the following question "Did health care providers make any decisions about your family member/friend's care that he/she would not have wanted?" (Caregiver VOICEs survey) 2. # of new CCPs initiated per quarter	1. % increase over baseline by March 31, 2020 2. Increase in the number of new CCPs initiated quarter over quarter by March 31, 2020	Baseline VOICEs survey 2018/19 results
							Medical Assistance in Dying (MAID) policy and process review	Under the leadership of the Palliative Care Community of Practice: 1. Update current MAID checklist 2. Develop standard process to ensure successful IV access to MAID patients	1. Revisions to policy and related documents including process maps and MAID checklist completed 2. Education of Palliative CCs and service provider organizations (nursing only)	1. Policies and processes updated by March 31, 2020 2. 100% of all Palliative CCs and service provider organizations (nursing only) completed by March 31, 2020	
							Standard contact sheet for palliative patients and their families/caregivers	In partnership with Ontario Palliative Care Networks (OCPN) and the Regional Palliative Care Network: 1. Clarification of the roles and responsibilities of care team members 2. Development of a standard contact sheet for patients/families to be used by all care team members	% of caregivers of palliative patients who responded 'Yes, definitely' to the question “When he/she was at home in the last 3 months of life, did the Home Care providers work well together?” (Caregiver VOICES survey)	% increase over baseline by March 31, 2020	Baseline VOICEs survey 2018/19 results
							Standard process for documenting preferred place of death throughout the patient's care journey	Under the leadership of the Palliative Care Community of Practice: 1. Implementation of new functionality with the HCC patient information system (CHRIS) for tracking preferred place of death 2. Process to ensure consistent documentation of changes in a patients preferred place of death throughout their care journey within the Coordinated Care Plan (CCP) 3. Education to Palliative Care Coordinators on process and new functionality	% of patients who died in their preferred place of death	To meet or exceed the provincial average by March 31, 2020	Target provincial average 2019/20

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		Patient Safety Culture : % of staff who graded the organization's overall patient safety as "Excellent, Very Good, Acceptable"	Patient Safety Culture Tool (November 2018 results)	96.4% (61.5% top two responses Excellent, Very Good)	96.4% (70% top two responses Excellent, Very good)	Sustain overall results Top 3 responses (Excellent, Very Good, Acceptable) and Increase % of staff who responded to top two responses (Excellent, Very Good) to 70% Based on % increase from 2017 to 2018 (2018 61.5%, 2017 52.5%)	Build on A "Just" Culture that supports Patient Safety and Quality Improvement	1. Identify opportunities where follow-up and recommendations from patient safety events (all risk levels) can be shared directly back to staff 2. Strengthen the use of patient and caregiver stories and patient experience survey data to highlight patient experience and to demonstrate system improvement as a follow-up to patient safety events 3. Continue to evolve the 'Good Catch' program by increasing reporting of near misses and expanded opportunities for recognition	% agreement with the statement "Staff are usually given feedback about changes put into place based on incident reports" (Patient Safety Culture Tool)	Improve % positive response on question "Staff are usually given feedback about changes put into place based on incident reports" (Patient Safety Culture Tool) by March 31, 2020	Baseline is 47.2% - Patient Safety Culture tool November 2018 results
									% agreement with the statement "Others make you feel like a bit of a failure when you make an error" (Patient Safety Culture Tool)	Improve % positive response on question "Others make you feel like a bit of a failure when you make an error" (Patient Safety Culture Tool) "Staff are usually given feedback about changes put into place based on incident reports" (Patient Safety Culture Tool) by March 31, 2020	Baseline is 59.1% disagreement (higher is better) - Patient Safety Culture Tool November 2018 results

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Safe & Effective Care	**Safe**	**Patient Safety:** % of Home Care patients who responded "Agree"/"Strongly Agree" to the following patient experience survey questions: • Satisfied with support from Care Coordinator to address safety concerns • Satisfied with support from Service Provider to address safety concerns	CCEE Annual Results FY 2017/18	91.9%	93.0%	50% improvement to provincial best (94.1%) Current range 90.1% to 94.1% (NSM is 7th amongst all LHINs)	Evolve the HCC Quality of Care review process following a critical incident to include patient partners	Review and implement practices within the Canadian Guide - Engaging patients in patient safety, supported by Accreditation Canada standards	1. Ongoing inclusion of patients/families in information gathering and the sharing of recommendations following a critical incident 2. Process for including patient partners in the incident analysis following a critical incident	Process in place and piloted by December 31, 2019	
							Independent double check (IDC) process for high risk medications to include a confirmation of completion	IDC process developed in partnership with contracted service provider organizations that includes a standard checklist and confirmation of completion	Reduction in number of medication errors due to non-adherence to the IDC process	Decrease quarter over quarterly in the number of medication errors due to non-adherence in the IDC process	Baseline - Total number of medication errors due to non-adherence 2018/19
							Medication reconciliation process for identified patients referred to Rapid Response Nurse (Accreditation Canada Required Organizational Practice)	Under the leadership of the Direct Nursing Community of Practice: 1. Process for ensuring completed medication orders/medication history is received by HCC as part of hospital discharge 2. Standard process to ensure best possible medication history (BPMH) is generated and documented for all identified patients at initial Rapid Response Nurse visit 3 Process to resolve medication discrepancies and to update medication list for patients/families	% of patients who Strongly/somewhat agree with the statement "Someone took the time to explain all my medication" (Hospital Discharge Survey)	Improve % positive response on question "Someone took the time to explain all my medication" by March 31, 2020	Baseline - 89.3% 2017/18 annual results Hospital Discharge Survey
							Collaborative approach with health system partners to review critical incidents specific to patient transitions	Through involvement in the Regional Patient Safety Committee, continue to engage in collaborative quality of care reviews with our health system partners with focus on improving transitions of care	Completion of collaborative quality of care reviews with hospital and other health system partners	Continue to Increase the number of Quality of Care reviews (over baseline) that are completed in collaboration with other health system partners by March 31, 2020	Baseline - 3 (MAHC + 2 RVH)
	Effective	**Early identification: Documented assessment of needs for palliative care patients** % of home care patients who have a documented assessment of their palliative care needs in their record	Not available	Not available	Baseline	New indicator will collect baseline data during 2019/20	Development and implementation of a regional tool for early identification of patients requiring a palliative approach to care	Regional Palliative Care Network (RPCN) is creating a regional tool to be implemented within each sub-region that assists clinicians in the early identification of patients that would benefit from a palliative approach to care. The tool will also suggest to the provider to make referrals to specific resources to support the patient and the provider in the palliative approach to care	Regional tool implemented at a sub-region level for use by all palliative care providers	Regional tool implemented within at least one sub-region by March 31, 2020	