

Central East 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 East LHIN Overview

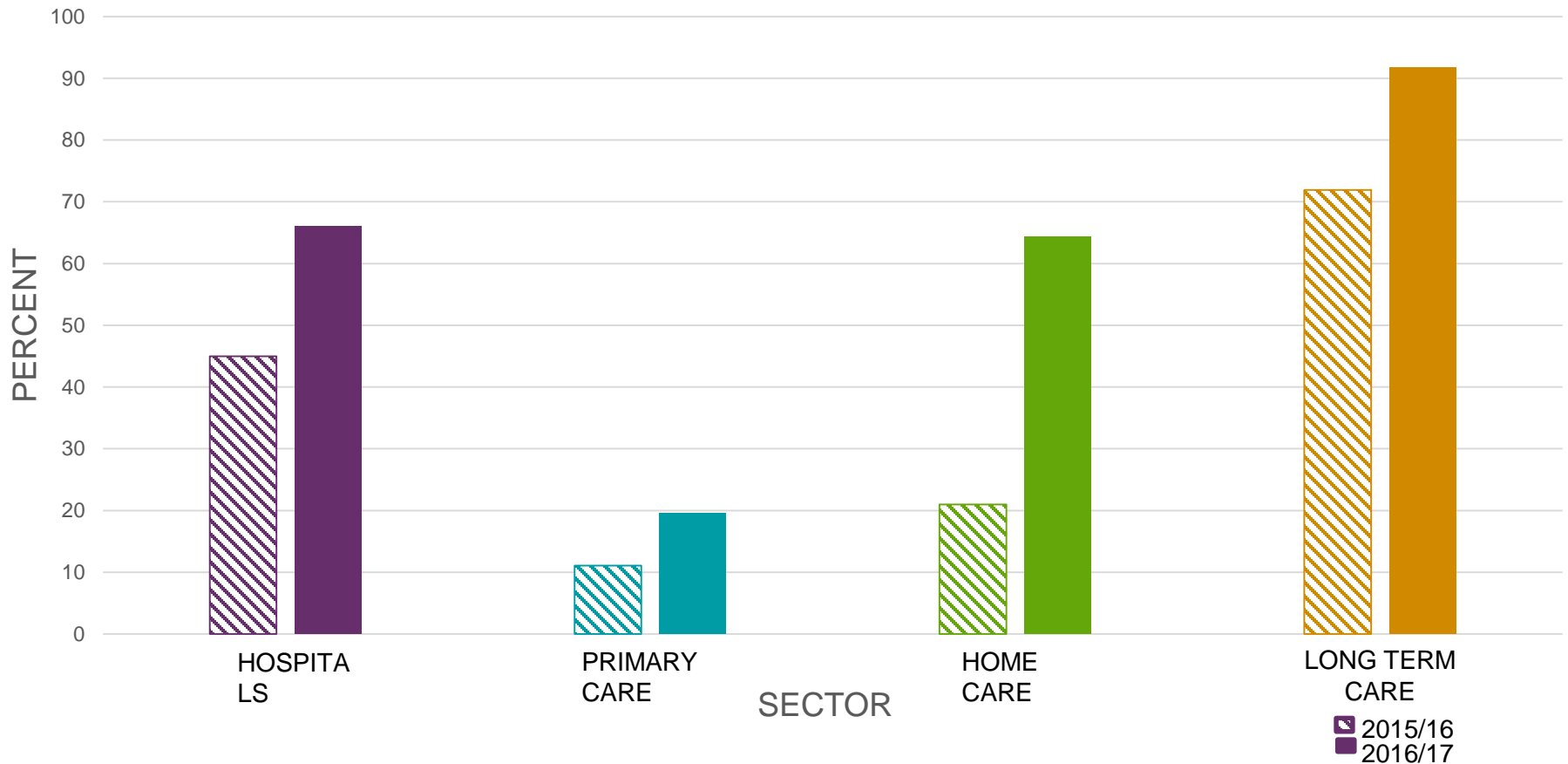
Sector	QIP Count	Description
Hospitals	8	<ul style="list-style-type: none"> • 6 large community • 1 small community • 1 mental health
Primary Care	21	<ul style="list-style-type: none"> • 10 Family Health Teams • 8 CHCs • 3 NPLCs
Community	1	<ul style="list-style-type: none"> • CCAC
Long-Term Care	68	<ul style="list-style-type: none"> • 11 Not-for-profit homes • 47 For-profit homes • 10 municipal
Multi-sector	1	<ul style="list-style-type: none"> • Haliburton Highlands Services Corporation

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.

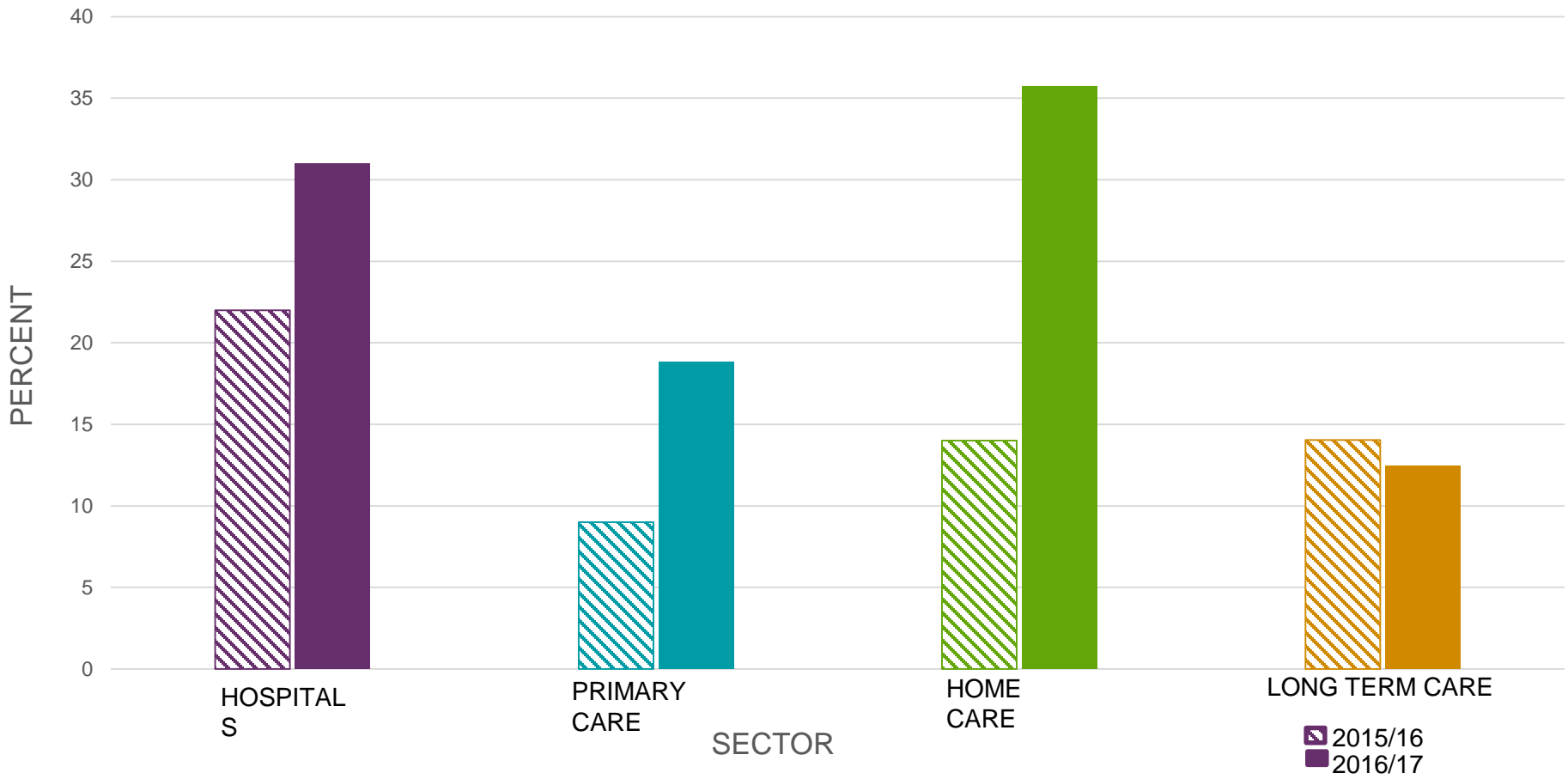
All sectors described an increased use of Patient and Family Advisory Councils and Forums in the development of their QIPs

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

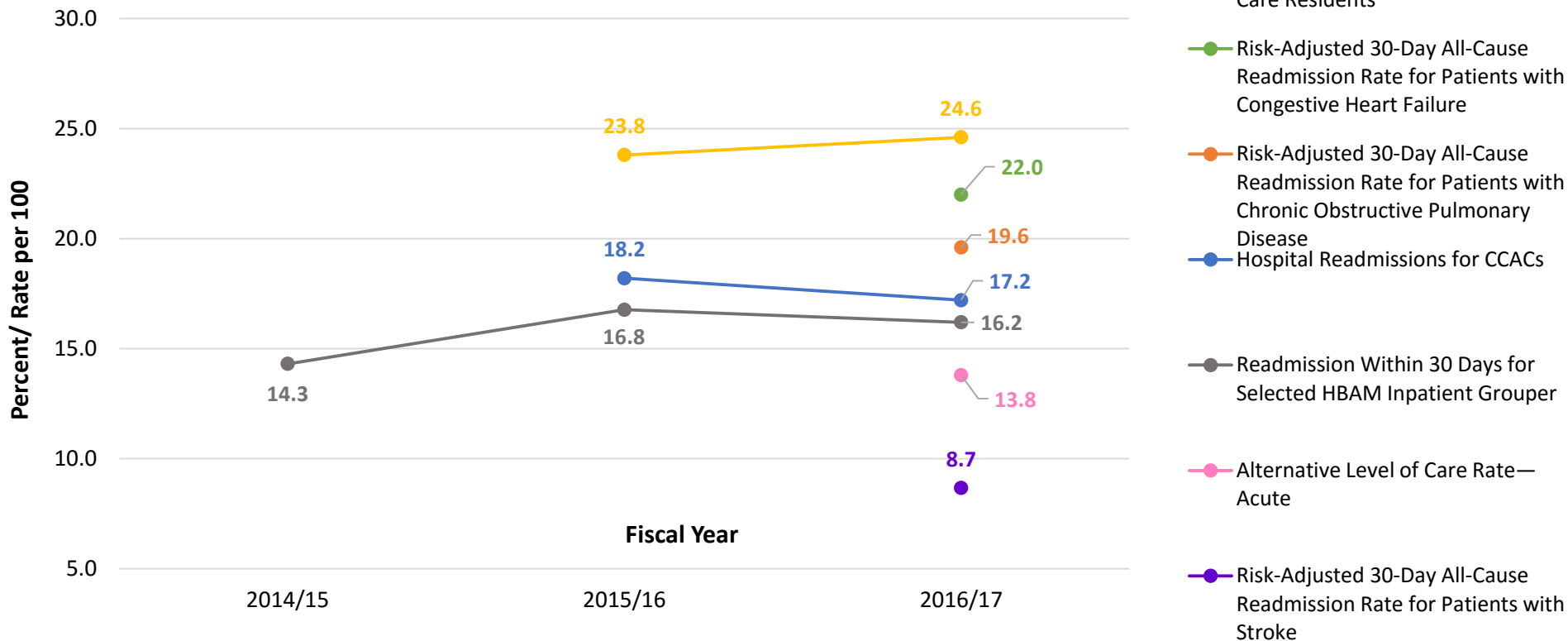
- **Hospitals:** The area where the most hospitals reported progress was emergency department length of stay (61% of hospitals reporting progress), followed by positive patient experience (recommend hospital; 60% of hospitals reporting progress).
- **Primary care:** The area where the most primary care 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.

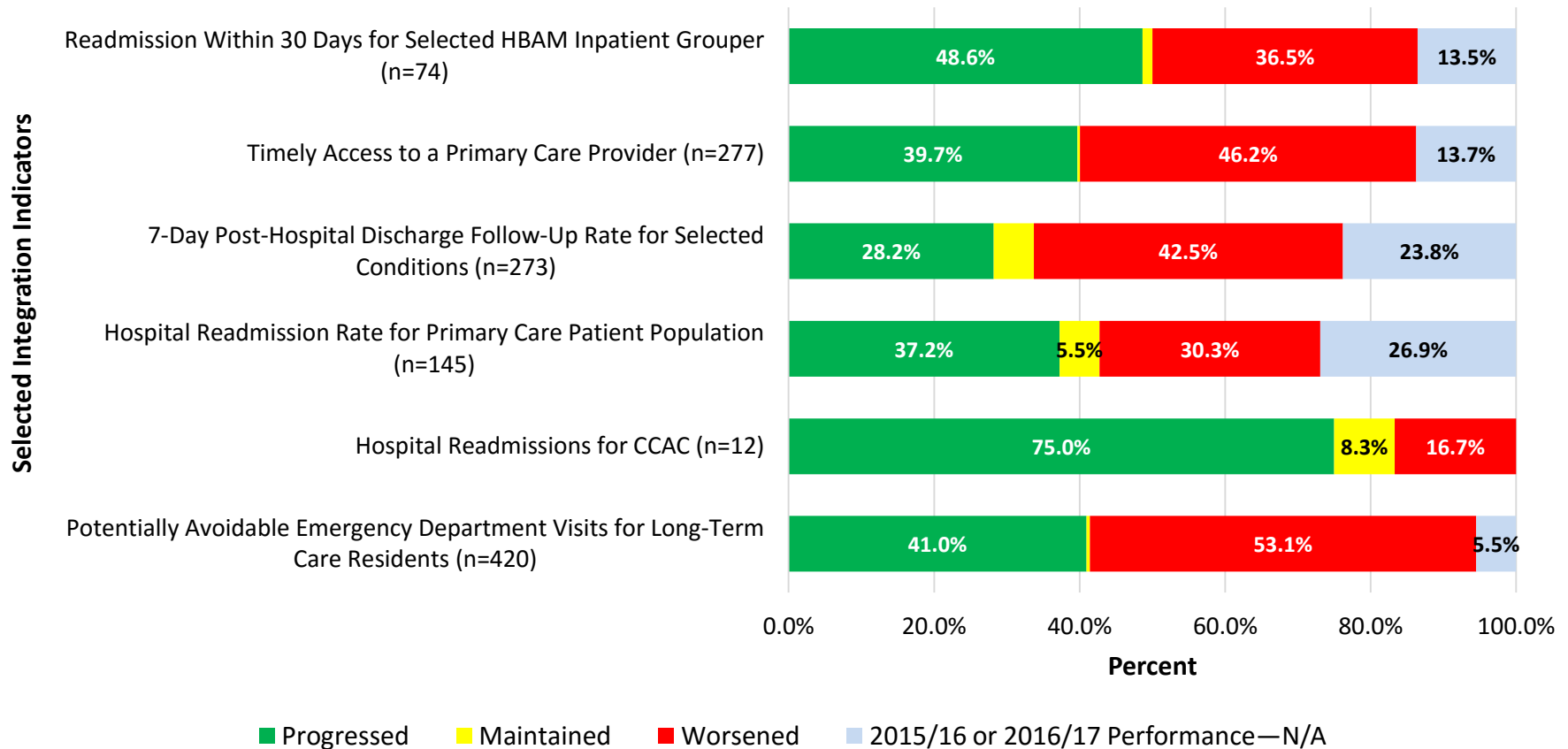
Risk-Adjusted 30-Day All-Cause Readmission Rate for Patients with Congestive Heart Failure; Risk-Adjusted 30-Day All-Cause Readmission Rate for Patients with Chronic Obstructive Pulmonary Disease, Readmission Within 30 Days for Selected HBAM Inpatient Groupers, Risk-Adjusted 30-Day All-Cause Readmission 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

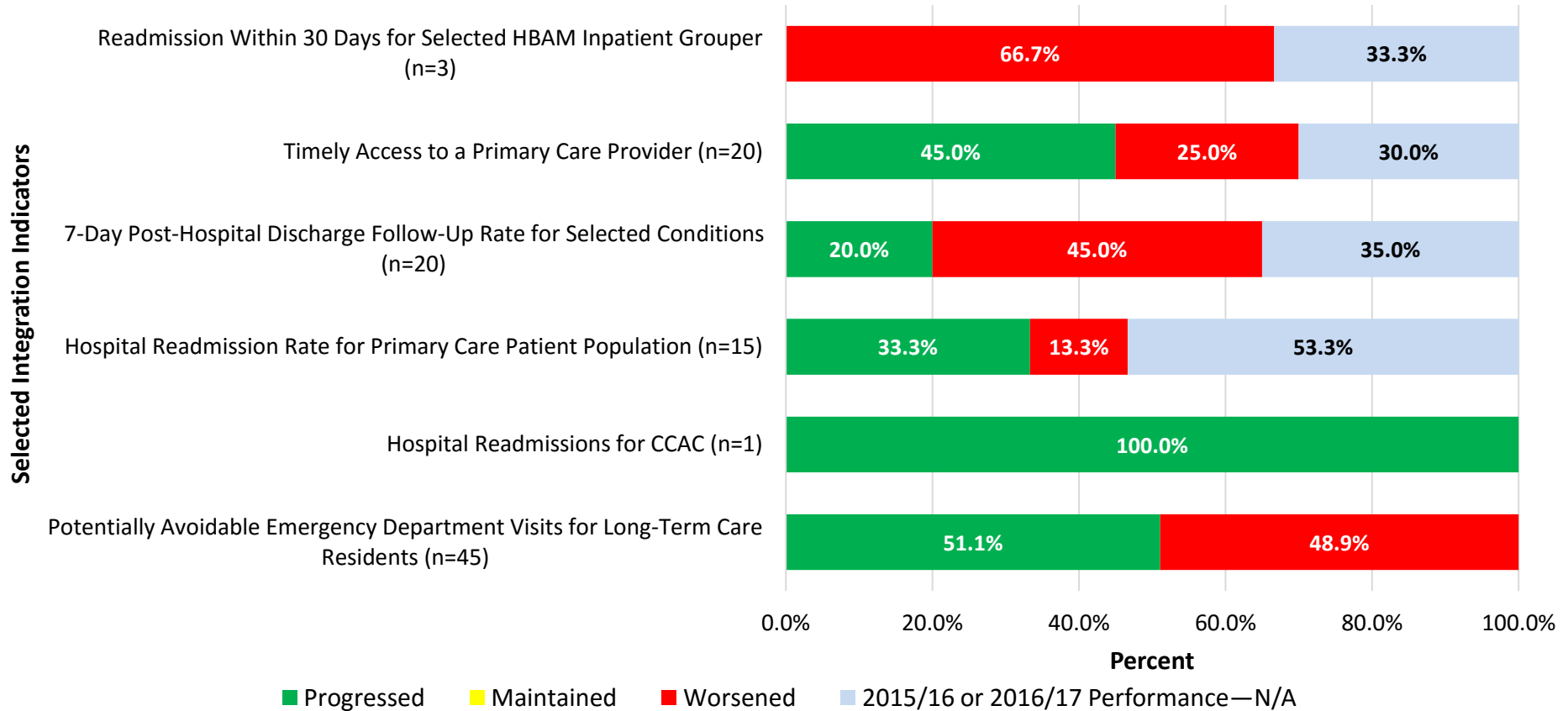
Looking back: Percentage of organizations in Ontario that progressed, maintained or worsened their performance between the 2015/16 QIP and the 2016/17 QIP on selected integration indicators, as reported in the QIP 2016/17 Progress Report



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 East LHIN QIP Data: Progress Made in 2016/17

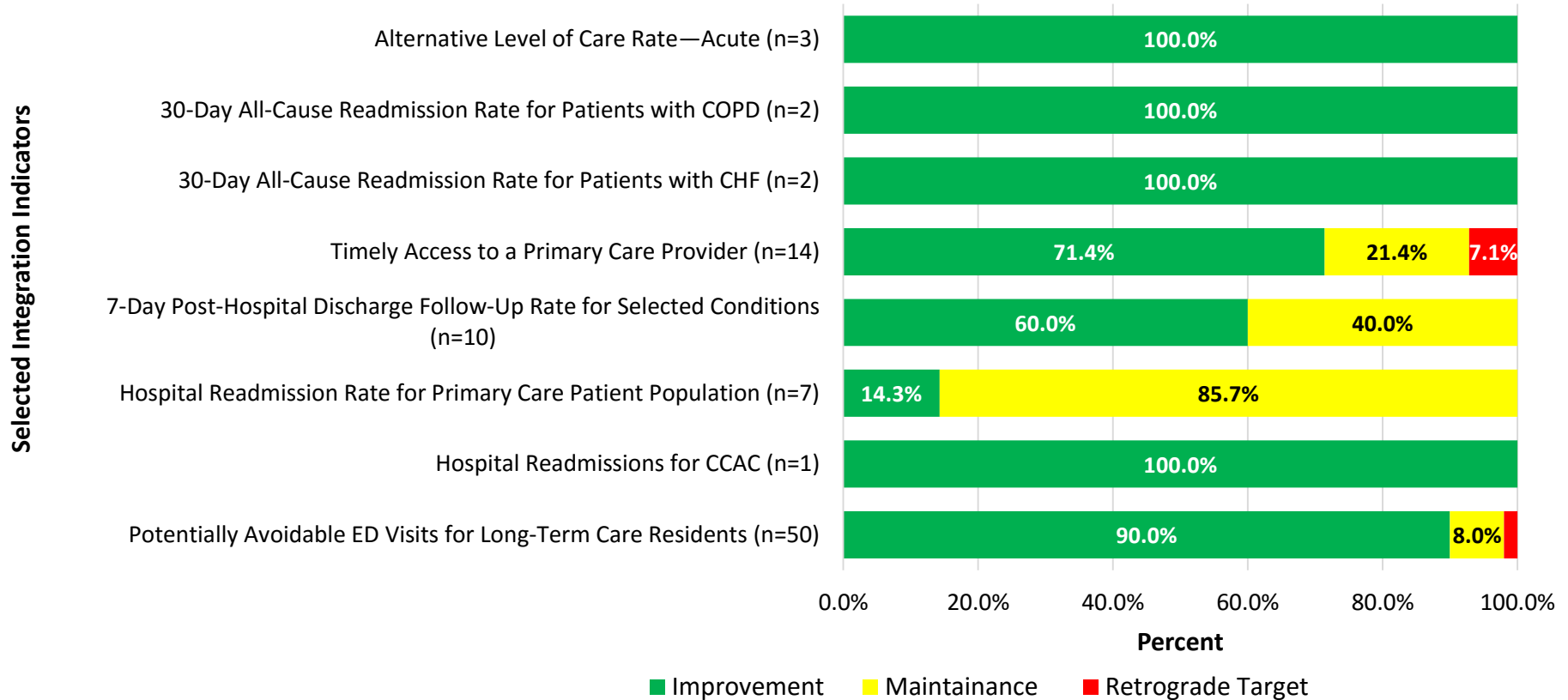
Looking back: Percentage of organizations in Central East LHIN that progressed, maintained or worsened in their performance between the 2015/16 QIP and the 2016/17 QIP on selected integration indicators, as reported in the 2016/17 QIP Progress Report



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 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 East LHIN QIP Data: Target Setting in 2016/17

Looking forward: Percentage of organizations in Central East 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 East LHIN QIP Data: 2016/17 Indicator Selection

Sector	General Areas of Focus: Integration Indicators	Current Performance CE LHIN Average	Current Performance Provincial Average	Indicator Selection: QIP 2016/17
Hospital/ Acute Care	i. 30-Day All-Cause Readmission Rate for Patients with Congestive Heart Failure (QBP)	22.48%	22.00%	2/9
	ii. 30-Day All-Cause Readmission Rate for Patients with Chronic Obstructive Pulmonary Disease (QBP)	18.55%	19.60%	2/9
	iii. 30-Day All-Cause Readmission Rate for Patients with Stroke (QBP)	8.49%	8.67%	0/9
	iv. Readmission Within 30 days for Selected HBAM Inpatient Grouper (HIGs)	16.68%	16.19%	0/9
	v. Alternate Level of Care Rate – Acute (ALC Rate)	17.73%	13.84%	3/9
Primary Care	i. 7-day Post-hospital Discharge Follow-Up Rate for Selected Conditions	N/A**	N/A**	17/20
	ii. Access to primary care (survey-based)	N/A**	N/A**	18/20
	iii. Hospital Readmission Rate for Primary Care Patient Population	N/A**	N/A**	11/20
Community Care Access Centres	i. Hospital Readmissions	17.33%	17.23%	1/1
Long Term Care	i. ED visits for Ambulatory Care Sensitive conditions	25.90%	24.55%	50/68

* 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 CE LHIN:

- 5 Hospitals selected a custom indicator related to *30- Day Readmission Rate* (A combined designation for all four 30-Day Readmissions indicators)
- 1 Hospital selected a custom indicator related to *Alternate Level of Care Rate*
- 1 Primary Care Organization selected a custom indicator related to *Hospital Readmission Rate for Primary Care Patient Population*
- 1 Primary Care Organization selected a custom indicator related to *Access to primary care*

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

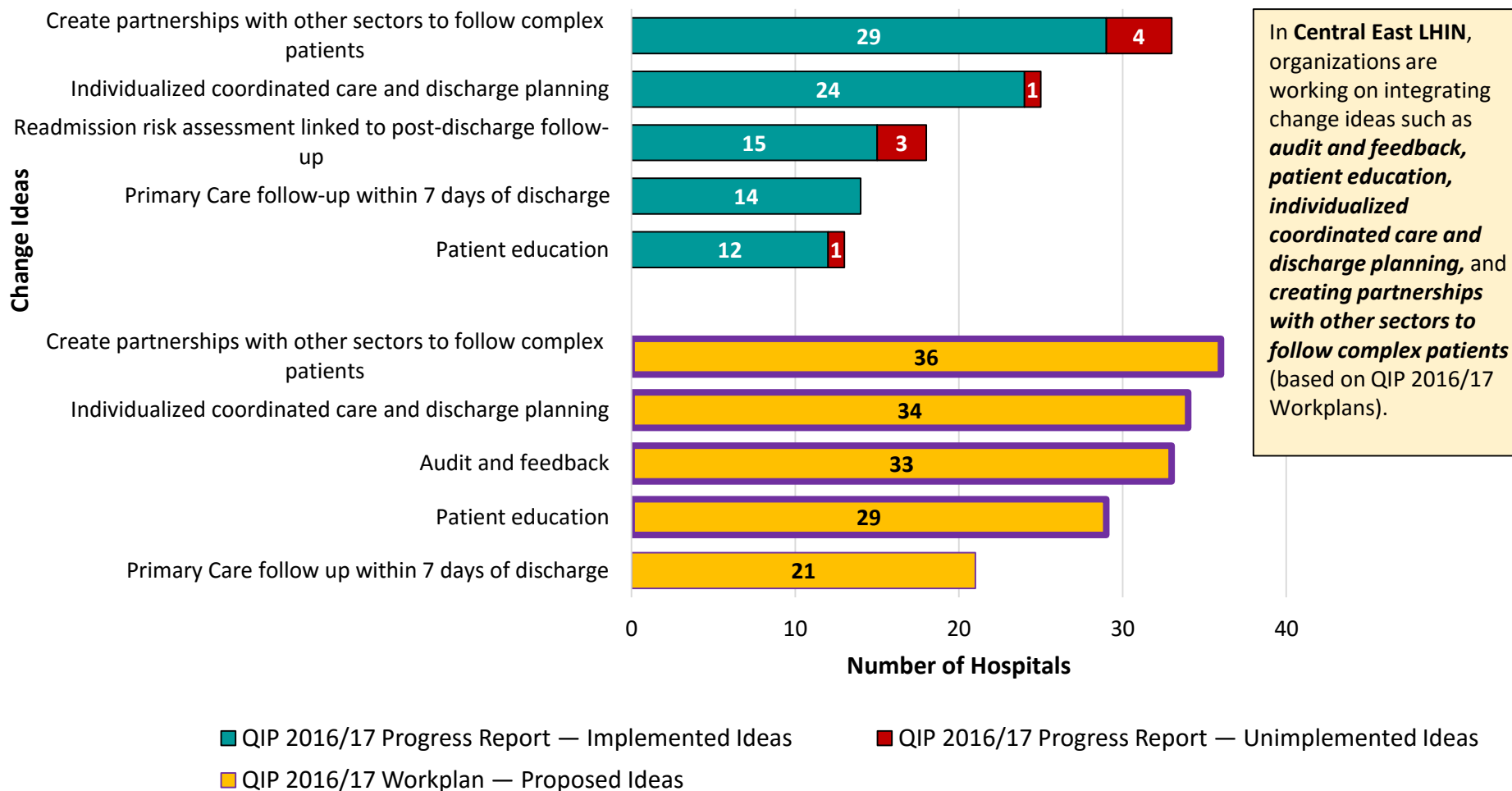
Note: Interpret data with caution; please refer to Technical Specifications; for instance, the three QBP indicators and the Readmissions HIG indicator are risk-adjusted, while the rest are not risk-adjusted.

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

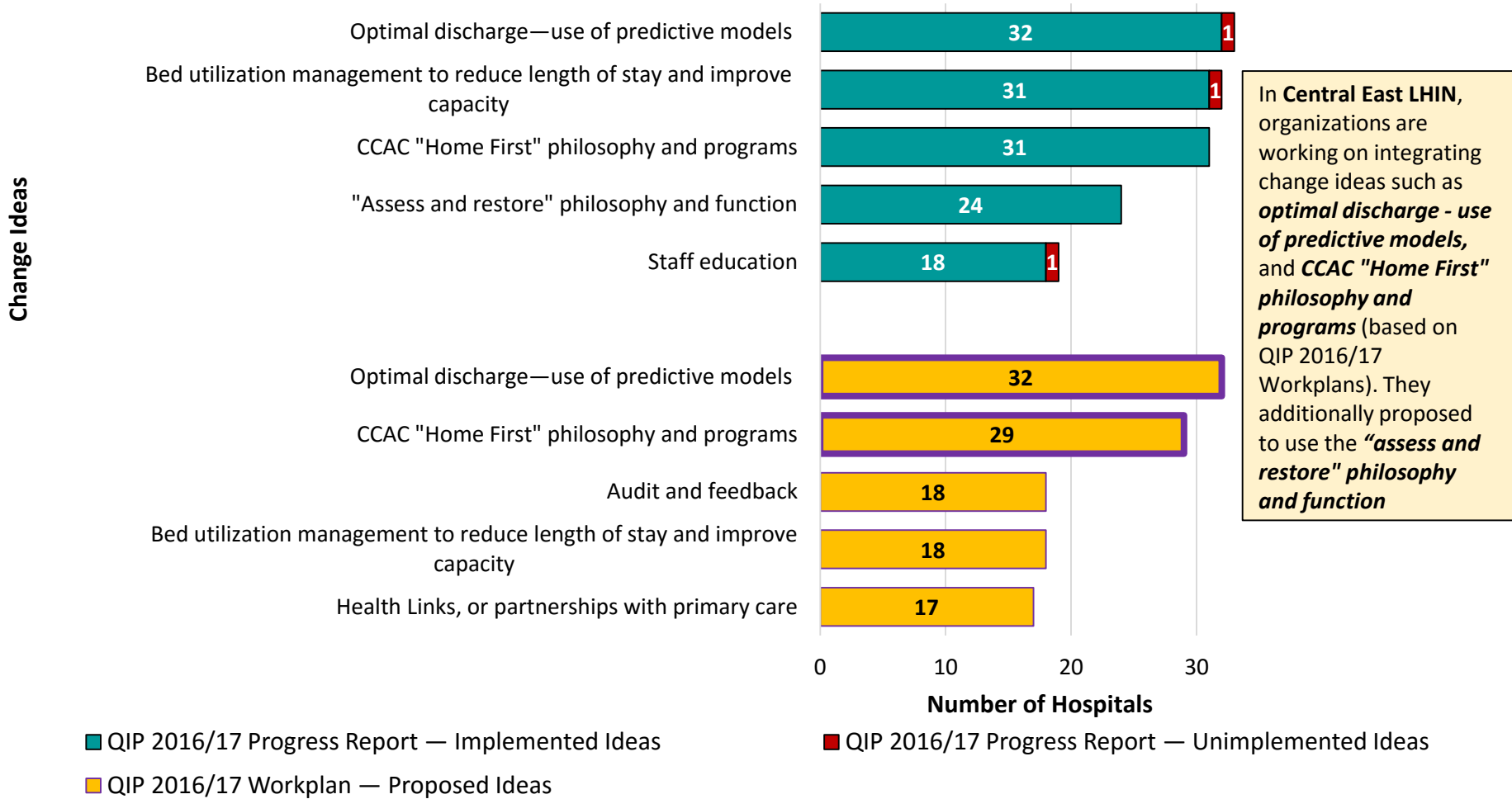
Most common change ideas in Ontario from 2015/16 and 2016/17 hospital QIPs for 30-Day Readmission Rate,* as reported in the 2016/17 QIPs



In Central East LHIN, organizations are working on integrating change ideas such as **audit and feedback, patient education, individualized coordinated care and discharge planning, and creating partnerships with other sectors to follow complex patients** (based on QIP 2016/17 Workplans).

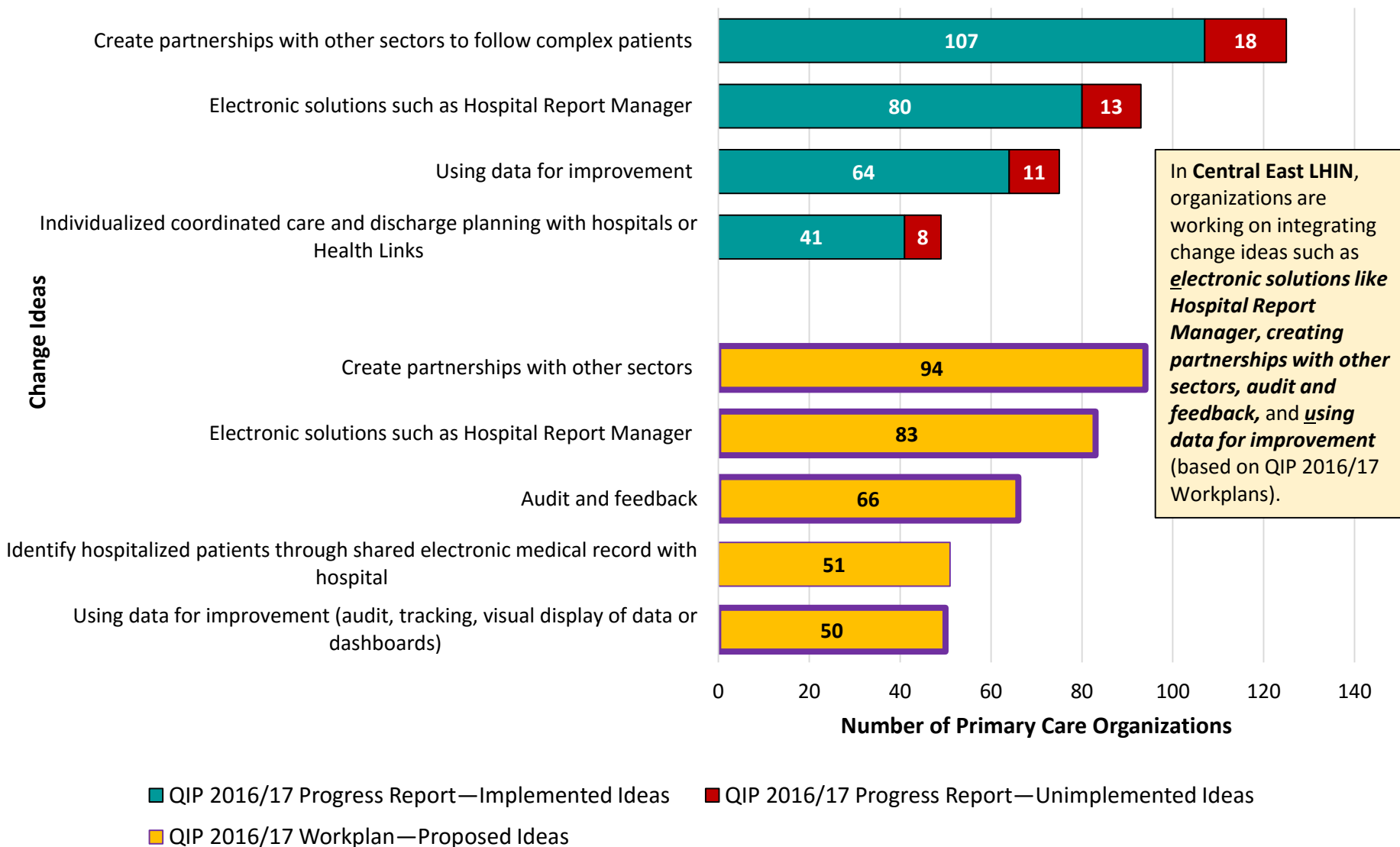
* The information presented combines data submitted by organizations on the following four 30-day readmission indicators: 30-Day All-Cause Readmission Rate for Patients with Congestive Heart Failure, 30-Day All-Cause Readmission Rate for Patients with Chronic Obstructive Pulmonary Disease, 30-Day All-Cause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

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

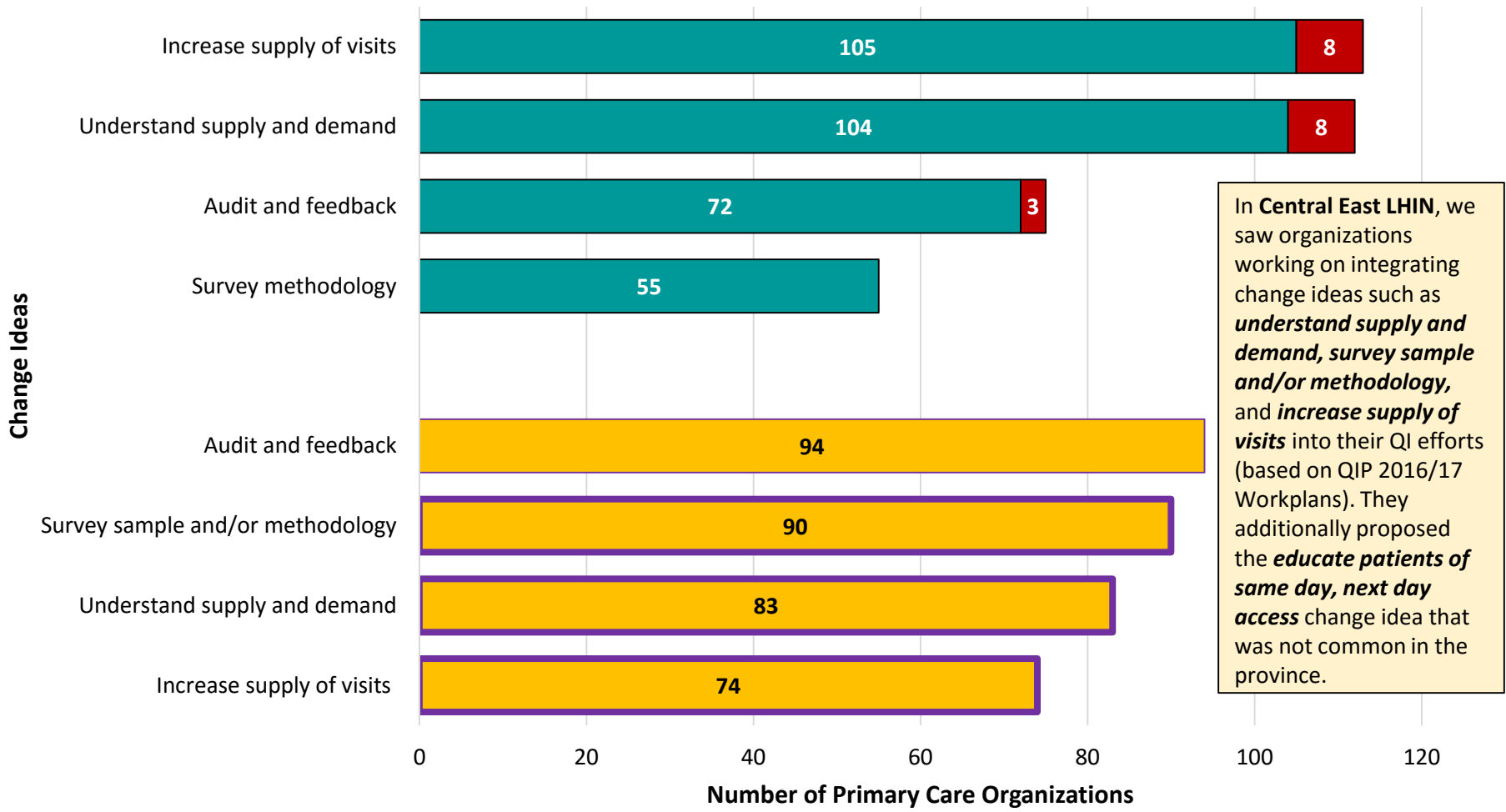


* The information presented combines data submitted by organizations on the following alternative level of care indicators: Alternative Level of Care Rate—Acute, and Percent Alternative Level of Care Days.

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



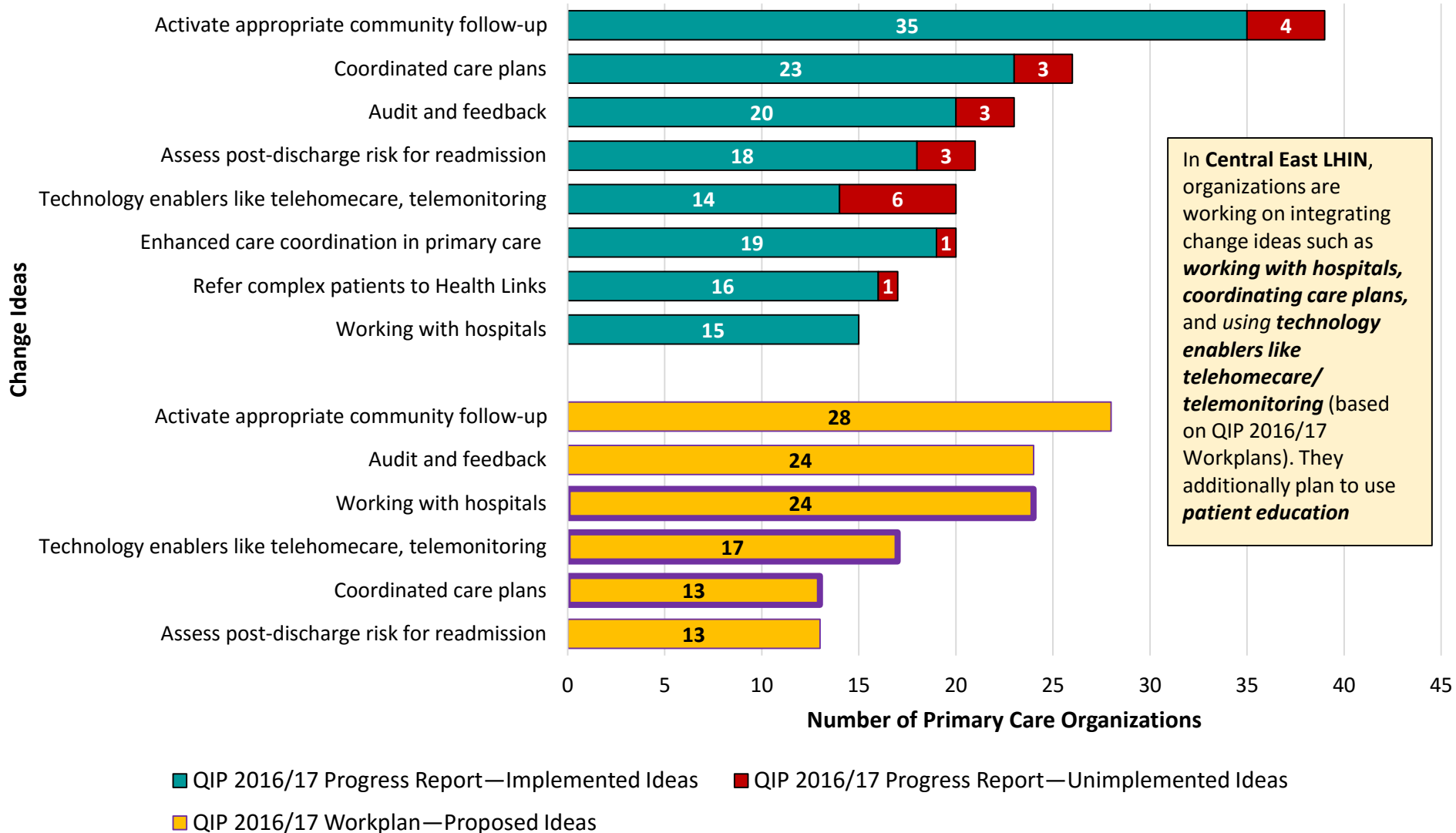
Most common change ideas in Ontario from 2015/16 and 2016/17 primary care QIPs for Timely Access to a Primary Care Provider, as reported in the 2016/17 QIPs



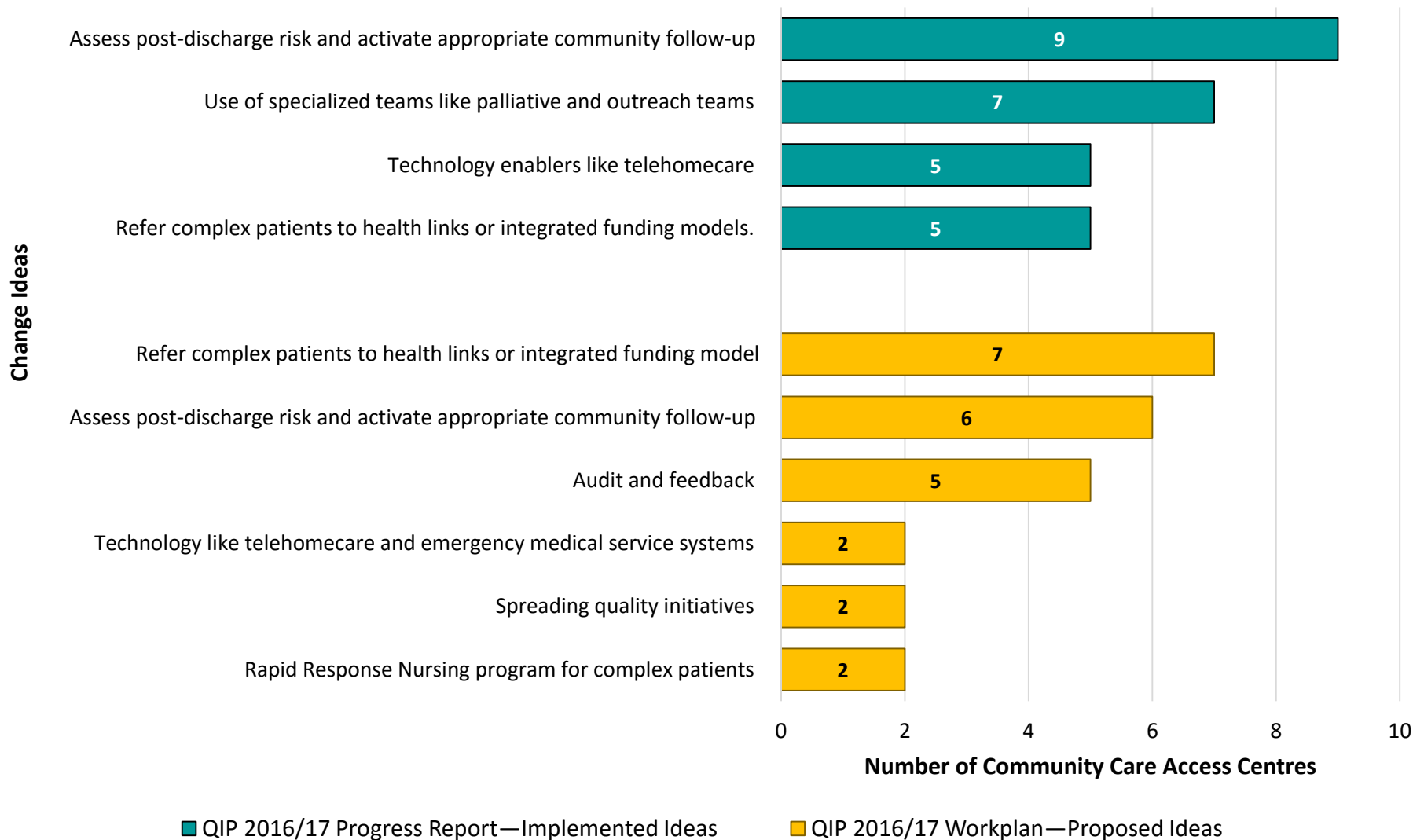
In Central East LHIN, we saw organizations working on integrating change ideas such as *understand supply and demand, survey sample and/or methodology, and increase supply of visits* into their QI efforts (based on QIP 2016/17 Workplans). They additionally proposed the *educate patients of same day, next day access* change idea that was not common in the province.

■ QIP 2016/17 Progress Report—Implemented Ideas
 ■ QIP 2016/17 Progress Report—Unimplemented Ideas
■ QIP 2016/17 Workplan—Proposed Ideas

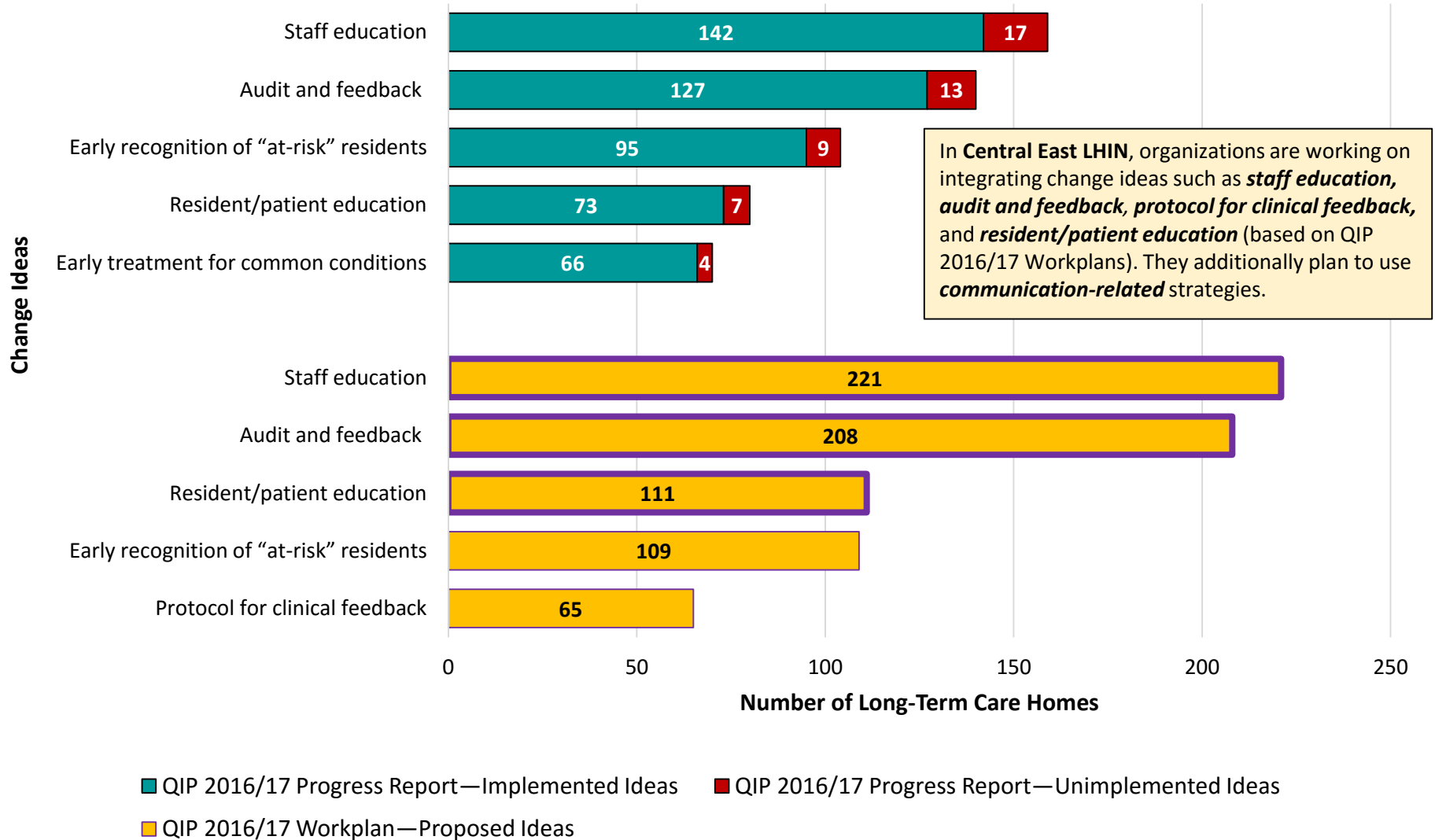
Most common change ideas in Ontario from 2015/16 and 2016/17 primary care QIPs for Readmission Within 30 Days for Selected HBAM Inpatient Groupers, as reported in the 2016/17 QIPs



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



SPOTLIGHTS

Improving Transitions in Care

The Scarborough Hospital (TSH)

- TSH will support the transition of patients from hospital to the community by pursuing leading models of interprofessional care and strengthening community partnerships
- One of the hospital's key change initiatives this year is to expand upon TSH's innovative ["Virtual Ward"](#) program and provide intensive restorative care that enables safe transitions home from the hospital.
- The Virtual Ward program is a partnership between TSH and CareFirst Seniors and Community Services Association and will be engaged in the "Strategies to Support Self-Management in Chronic Conditions, and Caregiving Strategies for Older Adults with Delirium, Dementia and Depression" best practice guidelines
- By leveraging their early adopter work in connectingGTA, TSH will continue to implement and deploy this eHealth project to share patient information electronically by connecting health care providers

Improving Mental Health Management

Ontario Shores

- The Centre for Addiction and Mental Health, Ontario Shores, The Royal, and Waypoint continue to collaborate and partner in several quality initiatives, including:
 - collectively reporting on key indicators for the mental health sector
 - embarking on a shared clinical initiative to collectively prevent and reduce the number of episodes (incidents) and time spent in restraints and seclusions in specialized mental health environments
 - sharing best practices and piloting a common set of bundled interventions in a program called the Restraint & Seclusion Prevention Minimization Project

Improving Equitable Access for the Mental Health Population

Canadian Mental Health Association (CMHA) Durham NPLC

- CMHA Durham's NPLC Outreach Program is an exciting new initiative that provides primary health care and mental health support (delivered by a Registered Nurse and a Case Manager) outside of the clinic setting
- Individuals are eligible for this program if they are a resident of Durham Region, do not have a primary care provider, and have a physical or psychological impairment that prevents them from accessing health care in traditional settings
- Services include bloodwork, annual reviews, physicals, chronic disease management, health screenings, cancer screenings, health teaching, medication management, injections and immunizations, mental health care, assistance with financial and residential supports, palliative care support, care coordination, coping and safe planning, as well as links to community resources

Collaborating to Improve Care for Complex Patients

Central East CCAC

- CCAC has partnered with the Aging, Community and Health Research Unit at McMaster University to evaluate the feasibility, acceptability, effects, and costs of a six month interprofessional community navigation and rehabilitation intervention compared to the usual home care services provided for stroke survivors having multiple chronic conditions
- The overall goal is to improve community reintegration and enhance health-related quality of life based on four main components:
 1. Strengths based practice
 2. Holistic care
 3. Engagement support through goal setting and care planning
 4. Collaborative practice

Reducing Emergency Department (ED) Visits

Lakeview Manor (Long-Term Care Home)

- Current quality improvement initiatives related to reducing ED visits:
 - Increase physician and registered nursing staff awareness and understanding of 1) the resident's advance care planning, and 2) the documented wishes of the patient and family in relation to declining Palliative Performance Scale (PPS) scores and end of life
 - Provide education and mentoring for all staff, and continue advance care planning discussions in all resident care conferences
 - Review and revise the SBAR (Situation-Background-Assessment-Recommendation) communication tool to include PPS and Edmonton Symptom Assessment system information, as well as advance care planning wishes (if known) and choices related to Do Not Resuscitate or Allow Natural Death

Hospital: Equity

The Scarborough Hospital (TSH)

- Health equity for Scarborough's disadvantaged and vulnerable population is of particular importance.
- To address disparities and better respond to the community's cultural and socioeconomic diversity, TSH will continue to evolve its Global Community Resource Centre, the only place of its kind among hospitals in the Greater Toronto Area.
 - The Centre is staffed by volunteers and representatives from 14 Scarborough community agencies.
 - Visitors can drop in, sit with agency staff and learn about their services.
 - They can also attend workshops on subjects like patients' rights and obligations, elder abuse, dementia, suicide prevention, finding appropriate housing, employment and diabetes management.

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?



www.HQOntario.ca

FOLLOW @HQOntario 