

# South 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 by the LHIN and its HSPs on successes and areas for improvement as reflected in the QIPs
- Stimulate collaboration within and among organizations across the LHINs 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 the Boards of the HSPs in your LHIN

This report has been produced in an editable PowerPoint format to support these 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](#)

# South East LHIN Overview

Sector	QIP Count	Description
Hospitals	5	<ul style="list-style-type: none"> <li>• 3 large community hospitals</li> <li>• 2 acute teaching hospitals</li> </ul>
Primary Care	21	<ul style="list-style-type: none"> <li>• 14 Family Health Teams</li> <li>• 5 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	36	<ul style="list-style-type: none"> <li>• 24 for-profit</li> <li>• 3 not-for-profit</li> <li>• 9 Municipal</li> </ul>
Multi-sector*	2	<ul style="list-style-type: none"> <li>• 2 Long-term care</li> </ul>

\*Please note that multi-sector sites are already included in the sector totals, above.

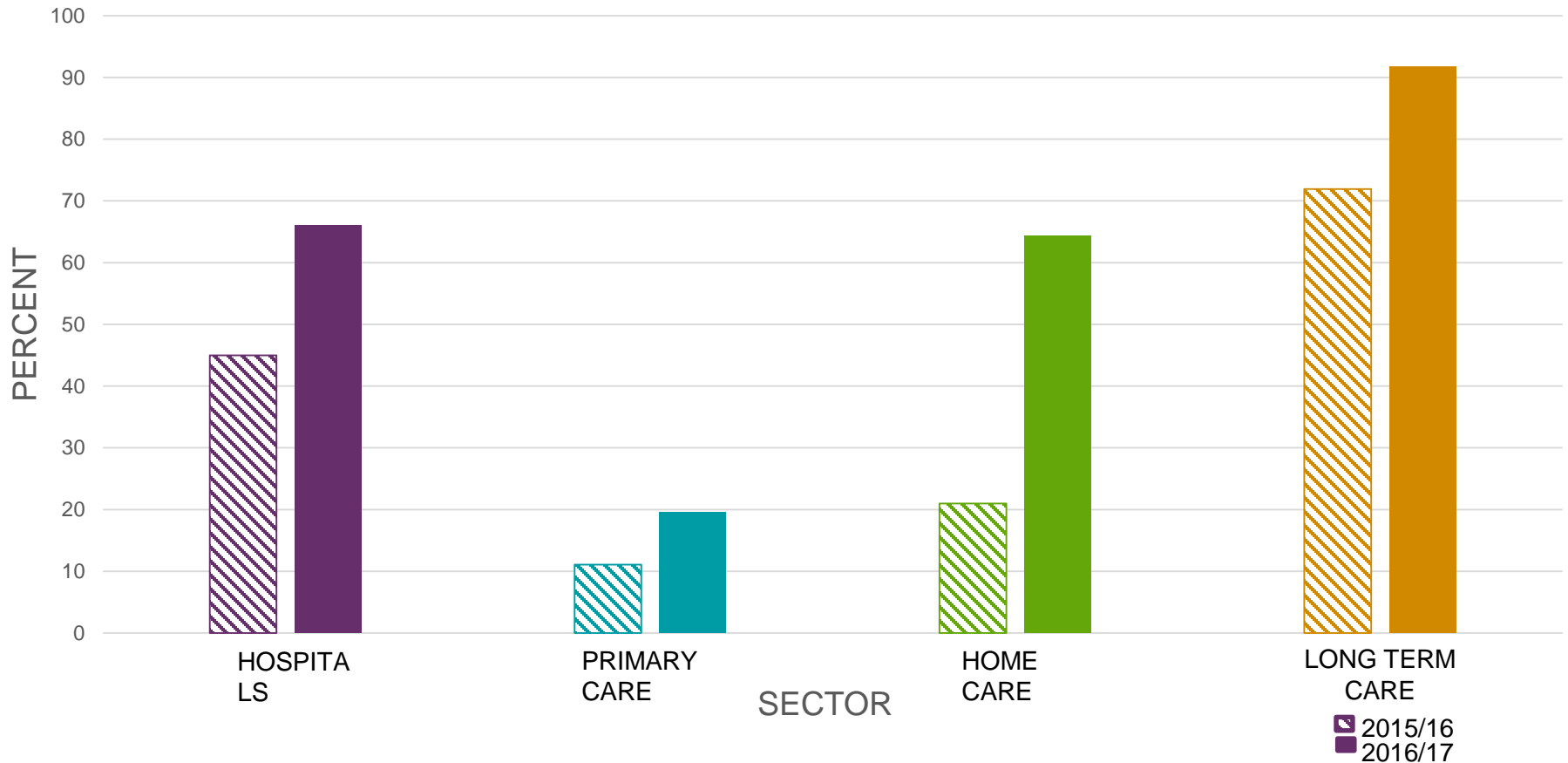
# Key Observations – Overarching

- 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.



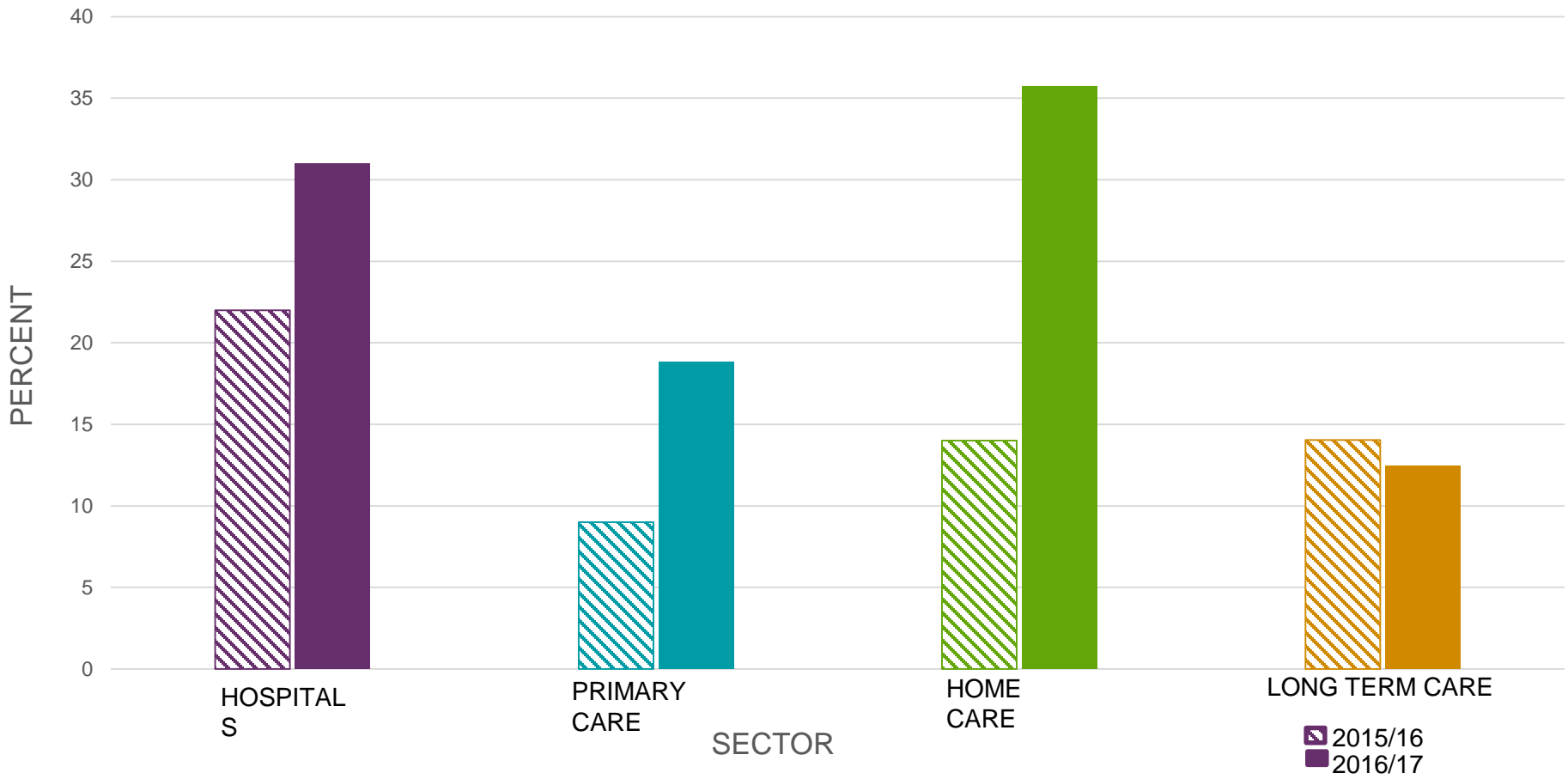
# All sectors described an increased use of Patient and Family Advisory Councils and Forums in the development of their QIPs

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



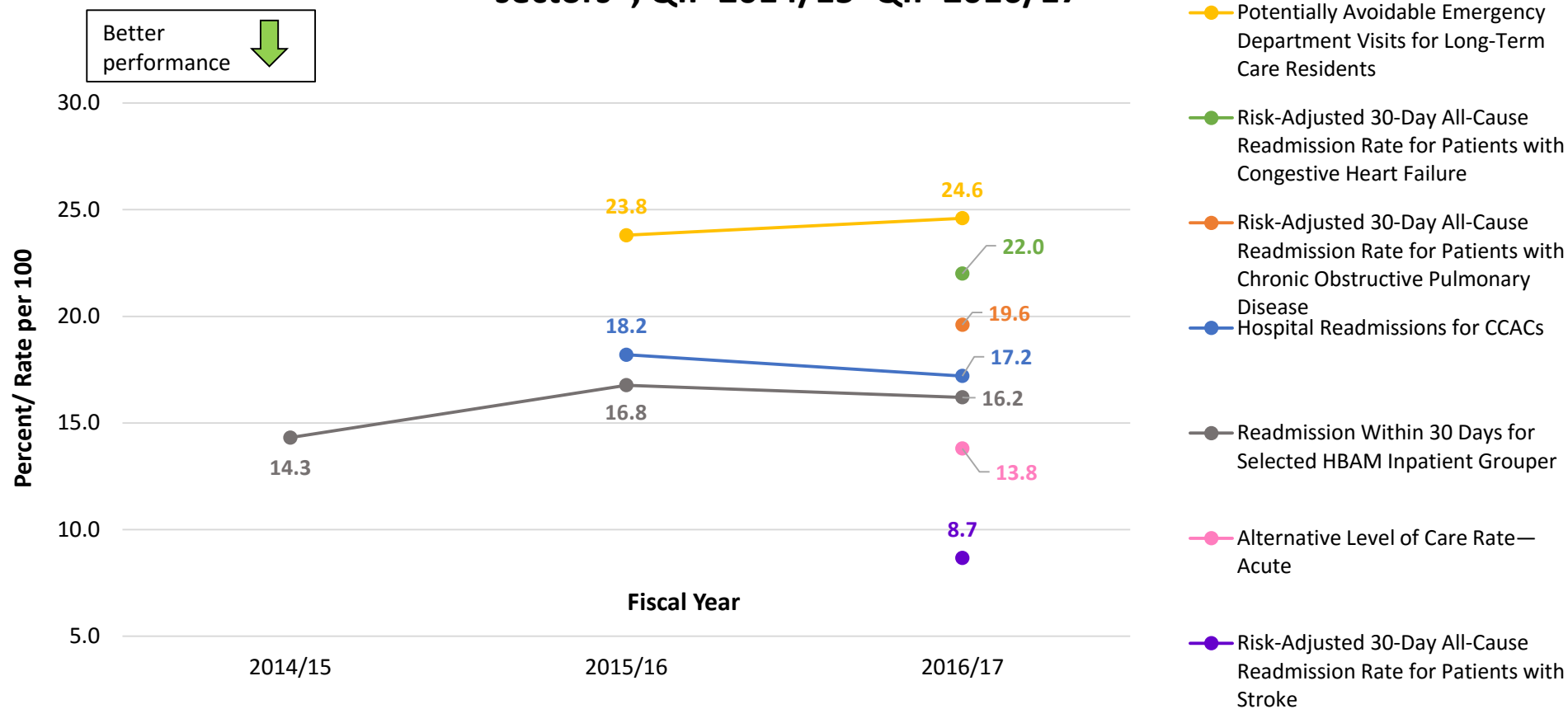
# Key Observations – Per Sector

- **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

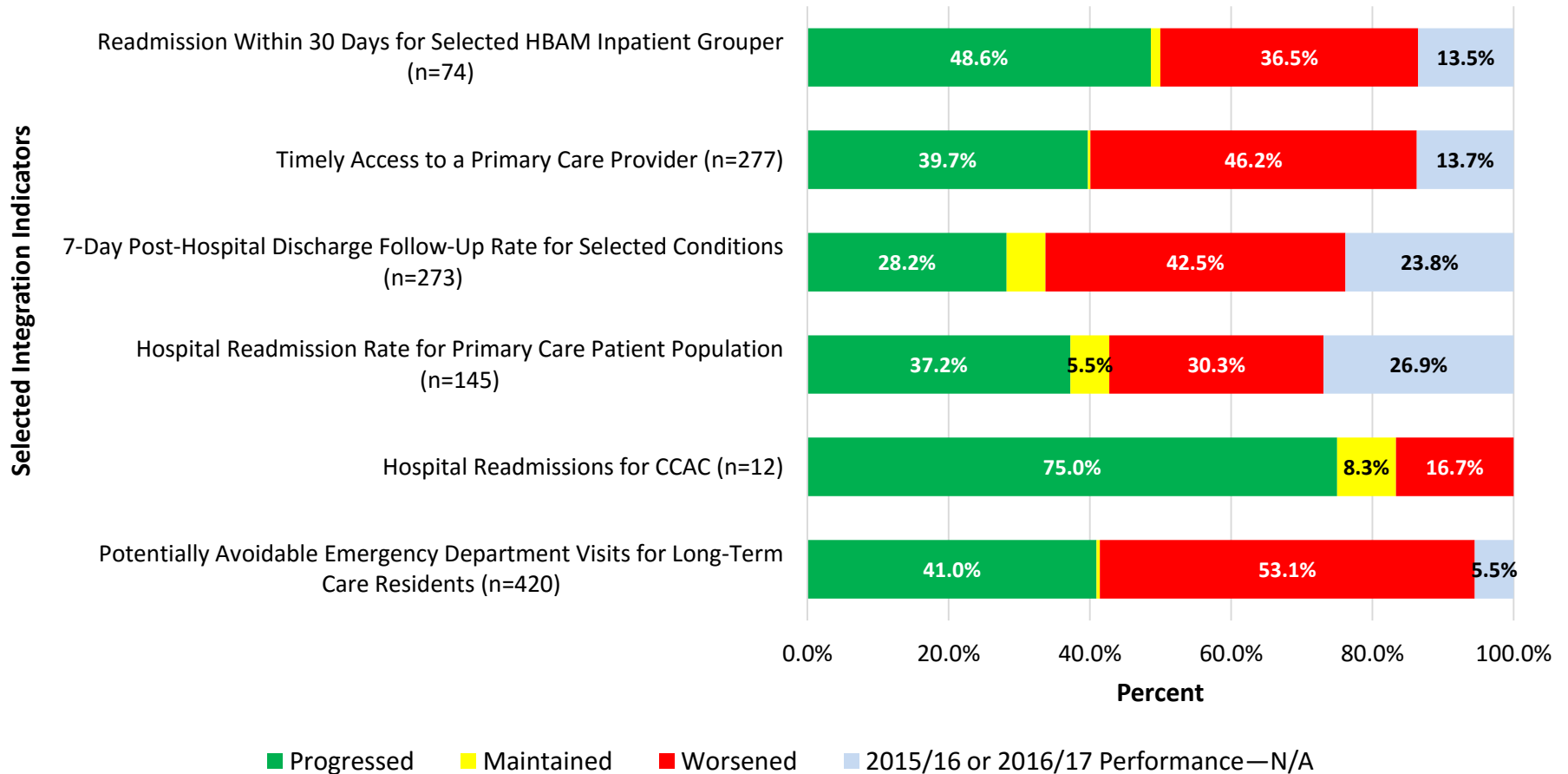


\*Data were obtained from external sources, and indicators presented in the graph are risk-unadjusted unless specified otherwise. Potentially avoidable ED visits for long-term care residents has a unit of rate per 100 long-term care residents; all other indicators have a unit of percent. Provincial average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

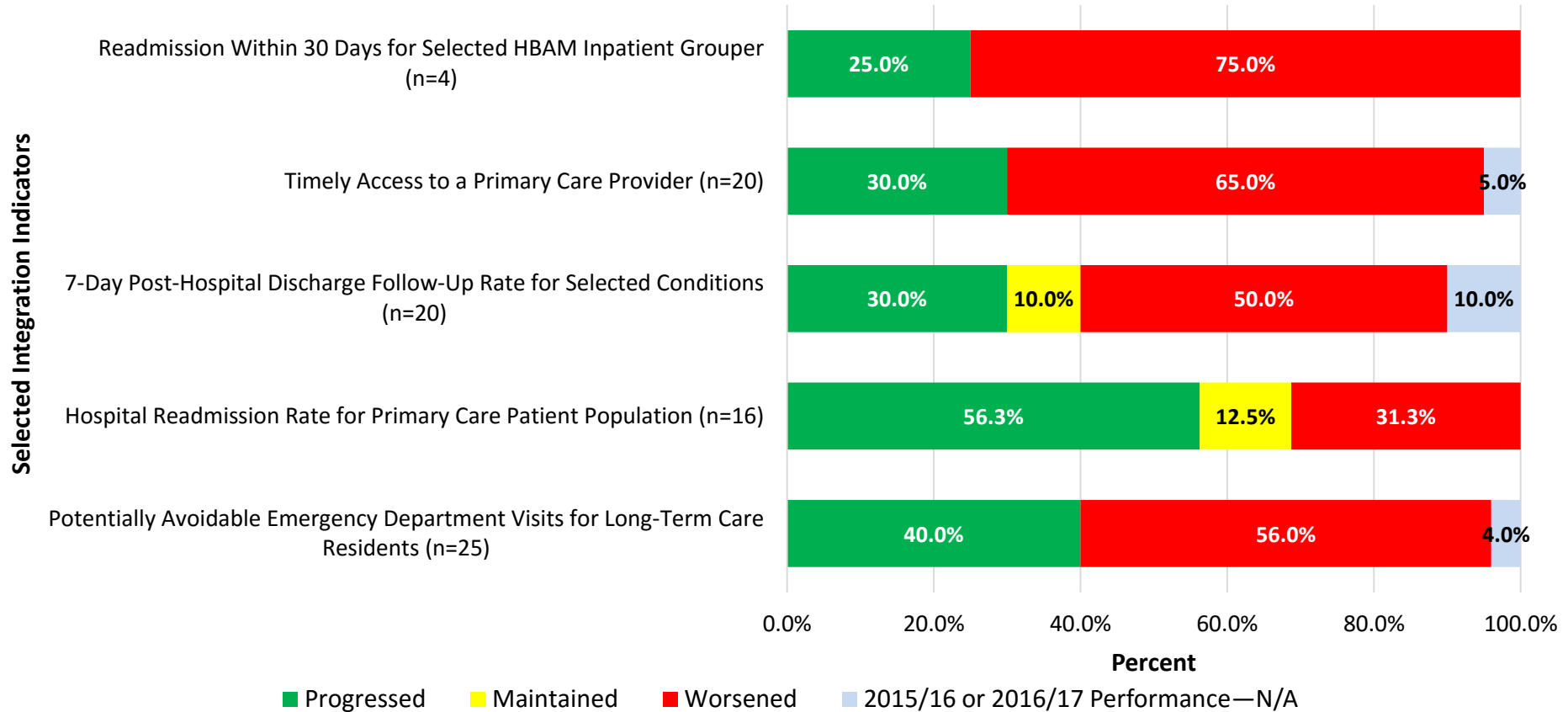
Looking back: Percentage of organizations in Ontario that progressed, maintained or worsened their performance between the 2015/16 QIP and the 2016/17 QIP on selected integration indicators, as reported in the QIP 2016/17 Progress Report



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.

# South East LHIN QIP Data: Progress Made in 2016/17

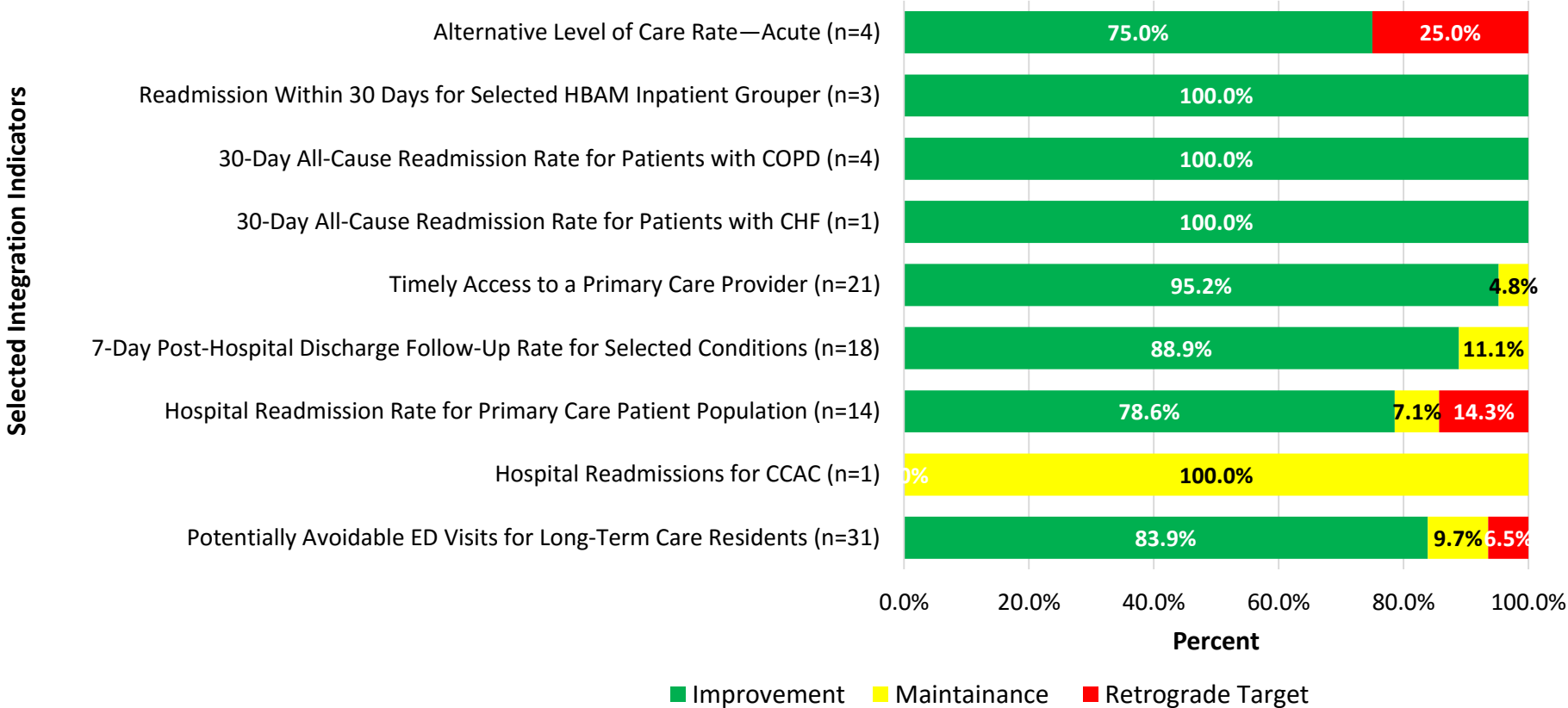
**Looking back: Percentage of organizations in South East LHIN that progressed, maintained or worsened in their performance between the 2015/16 QIP and the 2016/17 QIP on selected integration indicators, as reported in the 2016/17 QIP Progress Report**



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.

# South East LHIN QIP Data: Target Setting in 2016/17

**Looking forward: Percentage of organizations in South 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.



# South East LHIN QIP Data: 2016/17 Indicator Selection

Sector	General Areas of Focus: Integration Indicators	Current Performance SE 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)	20.17%	22.00%	1/7
	ii. 30-Day All-Cause Readmission Rate for Patients with Chronic Obstructive Pulmonary Disease (QBP)	19.14%	19.60%	4/7
	iii. 30-Day All-Cause Readmission Rate for Patients with Stroke (QBP)	7.60%	8.67%	0/7
	iv. Readmission Within 30 days for Selected HBAM Inpatient Grouper (HIGs)	16.05%	16.19%	3/7
	v. Alternate Level of Care Rate – Acute (ALC Rate)	18.35%	13.84%	4/7
Primary Care	i. 7-day Post-hospital Discharge Follow-Up Rate for Selected Conditions	N/A**	N/A**	20/21
	ii. Access to primary care (survey-based)	N/A**	N/A**	21/21
	iii. Hospital Readmission Rate for Primary Care Patient Population	N/A**	N/A**	14/21
Community Care Access Centres	i. Hospital Readmissions	17.27%	17.23%	1/1
Long Term Care	i. ED visits for Ambulatory Care Sensitive conditions	23.70%	24.55%	31/38

\* 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 SE LHIN:

- 1 Hospital selected a custom indicator related to *30- Day Readmission Rate* (A combined designation for all four 30-Day Readmissions indicators)
- 2 Hospitals selected a custom indicator related to *Alternate Level of Care Rate*
- 1 Long-Term Care Home selected a custom indicator related to *ED visits for Ambulatory Care Sensitive conditions*

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

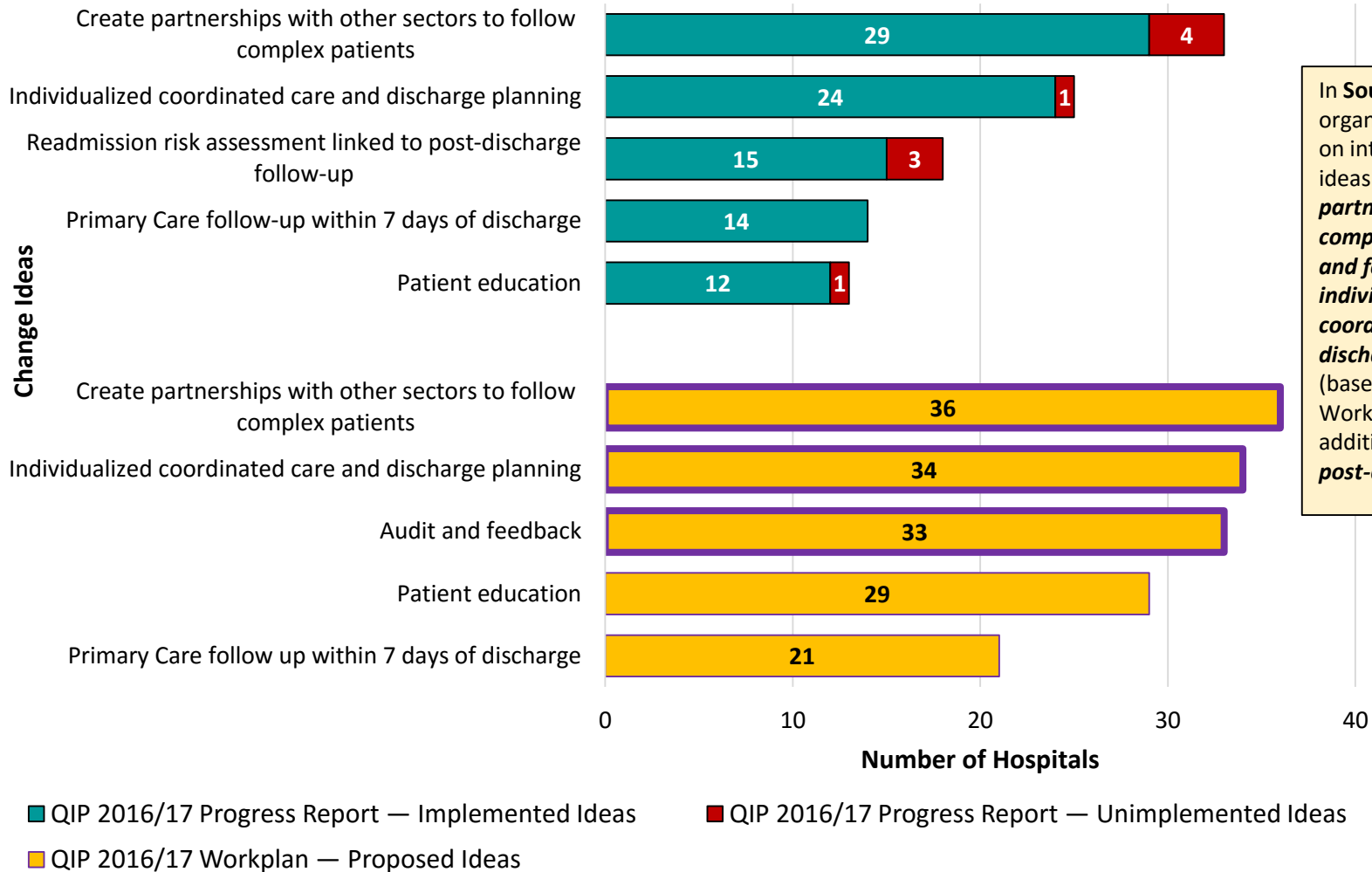
Note: Interpret data with caution; please refer to Technical Specifications; for instance, the three QBP indicators and the Readmissions HIG indicator are risk-adjusted, while the rest are not risk-adjusted.

# **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

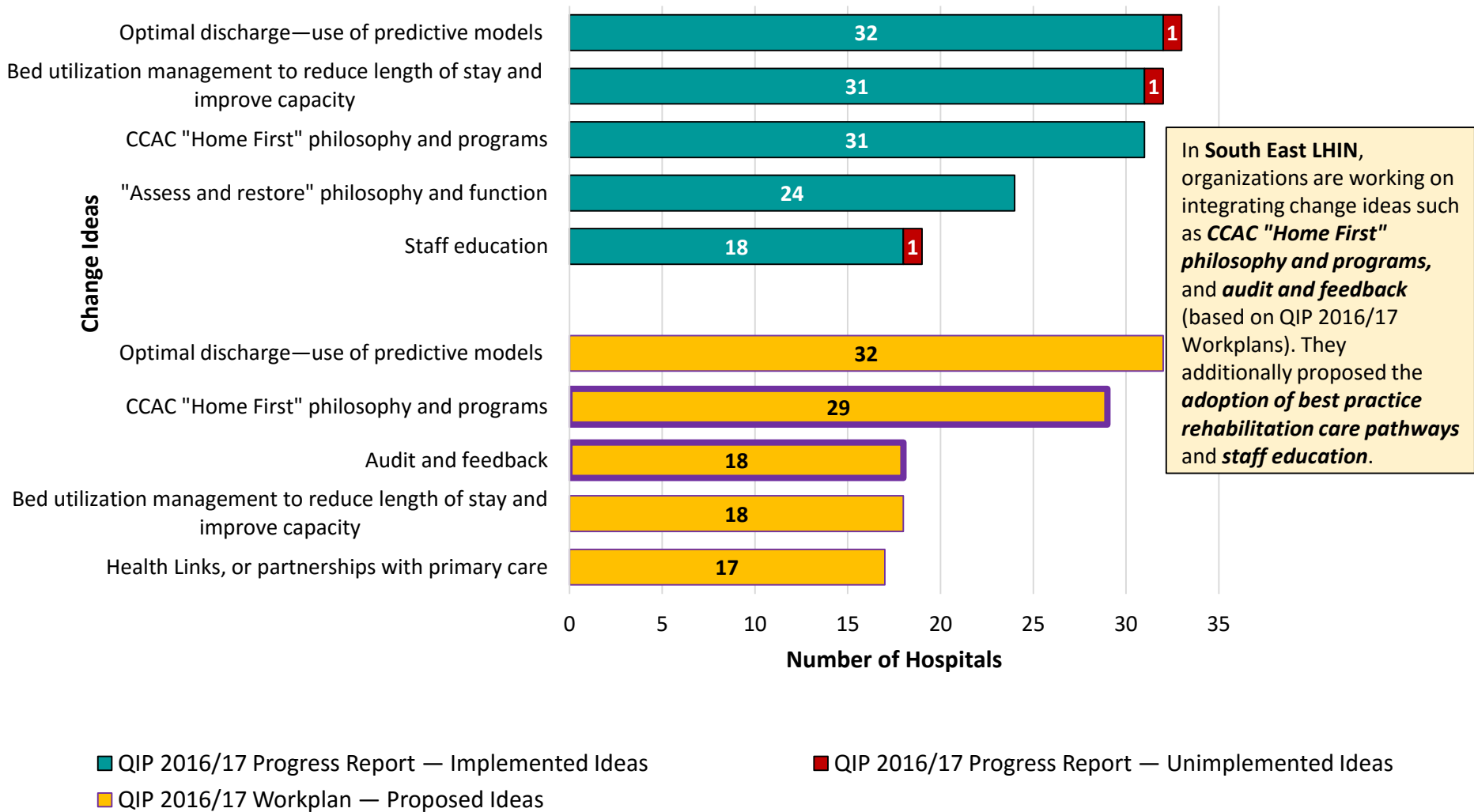
## Most common change ideas in Ontario from 2015/16 and 2016/17 hospital QIPs for 30-Day Readmission Rate,\* as reported in the 2016/17 QIPs



In South East LHIN, organizations are working on integrating change ideas such as **create partnerships to follow complex patients, audit and feedback, and individualized coordinated care and discharge planning** (based on QIP 2016/17 Workplans). They additionally proposed **post-discharge support**.

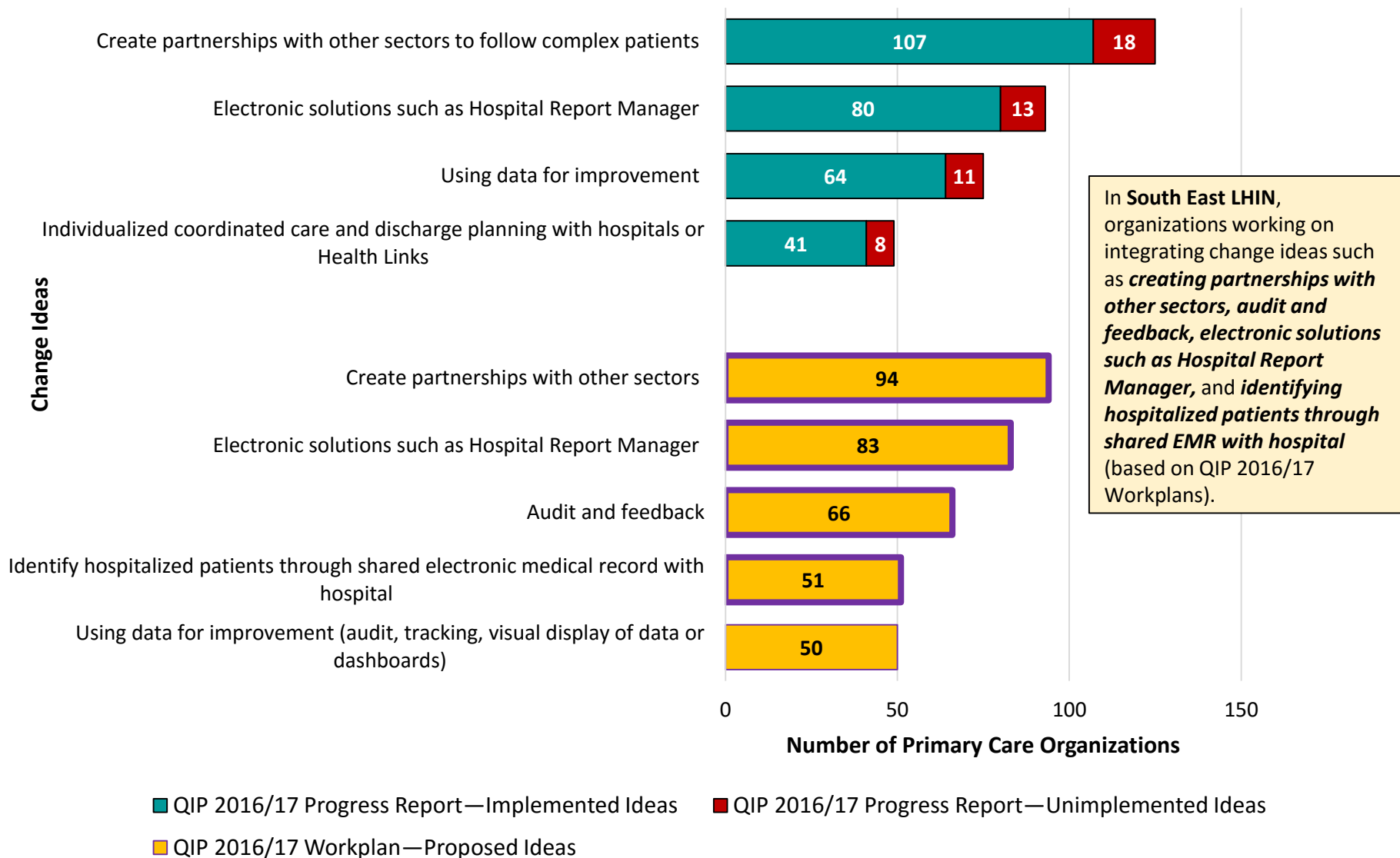
\* The information presented combines data submitted by organizations on the following four 30-day readmission indicators: 30-Day All-Cause Readmission Rate for Patients with Congestive Heart Failure, 30-Day All-Cause Readmission Rate for Patients with Chronic Obstructive Pulmonary Disease, 30-Day All-Cause 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

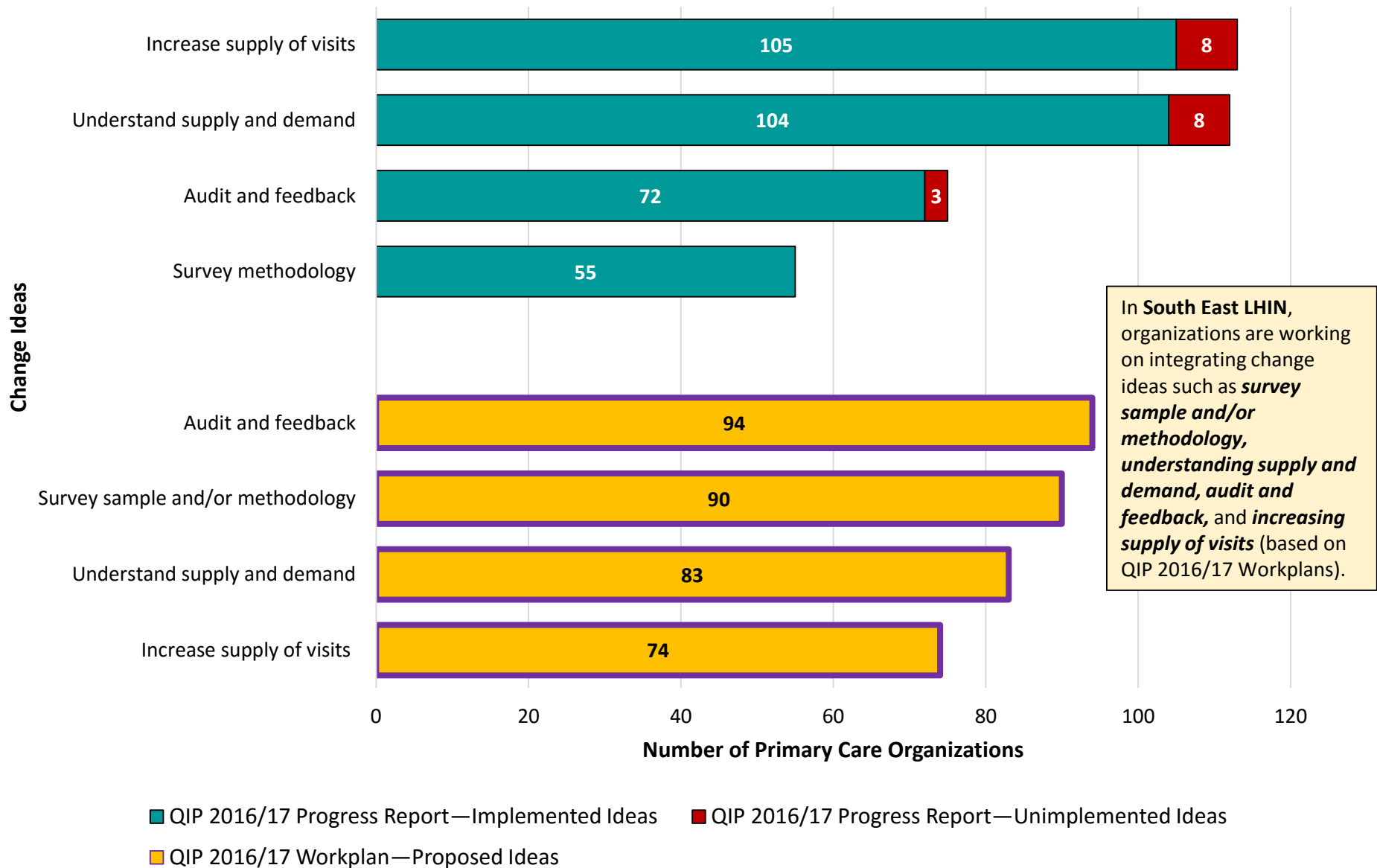


\* The information presented combines data submitted by organizations on the following alternative level of care indicators: Alternative Level of Care Rate—Acute, and Percent Alternative Level of Care Days.

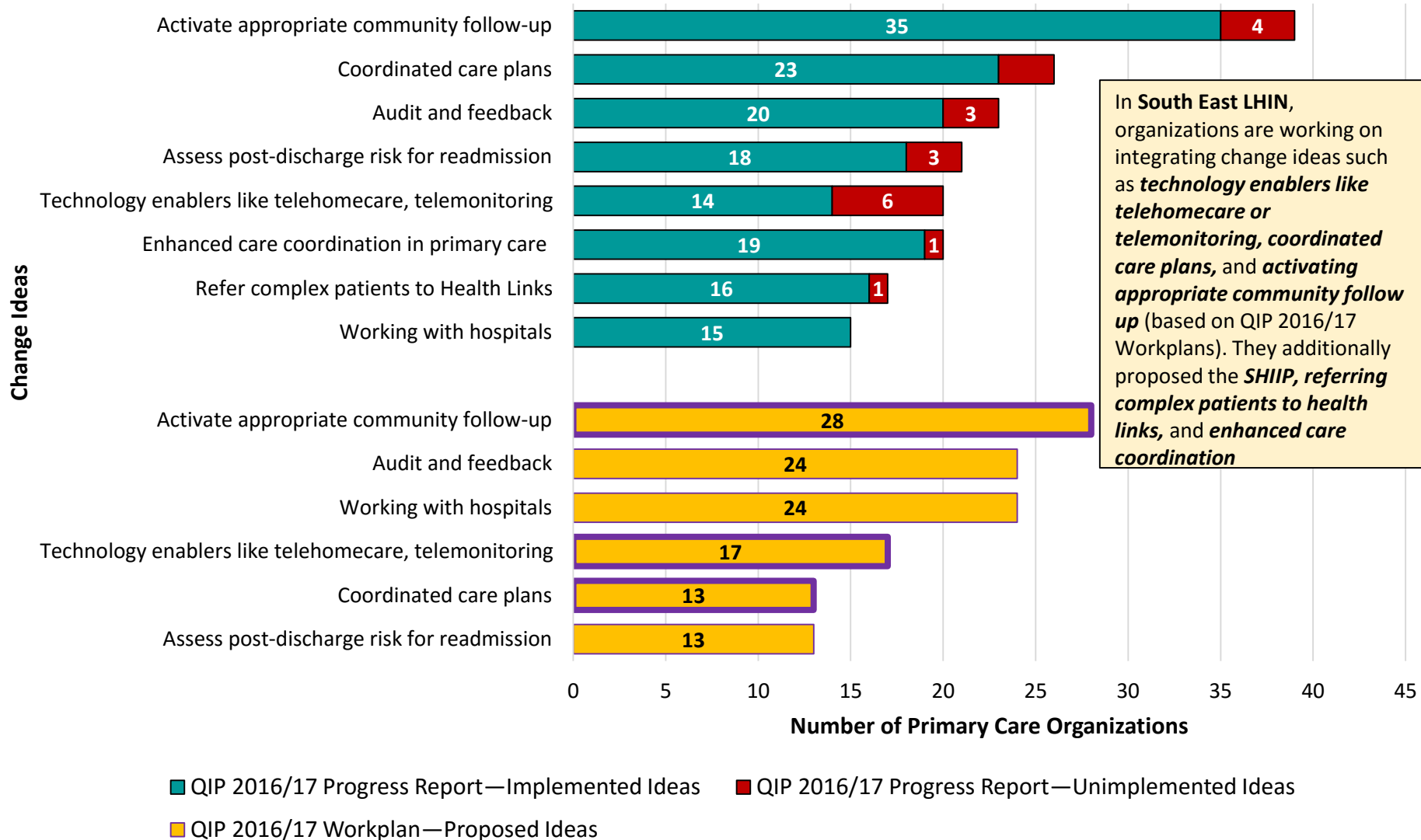
## Most common change ideas in Ontario from 2015/16 and 2016/17 primary care QIPs for 7-Day Post-Hospital Discharge Follow-Up Rate for Selected Conditions, as reported in the 2016/17 QIPs



## 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

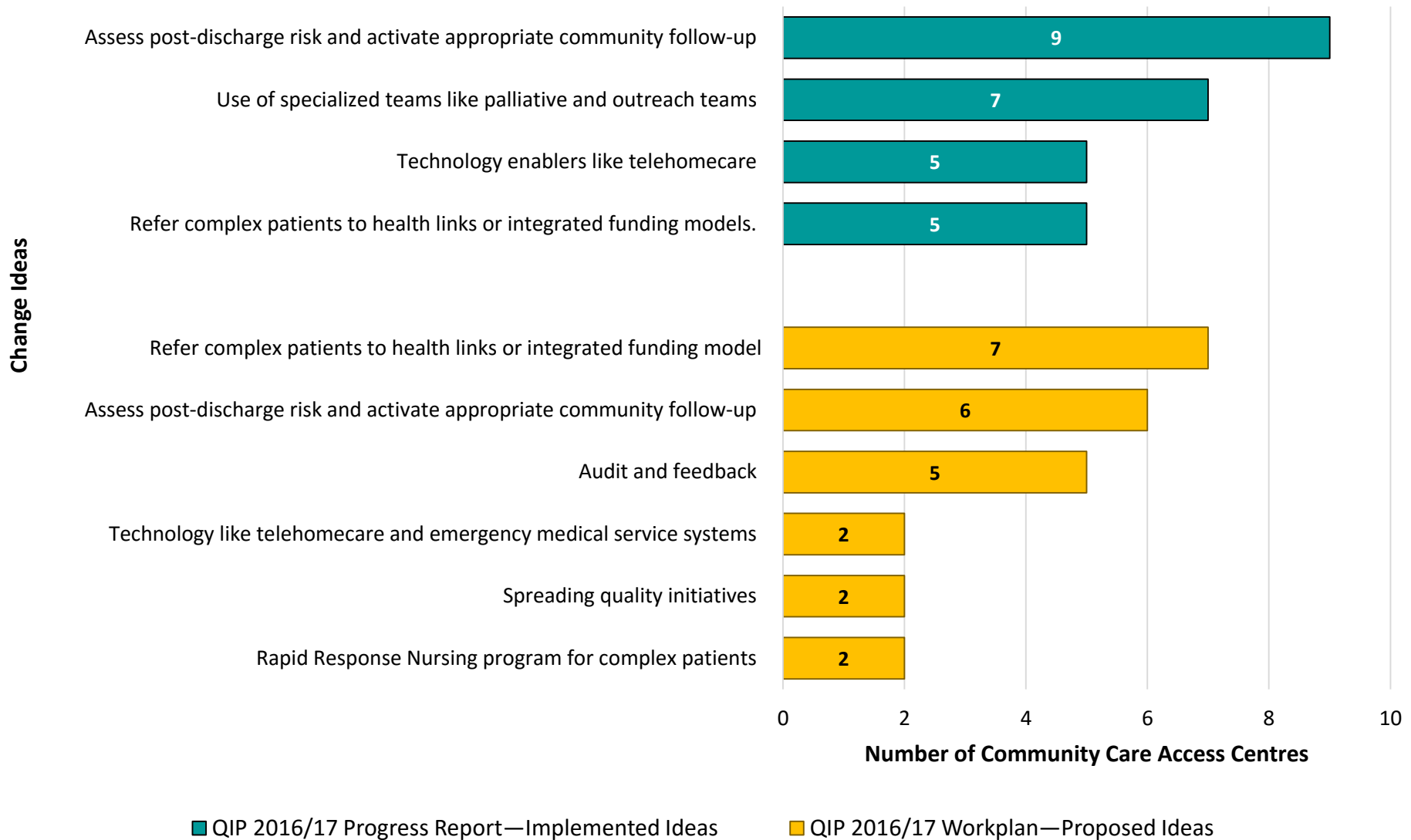


## Most common change ideas in Ontario from 2015/16 and 2016/17 primary care QIPs for Readmission Within 30 Days for Selected HBAM Inpatient Groupers, as reported in the 2016/17 QIPs

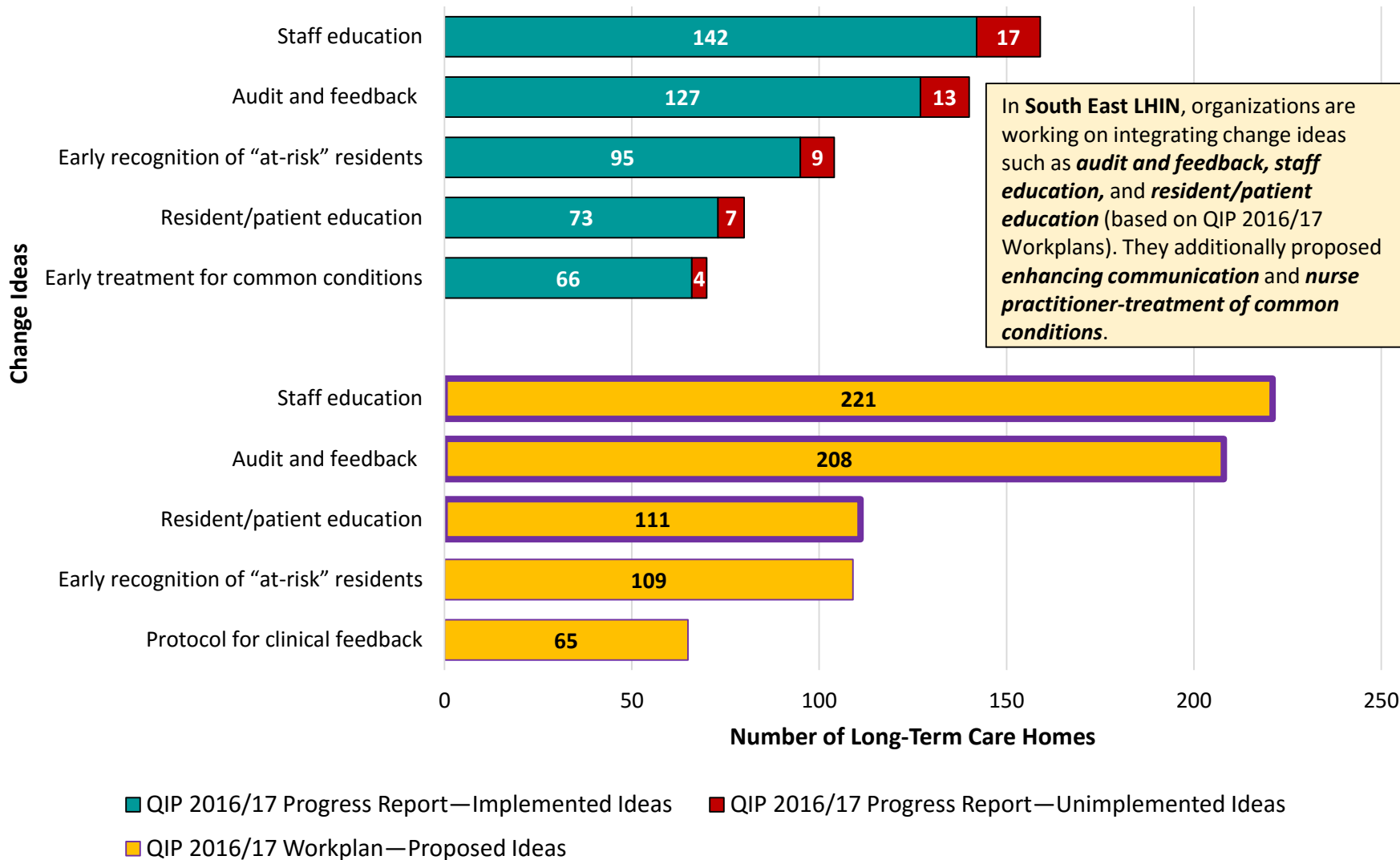




## Most common change ideas in Ontario from 2015/16 and 2016/17 QIPs for Hospital Readmissions for Community Care Access Centres, as reported in the 2016/17 QIPs



## 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

# Reducing Emergency Department (ED) Length of Stay

## Kingston General Hospital

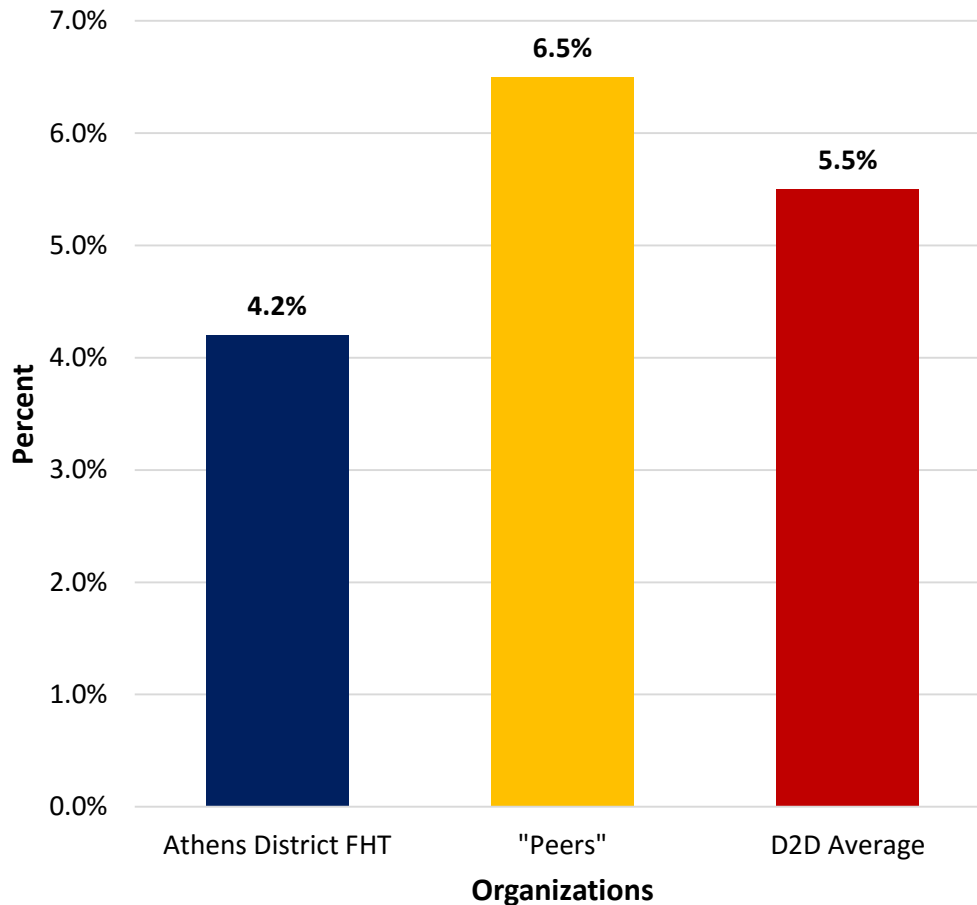
- Over the last four quarters, the 90th percentile wait time has decreased from 42.7 hours to 27.6 hours
- The hospital implemented a “Get Out Of Gridlock (GOOG)” initiative that engaged all clinical directors, managers, and charge nurses in twice daily huddles to review live patient flow data
- Help from Decision Support and program management, the team’s analysis of the daily bed census, Emergency Department Length of Stay and Volumes statistics (in addition to broader monthly tracking of the data), have provided invaluable insight into opportunities for process improvement:
  - Patient flow data sharing opportunities engaged physicians and enabled the team to drive earlier discharge times
  - Earlier communication with ED when a bed is ready
  - Trial of an “ED Surge Protocol” enabled team to move patients into pre-identified hallway locations on all wards

# Reducing Hospital Readmissions

## Athens District FHT

This bar graph image from the D2D.3 Association of Family Health Teams in Ontario Interactive Report shows our performance with "access" comparing our team (blue bar) with our "peers" (orange bar) and the "D2D average" (red bar). Our team's hospital readmission rate was 4.2%, our peers was 6.5% and average D2D overall rate was 5.5%. Another source for this statistic was from the Health Data Branch Web Portal for 2015/16 and our team had the lowest percentage (9%) of readmission in our South East LHIN.

Athens District FHT Hospital Readmissions



# Collaborating to Improve Care

## Kingston Health Link (KHL)

- The KHL is working with 9 differently governed primary care organizations with over 37 distinct primary care medical offices and over 120 family doctors
- To date, KHL has engaged over 50% of the family physicians in Kingston and completed over 400 coordinated care plans (CCP)
- The most recent 12 month results for 122 patients who had a CCP initiated between January 1, 2014 and December 31, 2014 show that our collective efforts are having the following impact:
  - 38.9% reduction in Kingston General Hospital Inpatient Visits
  - 31% reduction in Kingston General Hospital Emergency Department Visits
  - 37% reduction in Hotel Dieu Hospital Urgent Care Centre visits
  - 51.6% reduction in Kingston General Hospital Inpatient Length of Stay Days

# Improving and Standardizing Care

## South East CCAC

- Standardizing levels of personal support service offered to patients (based on similar needs) and developing common service standards with the aim of reducing variation among practices
- Aim from 2014. By December 2015, >85% long stay patients received service in line with standards
  - Not all patient needs fit within a standard and the CCAC has established an Exceptions Committee to review cases that Care Coordinators have identified as needing personal support outside of the standards
- Critical success factor: empowering Care Coordinators to identify and plan for exceptions to the standards, identify the needs of the growing number of complex patients in the community, and work with community partners to address service gaps
- Moving forward, developing standardized levels of care will allow the CCAC to:
  - Provide clearer information to patients, families, and partners about what home care services are available
  - Better identify needs that fall outside CCAC services, and work with community partners to address these gaps
  - Contribute to provincial standard service levels currently under development, as outlined in the Ministry's Action Plan for Home and Community Care

# Reducing Emergency Department (ED) Visits

## **Moira Place Long-Term Care Home**

- Physicians are very engaged in preventing ED transfers

## **Perth Community Care Centre**

- Perth is a rural area, which presents several ongoing challenges, including:
  - A 2<sup>nd</sup> on-call physician list at the local hospital that is accessed when the primary physician is unavailable
  - Physicians from the 2<sup>nd</sup> on-call list are not familiar with the residents
  - Mitigation: Improve communication with Primary Care Physicians



# 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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