

South West 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](#)

South West LHIN Overview

Sector	QIP Count	Description
Hospitals	14	<ul style="list-style-type: none"> " 1 acute teaching hospital " 5 large community hospitals " 6 small community hospitals " 2 Unknown-tbd
Primary care	27	<ul style="list-style-type: none"> " 19 Family Health Teams " 5 Community Health Centres " 2 Nurse Practitioner Led Clinics " 1 Aboriginal Health Access Centre
Community	1	<ul style="list-style-type: none"> " CCAC
Long-term care	77	<ul style="list-style-type: none"> " 51 for-profit " 9 not-for-profit " 17 municipal
Multi-sector*	1	<ul style="list-style-type: none"> " 1 hospital " 2 long-term care

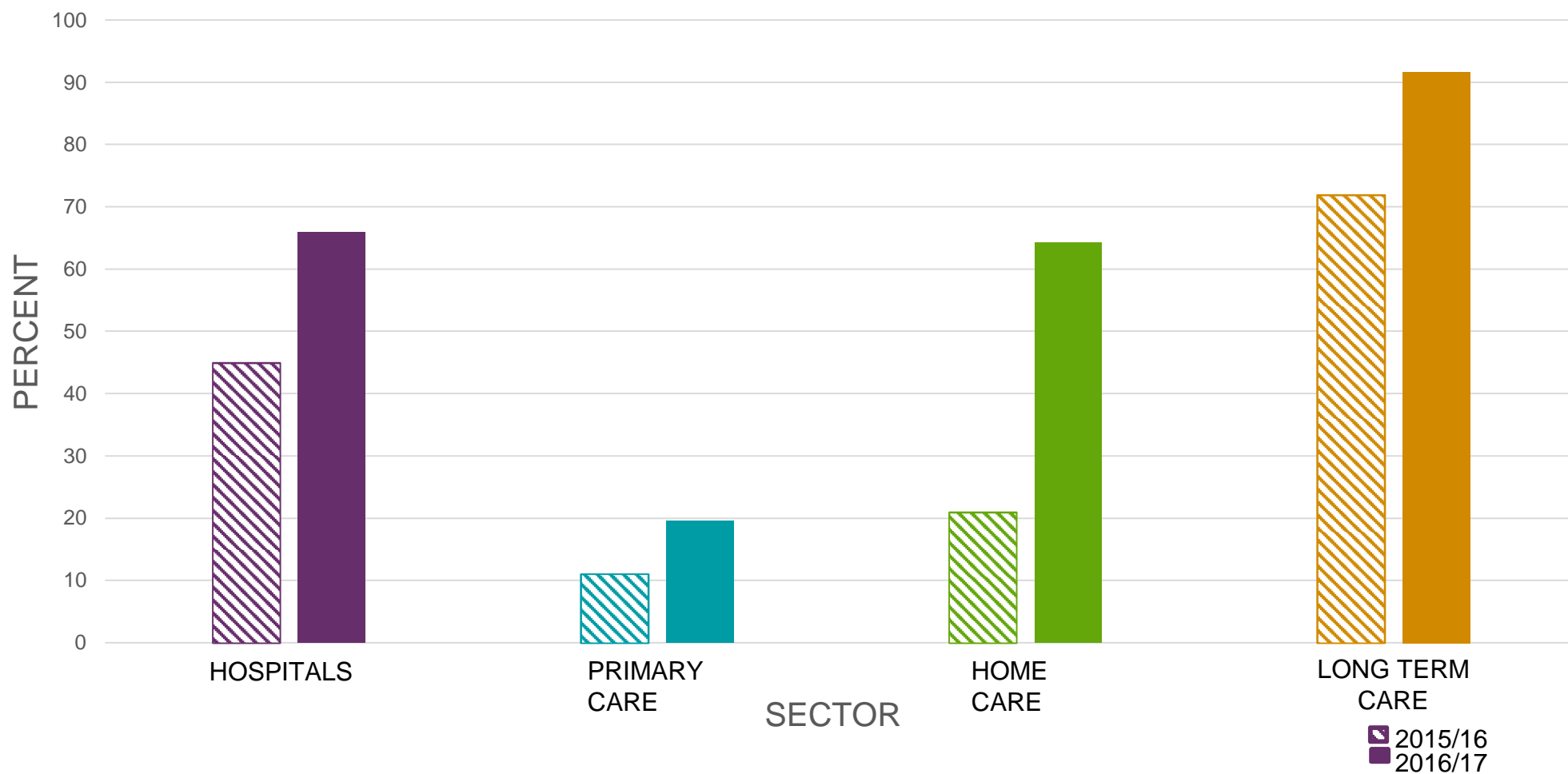
*Please note that multi-sector sites are already included in the sector totals, above.

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.

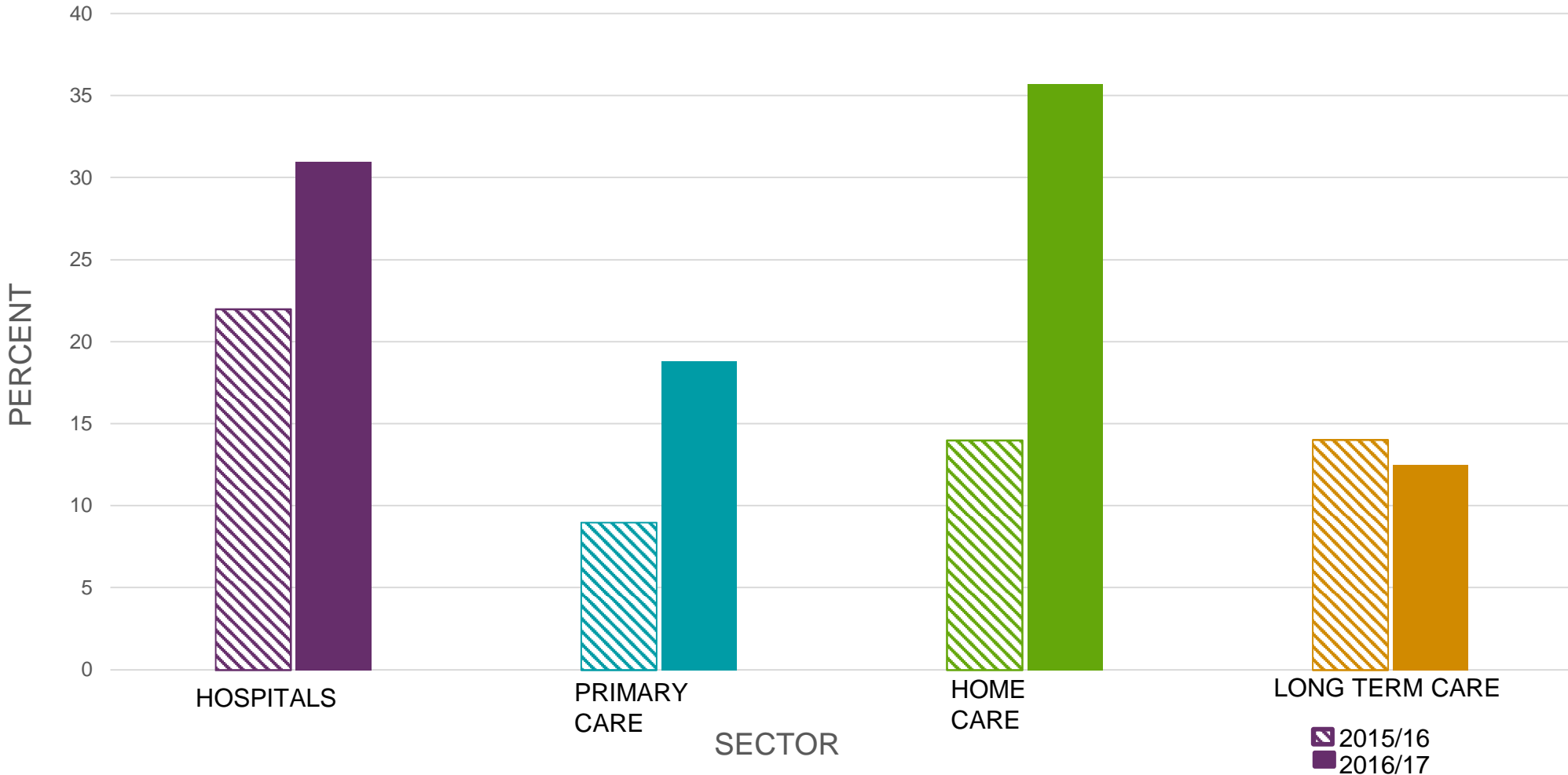
All sectors described an increased use of Patient and Family Advisory Councils and Forums in the development of their QIPs

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



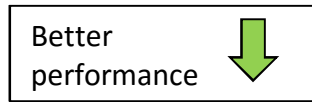
Key Observations – Per Sector

- “ **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).

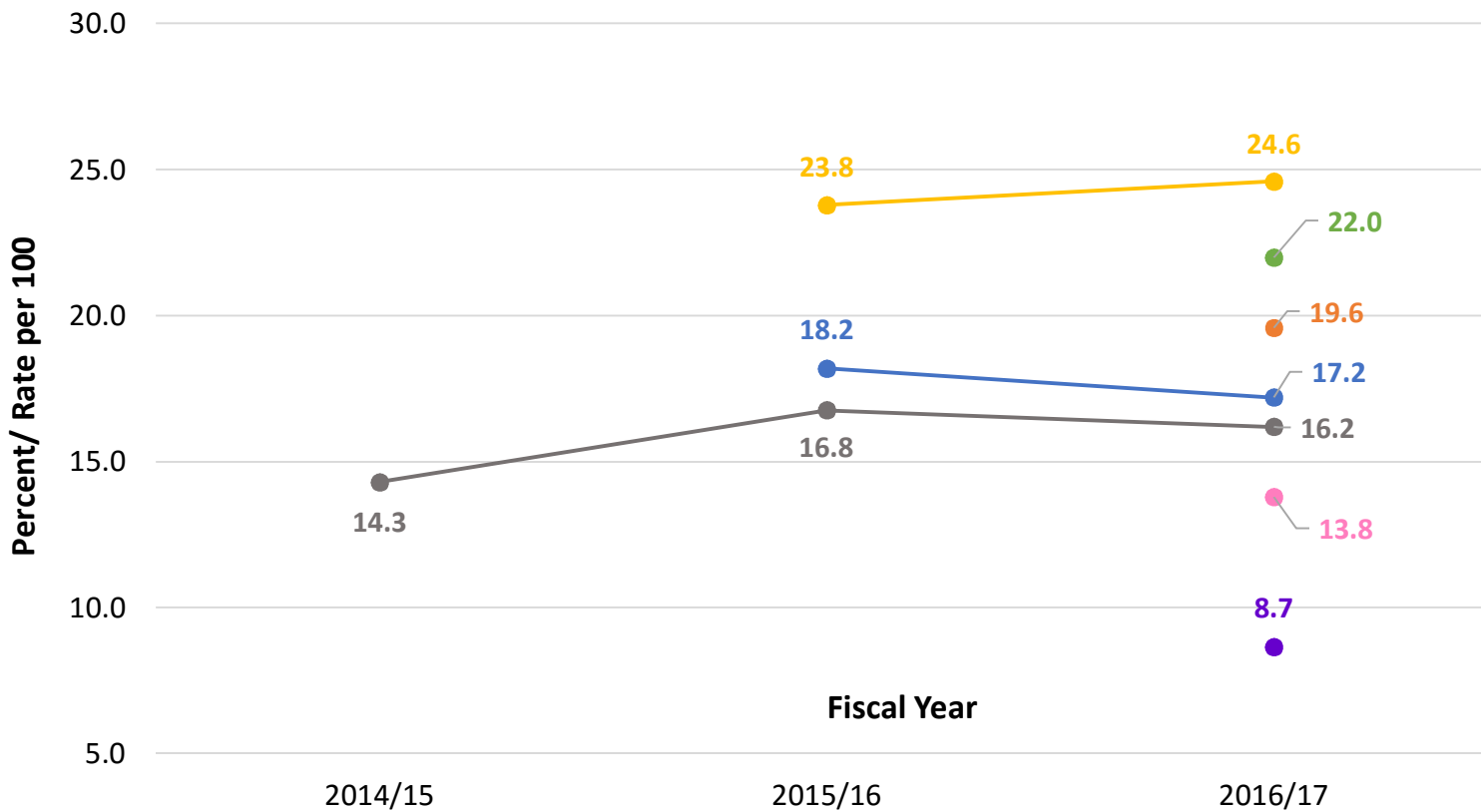
QUALITY IMPROVEMENT PLAN DATA

Provincial Averages

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



- 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

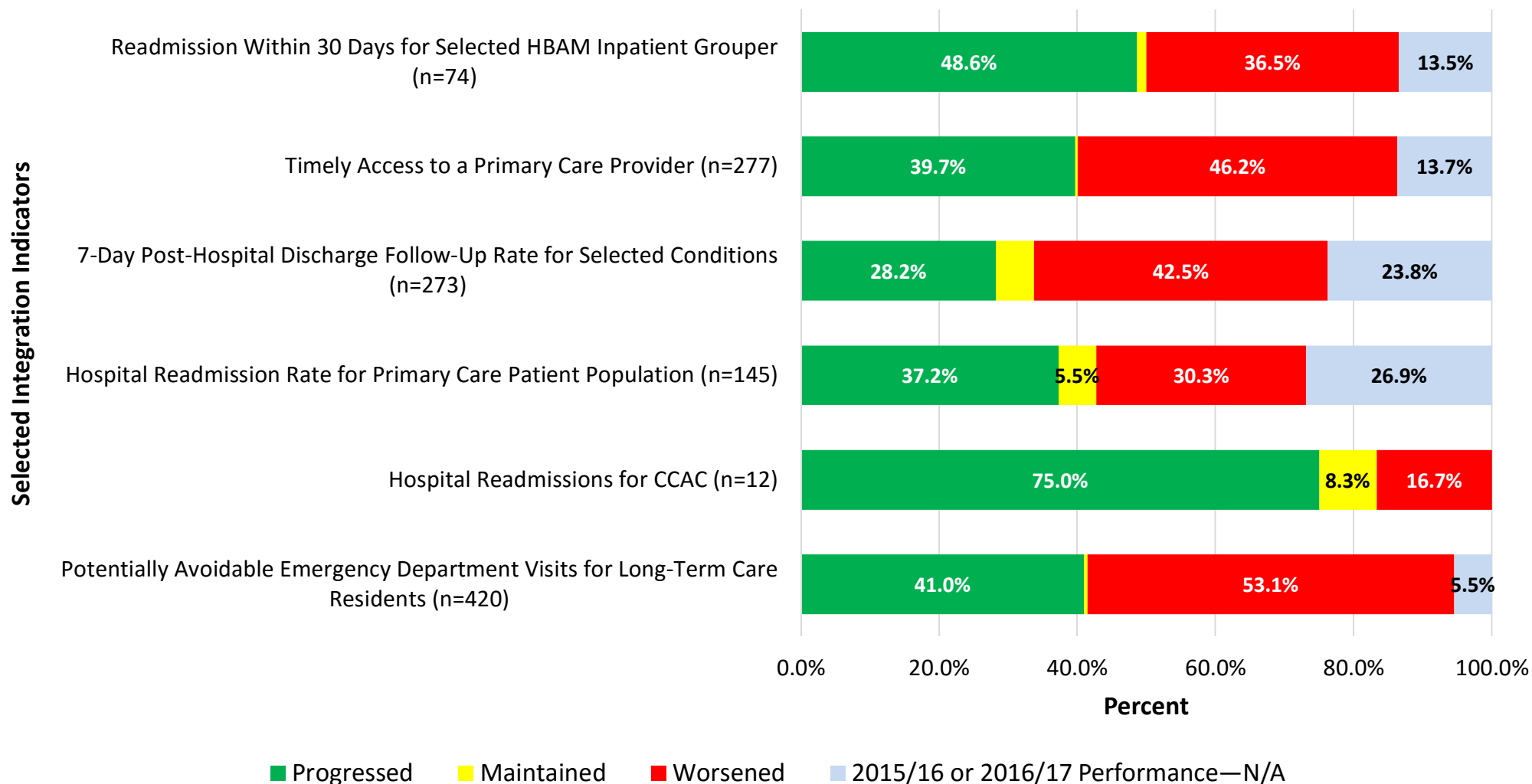


*Data were obtained from external sources, and indicators presented in the graph are risk-unadjusted unless specified otherwise. Potentially avoidable ED visits for long-term care residents has a unit of rate per 100 long-term care residents; all other indicators have a unit of percent. Provincial average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

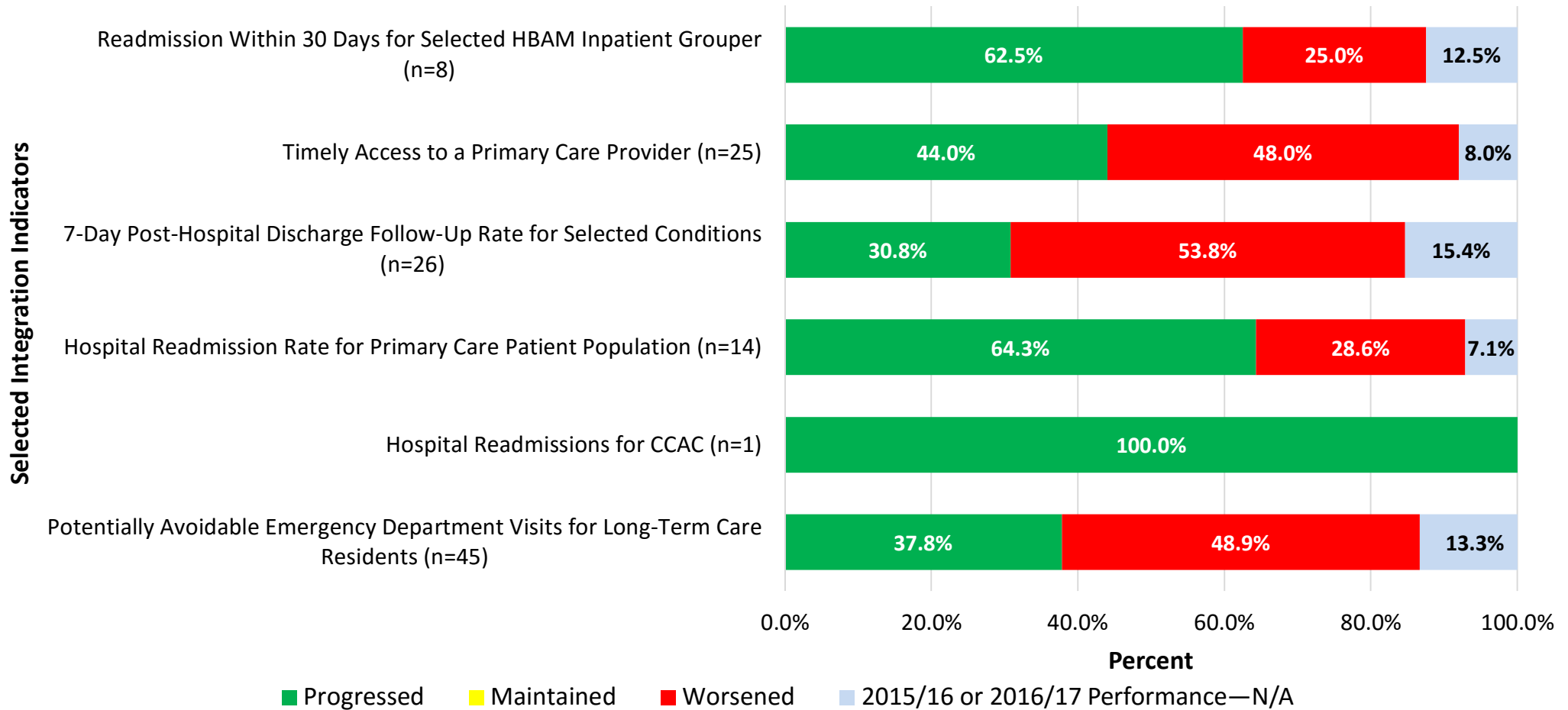
Looking back: Percentage of organizations in Ontario that progressed, maintained or worsened their performance between the 2015/16 QIP and the 2016/17 QIP on selected integration indicators, as reported in the QIP 2016/17 Progress Report



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.

South West LHIN QIP Data: Progress Made in 2016/17

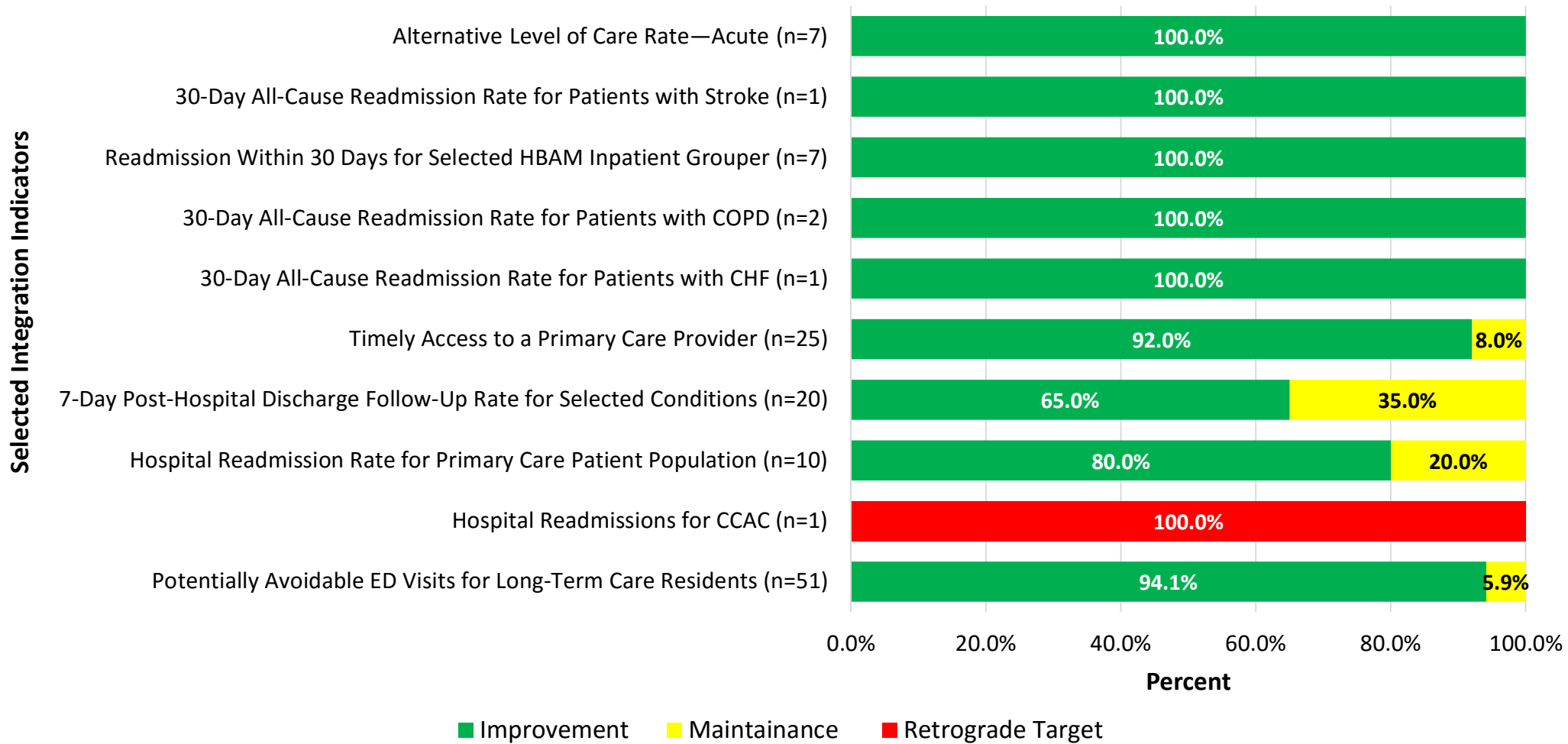
Looking back: Percentage of organizations in South West LHIN that progressed, maintained or worsened in their performance between 2015/16 QIP and 2016/17 QIP on selected integration indicators, as reported in QIP 2016/17 Progress Report



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.

South West LHIN QIP Data: Target Setting in 2016/17

Looking forward: Percentage of organizations in South West 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 West LHIN QIP Data: 2016/17 Indicator Selection

Sector	General Areas of Focus: Integration Indicators	Current Performance SW 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)	23.73%	22.00%	1/14
	ii. 30-Day All-Cause Readmission Rate for Patients with Chronic Obstructive Pulmonary Disease (QBP)	18.93%	19.60%	2/14
	iii. 30-Day All-Cause Readmission Rate for Patients with Stroke (QBP)	8.05%	8.67%	1/14
	iv. Readmission Within 30 days for Selected HBAM Inpatient Grouper (HIGs)	16.69%	16.19%	7/14
	v. Alternate Level of Care Rate – Acute (ALC Rate)	11.13%	13.84%	7/14
Primary Care	i. 7-day Post-hospital Discharge Follow-Up Rate for Selected Conditions	N/A**	N/A**	27/27
	ii. Access to primary care (survey-based)	N/A**	N/A**	27/27
	iii. Hospital Readmission Rate for Primary Care Patient Population	N/A**	N/A**	13/27
Community Care Access Centres	i. Hospital Readmissions	16.46%	17.23%	1/1
Long Term Care	i. ED visits for Ambulatory Care Sensitive conditions	24.00%	24.55%	56/77

* 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 SW LHIN:

- 3 Hospitals 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*

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

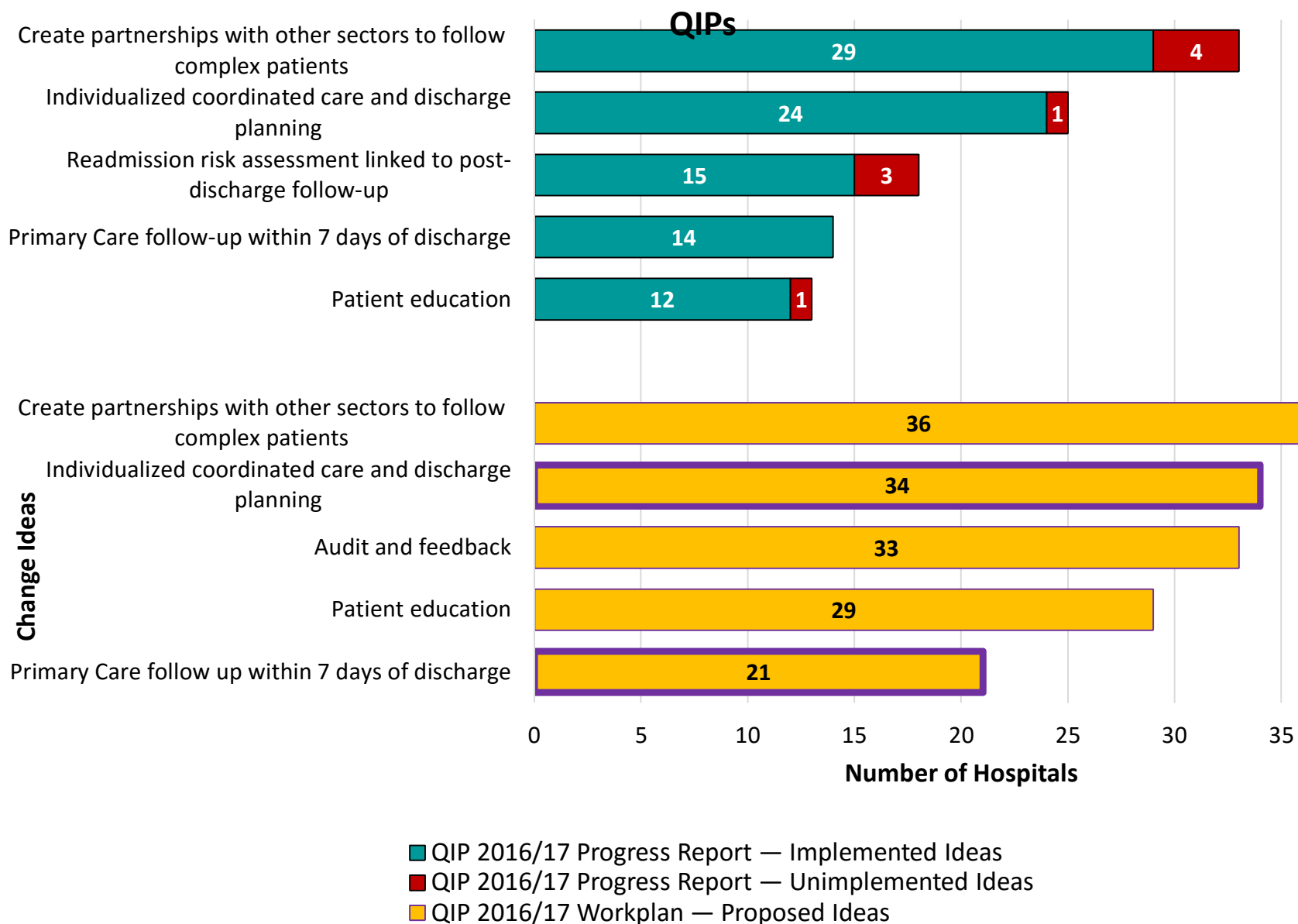
Note: Interpret data with caution; please refer to Technical Specifications; for instance, the three QBP indicators and the Readmissions HIG indicator are risk-adjusted, while the rest are not risk-adjusted.

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

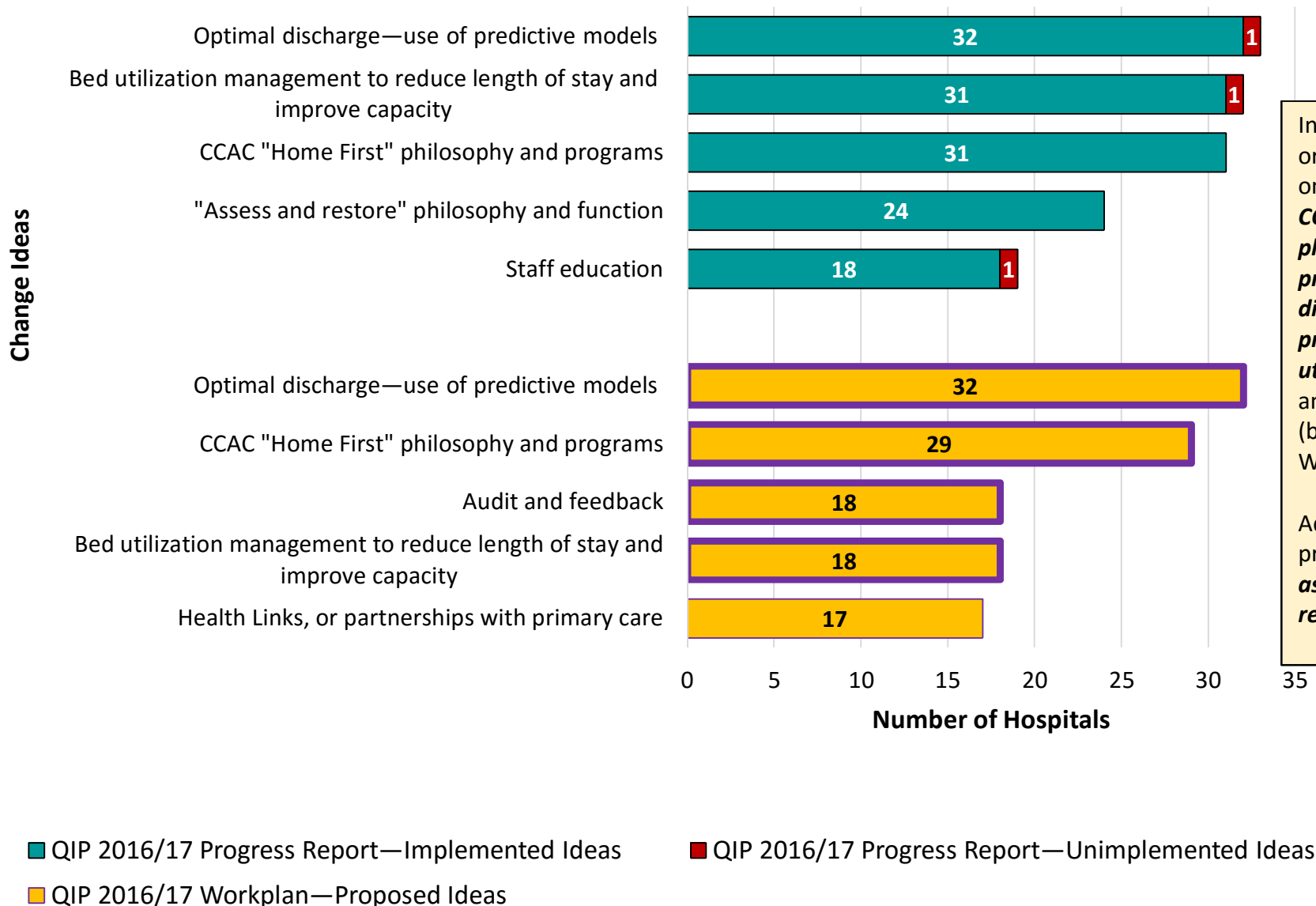


In South West LHIN, organizations are working on change ideas such as **PC follow up within 7 days, patient education, and individualized care and discharge planning** (based on QIP 2016/17 Workplans).

Additionally organizations proposed change ideas relating to **medication reconciliation at discharge and use of clinical pathways.**

* 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

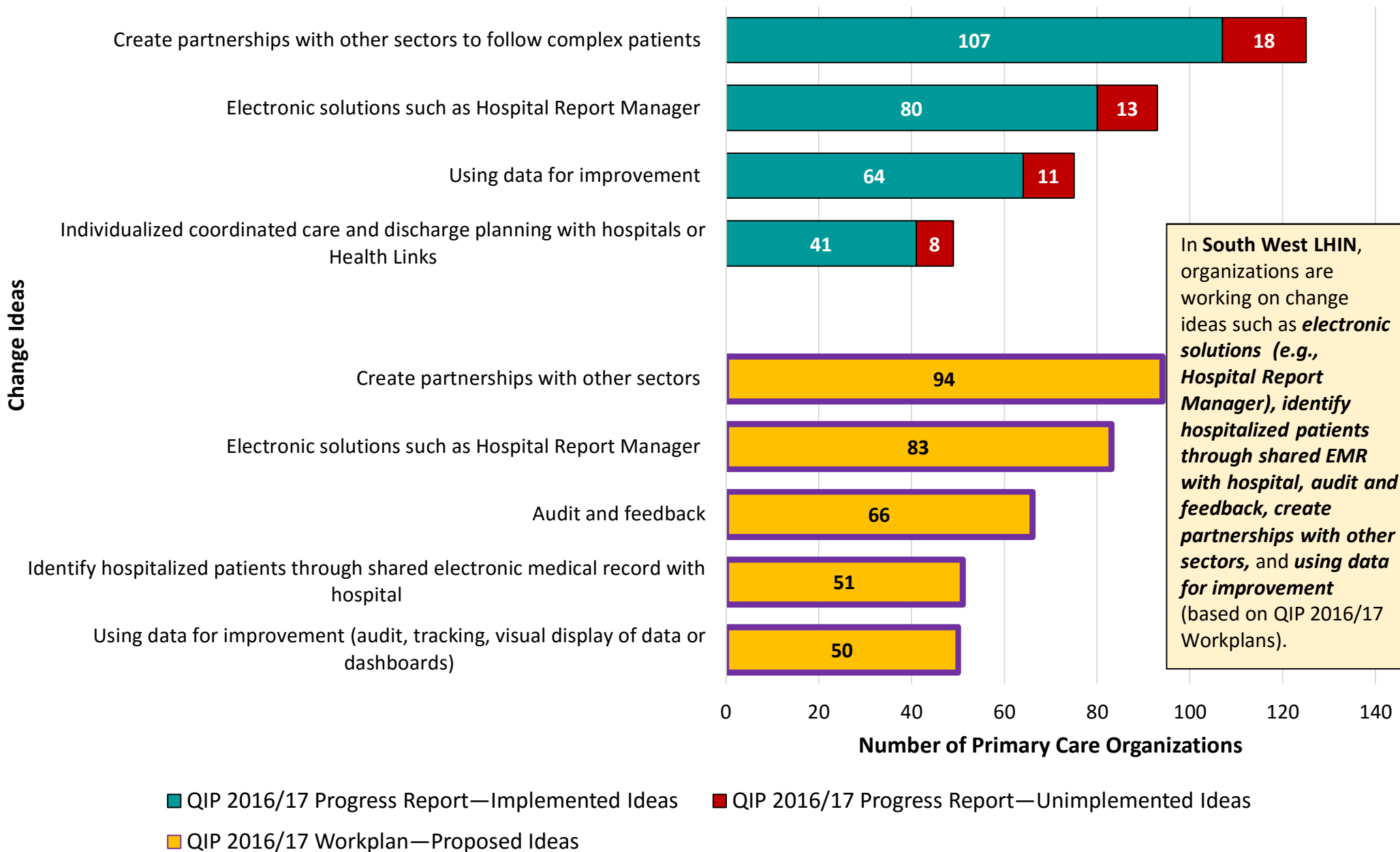


In South West LHIN, organizations are working on change ideas such as **CCAC "Home First" philosophy and programs, optimal discharge- use of predictive models, bed utilization management, and audit and feedback** (based on QIP 2016/17 Workplans).

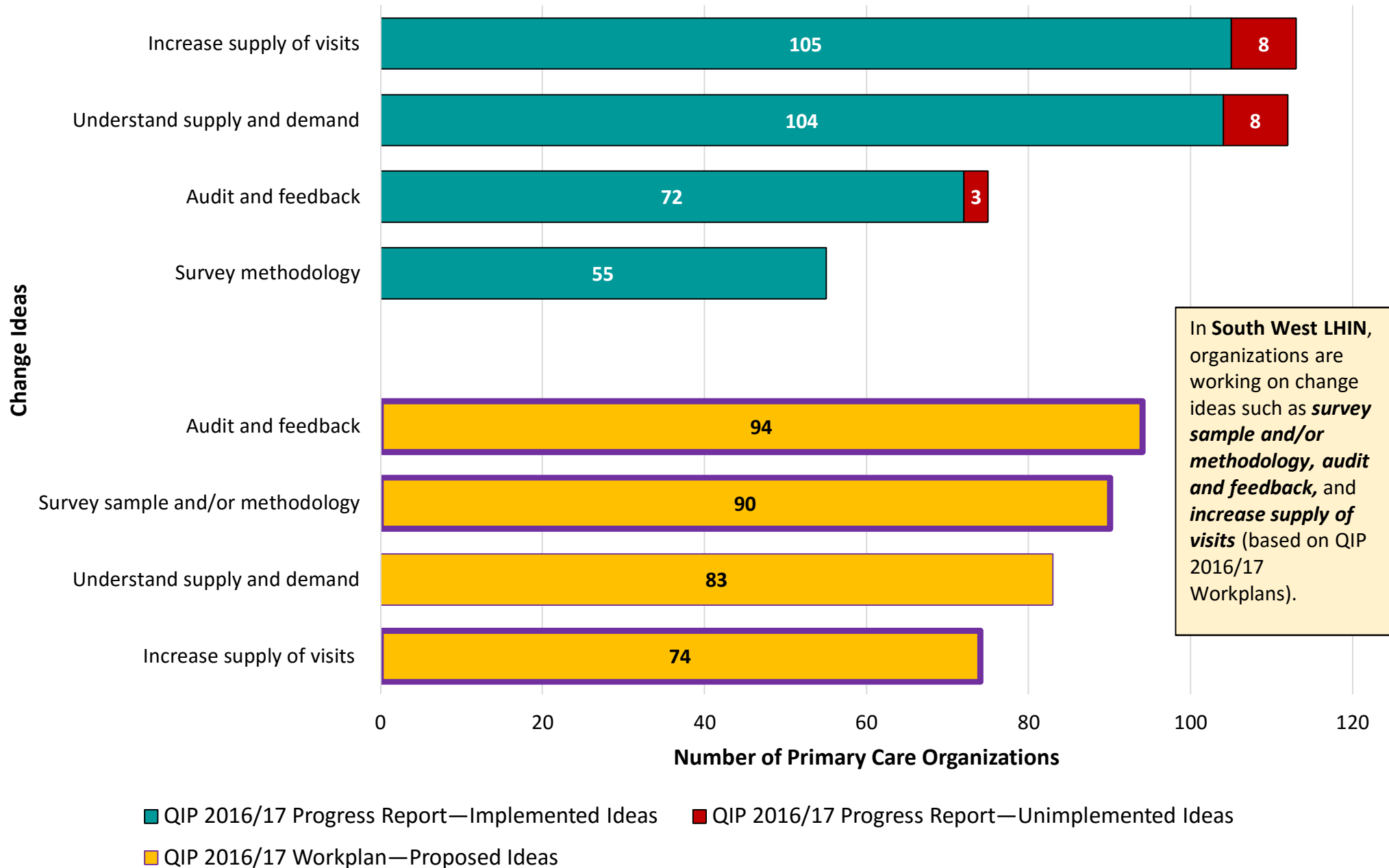
Additionally organizations proposed change ideas **assess and restore/ rehabilitation.**

* 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.

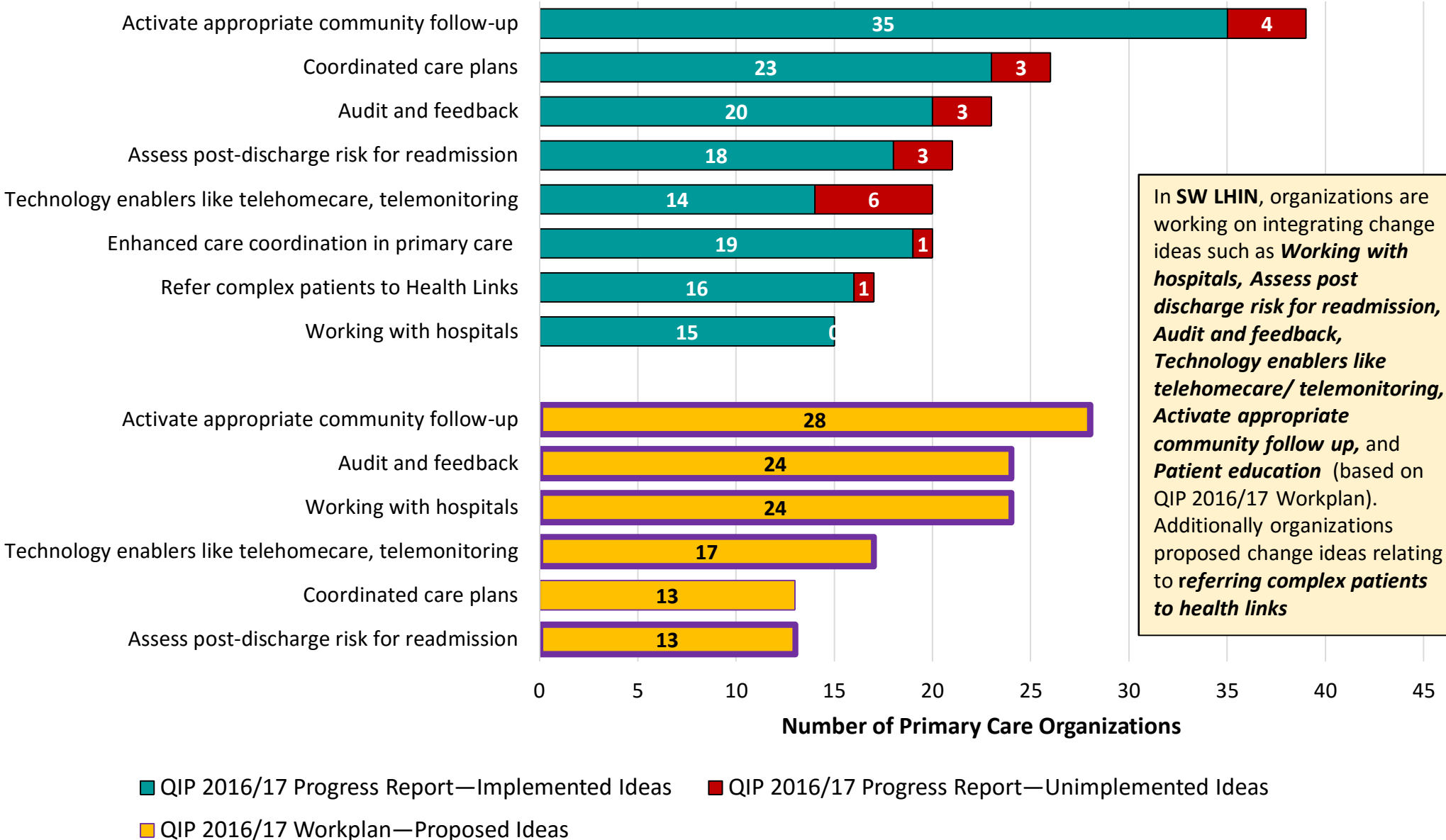
Most common change ideas in Ontario from 2015/16 and 2016/17 primary care QIPs for 7-Day Post-Hospital Discharge Follow-Up Rate for Selected Conditions, as reported in the 2016/17 QIPs



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

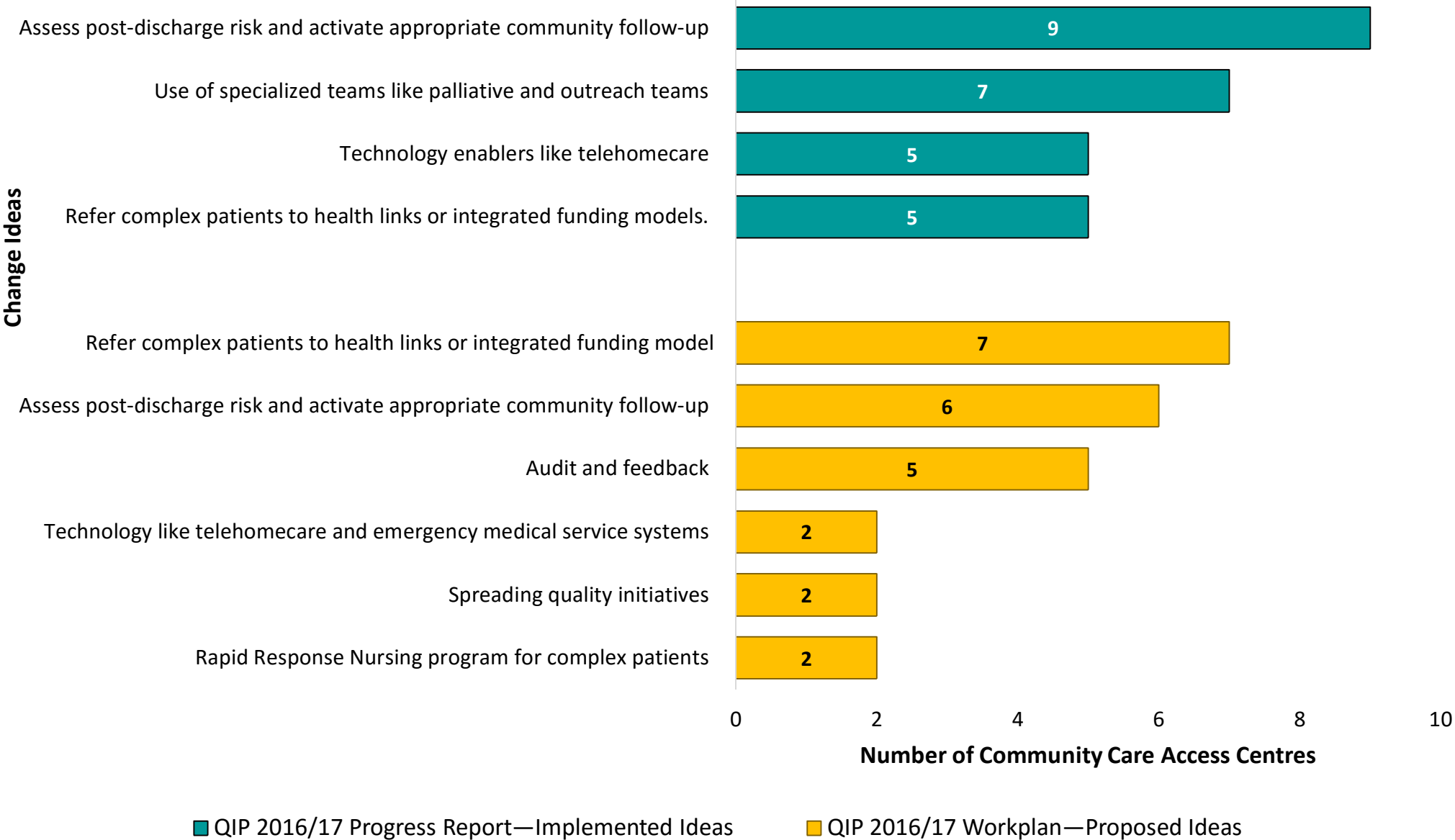


Most common change ideas in Ontario from 2015/16 and 2016/17 primary care QIPs for Readmission Within 30 Days for Selected HBAM Inpatient Groupers, as reported in the 2016/17 QIPs

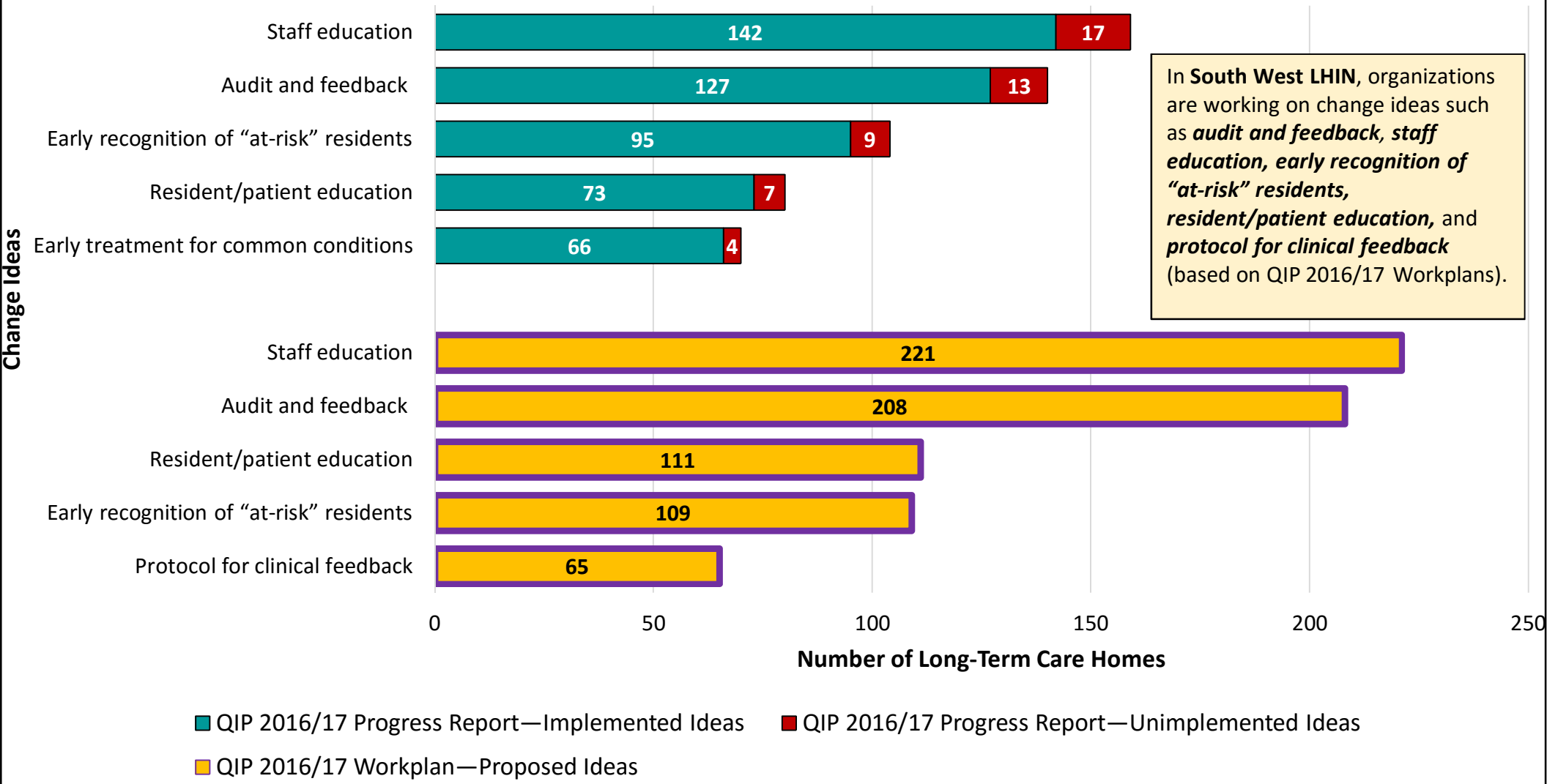


In **SW LHIN**, organizations are working on integrating change ideas such as ***Working with hospitals, Assess post discharge risk for readmission, Audit and feedback, Technology enablers like telehomecare/ telemonitoring, Activate appropriate community follow up, and Patient education*** (based on QIP 2016/17 Workplan). Additionally organizations proposed change ideas relating to ***referring complex patients to health links***

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

SPOTLIGHTS

Optimizing Transitions of Care

St. Thomas-Elgin General Hospital

Change Ideas:

- “ Physicians discharge summaries within 48 hours of discharge
- “ Hospital ward clerks to schedule follow-up appointments with patients & family doctor
- “ Transcription outsourced

Results:

- “ Reached 94% on follow-up appointments booked for discharged patients and their primary care giver
- “ 90% compliance with completion of Best Possible Medical History for admitted patients
- “ Discharge summaries being completed within 48 hours of patient discharge = 89% (baseline 41%)

Reducing Readmissions

Bluewater Area Family Health Team

Accomplishments:

- “ Reduced hospital readmissions from 20% to 2% in one year (SW LHIN average 17%)
- “ Clinicians will see any patient who is ill and needs to be seen the same day
- “ The clinic has not had any Health Links patients identified to them by local hospitals

Future Plans:

1. Review Coordinated Care Plans for Health Links patients to reduce readmissions
2. Increase communication between the General Practitioner and home care support services
3. Increase the frequency of house calls by either the General Practitioner or an Allied Health Professional

Reducing Alternate Level of Care (ALC) Rates

South West CCAC

- “ The CCAC’s successful implementation of Intensive Hospital to Home program contributed greatly to the reduction of Alternate Level of Care (ALC) rates across the region
- “ A refresh of the Home First approach was completed in 2015/16 for all Hospital Care Coordinators and Hospital staff
- “ The Access to Care program has positioned CCAC Care Coordinators to support assessment and coordinated access for rehabilitation, transitional care, restorative care, and complex continuing care beds in hospitals, adult day programs, supportive housing, and assisted living

Reducing Emergency Department (ED) Visits

Southampton Care Centre

- “ Doctors on call would have long-term care residents transferred to the hospital for further assessment if they were working in emergency department instead of visiting the long-term care home
- “ The Medical Director engaged attending physicians who were on call in the emergency department to the importance of seeing residents at the home rather than transferring them to hospital for further assessment
- “ The number of unnecessary transfers immediately stopped. This was effective at the home level as well as in the community

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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