

Erie St Clair 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](#)

Erie St Clair LHIN Overview

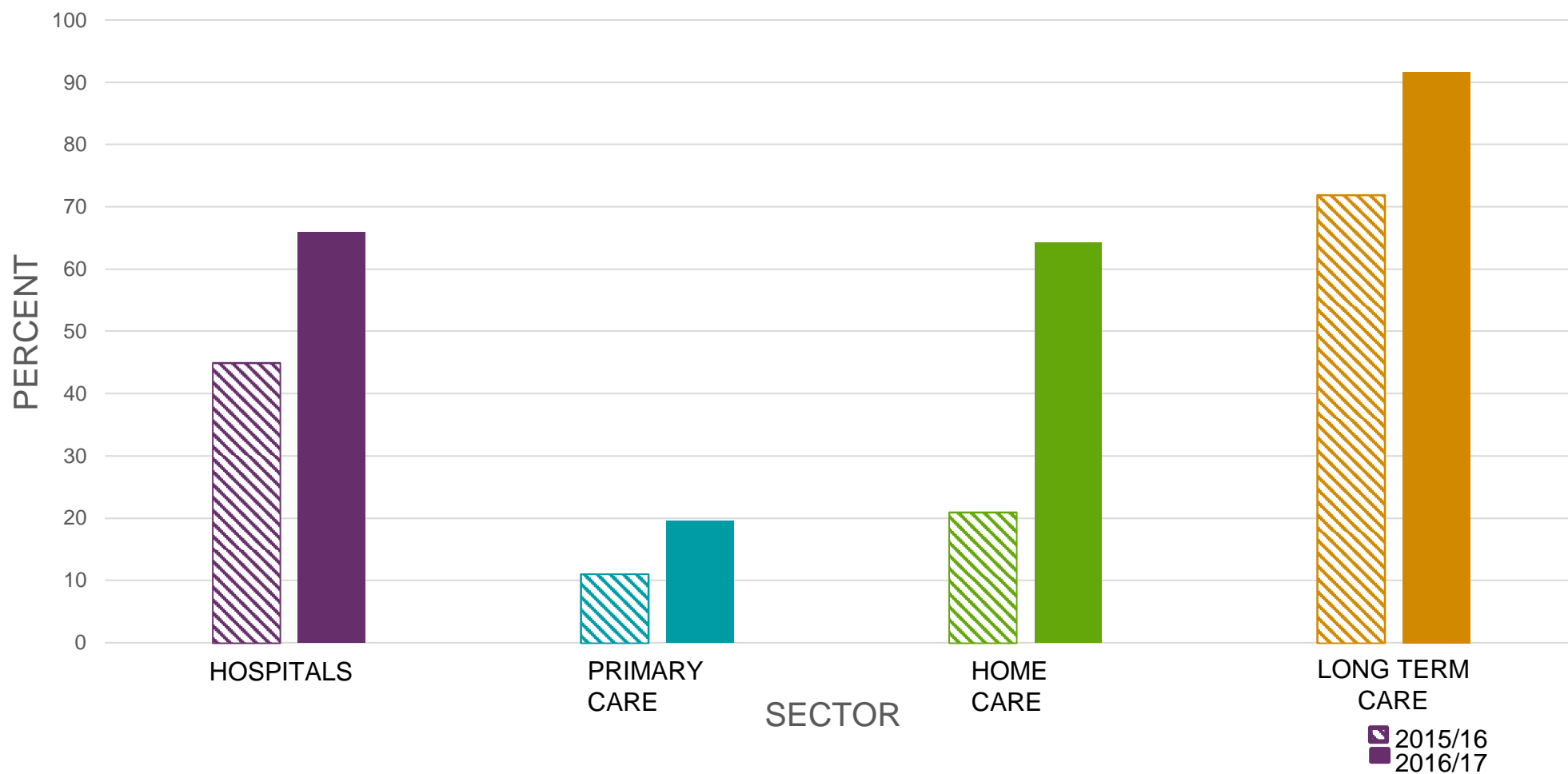
Sector	QIP Count	Description
Hospitals	5	" 5 large community hospitals
Primary Care	17	" 9 Family Health Teams " 5 Community Health Centers " 3 Nurse Practitioner Led Clinics
Community	1	" CCAC
Long-Term Care	37	" 2 not-for-profit " 29 for-profit " 6 municipal
Multi-sector	0	

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.

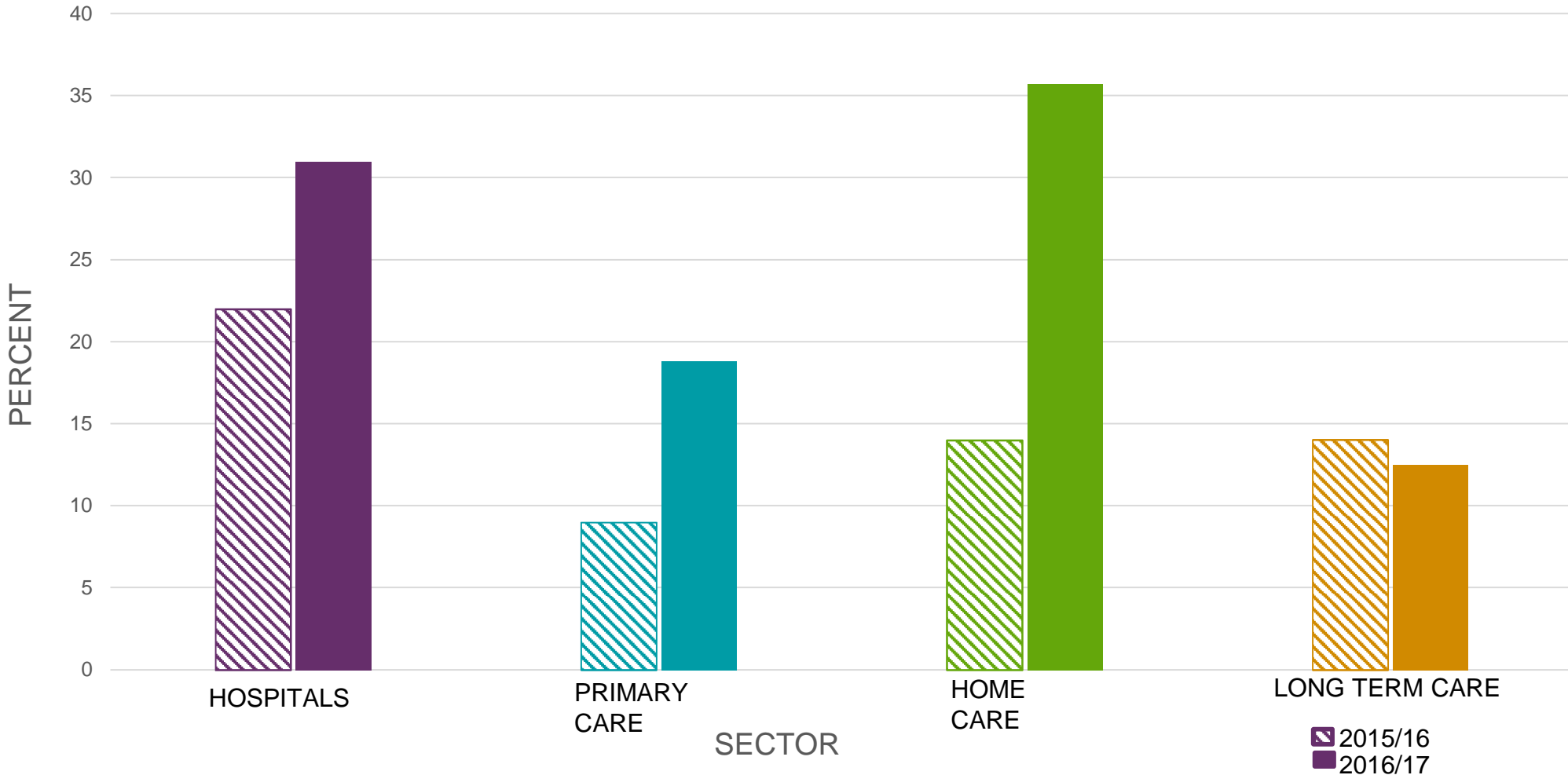
All sectors described an increased use of Patient and Family Advisory Councils and Forums in the development of their QIPs

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).

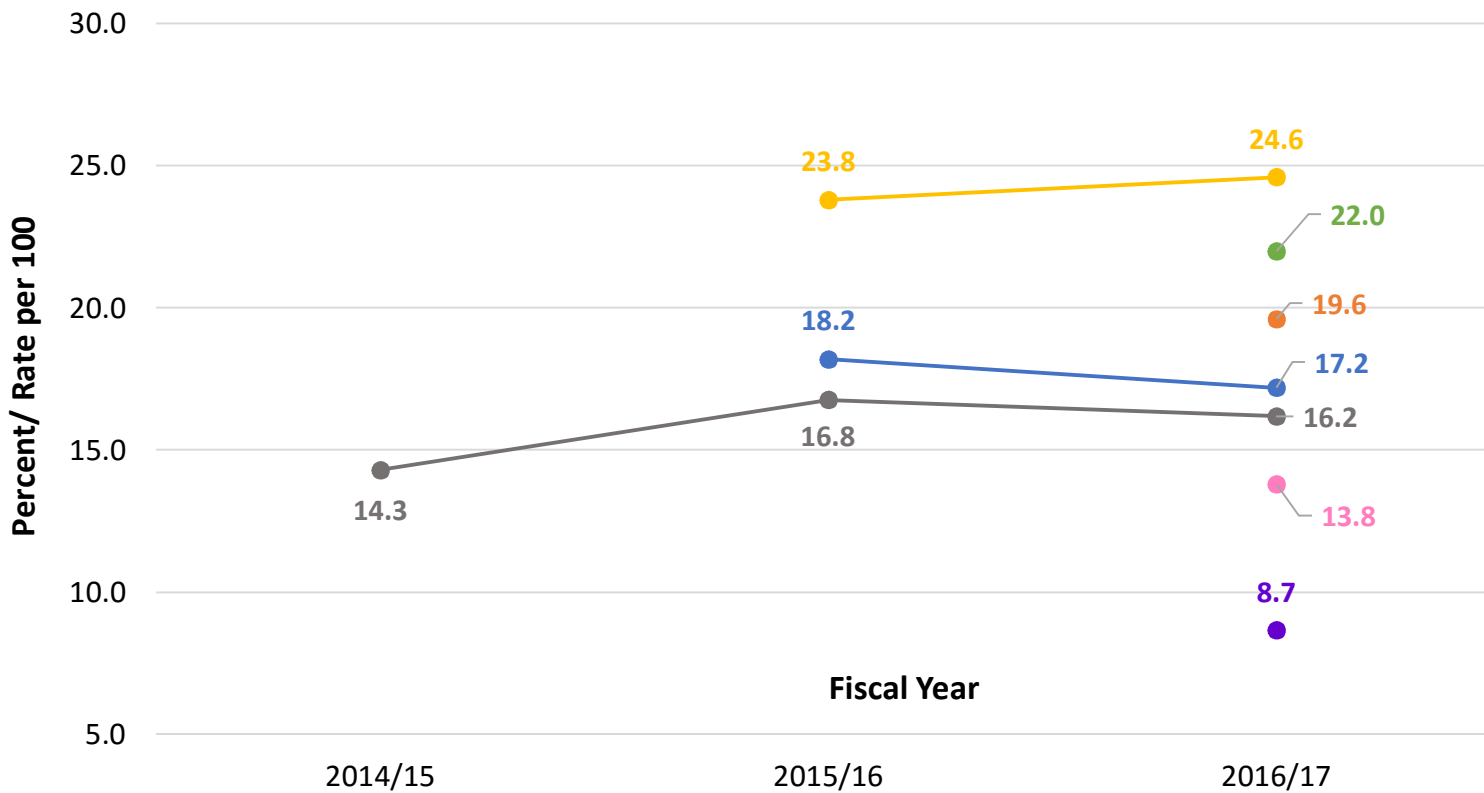
QUALITY IMPROVEMENT PLAN DATA

Provincial Averages

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

Better performance 

- Potentially Avoidable Emergency Department Visits for Long-Term Care Residents
- 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
- Hospital Readmissions for CCACs
- Readmission Within 30 Days for Selected HBAM Inpatient Groupers
- Alternative Level of Care Rate—Acute
- Risk-Adjusted 30-Day All-Cause Readmission Rate for Patients with Stroke

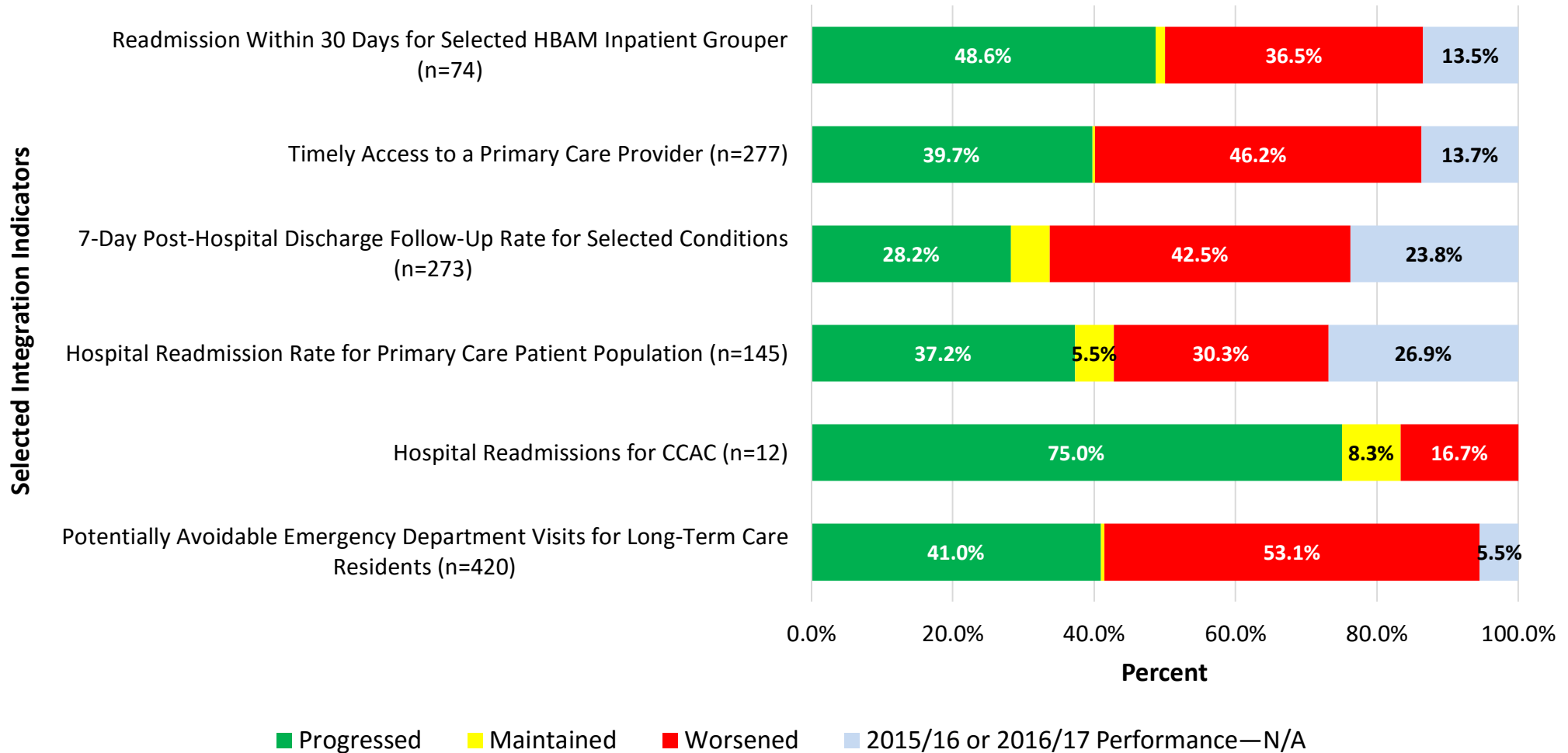


*Data were obtained from external sources, and indicators presented in the graph are risk-unadjusted unless specified otherwise. Potentially avoidable ED visits for long-term care residents has a unit of rate per 100 long-term care residents; all other indicators have a unit of percent. Provincial average 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

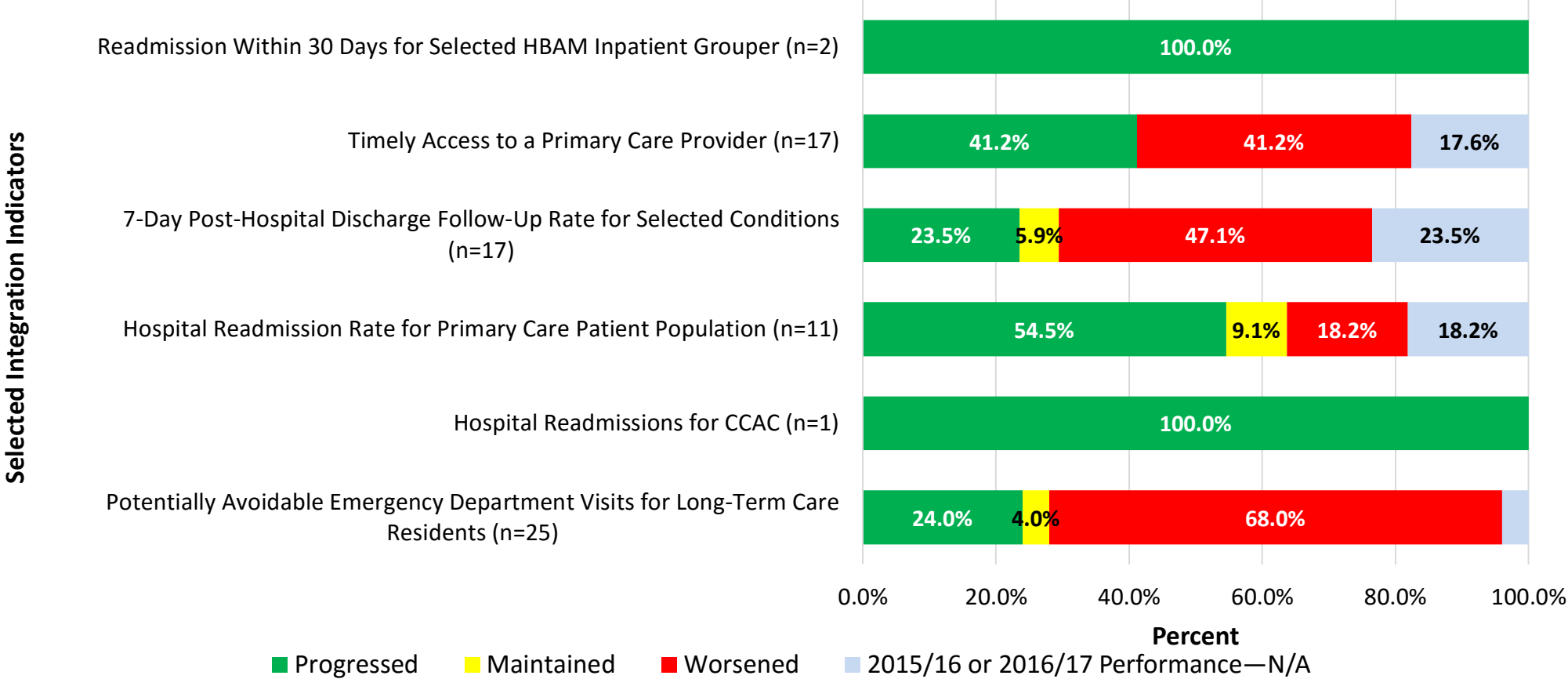
Looking back: Percentage of organizations in Ontario that progressed, maintained or worsened their performance between the 2015/16 QIP and the 2016/17 QIP on selected integration indicators, as reported in the QIP 2016/17 Progress Report



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.

ESC LHIN QIP Data: Progress Made in 2016/17

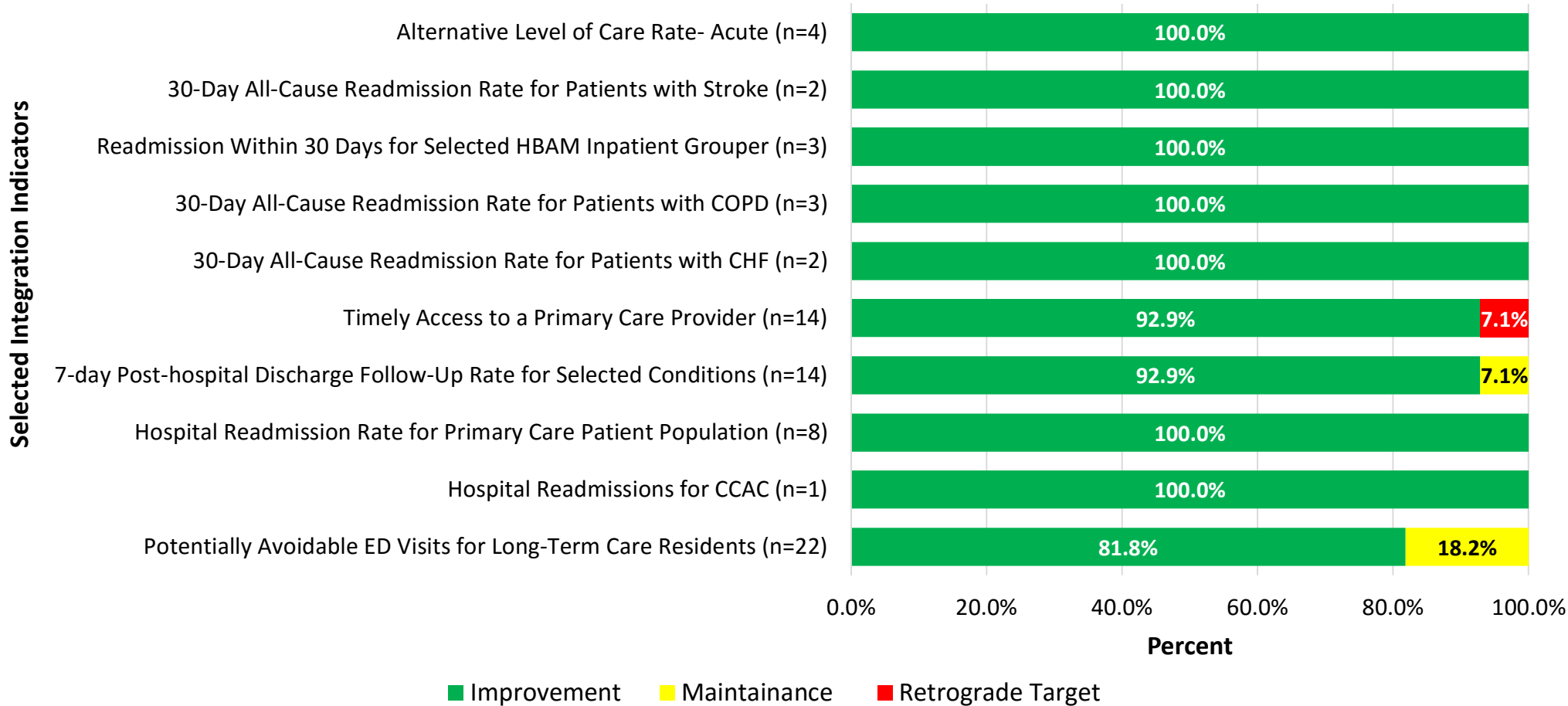
Looking back: Percentage of organizations in Erie St. Clair LHIN that progressed, maintained or worsened in their performance between 2015/16 QIP and 2016/17 QIP on selected integration indicators, as reported in QIP 2016/17 Progress Report



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.

ESC LHIN QIP Data: Target Setting in 2016/17

Looking forward: Percentage of organizations in Erie St. Clair LHIN that set a target to improve, maintain or worsen performance in 2016/17 QIP on selected integration indicators, as reported in 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.

ESC LHIN QIP Data: 2016/17 Indicator Selection

Sector	General Areas of Focus: Integration Indicators	Current Performance ESC 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)	20.22%	22.00%	2/5
	ii. 30-Day All-Cause Readmission Rate for Patients with Chronic Obstructive Pulmonary Disease (QBP)	21.11%	19.60%	3/5
	iii. 30-Day All-Cause Readmission Rate for Patients with Stroke (QBP)	8.45%	8.67%	2/5
	iv. Readmission Within 30 days for Selected HBAM Inpatient Grouper (HIGs)	14.53%	16.19%	3/5
	v. Alternate Level of Care Rate – Acute (ALC Rate)	20.77%	13.84%	4/5
Primary Care	i. 7-day Post-hospital Discharge Follow-Up Rate for Selected Conditions	N/A**	N/A**	17/17
	ii. Access to primary care (survey-based)	N/A**	N/A**	16/17
	iii. Hospital Readmission Rate for Primary Care Patient Population	N/A**	N/A**	8/17
Community Care Access Centres	i. Hospital Readmissions	14.71%	17.23%	1/1
Long Term Care	i. ED visits for Ambulatory Care Sensitive conditions	27.70%	24.55%	22/37

* 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 ESC 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

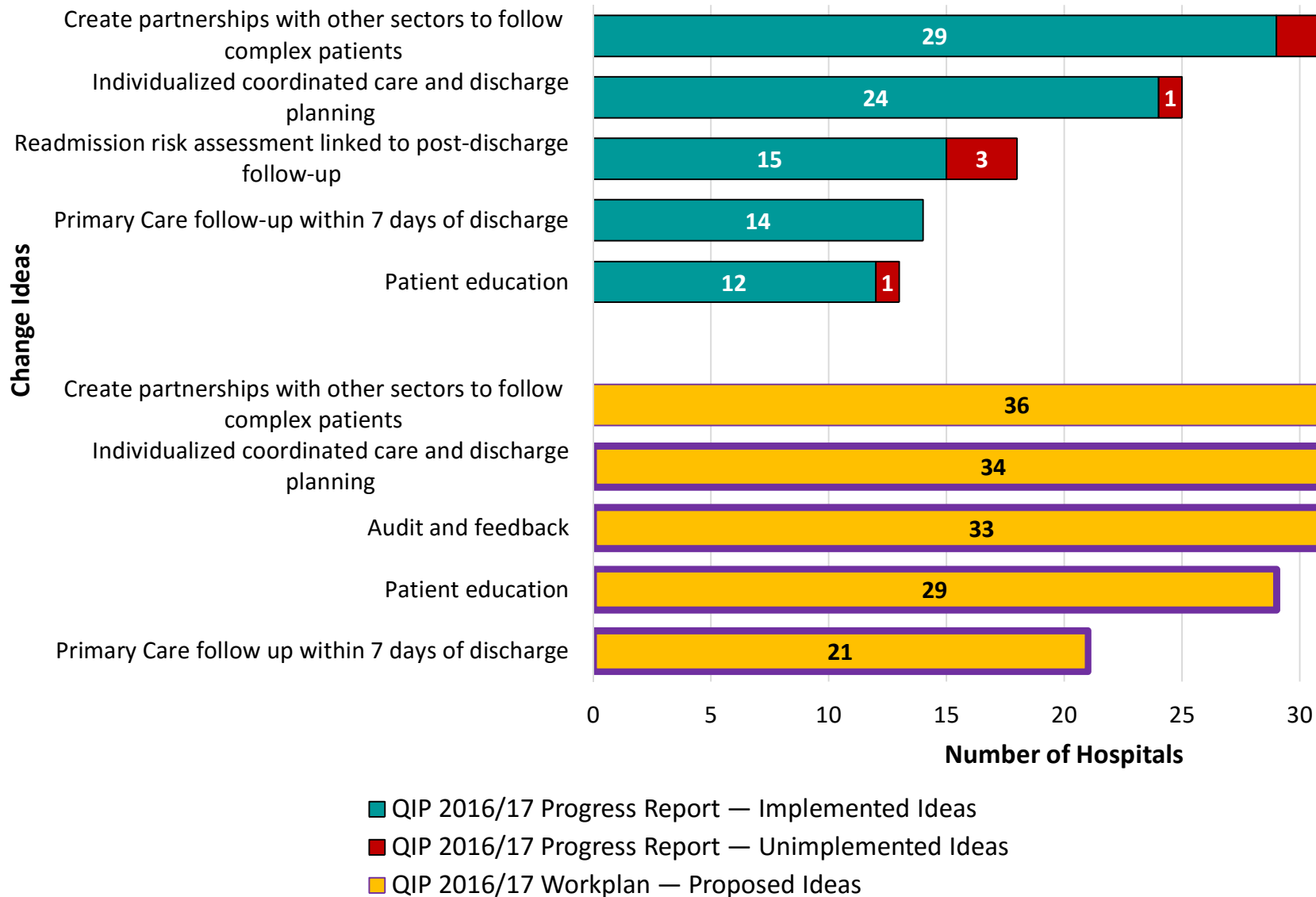
Note: Interpret data with caution; please refer to Technical Specifications; for instance, the three QBP indicators and the Readmissions HIG indicator are risk-adjusted, while the rest are not risk-adjusted.

MOST COMMON CHANGE IDEAS FROM 2015/16 AND 2016/2017

Common Change Ideas

- “ The following graphs provide provincial context, as well as LHIN-specific observations (whenever possible or appropriate)
- “ They show whether the most common change ideas included in the 2015/16 QIPs (work plan) were implemented with positive results, implemented with negative results (as in, it did not go as intended), or not implemented at all
- “ Data is extracted from 2016/17 QIP progress reports, which provide a retrospective look at an organization's plan from the previous year, including whether they achieved progress and whether proposed change ideas were implemented as planned

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

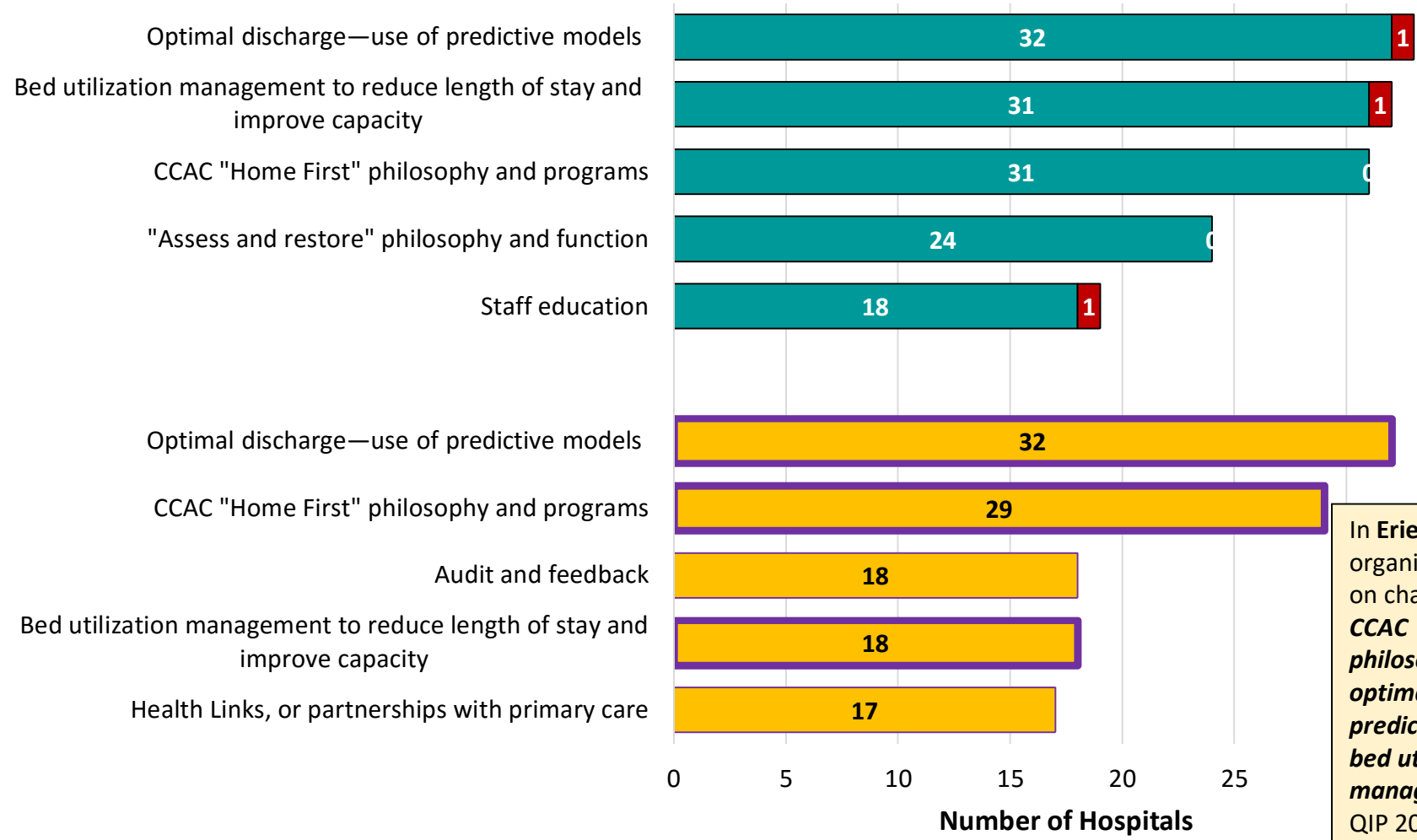


In Erie St. Clair LHIN, organizations are working on change ideas such as **audit and feedback**, **patient education**, **individualized care and discharge planning**, and **PC follow up within 7 days** (based on QIP 2016/17 Workplan).

* 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 Groups.

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

Change Ideas

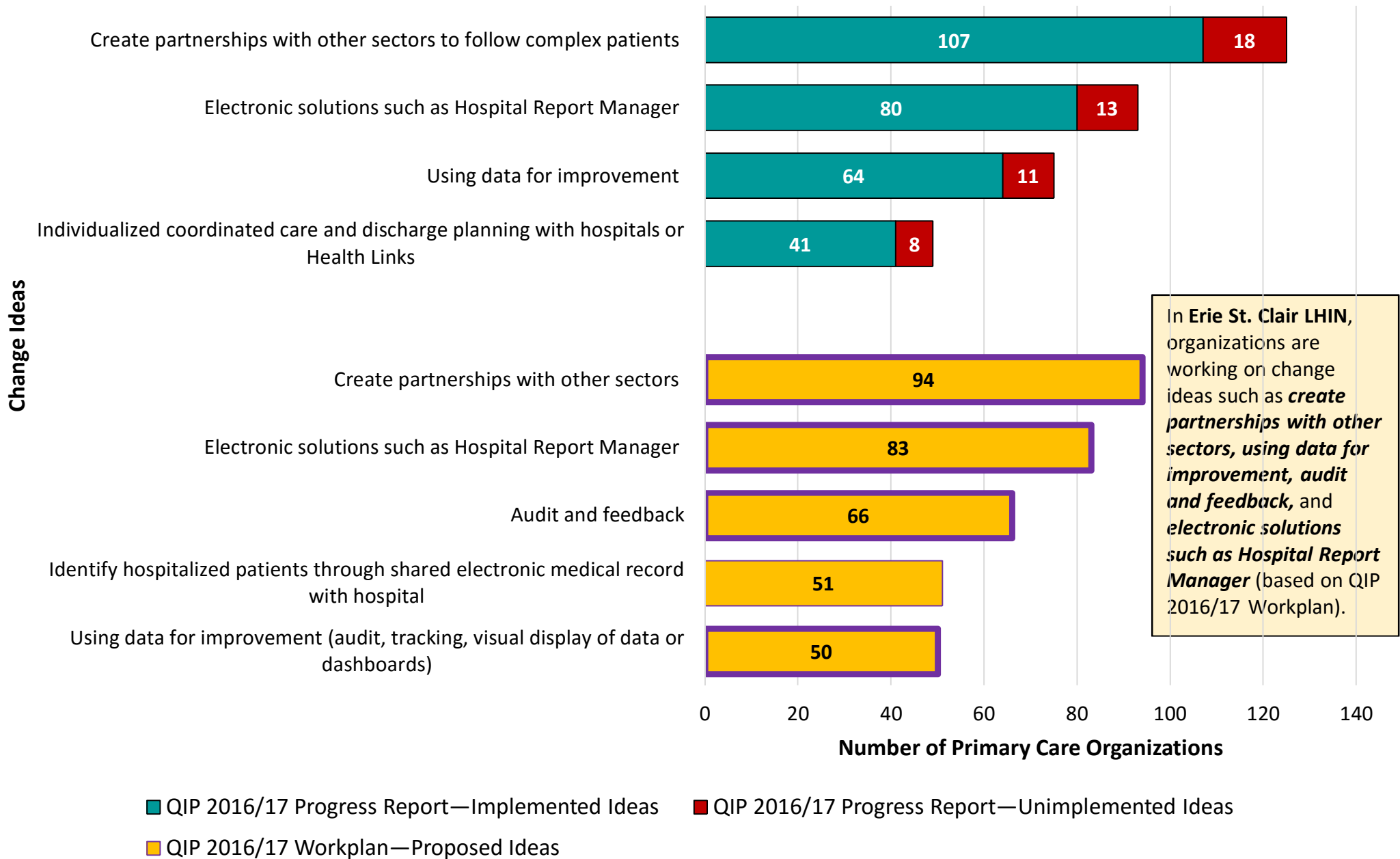


In Erie St. Clair LHIN, organizations are working on change ideas such as **CCAC "Home First" philosophy and programs, optimal discharge- use of predictive models, and bed utilization management** (based on QIP 2016/17 Workplan).

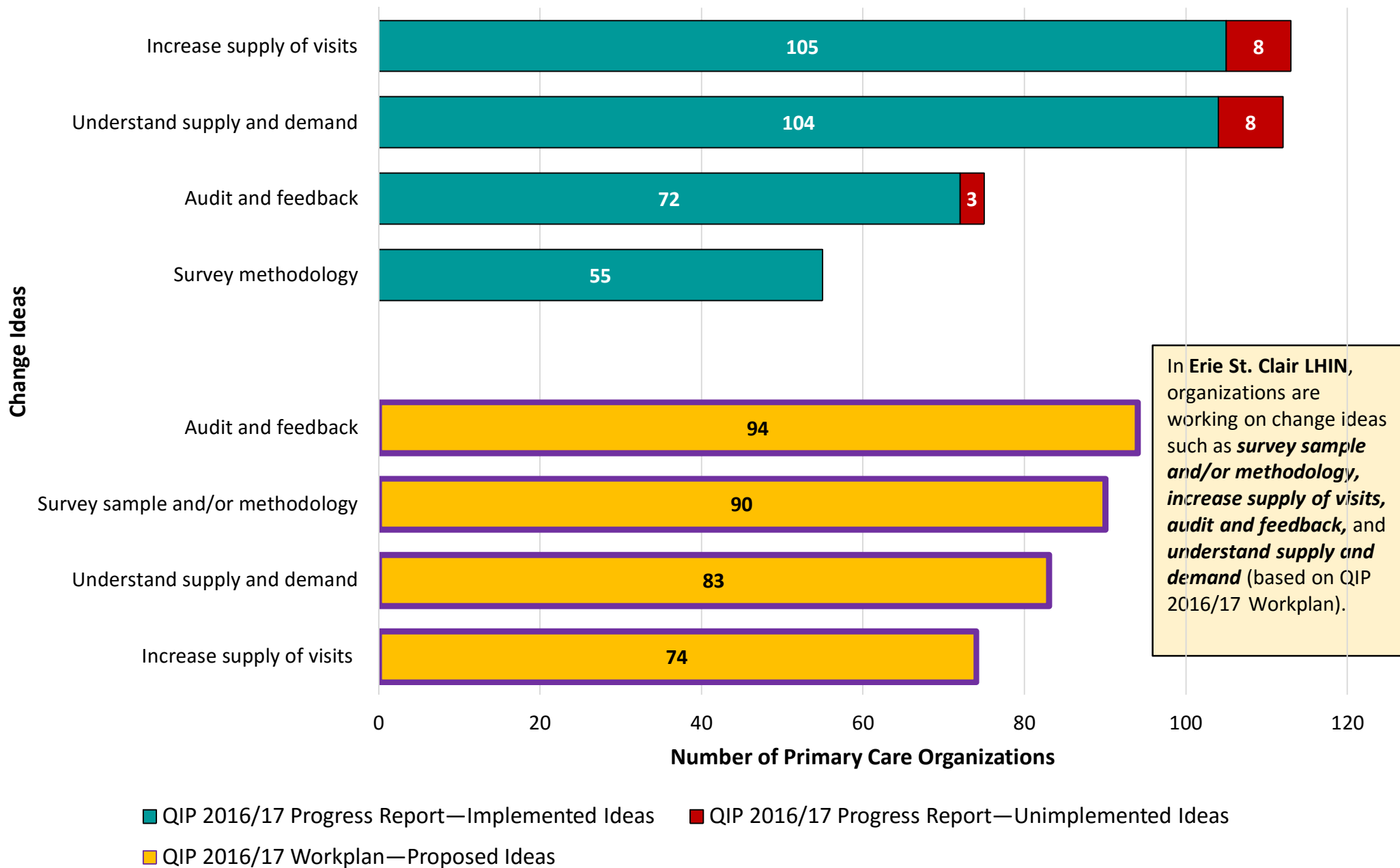
■ QIP 2016/17 Progress Report—Implemented Ideas
 ■ QIP 2016/17 Progress Report—Unimplemented Ideas
■ QIP 2016/17 Workplan—Proposed Ideas

* 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

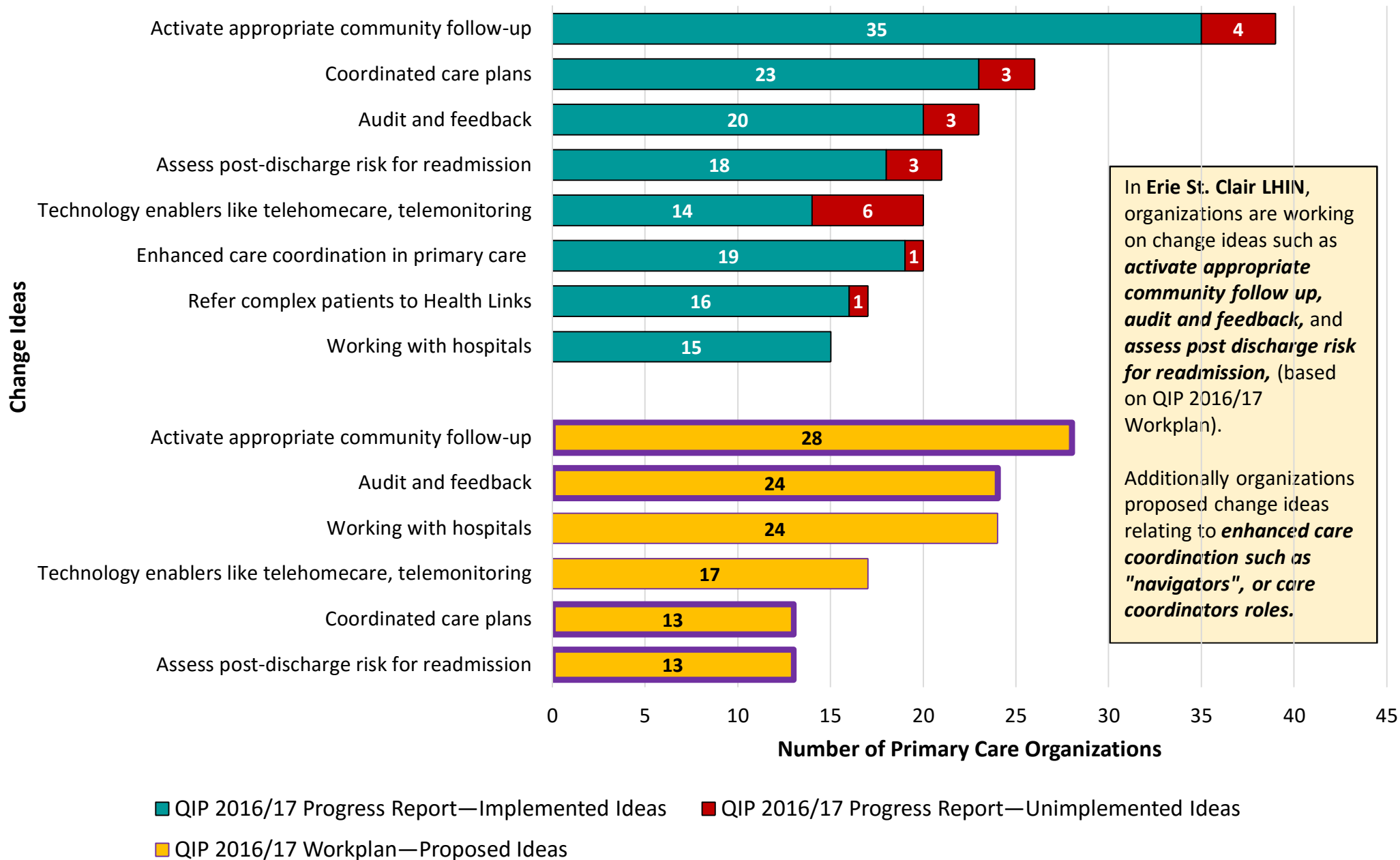


Most common change ideas in Ontario from 2015/16 and 2016/17 primary care QIPs for Timely Access to a Primary Care Provider, as reported in the 2016/17 QIPs

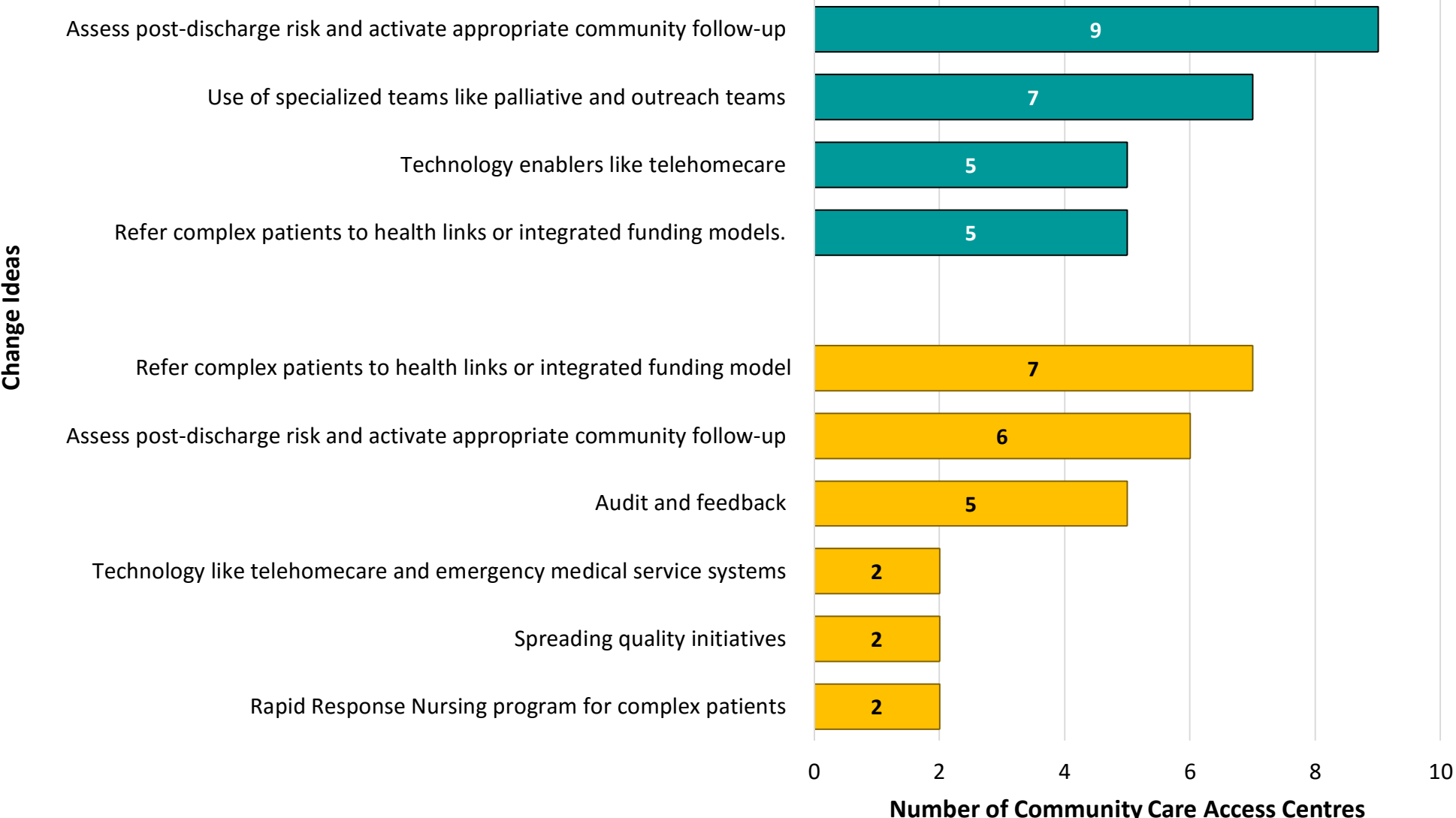


In Erie St. Clair LHIN, organizations are working on change ideas such as *survey sample and/or methodology, increase supply of visits, audit and feedback, and understand supply and demand* (based on QIP 2016/17 Workplan).

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



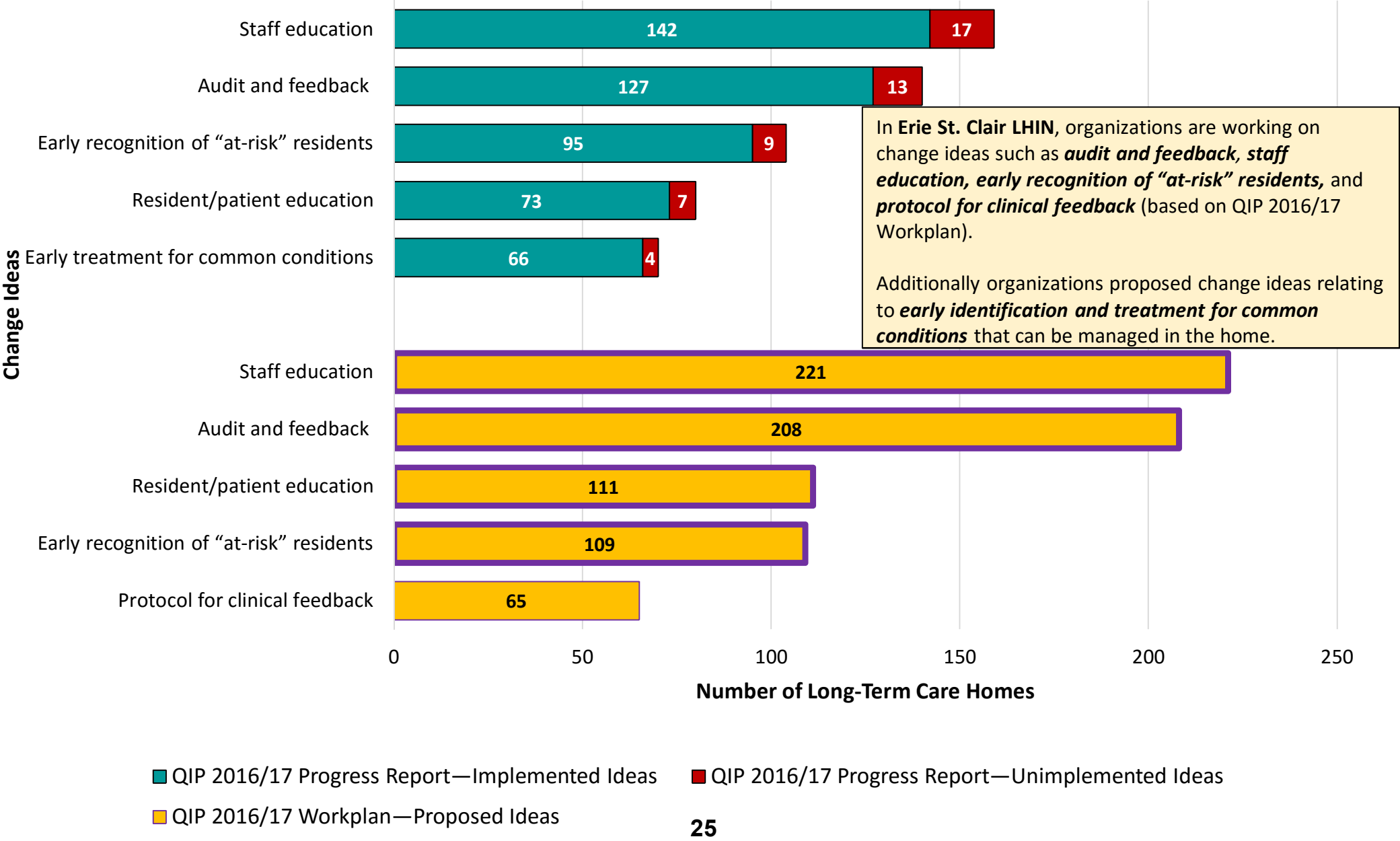
Most common change ideas in Ontario from 2015/16 and 2016/17 QIPs for Hospital Readmissions for Community Care Access Centres, as reported in the 2016/17 QIPs



■ QIP 2016/17 Progress Report—Implemented Ideas

■ QIP 2016/17 Workplan—Proposed Ideas

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 Erie St. Clair LHIN, organizations are working on change ideas such as *audit and feedback*, *staff education*, *early recognition of “at-risk” residents*, and *protocol for clinical feedback* (based on QIP 2016/17 Workplan).

Additionally organizations proposed change ideas relating to *early identification and treatment for common conditions* that can be managed in the home.

SPOTLIGHTS

Reducing Readmissions and Improving 7-Day Follow-Up

Charlotte Eleanor Englehart Hospital of Bluewater Health (CEEH) and the Central Lambton Family Health Team (CLFHT)

- “ The teams collaborated on two shared goals for the following indicators:
 - %Improve primary care provider follow-up within 7 days of discharge from hospital+(primary care indicator)
 - %Reduce readmissions to hospital within 30 days of discharge+(hospital Quality Improvement Plan indicator)
- “ Results: The collaboration has resulted in an improvement from 80% to 100% of patients who attended their 7-day follow-up appointment in primary care (from February to June 2015)
- “ The Director of CEEH and Executive Director of Central Lambton FHT meet monthly to review the data, looking for trends of patients presenting multiple times at hospital and drill down deeper to gather information about the reasons and ways to decrease hospital use. The hospital's current performance improved and exceeded their target.

Improving 7-Day Follow-Up Post-Discharge

VON Nurse Practitioner-Led Clinic

Our target of 100% follow up upon hospital discharge requires significant effort and implementation of the following methods:

- “ Contacting the local hospitals and ensuring the NPs were listed as Primary Care Providers
- “ Creating a wallet hospital card with NP's and NPLC contact information for patients to present to ER
- “ Inform and educate patients and community of the importance of follow up after a hospital visit
- “ Reception tracking the known ER and hospital discharge dates and follow up dates on a spread sheet
- “ Implement use of **Ontario MD Hospital Report Manager**

For the first 2 quarters of 2015 our follow up rate was 53%. Third quarter stats and including January 2016 results reveal that we did reach our goal of 100%.

Improving Patient Experience

Tilbury District Family Health Team Inc.

- “ Expanded the scope of their quality improvement projects by hiring summer students, volunteers, and student placements to develop educational tools, distribute patient surveys, and assist with preventative care programs
- “ Received tremendous support from staff, physicians, and Board to implement their quality improvement initiatives
- “ Patients had a greater voice in their Quality Improvement Plan as a result of adding new questions to their basic survey, conducting in-depth patient discussion groups, and having a patient join the team’s Quality Improvement Committee
- “ Results: Capturing the patient perspective helped enable the team to learn directly from their patients what they felt were the issues and challenges, and helped identify priority areas for improvement

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~~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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