

# Central LHIN 2016/2017 QIP Snapshot Report

# INTRODUCTION

# Purpose

- To give each Local Health Integration Network (LHIN) a snapshot of its quality improvement efforts as reflected in the 2016/17 Quality Improvement Plans (QIPs) submitted to Health Quality Ontario by hospitals, interdisciplinary primary care organizations, community care access centres and long-term care homes
- To identify general observations, highlight areas that have shown improvement, and identify potential areas for improvement (focusing on a few indicators)

# How This Report Should Be Used

- We intend for this report to:
  - Be used for discussion between the LHIN and its health service providers on successes and areas for improvement as reflected in the QIPs
  - Stimulate collaboration within and among organizations across the LHIN who may be working on similar change ideas or areas for improvement
  - Be used as a discussion point with the Regional Quality Tables
  - Be shared with the LHIN board and/or health service provider boards in the LHIN
- This report has been produced in an editable PowerPoint format to support the above uses

# Report Structure

For a select number of 2016/17 QIP indicators, this report will summarize:

**1. Quantitative data**, including:

- Current performance and indicator selection
- Progress made on 2015/16 QIPs

**2. Qualitative data**, including:

- Change ideas and partnerships
- Barriers and challenges
- Success stories

For more information about these and other indicators, please visit the Health Quality Ontario website to access the publicly posted QIPs ([Sector QIP](#)) or search the QIP database ([QIP Query](#))

# Rationale for Selected Indicators

This snapshot provides information on priority indicators that require collaboration and integration across sectors

## Hospital

- 30-Day Readmissions for Select HBAM Inpatient Groupers
- 30-Day Readmissions for Select Quality-Based Procedure (QBP) Cohorts (Chronic Obstructive Pulmonary Disease, Stroke, Congestive Heart Failure)
- Alternative Level of Care Rate

## Primary care

- 7-Day Post-Discharge Follow-up
- Timely Access to Primary Care
- Hospital Readmissions for Primary Care Patients

## Community care

- Hospital Readmissions for Community Care Access Centre (CCAC) Clients

## Long-term care (LTC)

- Emergency Department Visits for Ambulatory Care–Sensitive Conditions

For more information about these QIP indicators, see the [2016/17 QIP indicator technical specification document](#)

# Central LHIN Overview

Sector	QIP Count	Description
Hospitals	6	<ul style="list-style-type: none"><li>• 5 large community hospitals</li><li>• 1 small community hospitals</li></ul>
Primary Care	15	<ul style="list-style-type: none"><li>• 11 Family Health Teams</li><li>• 2 Community Health Centres</li><li>• 2 Nurse Practitioner Led Clinics</li></ul>
Community	1	<ul style="list-style-type: none"><li>• CCAC</li></ul>
Long-Term Care	46	<ul style="list-style-type: none"><li>• 23 for-profit</li><li>• 18 not-for-profit</li><li>• 5 municipal</li></ul>
Multi-sector	0	

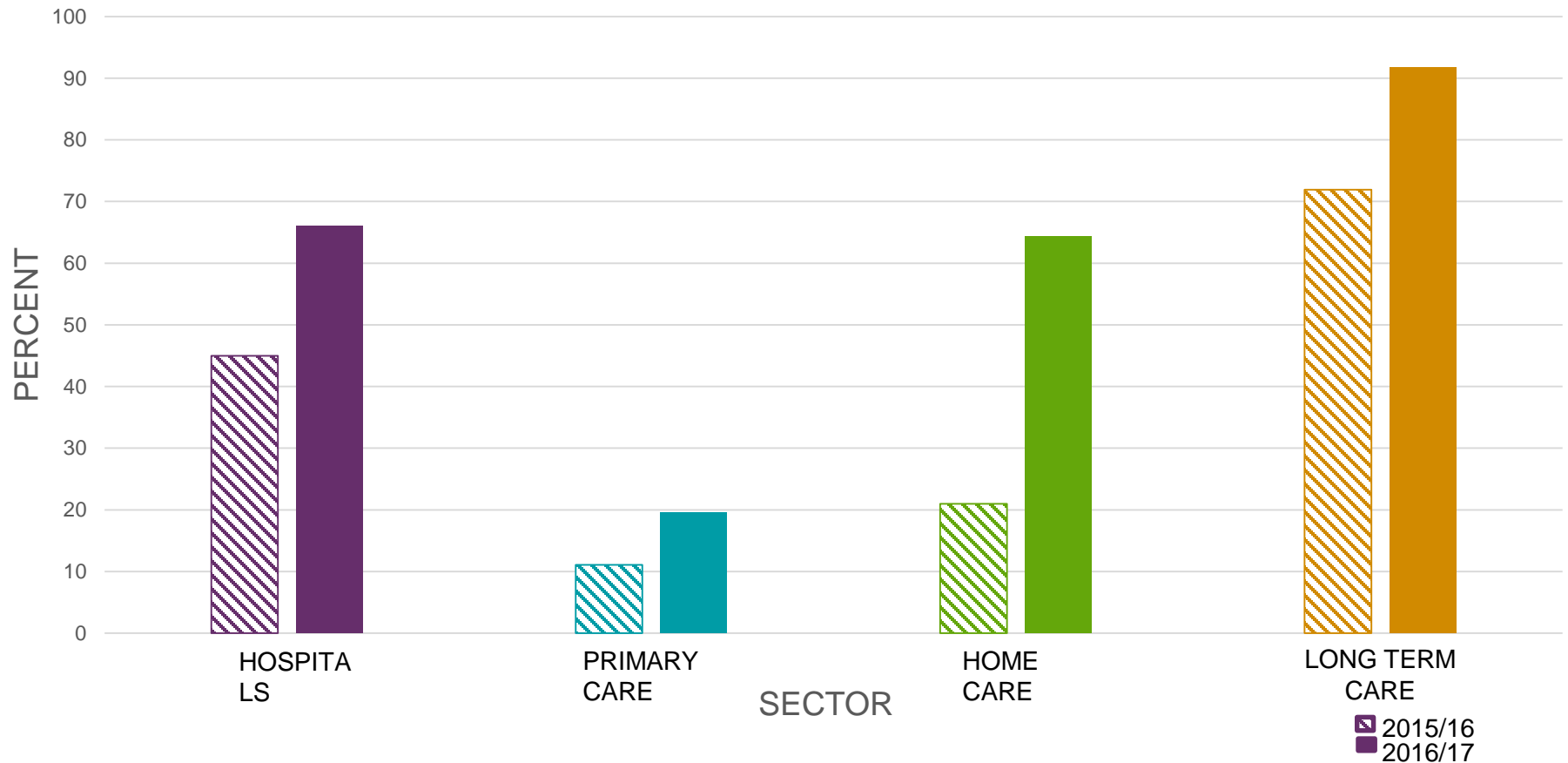
# Key Observations – Overarching

- Reflecting back on their 2015/16 QIPs, more than 85% of organizations reported progress on at least one priority or additional indicator, and more than half reported progress on three or more.
- There was a high uptake of priority issues in the 2016/17 QIPs, particularly patient experience and integration.
  - More than three-quarters (78%) of organizations described working on at least one of the indicators related to integration.
  - More than 80% of organizations described working on at least one of the indicators related to patient experience.
- Most organizations set targets to improve, but many of these targets are modest – typically within 1–5% of their current performance.
  - While this may be appropriate for some indicators, organizations are encouraged to reflect on their current performance and consider whether a stretch target might be appropriate.



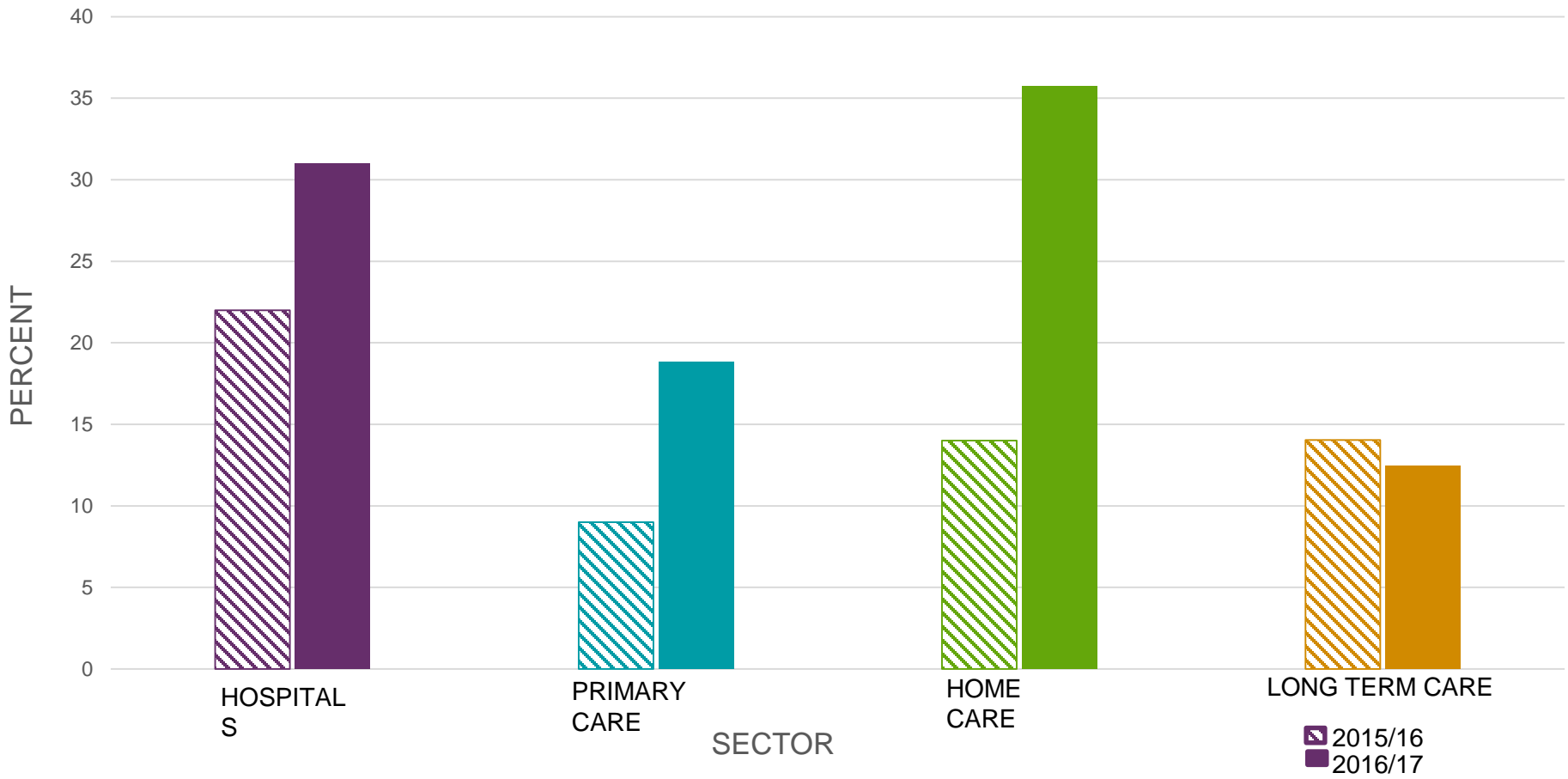
# All sectors described an increased use of Patient and Family Advisory Councils and Forums in the development of their QIPs

Percentage of Organizations that reported engaging Patient Advisory Councils and Forums in development of 2015/16 QIPs and 2016/17 QIPs across all four sectors



# Most sectors described an increased engagement of patients and families in the co-design of QI initiatives

Percentage of Organizations that reported engaging Patients and Families in development of 2015/16 QIPs and 2016/17 QIPs across all four sectors




# Key Observations – Per Sector

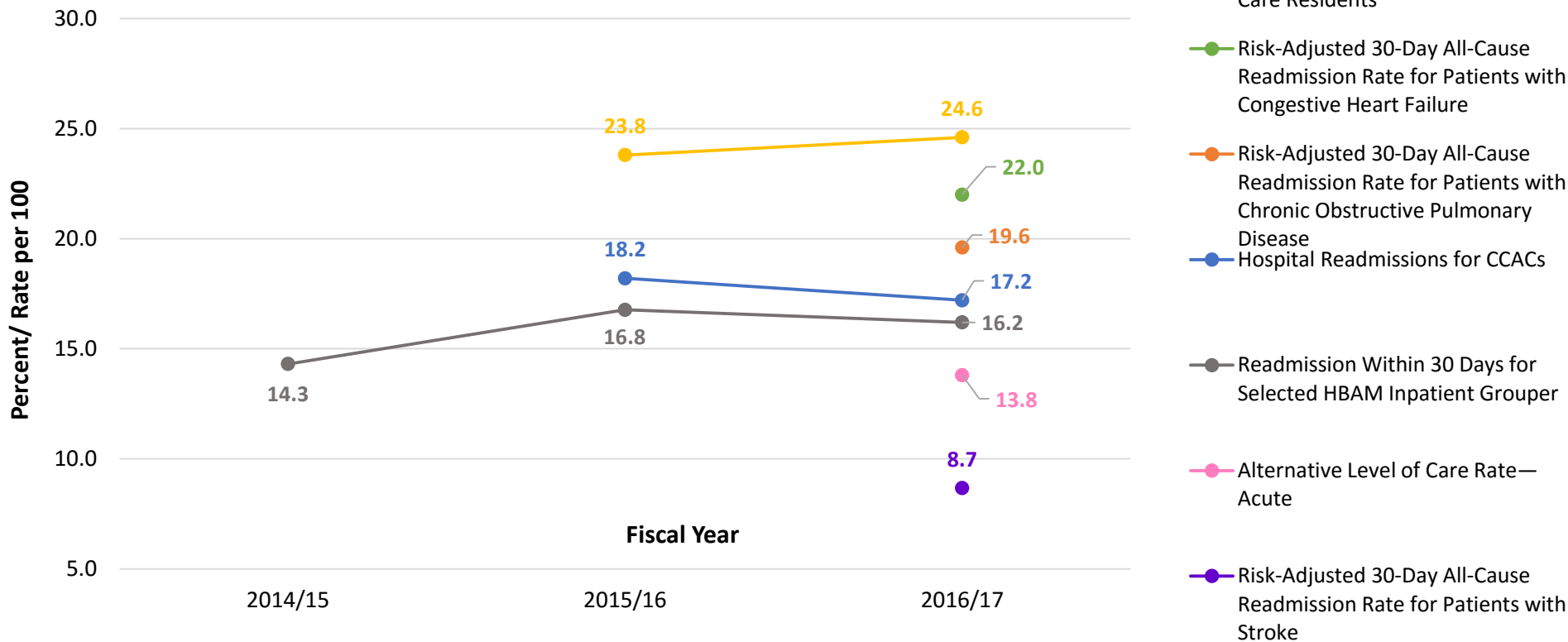
- **Hospitals:** The area where the most hospitals reported progress was emergency department length of stay (61% of hospitals reporting progress), followed by positive patient experience (recommend hospital; 60% of hospitals reporting progress).
- **Primary care:** The area where the most primary care organizations reported progress was cancer screening (65% reporting progress in colorectal cancer screening and 55% reporting progress in cervical cancer screening).
- **Home care:** The area where the most CCACs saw progress was related to integration issues (77% of CCACs reported progress on unplanned emergency visits and 75% of CCACs reported progress on hospital readmissions).
- **Long-term care:** The area where the most homes reported progress was appropriate prescribing of antipsychotics (78% of homes reporting progress).

# QUALITY IMPROVEMENT PLAN DATA

# Provincial Averages

## Ontario provincial averages (%) for selected integration indicators across sectors\*, QIP 2014/15–QIP 2016/17

Better performance 



\*Data were obtained from external sources, and indicators presented in the graph are risk-unadjusted unless specified otherwise. Potentially avoidable ED visits for long-term care residents has a unit of rate per 100 long-term care residents; all other indicators have a unit of percent. Provincial average data were not available for primary care organization indicators from external data sources and are not presented in this graph.

### Data sources

Potentially Avoidable Emergency Department Visits for Long-term Care Residents: Canadian Institute for Health Information.

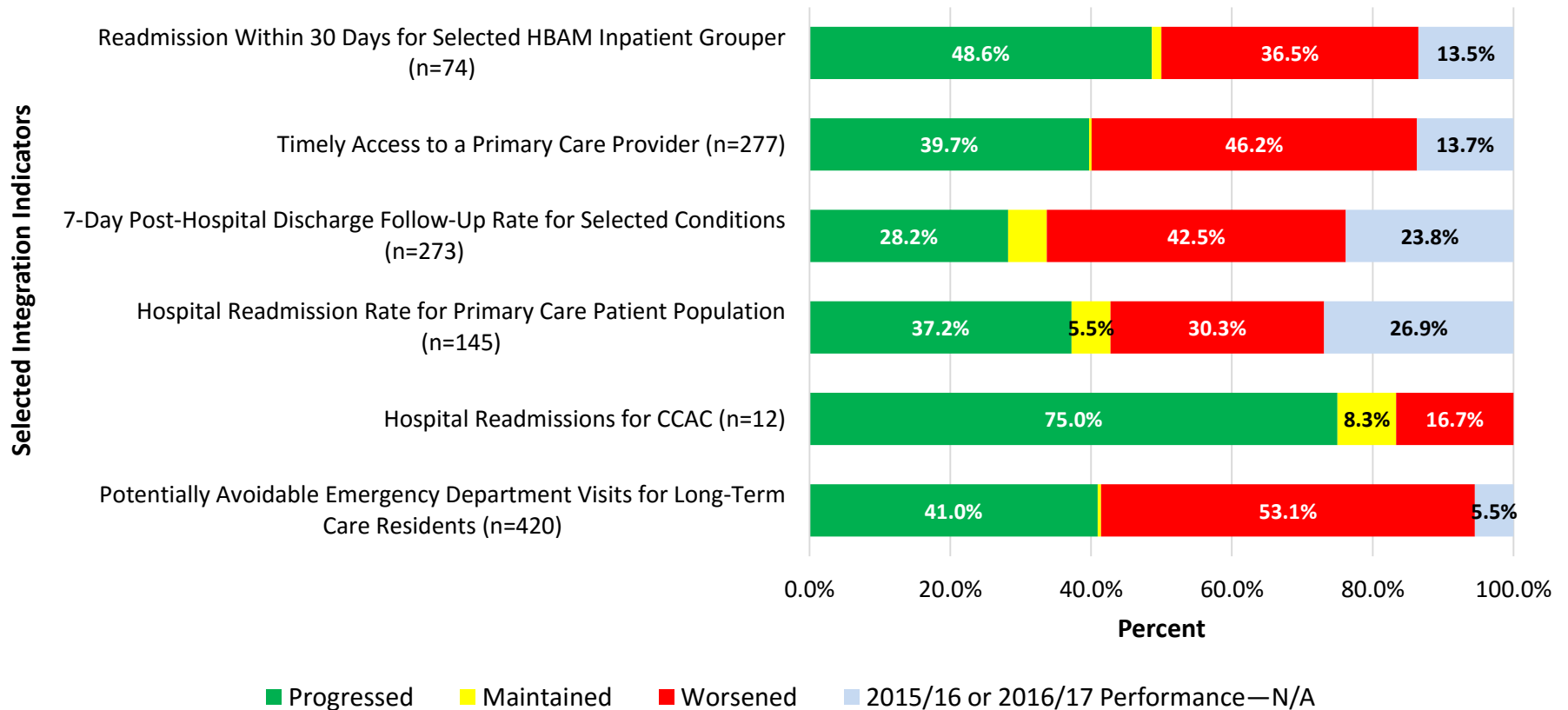
Risk-Adjusted 30-Day All-Cause Readmission Rate for Patients with Congestive Heart Failure; Risk-Adjusted 30-Day All-Cause Readmission Rate for Patients with Chronic Obstructive Pulmonary Disease, Readmission Within 30 Days for Selected HBAM Inpatient Groupers, Risk-Adjusted 30-Day All-Cause Readmission Rate for Patients with Stroke: Canadian Institute for Health Information, Discharge Abstract Database.

Hospital Readmissions for CCAC: Home Care Database, Canadian Institute for Health Information, Discharge Abstract Database, National Ambulatory Care Reporting System.

Alternative Level of Care Rate—Acute: Cancer Care Ontario, Wait Time Information System.

# Ontario QIP Data: Progress Made in 2016/17

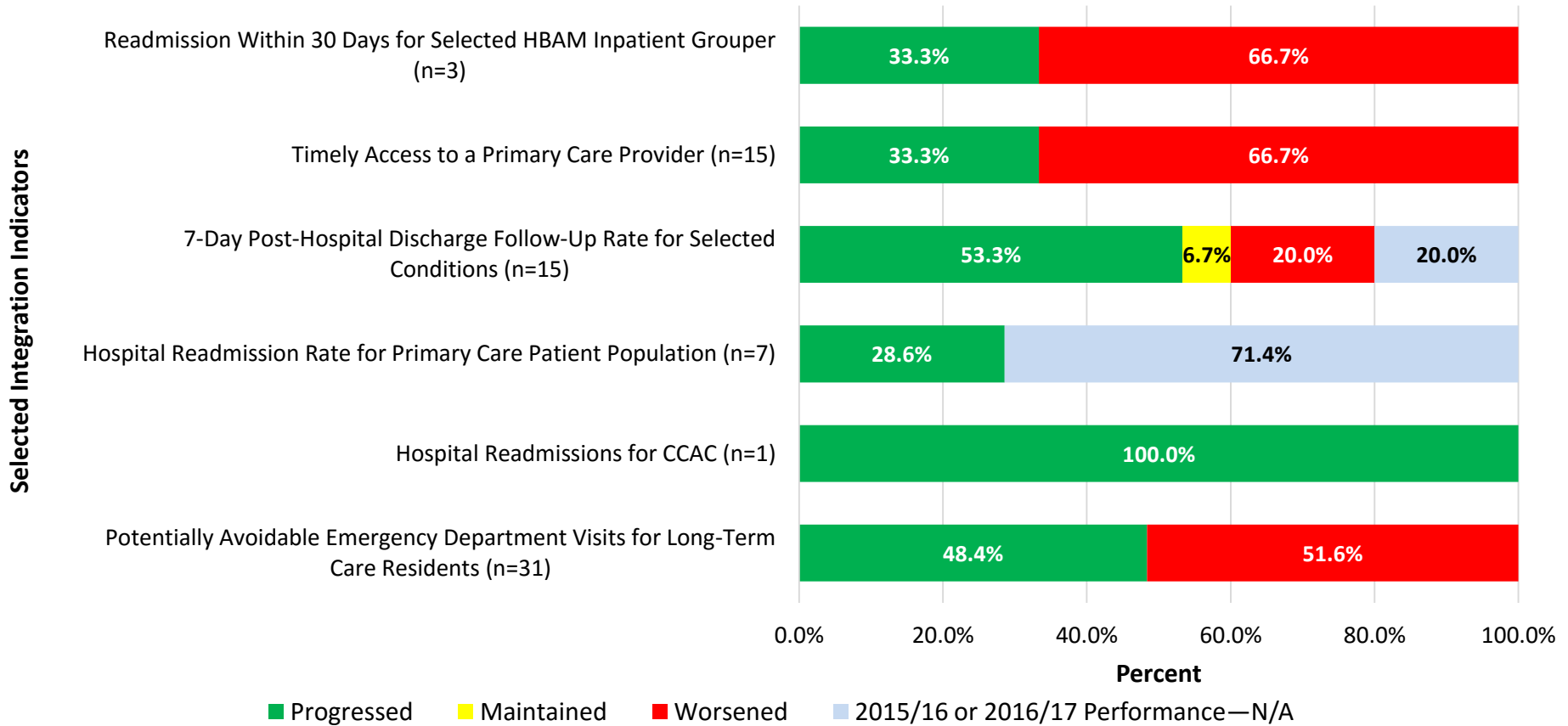
Looking back: Percentage of organizations in Ontario that progressed, maintained or worsened their performance between the 2015/16 QIP and the 2016/17 QIP on selected integration indicators, as reported in the QIP 2016/17 Progress Report



This graph represents organizations that selected the indicator in their 2015/16 and 2016/17 QIPs, comparing their current performance from both years, as reported in the 2016/17 QIP Progress Report. The numbers represent the original definitions of the indicators only.

# Central LHIN QIP Data: Progress Made in 2016/17

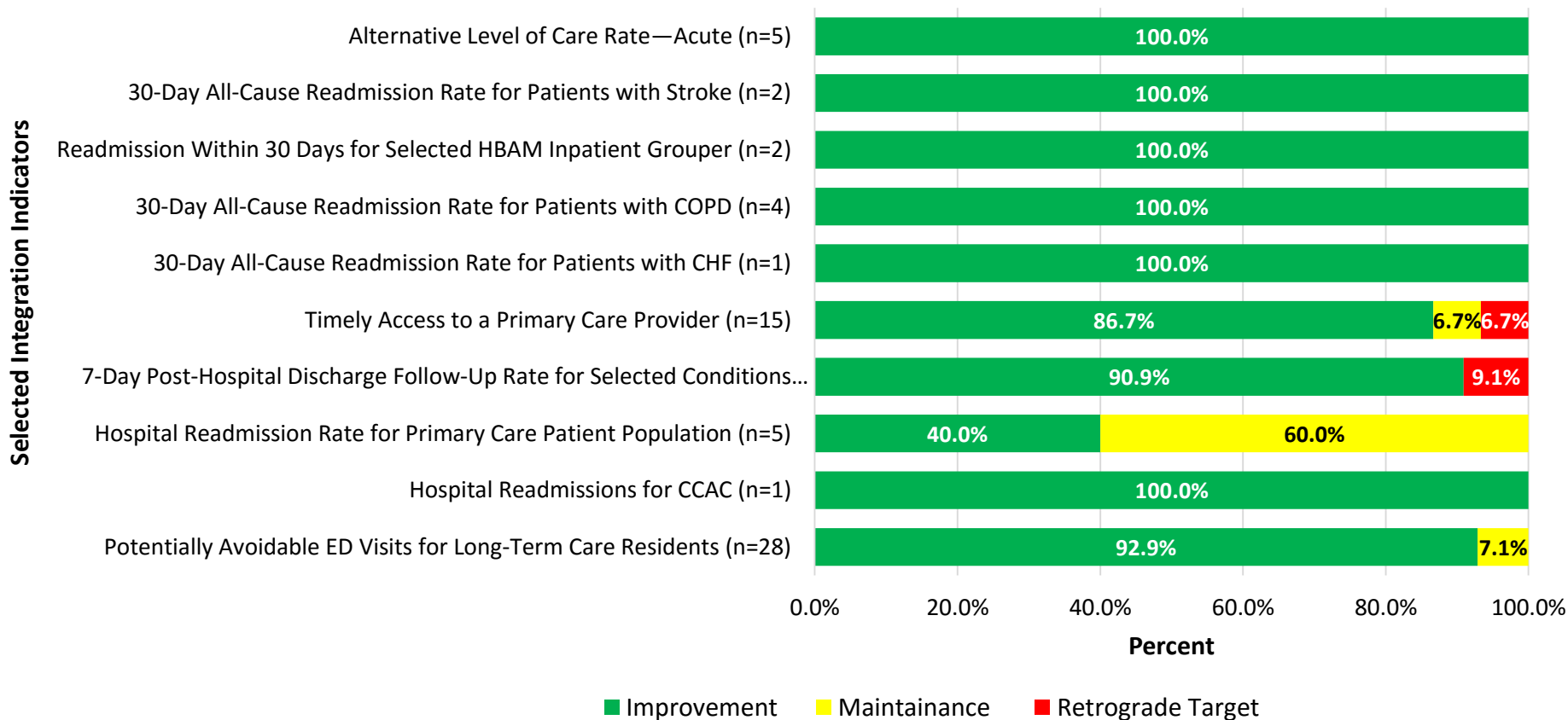
**Looking back: Percentage of organizations in Central LHIN that progressed, maintained or worsened in their performance between the 2015/16 QIP and the 2016/17 QIP on selected integration indicators, as reported in the 2016/17 QIP Progress Report**



The graph represents organizations that selected the indicator in their 2015/16 and 2016/17 QIPs, comparing the current performance (CP) from both years, as reported in the 2016/17 QIP Progress Report. The numbers represent the original definitions of the indicators only. The number of organizations in each LHIN may be small; please consider the sample size (n) of each indicator when interpreting the data presented – for example, there is only one CCAC per LHIN, so interpret data with caution.

# Central LHIN QIP Data: Target Setting in 2016/17

**Looking forward: Percentage of organizations in Central LHIN that set a target to improve, maintain or worsen performance in the 2016/17 QIP on selected integration indicators, as reported in the 2016/17 QIP Workplan**



The graph represents organizations that selected the indicator in their 2016/17 QIPs, comparing the Current Performance (CP) from 2016/17 to Target Performance (TP) in 2016/17, as reported in 2016/17 QIP Workplan. The numbers represent the original definitions of the indicators only. The number of organizations in each LHIN may be small; please consider the sample size (n) of each indicator when interpreting the data presented – for example, there is only one CCAC per LHIN, so interpret data with caution.



# Central LHIN QIP Data: 2016/17 Indicator Selection

Sector	General Areas of Focus: Integration Indicators	Current Performance CENTRAL LHIN Average	Current Performance Provincial Average	Indicator Selection: QIP 2016/17 *
<b>Hospital/ Acute Care</b>	i. 30-Day All-Cause Readmission Rate for Patients with Congestive Heart Failure (QBP)	22.39%	22.00%	1/6
	ii. 30-Day All-Cause Readmission Rate for Patients with Chronic Obstructive Pulmonary Disease (QBP)	21.08%	19.60%	4/6
	iii. 30-Day All-Cause Readmission Rate for Patients with Stroke (QBP)	9.44%	8.67%	2/6
	iv. Readmission Within 30 days for Selected HBAM Inpatient Grouper (HIGs)	15.68%	16.19%	2/6
	v. Alternate Level of Care Rate – Acute (ALC Rate)	13.34%	13.84%	5/6
<b>Primary Care</b>	i. 7-day Post-hospital Discharge Follow-Up Rate for Selected Conditions	N/A**	N/A**	15/15
	ii. Access to primary care (survey-based)	N/A**	N/A**	15/15
	iii. Hospital Readmission Rate for Primary Care Patient Population	N/A**	N/A**	7/15
<b>Community Care Access Centres</b>	i. Hospital Readmissions	17.68%	17.23%	1/1
<b>Long Term Care</b>	i. ED visits for Ambulatory Care Sensitive conditions	25.00%	24.55%	28/46

\* Indicator selection analysis presented in table includes original definition of the indicators only. The denominator represents the total number of QIPs submitted within LHIN in each sector. Custom Indicator Selection were as follows for Central LHIN:

- 1 Primary Care Organization selected a custom indicator related to *Access to primary care*

\*\* LHIN and provincial averages not available from external data providers

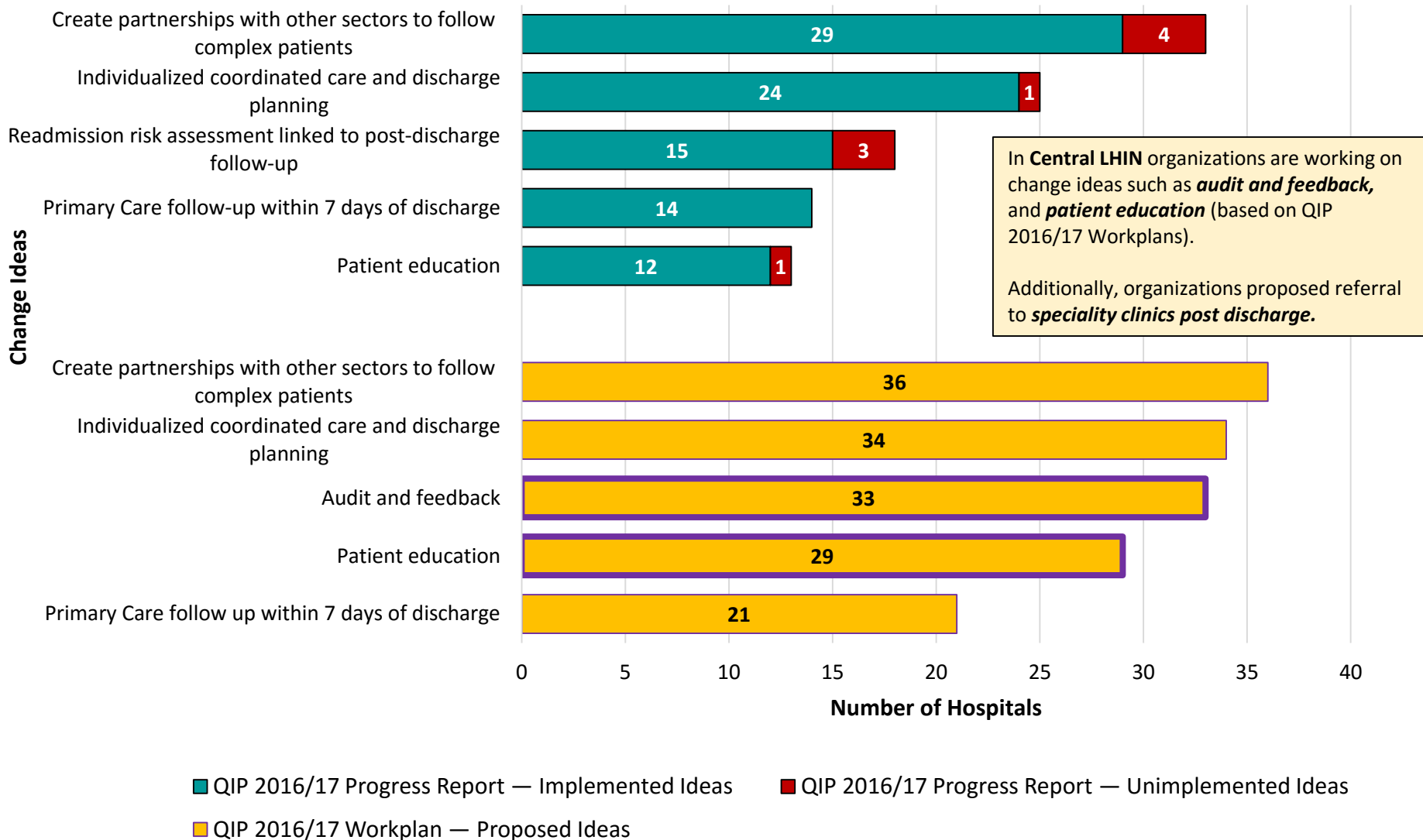
Note: Interpret data with caution; please refer to Technical Specifications; for instance, the three QBP indicators and the Readmissions HIG indicator are risk-adjusted, while the rest are not risk-adjusted.

# **MOST COMMON CHANGE IDEAS FROM 2015/16 AND 2016/17**

# Common Change Ideas

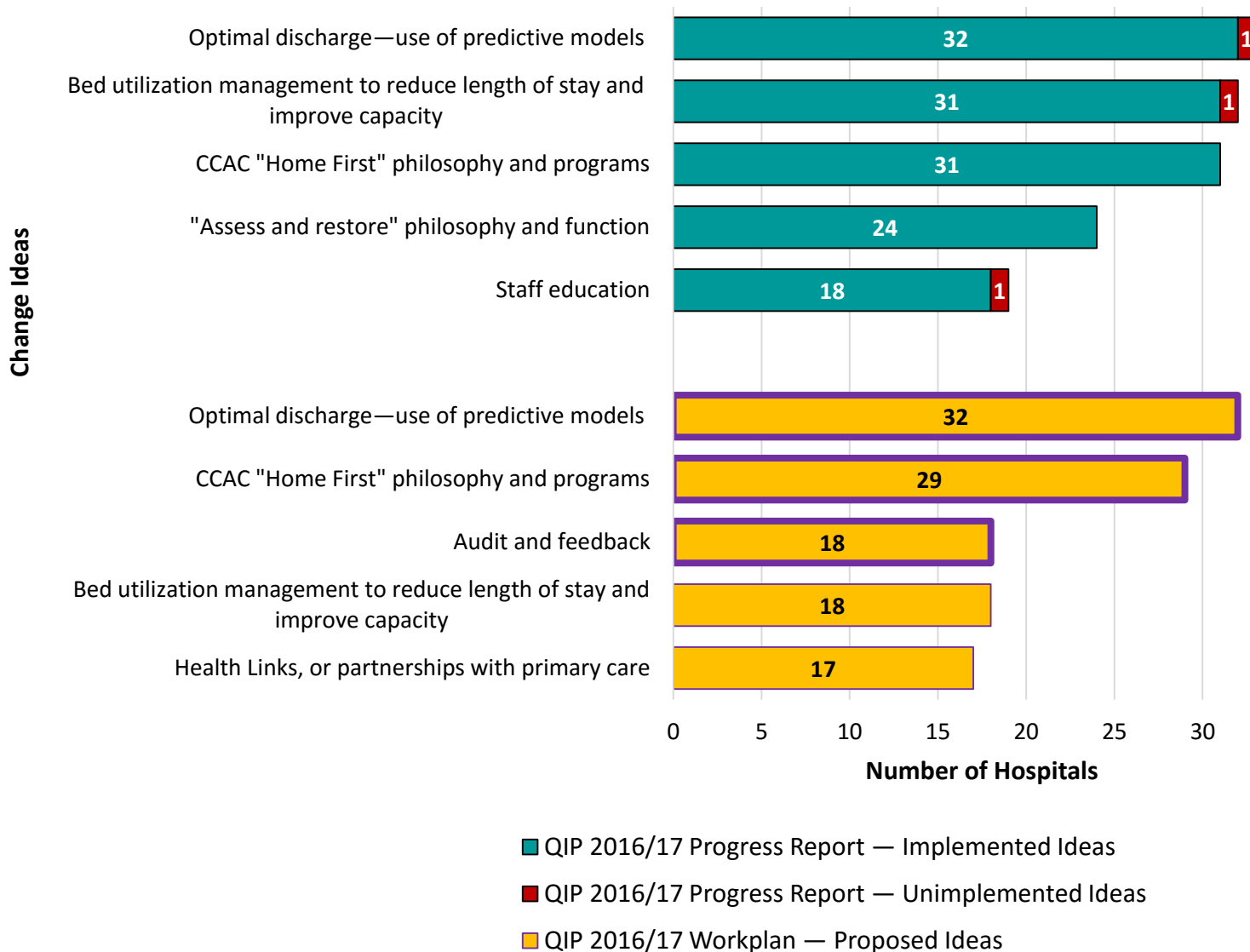
- The following slides show common change ideas at the provincial level; ideas have been categorized by theme
- Graphs display change ideas by indicator and show:
  - The most common change ideas included in the 2016/17 QIPs (Progress Report), and a look back at progress made in implementing change ideas
  - The extent to which these change ideas were also included in QIP Workplans
  - LHIN-specific notes to capture regional change ideas or unique ideas in Workplans

## Most common change ideas in Ontario from 2015/16 and 2016/17 hospital QIPs for 30-Day Readmission Rate,\* as reported in the 2016/17 QIPs



\* The information presented combines data submitted by organizations on the following four 30-Day Readmission indicators: 30-Day All-Cause Readmission Rate for Patients with Congestive Heart Failure, 30-Day All-Cause Readmission Rate for Patients with Chronic Obstructive Pulmonary Disease, 30-Day All-Cause Readmission Rate for Patients with Stroke and Readmission Within 30 Days for Selected HBAM Inpatient Grouper.

## Most common change ideas in Ontario from 2015/16 and 2016/17 hospital QIPs for Alternative Level of Care,\* as reported in the 2016/17 QIPs

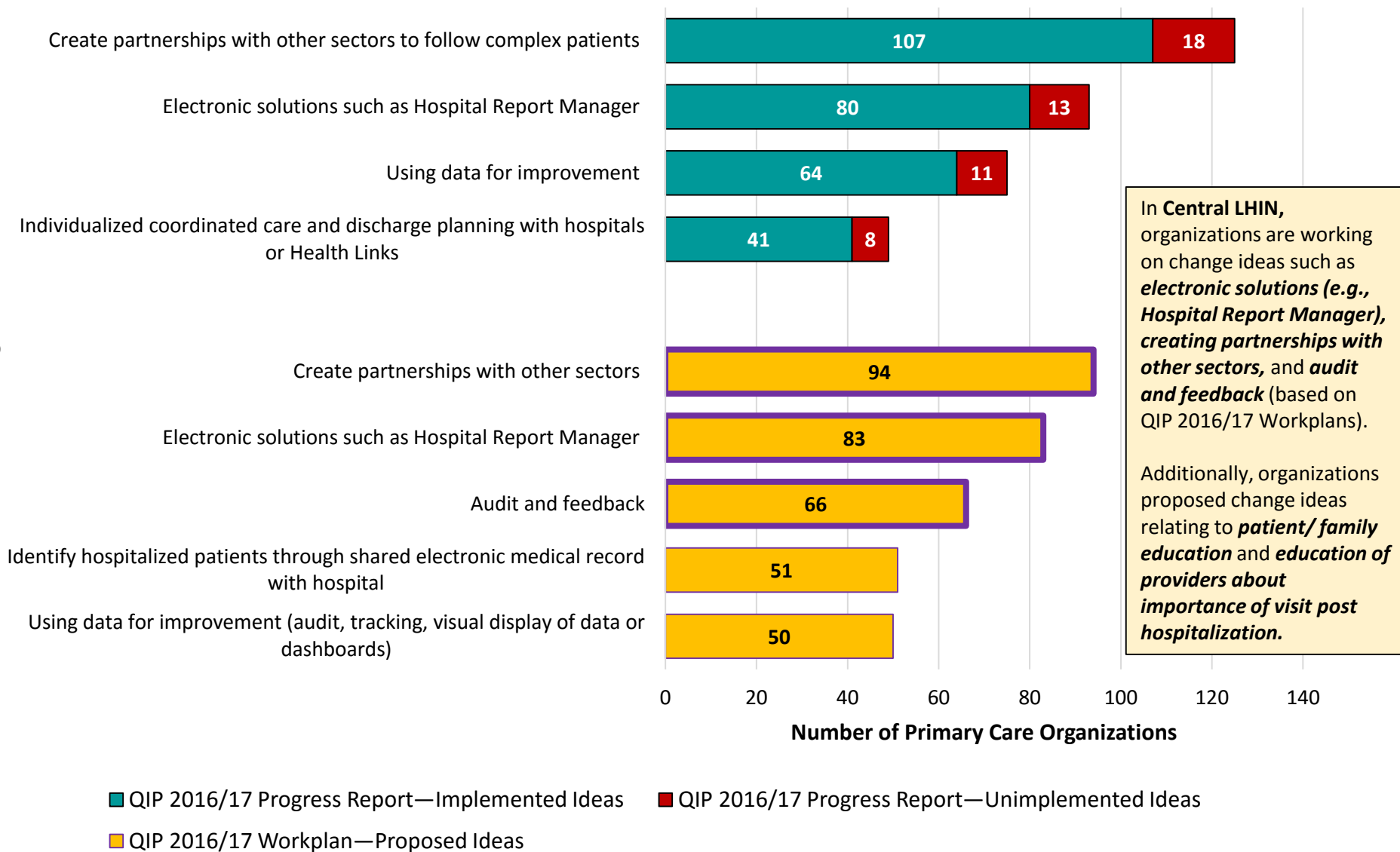


In Central LHIN, organizations are working on change ideas such as **CCAC "Home First" philosophy and programs, optimal discharge - use of predictive models, bed utilization management, and audit and feedback** (based on QIP 2016/17 Workplans).

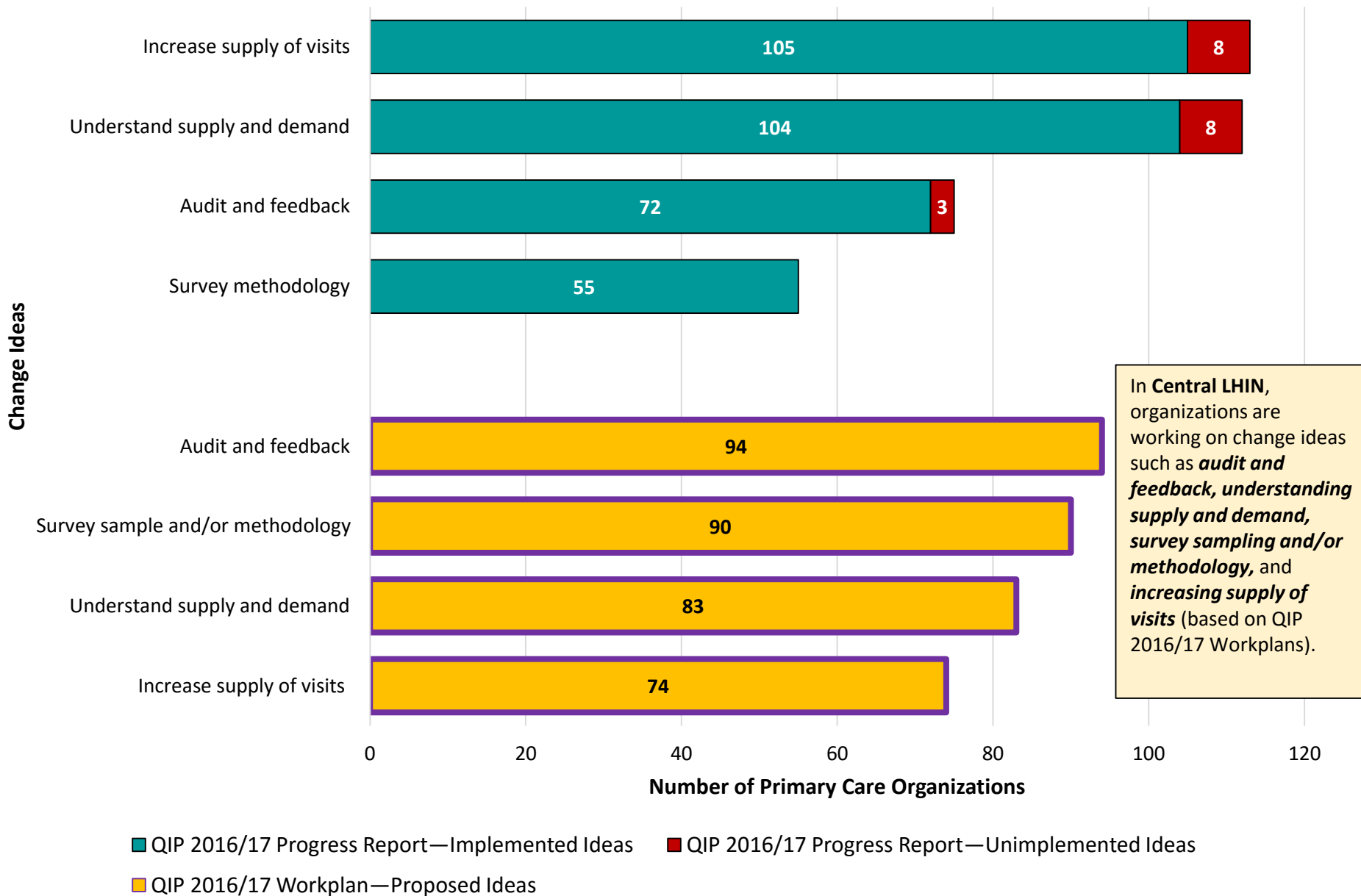
Additionally, organizations proposed change ideas relating to the **"assess and restore" philosophy and function.**

\* The information presented combines data submitted by organizations on the following Alternative Level of Care indicators: Alternative Level of Care Rate—Acute, and Percent Alternative Level of Care Days.

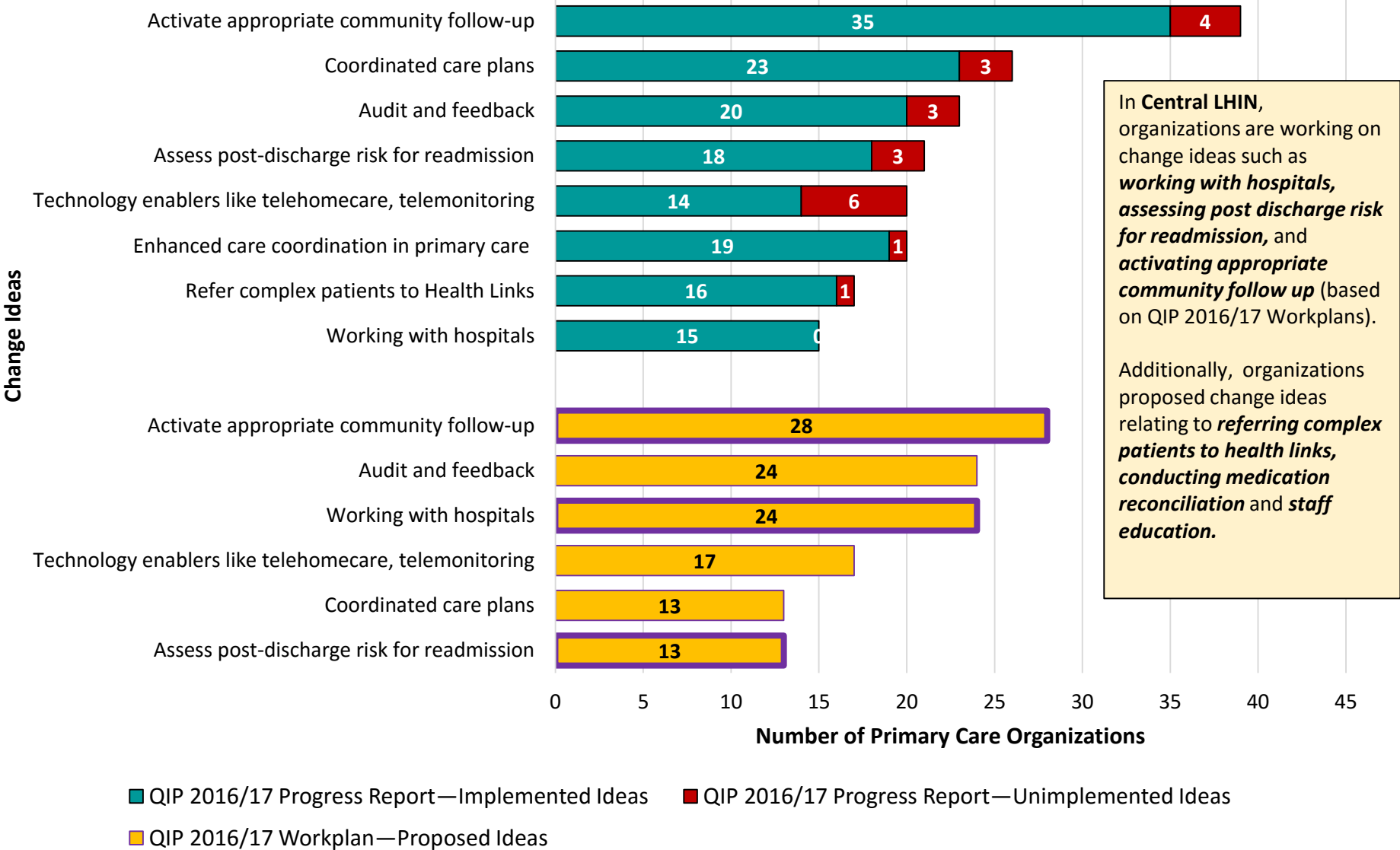
## Most common change ideas in Ontario from 2015/16 and 2016/17 primary care QIPs for 7-Day Post-Hospital Discharge Follow-Up Rate for Selected Conditions, as reported in the 2016/17 QIPs



# Most common change ideas in Ontario from 2015/16 and 2016/17 primary care QIPs for Timely Access to a Primary Care Provider, as reported in the 2016/17 QIPs

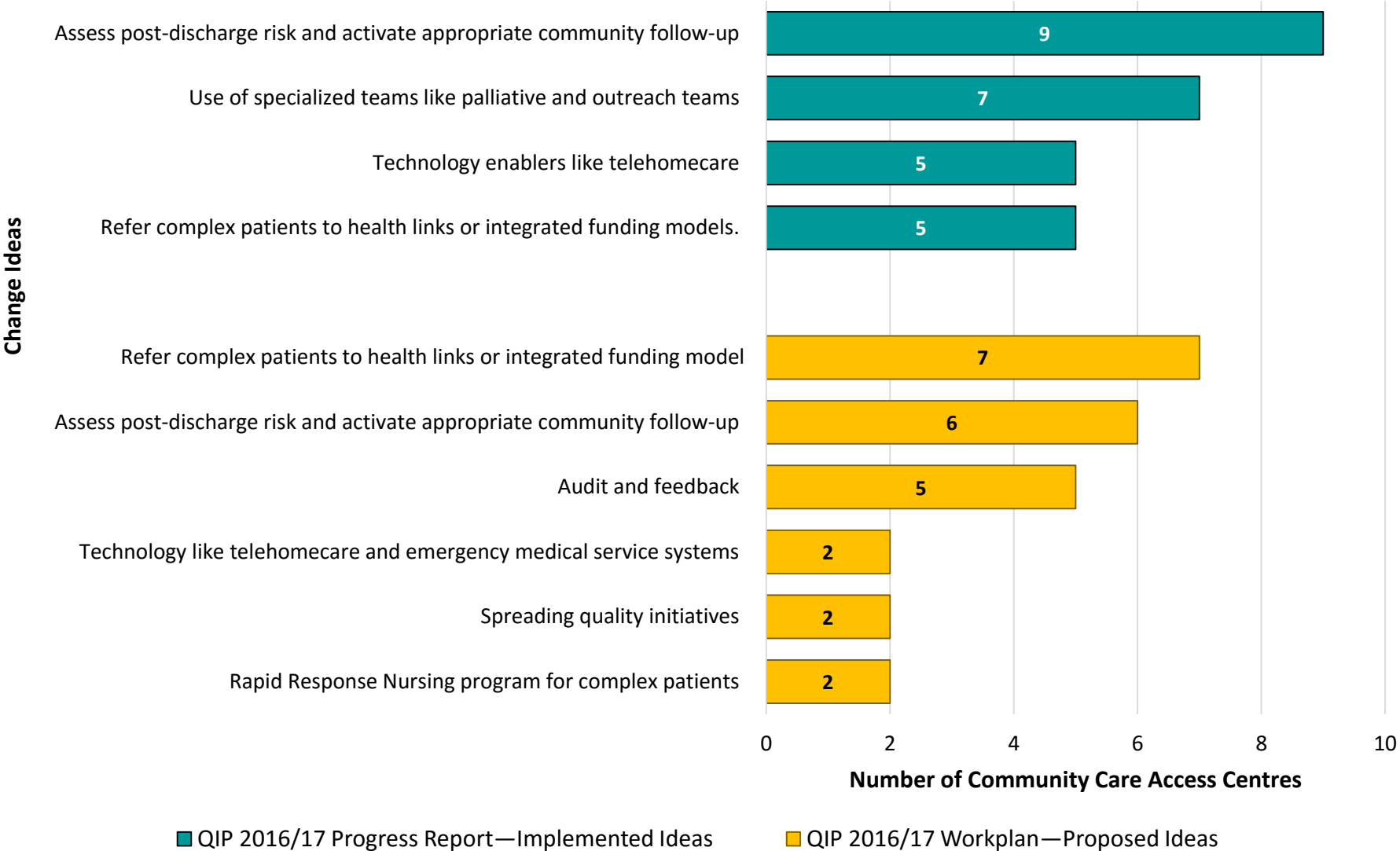


# Most common change ideas in Ontario from 2015/16 and 2016/17 primary care QIPs for Readmission Within 30 Days for Selected HBAM Inpatient Groupers, as reported in the 2016/17 QIPs

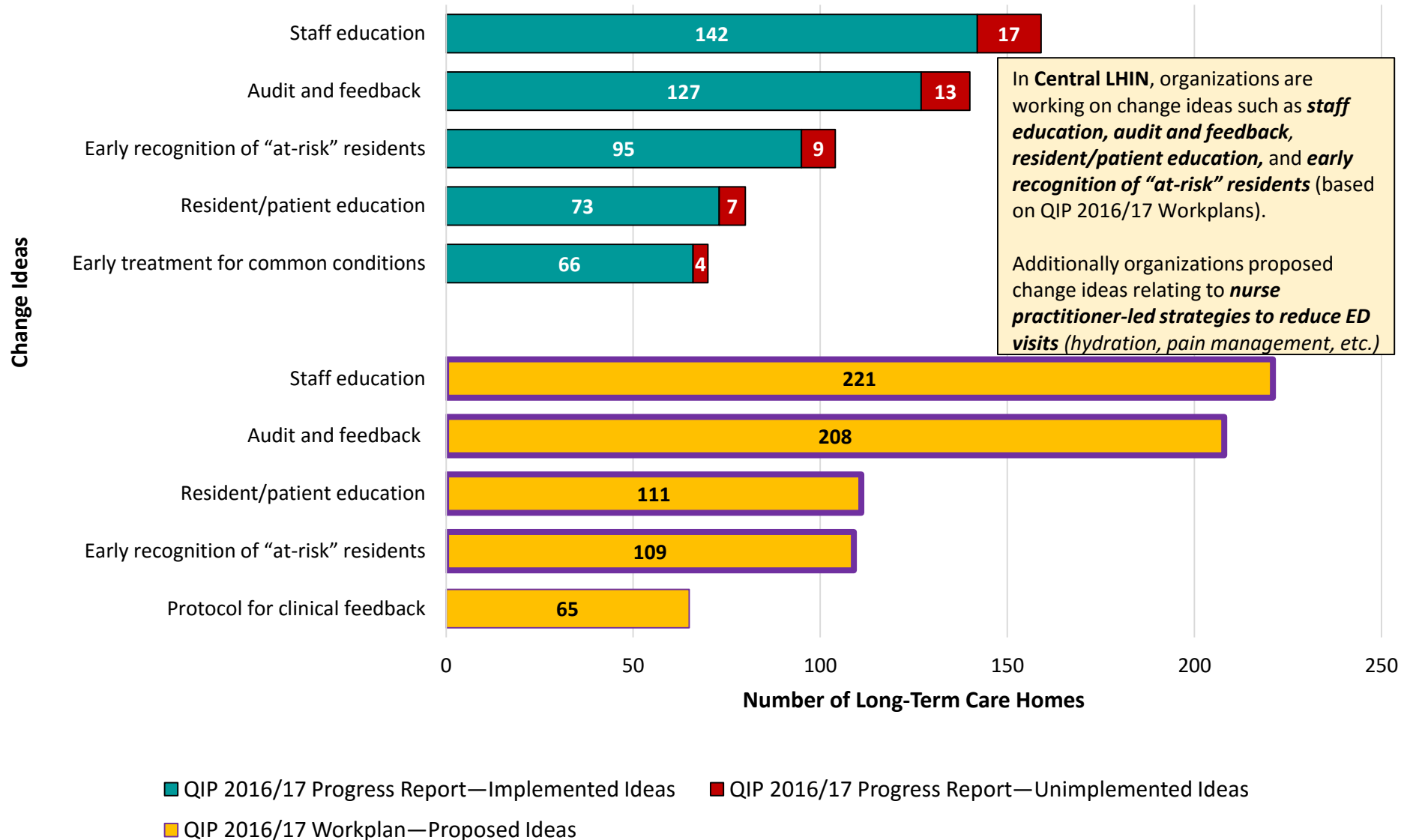




# Most common change ideas in Ontario from 2015/16 and 2016/17 QIPs for Hospital Readmissions for Community Care Access Centres, as reported in the 2016/17 QIPs



# Most Common Change Ideas in Ontario from 2015/16 and 2016/17 Long-Term Care QIP for Potentially Avoidable Emergency Department Visits for Long-Term Care Residents, as reported in 2016/17 QIP



In Central LHIN, organizations are working on change ideas such as *staff education, audit and feedback, resident/patient education, and early recognition of “at-risk” residents* (based on QIP 2016/17 Workplans). Additionally organizations proposed change ideas relating to *nurse practitioner-led strategies to reduce ED visits (hydration, pain management, etc.)*

# SPOTLIGHTS

# Reducing Emergency Department (ED) Visits

## Union Villa Long-Term Care and Markham Stouffville Hospital

- Union Villa Long-Term Care Collaborated with Markham Stouffville Hospital (MSH) in an Improving & Driving Excellence Across Sectors (IDEAS) project and to decrease potentially avoidable emergency department (ED) transfers and increase communication between hospitals and long-term care homes (LTCH)
- A MSH/LTCH Joint Committee has been formed, and currently meets quarterly
- The organizations used the generalized SBARD (Situation, Background, Assessment, Recommendation, Decision) tool, which is designed to improve the care of the patient/resident between the two sites
- To date, there has been no general consensus of what is a potentially avoidable transfer and improvement of communication between the two sites

# Reducing Pressure Ulcers Through Partnership

## Southlake Regional Health Centre

### Aim:

- To reduce new pressure ulcers stage two or higher by 39% (from 6.4% to 3.9%)

### Change ideas:

- Analyzed the data and high performing units
- Hourly rounding and increasing the number of nurses who have completed the Nurse Certificate Program in Pressure Ulcer Staging
- Chart audits for all patients who develop a pressure ulcer (stage 2 or greater)
- Engaged peer hospitals to share incidence data to identify improvement opportunities
- In 2013, implemented the use of heel boots for patients at risk for heel ulcers, and achieved *zero* heel ulcers

### Results:

Improvement of 52% exceeding our target with a rate of 3.1%.

- Further investment in bed surfaces, and new beds, has been made to help drive this rate even lower

# Reducing Readmissions

## Central CCAC

### Change Ideas:

- Implemented best practices for transitions from hospital to home for complex patients
- Expanded emergency department notification tested at North York General Hospital to Markham Stouffville Hospital

### Potential Challenge:

- Lack of timely data available to help determine which changes ideas have contributed to improvement

# Improving Transitions in Care

## Markham Family Health Team

- The Markham Family Health Team developed a “Transitions Program,” designed to ensure optimal communication between the their practice and their local hospital (Markham Stouffville Hospital)
- The program is intended to facilitate a smooth and seamless transition from MSH back to primary care
- The program’s Registered Nurse will often visit the patient in hospital to facilitate the discharge process and may do a follow-up home visit following discharge, which enables a more timely reassessment by the patient's primary care provider, where necessary

# Improving Patient Engagement

## Woodbridge Medical Centre Family Health Team

- The practice implemented a new role for a Patient Relations Coordinator in 2015 to:
  - Provide support for new patients
  - Become oriented with the clinic
  - Receive information regarding all aspects of the clinic
  - Receive assistance to register themselves and their families with the family health team
- The Patient Relations Coordinator is the patient liaison, providing an outlet for sharing concerns, experiences or suggestions, creating a structure and process to identify gaps between patient expectations and experiences
- All matters are handled openly, honestly, and with the utmost confidentiality and sensitivity



# DISCUSSION

# Discussion Points

Based on the LHIN 2016/17 QIP Snapshot Report:

- What are your overall impressions about the quality initiatives underway in your LHIN as reflected in the QIPs?
- Were there any “Aha” moments (positive or negative)?
- Did you observe any gaps or areas for improvement across the LHIN?
- How might this information be useful for your LHIN?
- How does this information tie into the LHIN’s Integrated Health Services Plan and the Regional Quality Table?



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