North West LHIN 2016/2017 QIP Snapshot Report

Health Quality Ontario
The provincial advisor on the quality of health care in Ontario

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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

For more information about these QIP indicators, see the 2016/17 QIP indicator technical specification document

Community care

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

Long-term care (LTC)

- Emergency Department Visits for Ambulatory Care–Sensitive Conditions

North West LHIN Overview

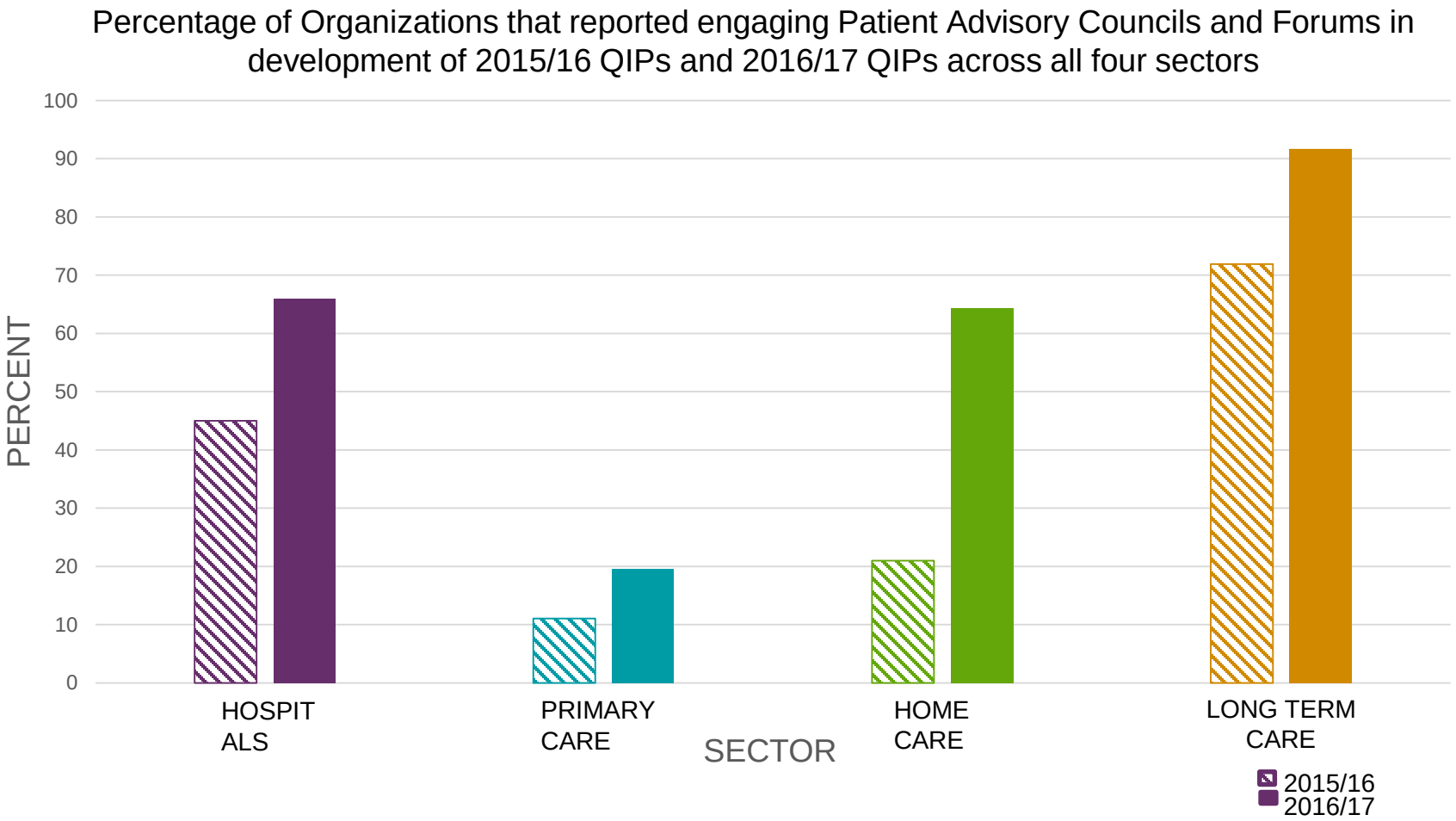
Sector	QIP Count	Description
Hospitals	16	• 1 teaching • 5 large community • 9 small community/rural • 1 rehab
Primary care	22	• 15 FHTs • 2 CHCs • 3 AHACs • 2 NPLC
Community care	1	• 1 CCAC
Long-Term care	19	• 9 not-for-profit homes • 6 for-profit homes • 4 municipal homes
Multi-sector*	8	• 8 hospitals • 2 FHTS • 10 LTCs

*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



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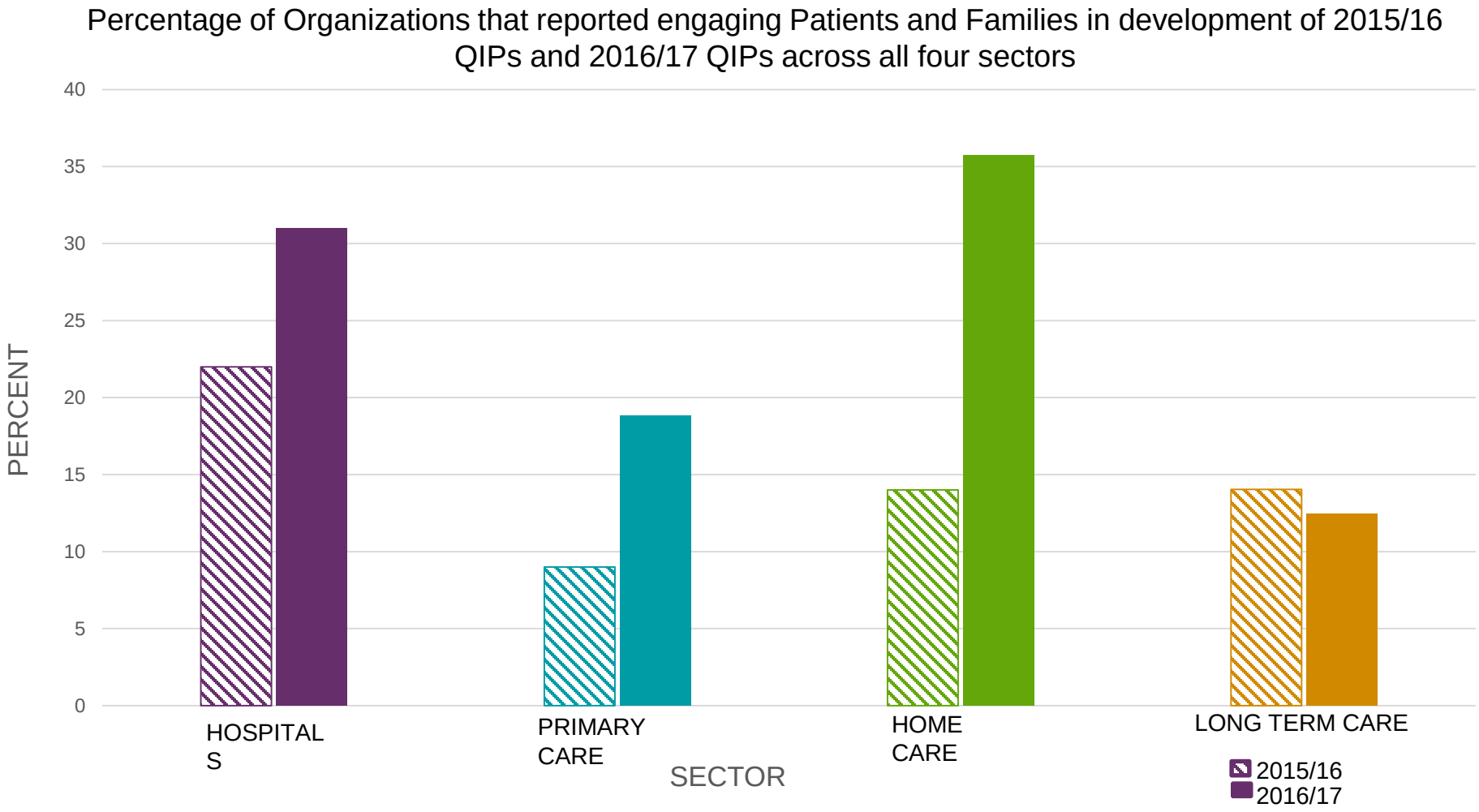
Most sectors described an increased engagement of patients and families in the co-design of QI initiatives



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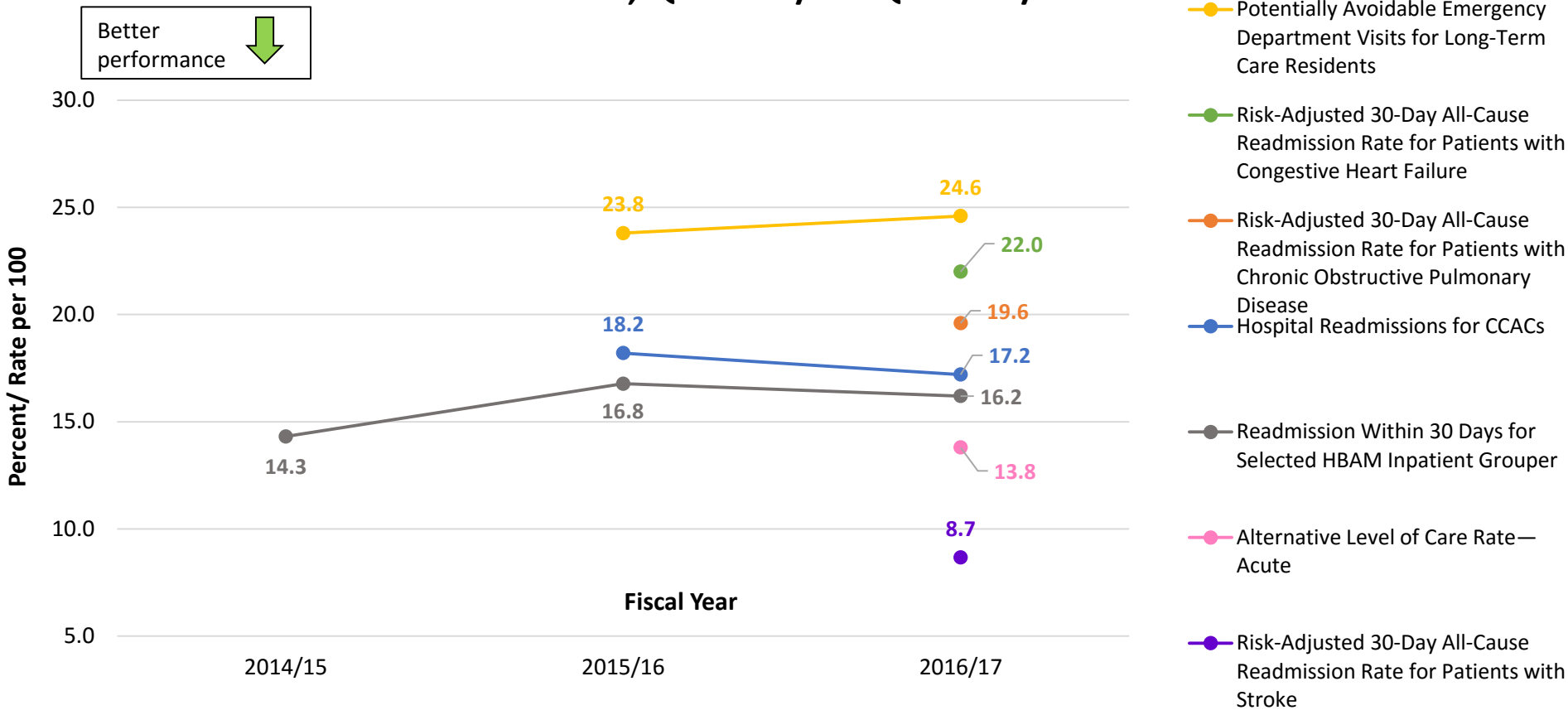
Key Observations – Per Sector

- **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.

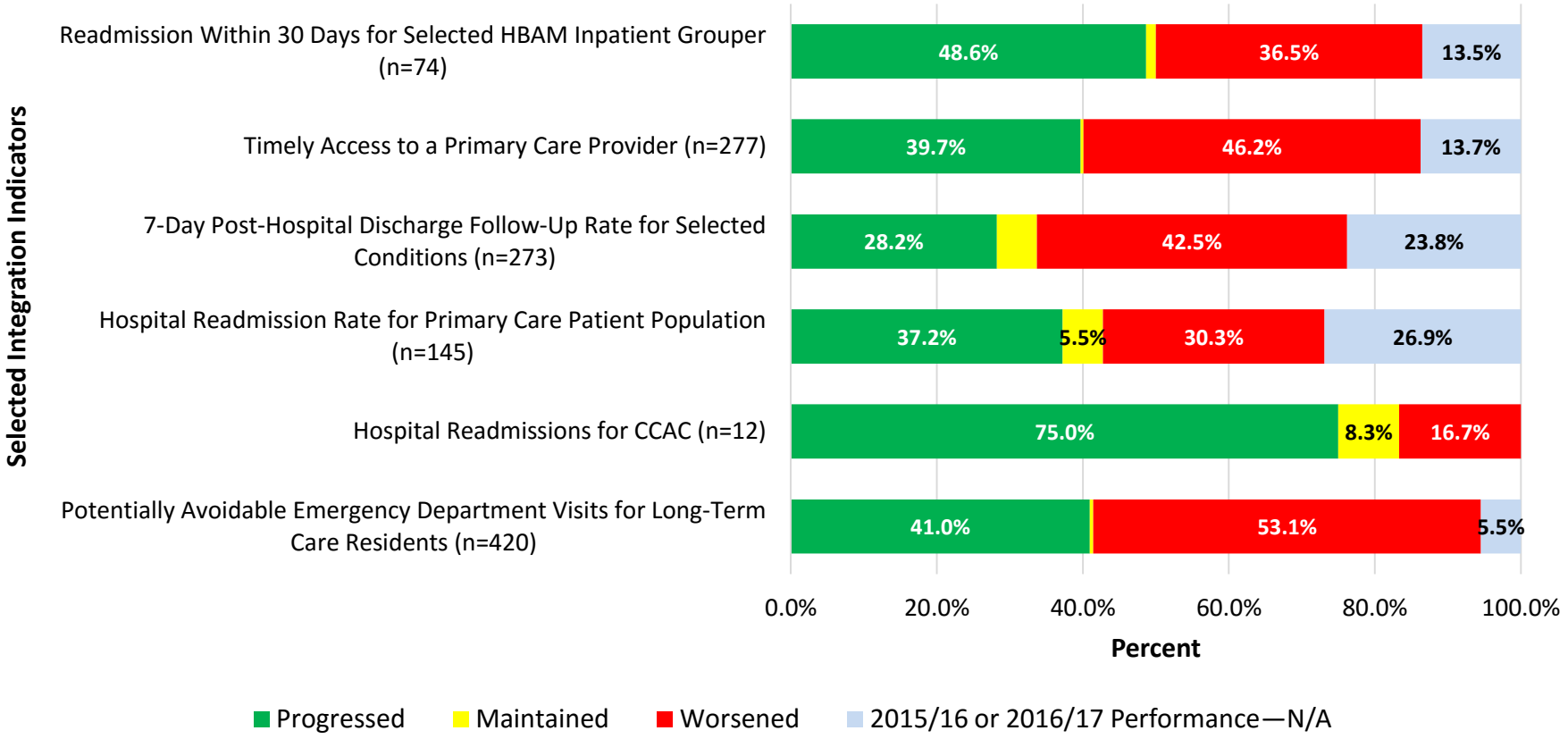
Risk-Adjusted 30-Day All-Cause Readmission Rate for Patients with Congestive Heart Failure; Risk-Adjusted 30-Day All-Cause Readmission Rate for Patients with Chronic Obstructive Pulmonary Disease, Readmission Within 30 Days for Selected HBAM Inpatient Groupers, Risk-Adjusted 30-Day All-Cause Readmission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

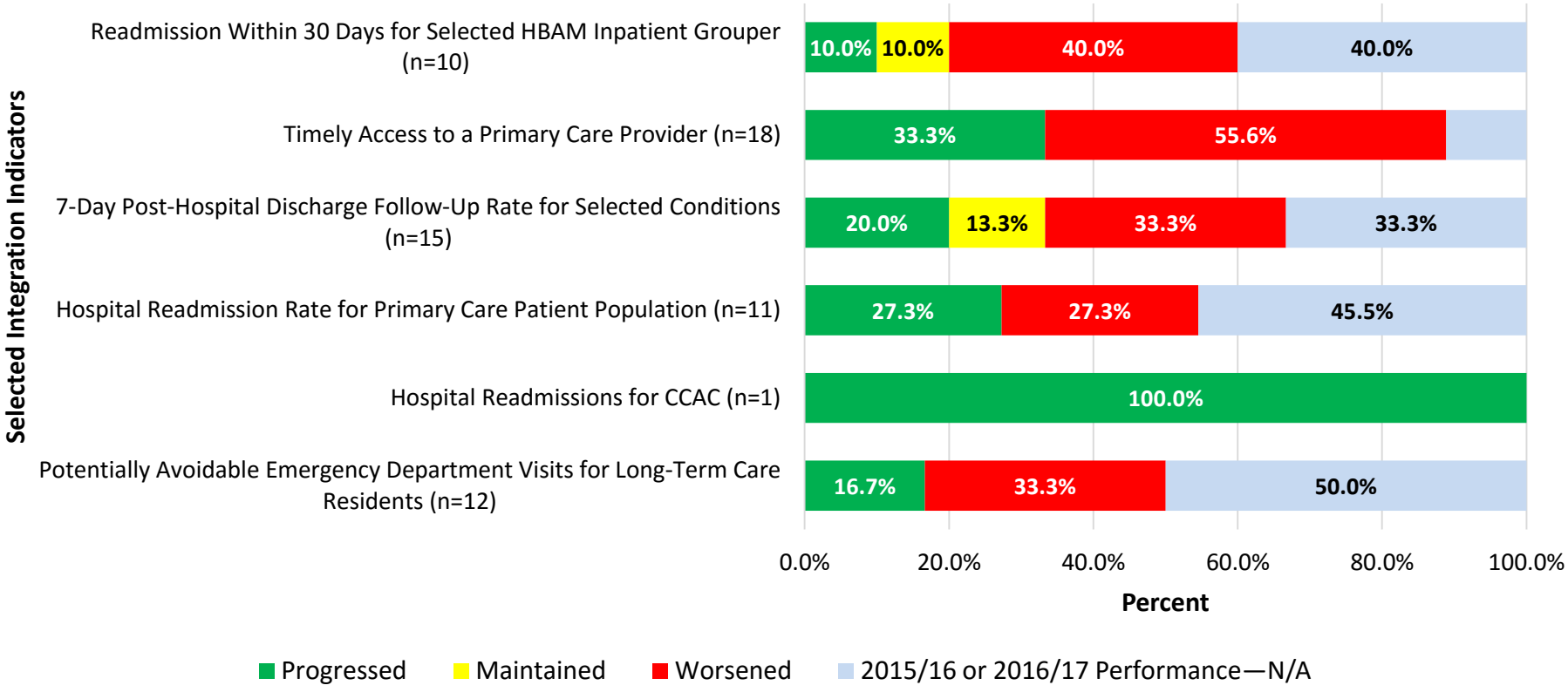
Looking back: Percentage of organizations in Ontario that progressed, maintained or worsened their performance between the 2015/16 QIP and the 2016/17 QIP on selected integration indicators, as reported in the QIP 2016/17 Progress Report



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.

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

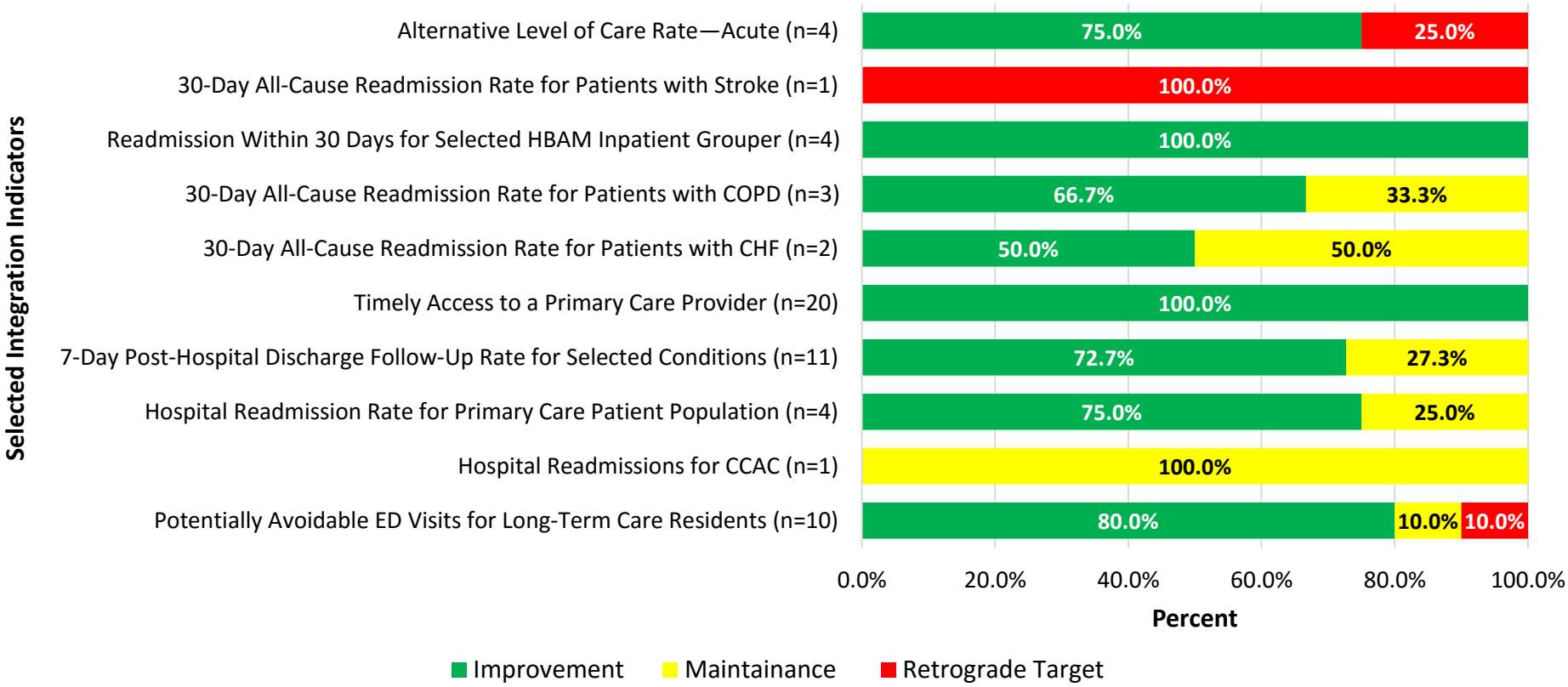
Looking back: Percentage of organizations in North West LHIN that progressed, maintained or worsened in their performance between the 2015/16 QIP and the 2016/17 QIP on selected integration indicators, as reported in the 2016/17 QIP Progress Report



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.

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

Looking forward: Percentage of organizations in North 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.

North West LHIN QIP Data: 2016/17 Indicator Selection

Sector	General Areas of Focus: Integration Indicators	Current Performance NW 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)	22.31%	22.00%	6/13
	ii. 30-Day All-Cause Readmission Rate for Patients with Chronic Obstructive Pulmonary Disease (QBP)	20.83%	19.60%	5/13
	iii. 30-Day All-Cause Readmission Rate for Patients with Stroke (QBP)	8.96%	8.67%	3/13
	iv. Readmission Within 30 days for Selected HBAM Inpatient Grouper (HIGs)	15.50%	16.19%	4/13
	v. Alternate Level of Care Rate – Acute (ALC Rate)	26.29%	13.84%	4/13
Primary Care	i. 7-day Post-hospital Discharge Follow-Up Rate for Selected Conditions	N/A**	N/A**	18/22
	ii. Access to primary care (survey-based)	N/A**	N/A**	22/22
	iii. Hospital Readmission Rate for Primary Care Patient Population	N/A**	N/A**	9/22
Community Care Access Centres	i. Hospital Readmissions	17.60%	17.23%	1/1
Long Term Care	i.ED visits for Ambulatory Care Sensitive conditions	21.10%	24.55%	13/19

* 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 NW LHIN:

- 1 Hospital 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*

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

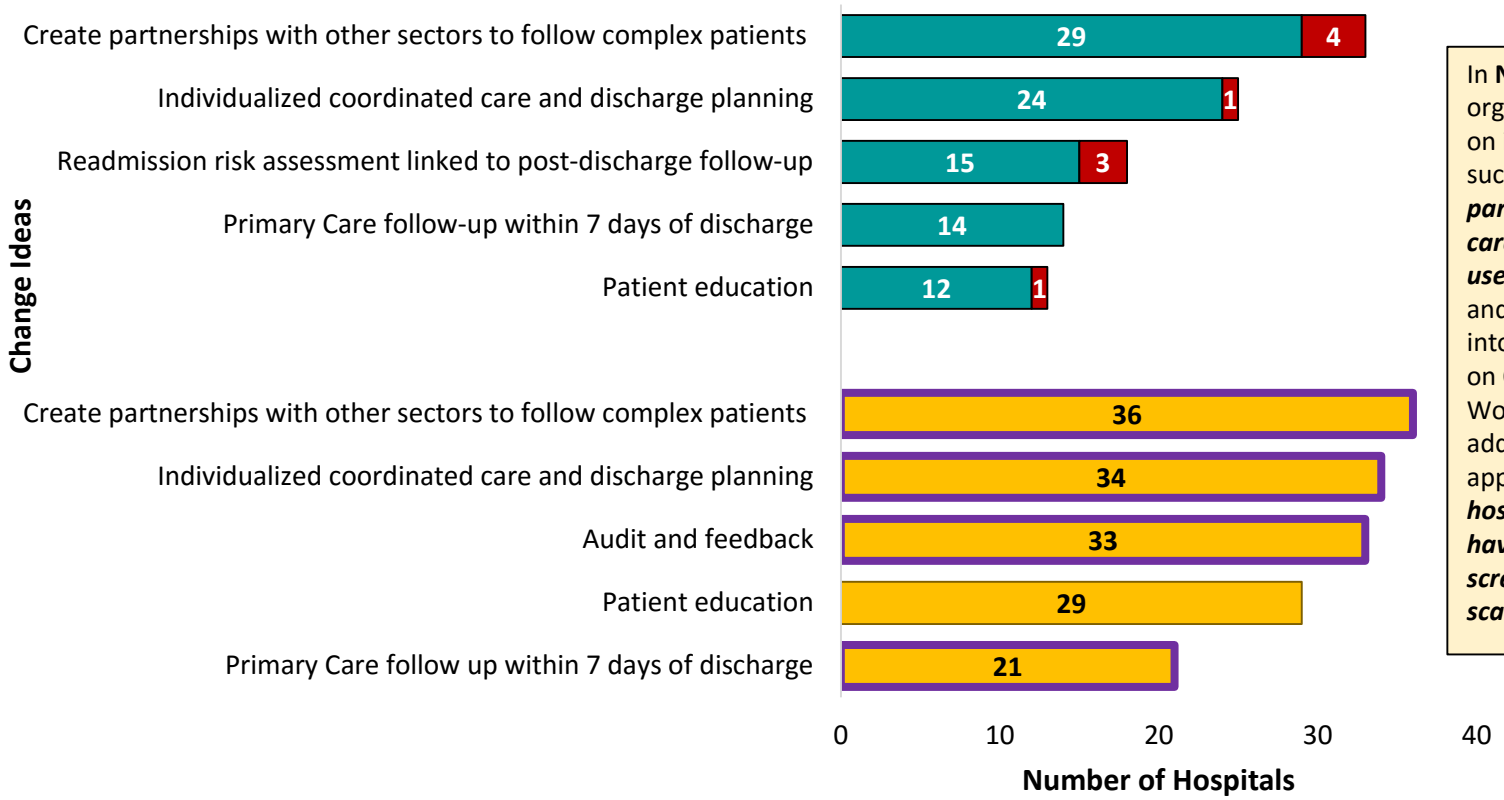
Note: Interpret data with caution; please refer to Technical Specifications; for instance, the three QBP indicators and the Readmissions HIG indicator are risk-adjusted, while the rest are not risk-adjusted.

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

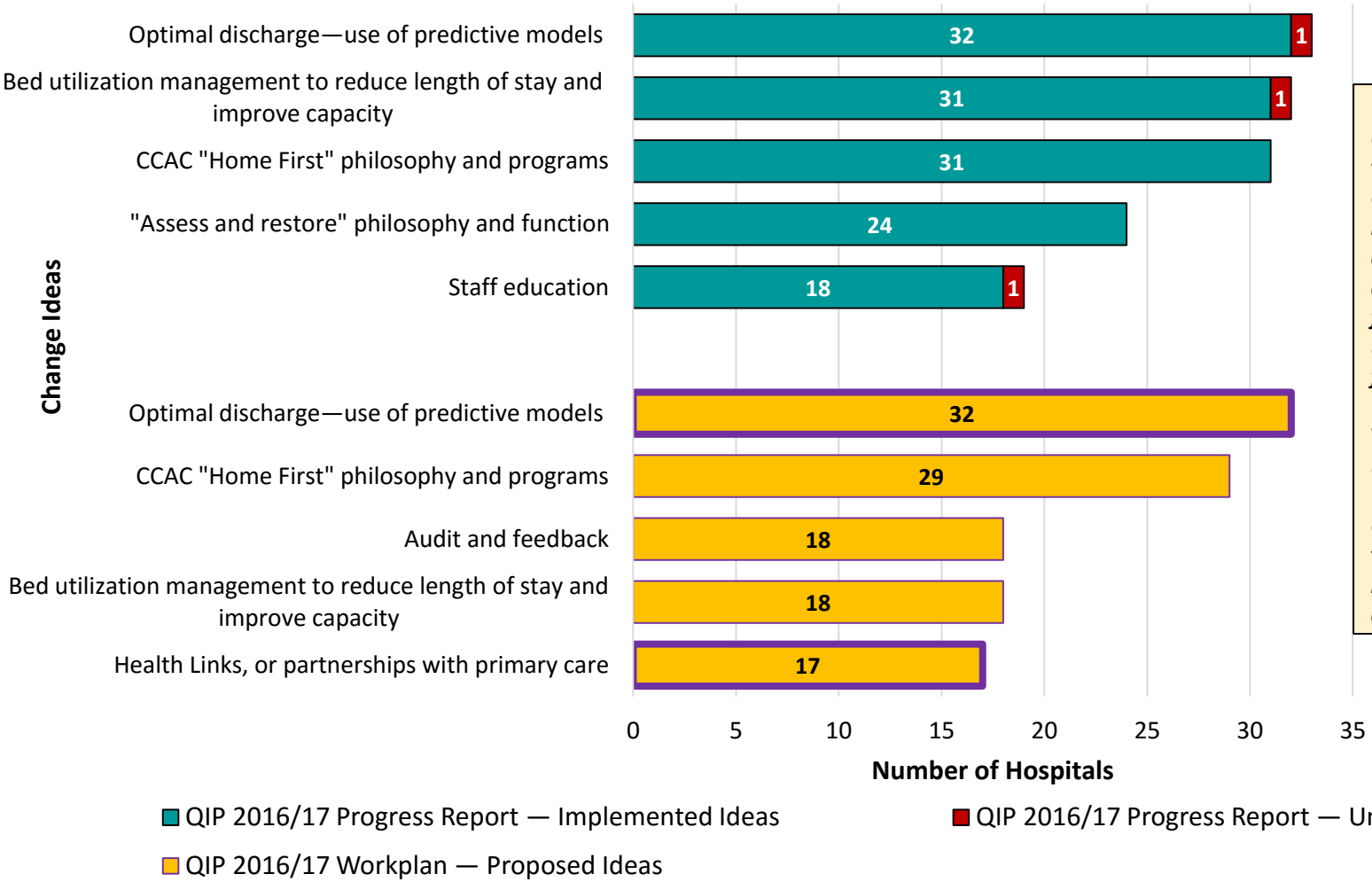
Most common change ideas in Ontario from 2015/16 and 2016/17 hospital QIPs for 30-Day Readmission Rate,* as reported in the 2016/17 QIPs



In **North West LHIN**, organizations are working on integrating change ideas such as ***Health Links or partnerships with primary care, optimal discharge-use of predictive models*** and ***audit and feedback*** into their QI efforts (based on QIP 2016/17 Workplans). They additionally propose applying ***senior friendly hospital principles by having all seniors >70 be screened using a functional scale (the Barthel scale) .***

* 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.

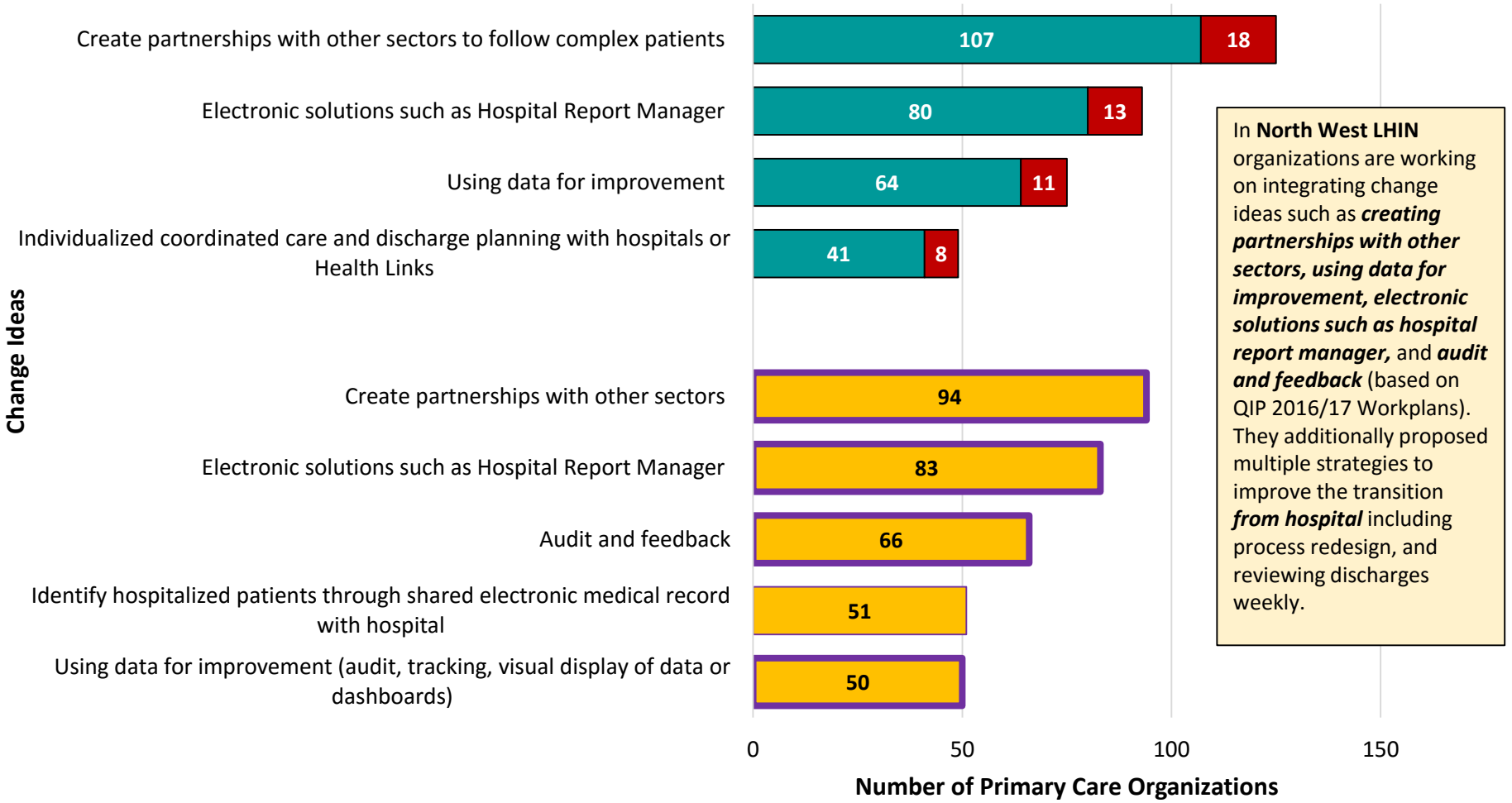
Most common change ideas in Ontario from 2015/16 and 2016/17 hospital QIPs for Alternative Level of Care,* as reported in the 2016/17 QIPs



In **North West LHIN**, organizations are working on integrating change ideas such as ***individualized care and discharge planning, audit and feedback, PC follow up within 7 days,*** and ***partnerships to follow complex patients*** (based on QIP 2016/17 Workplans). They additionally proposed using ***telehomecare*** to connect patients to follow up and linking ***risk- assessment to discharge follow-up***.

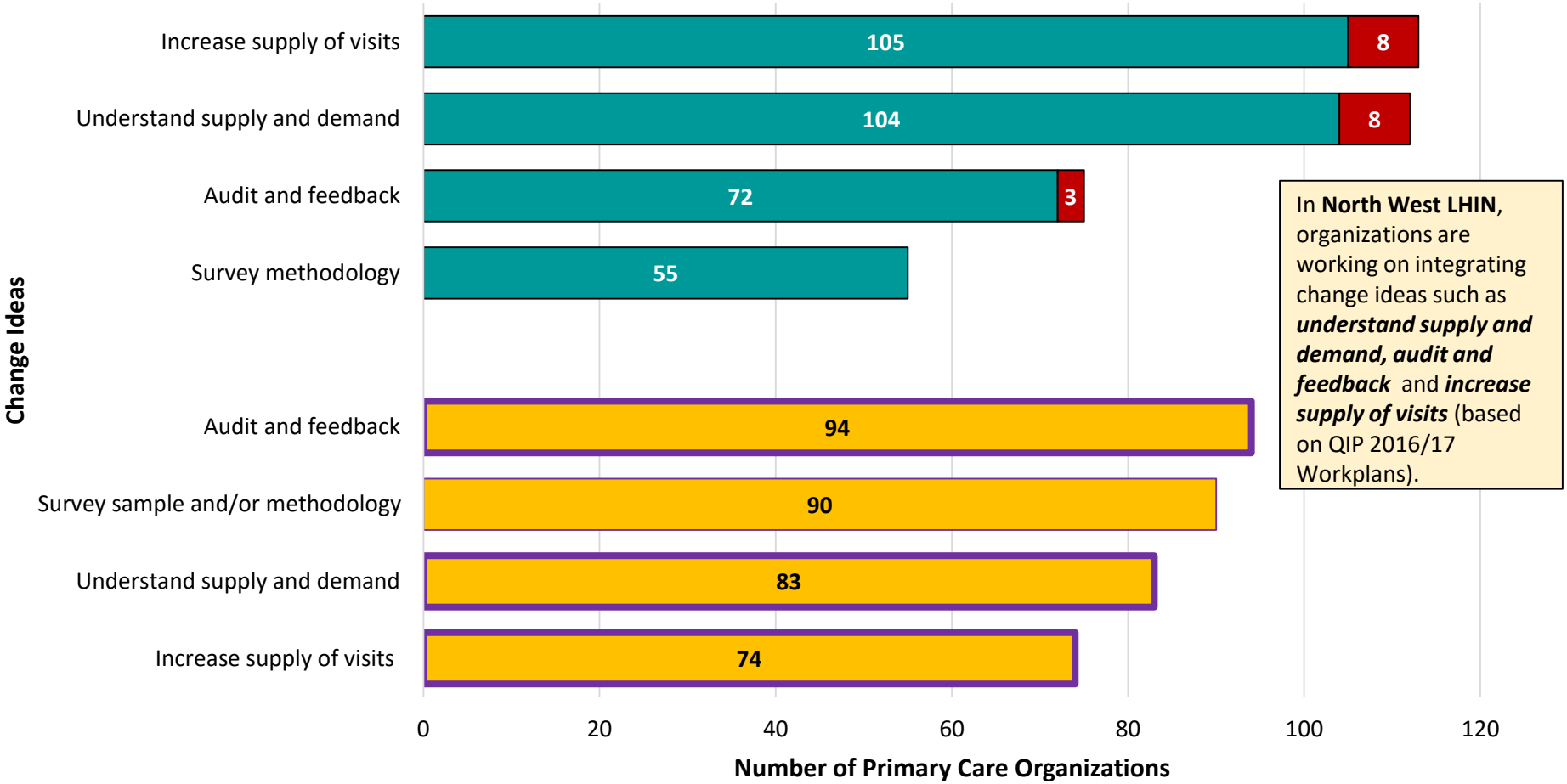
* The information presented combines data submitted by organizations on the following alternative level of care indicators: Alternative Level of Care Rate—Acute, and Percent Alternative Level of Care Days.

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



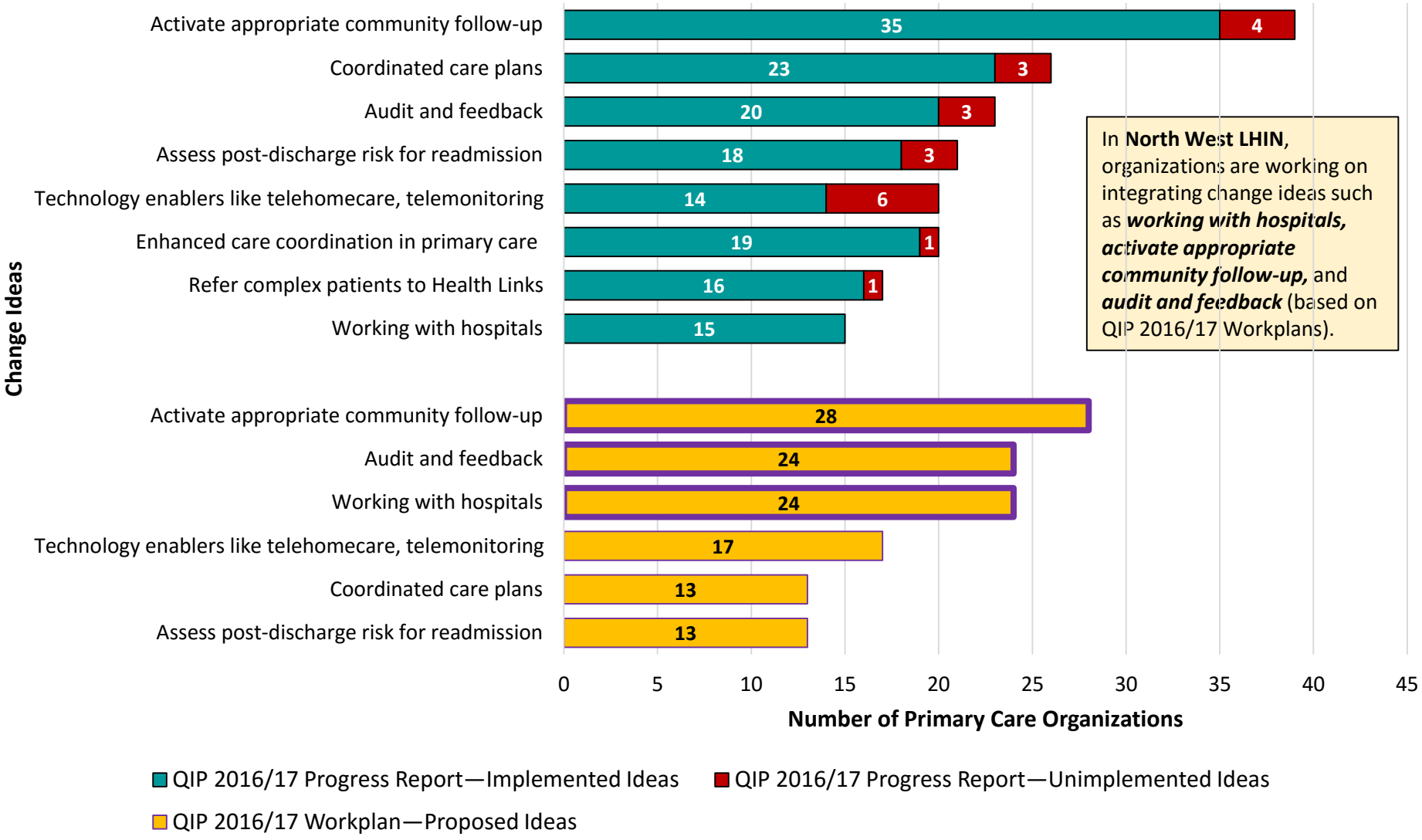
In **North West LHIN** organizations are working on integrating change ideas such as ***creating partnerships with other sectors, using data for improvement, electronic solutions such as hospital report manager,*** and ***audit and feedback*** (based on QIP 2016/17 Workplans). They additionally proposed multiple strategies to improve the transition ***from hospital*** including process redesign, and reviewing discharges weekly.

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

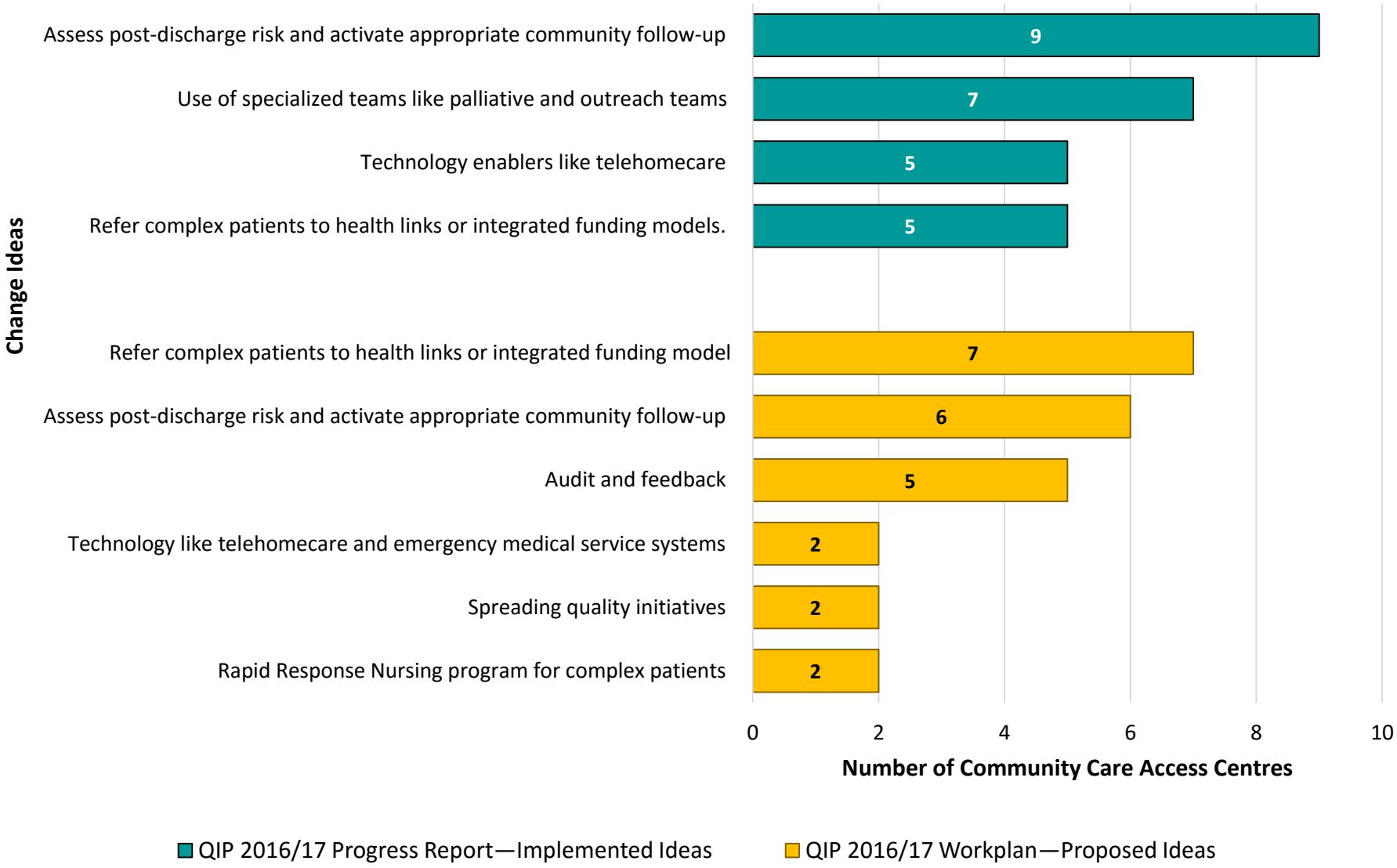


In **North West LHIN**, organizations are working on integrating change ideas such as ***understand supply and demand, audit and feedback*** and ***increase supply of visits*** (based on QIP 2016/17 Workplans).

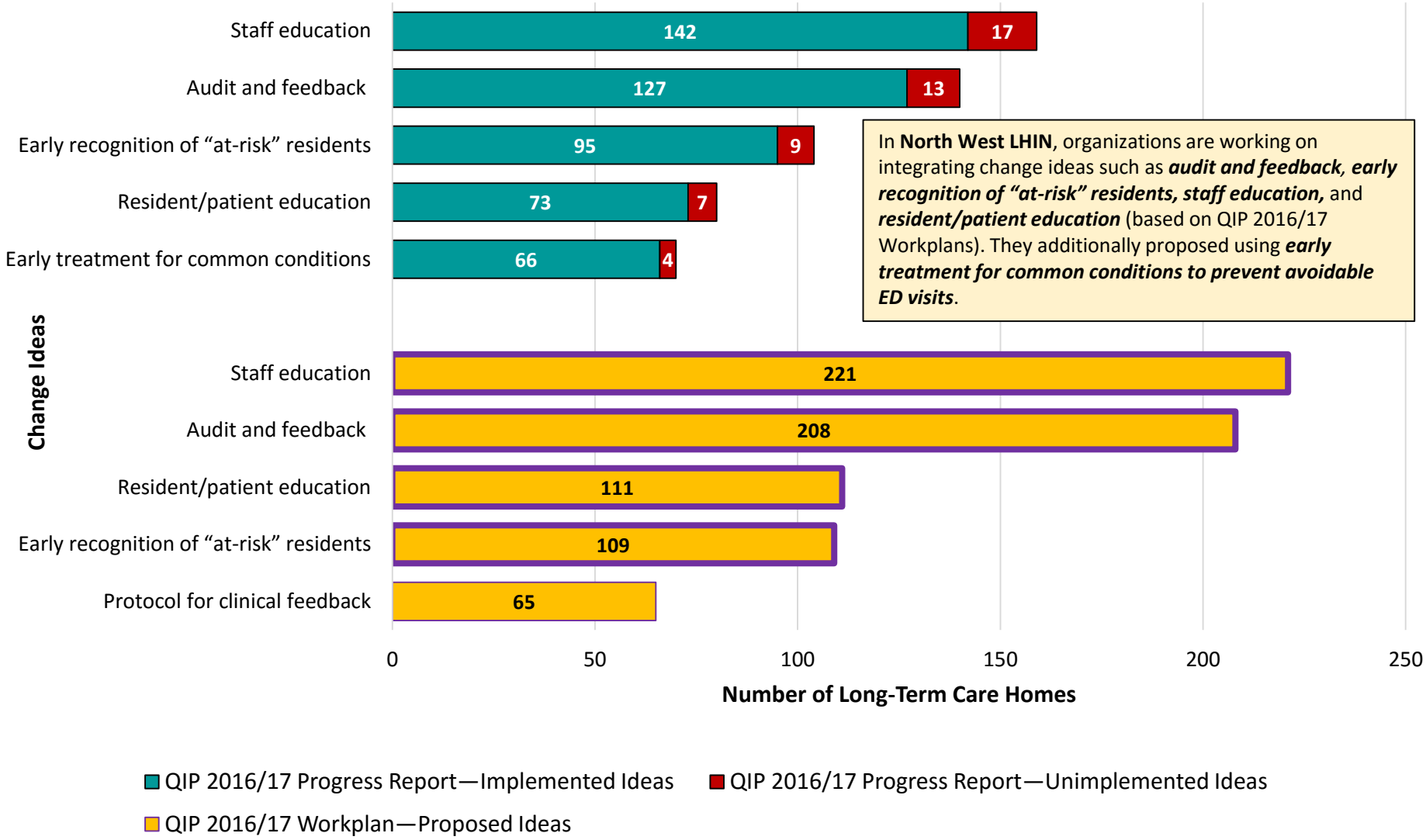
Most common change ideas in Ontario from 2015/16 and 2016/17 primary care QIPs for Readmission Within 30 Days for Selected HBAM Inpatient Groupers, as reported in the 2016/17 QIPs



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

Collaboration

Sioux Lookout Meno-Ya-Win Health Centre

- Leading collaborative activities across 11 small and rural hospitals in the NW LHIN
  - Continued participation in the Better Admissions and Transitions in Ontario's Northwest (BATON) aligning discharge plan approaches and tools to reduce readmissions.
  - In 2016/17, the collaborative will focus on the development of a Small Hospital Quality Scorecard. The scorecard and implementation playbook will be ready for use in 2016/2017.
  - By working together, the small rural hospitals seek to reduce overall readmissions within the region
  - The collaborative has future plans for a broader focus on transfers

QIP Achievements

- **Manitouwadge General Hospital – FHT** was instrumental in starting the "My Ride" program which will bring affordable transportation to those in need including those people utilizing devices that do not fit in cars and currently do not fit in our local taxi vehicles.

- **Waasegiizhig Nanaandawe'iyewigamig –** Client surveys revealed that 30% of clients surveyed always/often practice traditional healing and 53% would like to learn more. This information will be useful in planning client centred services.

QIP Achievements

- **Marathon FHT** – three physicians invested significant time in developing a protocol for addictions and chronic pain patients, particularly with regards to management of patients on opioid medications with the goal to increase safety for patients and reduce illicit use of opioids in the MFHT catchment area

- **Points North Family Health Team** set the goal of 68.8% for patients living with diabetes that have a documented self-management goal in the past 365 days. This improved 8.2% recognizing a final value of 77%.

Spreading OTN to support chronic care management

NW CCAC

2013: Launch of OTN programming for COPD/CHF in NW LHIN

2015: OTN funded engagement lead position and Telehomecare expanded to 23+ communities

2015-2016

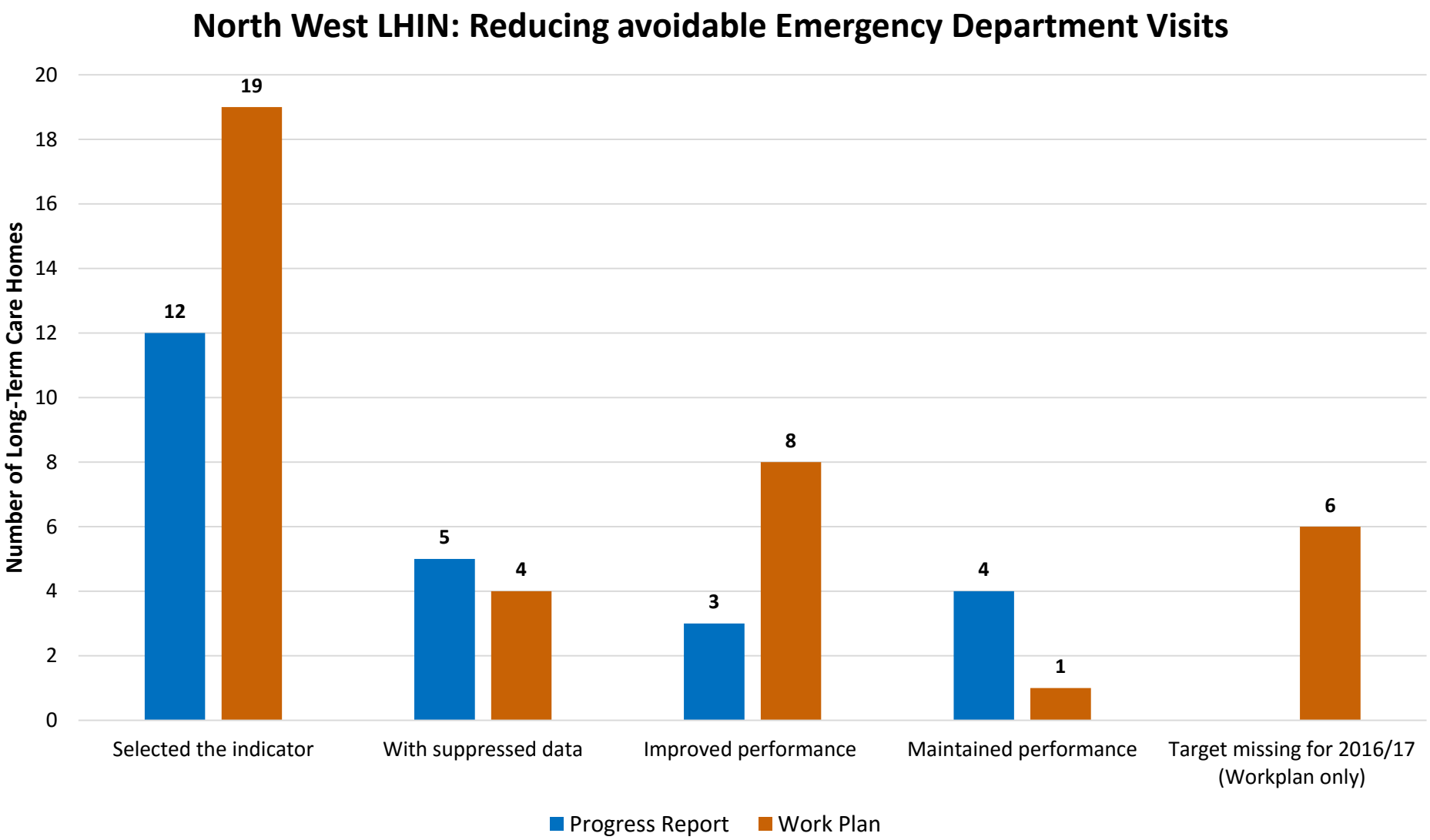
>500 clinicians engaged in 55 presentations

2016-2017

Diabetes added as a comorbidity in order to help patients with health coaching.

Engagement continues adding more partnerships with FHTs, CHCs, and hospitals

Reducing ED visits: LTC



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CONCLUSIONS/NEXT STEPS

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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