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

Â We intend for this report to:

ï Be used for discussion between the LHIN and its health service providers on successes and areas for improvement as reflected in the QIPs

ï Stimulate collaboration within and among organizations across the LHIN who may be working on similar change ideas or areas for improvement

ï Be used as a discussion point with the Regional Quality Tables

ï Be shared with the LHIN board and/or health service provider boards in the LHIN

Â 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](http://example.com)) or search the QIP database ([QIP Query](http://example.com))
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.
## Waterloo Wellington LHIN Overview

<table>
<thead>
<tr>
<th>Sector</th>
<th>QIP Count</th>
<th>Description</th>
</tr>
</thead>
</table>
| Hospitals            | 6         | • 4 large community hospitals  
                     |           | • 2 small community hospitals                                              |
| Primary Care         | 15        | • 10 Family Health Teams  
                     |           | • 4 Community Health Centres  
                     |           | • 1 Nurse Practitioner Led Clinics                                           |
| Community            | 1         | • CCAC                                                                      |
| Long-Term Care       | 35        | • 26 for-profit  
                     |           | • 7 not-for profit  
                     |           | • 2 municipal                                                                |
| Multi-sector*        | 1         | • 1 hospital  
                     |           | • 1 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.

- **Hospitals**: 60% (2015/16) to 70% (2016/17)
- **Primary Care**: 10% (2015/16) to 15% (2016/17)
- **Home Care**: 20% (2015/16) to 30% (2016/17)
- **Long Term Care**: 80% (2015/16) to 90% (2016/17)
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

 Â 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).

 Â 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).

 Â 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).

 Â 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
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

Better performance

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.

<table>
<thead>
<tr>
<th>Selected Integration Indicators</th>
<th>Progressed</th>
<th>Maintained</th>
<th>Worsened</th>
<th>2015/16 or 2016/17 Performance—N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Readmission Within 30 Days for Selected HBAM Inpatient Grouper (n=74)</td>
<td>48.6%</td>
<td>36.5%</td>
<td>13.5%</td>
<td></td>
</tr>
<tr>
<td>Timely Access to a Primary Care Provider (n=277)</td>
<td>39.7%</td>
<td>46.2%</td>
<td>13.7%</td>
<td></td>
</tr>
<tr>
<td>7-Day Post-Hospital Discharge Follow-Up Rate for Selected Conditions (n=273)</td>
<td>28.2%</td>
<td>42.5%</td>
<td>23.8%</td>
<td></td>
</tr>
<tr>
<td>Hospital Readmission Rate for Primary Care Patient Population (n=145)</td>
<td>37.2%</td>
<td>30.3%</td>
<td>26.9%</td>
<td></td>
</tr>
<tr>
<td>Hospital Readmissions for CCAC (n=12)</td>
<td>75.0%</td>
<td>8.3%</td>
<td>16.7%</td>
<td></td>
</tr>
<tr>
<td>Potentially Avoidable Emergency Department Visits for Long-Term Care Residents (n=420)</td>
<td>41.0%</td>
<td>53.1%</td>
<td>5.5%</td>
<td></td>
</tr>
</tbody>
</table>

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.
Looking back: Percentage of organizations in Waterloo Wellington 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 Repo

- **Readmission Within 30 Days for Selected HBAM Inpatient Grouper (n=4)**
  - Progressed: 50.0%
  - Maintained: 50.0%
  - Worsened: 50.0%

- **Timely Access to a Primary Care Provider (n=15)**
  - Progressed: 53.3%
  - Maintained: 46.7%

- **7-Day Post-Hospital Discharge Follow-Up Rate for Selected Conditions (n=15)**
  - Progressed: 26.7%
  - Maintained: 53.3%
  - Worsened: 20.0%

- **Hospital Readmission Rate for Primary Care Patient Population (n=7)**
  - Progressed: 14.3%
  - Maintained: 42.9%

- **Hospital Readmissions for CCAC (n=1)**
  - Progressed: 100.0%

- **Potentially Avoidable Emergency Department Visits for Long-Term Care Residents (n=21)**
  - Progressed: 38.1%
  - Maintained: 61.9%

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 the 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.
Waterloo Wellington LHIN QIP Data: Target Setting in 2016/17

Looking forward: Percentage of organizations in Waterloo Wellington 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

Selected Integration Indicators

- Alternative Level of Care Rate—Acute (n=4)
  - Improvement: 50.0%
  - Maintenance: 50.0%

- 30-Day All-Cause Readmission Rate for Patients with Stroke (n=1)
  - Improvement: 100.0%

- Readmission Within 30 Days for Selected HBAM Inpatient Grouper (n=3)
  - Improvement: 100.0%

- 30-Day All-Cause Readmission Rate for Patients with COPD (n=3)
  - Improvement: 100.0%

- 30-Day All-Cause Readmission Rate for Patients with CHF (n=1)
  - Improvement: 100.0%

- Timely Access to a Primary Care Provider (n=15)
  - Improvement: 93.3%
  - Retrograde Target: 6.7%

- 7-Day Post-Hospital Discharge Follow-Up Rate for Selected Conditions (n=10)
  - Improvement: 90.0%
  - Maintenance: 10.0%

- Hospital Readmission Rate for Primary Care Patient Population (n=2)
  - Improvement: 100.0%

- Hospital Readmissions for CCAC (n=1)
  - Improvement: 100.0%

- Potentially Avoidable ED Visits for Long-Term Care Residents (n=23)
  - Improvement: 95.7%
  - Maintenance: 4.3%

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.
## Waterloo Wellington LHIN QIP Data: 2016/17 Indicator Selection

<table>
<thead>
<tr>
<th>Sector</th>
<th>General Areas of Focus: Integration Indicators</th>
<th>Current Performance WW LHIN Average</th>
<th>Current Performance Provincial Average</th>
<th>Indicator Selection: QIP 2016/17 *</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hospital/ Acute Care</strong></td>
<td>i. 30-Day All-Cause Readmission Rate for Patients with Congestive Heart Failure (QBP)</td>
<td>17.80%</td>
<td>22.00%</td>
<td>1/7</td>
</tr>
<tr>
<td></td>
<td>ii. 30-Day All-Cause Readmission Rate for Patients with Chronic Obstructive Pulmonary Disease (QBP)</td>
<td>21.10%</td>
<td>19.60%</td>
<td>3/7</td>
</tr>
<tr>
<td></td>
<td>iii. 30-Day All-Cause Readmission Rate for Patients with Stroke (QBP)</td>
<td>9.37%</td>
<td>8.67%</td>
<td>1/7</td>
</tr>
<tr>
<td></td>
<td>iv. Readmission Within 30 days for Selected HBAM Inpatient Grouper (HIGs)</td>
<td>15.29%</td>
<td>16.19%</td>
<td>3/7</td>
</tr>
<tr>
<td></td>
<td>v. Alternate Level of Care Rate – Acute (ALC Rate)</td>
<td>9.28%</td>
<td>13.84%</td>
<td>4/7</td>
</tr>
<tr>
<td><strong>Primary Care</strong></td>
<td>i. 7-day Post-hospital Discharge Follow-Up Rate for Selected Conditions</td>
<td>N/A**</td>
<td>N/A**</td>
<td>15/15</td>
</tr>
<tr>
<td></td>
<td>ii. Access to primary care (survey-based)</td>
<td>N/A**</td>
<td>N/A**</td>
<td>15/15</td>
</tr>
<tr>
<td></td>
<td>iii. Hospital Readmission Rate for Primary Care Patient Population</td>
<td>N/A**</td>
<td>N/A**</td>
<td>6/15</td>
</tr>
<tr>
<td><strong>Community Care Access Centres</strong></td>
<td>i. Hospital Readmissions</td>
<td>15.10%</td>
<td>17.23%</td>
<td>1/1</td>
</tr>
<tr>
<td><strong>Long Term Care</strong></td>
<td>i. ED visits for Ambulatory Care Sensitive conditions</td>
<td>18.80%</td>
<td>24.55%</td>
<td>24/36</td>
</tr>
</tbody>
</table>

* 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 WW LHIN:
  - 1 Hospital selected a custom indicator related to **30-Day Readmission Rate** (A combined designation for all four 30-Day Readmissions indicators)

** 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

<table>
<thead>
<tr>
<th>Change Ideas</th>
<th>Number of Hospitals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Create partnerships with other sectors to follow complex patients</td>
<td>29</td>
</tr>
<tr>
<td>Individualized coordinated care and discharge planning</td>
<td>24</td>
</tr>
<tr>
<td>Readmission risk assessment linked to post-discharge follow-up</td>
<td>15</td>
</tr>
<tr>
<td>Primary Care follow-up within 7 days of discharge</td>
<td>14</td>
</tr>
<tr>
<td>Patient education</td>
<td>12</td>
</tr>
</tbody>
</table>

In Waterloo Wellington LHIN, organizations are working on change ideas such as patient education, Individualized care and discharge planning, and create partnerships with other sectors (based on QIP 2016/17 Workplans).

Additionally, organizations proposed change ideas relating to medication reconciliation at discharge, discharge checklists and teach back.

* 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 Grouper.
**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**

<table>
<thead>
<tr>
<th>Change Ideas</th>
<th>Number of Hospitals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Optimal discharge—use of predictive models</td>
<td>32</td>
</tr>
<tr>
<td>Bed utilization management to reduce length of stay and improve capacity</td>
<td>31</td>
</tr>
<tr>
<td>CCAC &quot;Home First&quot; philosophy and programs</td>
<td>31</td>
</tr>
<tr>
<td>&quot;Assess and restore&quot; philosophy and function</td>
<td>24</td>
</tr>
<tr>
<td>Staff education</td>
<td>18</td>
</tr>
<tr>
<td>Optimal discharge—use of predictive models</td>
<td>32</td>
</tr>
<tr>
<td>CCAC &quot;Home First&quot; philosophy and programs</td>
<td>29</td>
</tr>
<tr>
<td>Audit and feedback</td>
<td>18</td>
</tr>
<tr>
<td>Bed utilization management to reduce length of stay and improve capacity</td>
<td>18</td>
</tr>
<tr>
<td>Health Links, or partnerships with primary care</td>
<td>17</td>
</tr>
</tbody>
</table>

In Waterloo Wellington LHIN, organizations are working on change ideas such as **CCAC "Home First" philosophy and programs** and **optimal discharge - use of predictive models** (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 primary care QIPs for 7-Day Post-Hospital Discharge Follow-Up Rate for Selected Conditions, as reported in the 2016/17 QIPs

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Create partnerships with other sectors to follow complex patients</td>
<td>107</td>
<td>18</td>
<td></td>
</tr>
<tr>
<td>Electronic solutions such as Hospital Report Manager</td>
<td>80</td>
<td>13</td>
<td></td>
</tr>
<tr>
<td>Using data for improvement</td>
<td>64</td>
<td>11</td>
<td></td>
</tr>
<tr>
<td>Individualized coordinated care and discharge planning with hospitals or Health Links</td>
<td>41</td>
<td>8</td>
<td></td>
</tr>
</tbody>
</table>

In Waterloo Wellington LHIN, organizations are working on change ideas such as electronic solutions (e.g., Hospital Report Manager), identify hospitalized patients through shared EMR with hospital, using data for improvement and audit and feedback (based on QIP 2016/17 Workplans).
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

- Increase supply of visits: 105 (8 implemented)
- Understand supply and demand: 104 (8 implemented)
- Audit and feedback: 72 (3 implemented)
- Survey methodology: 55

In Waterloo Wellington LHIN organizations are working on change ideas such as survey sample and/or methodology, understand supply and demand, and audit and feedback (based on QIP 2016/17 Workplans).
In Waterloo Wellington LHIN, organizations are working on change ideas such as working with hospitals, activate appropriate community follow up, coordinated care plans, and assess post discharge risk for readmission (based on QIP 2016/17 Workplans).

Additionally organizations proposed change ideas relating to referral of complex patients to health links.

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

<table>
<thead>
<tr>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>Activate appropriate community follow-up</td>
<td>35</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Coordinated care plans</td>
<td>23</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Audit and feedback</td>
<td>20</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Assess post-discharge risk for readmission</td>
<td>18</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Technology enablers like telehomecare, telemonitoring</td>
<td>14</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>Enhanced care coordination in primary care</td>
<td>19</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Refer complex patients to Health Links</td>
<td>16</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Working with hospitals</td>
<td>15</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Activate appropriate community follow-up</td>
<td>28</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Audit and feedback</td>
<td>24</td>
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<td>Working with hospitals</td>
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<td>Assess post-discharge risk for readmission</td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>
Rapid Response Nursing program for complex patients

Spreading quality initiatives

Technology like telehomecare and emergency medical service systems

Audit and feedback

Assess post-discharge risk and activate appropriate community follow-up

Refer complex patients to health links or integrated funding models.

Refer complex patients to health links or integrated funding model

Assess post-discharge risk and activate appropriate community follow-up

Audit and feedback

Technology enablers like telehomecare

Use of specialized teams like palliative and outreach teams

Refer complex patients to health links or integrated funding models.

Number of Community Care Access Centres

### QIP 2016/17 Progress Report—Implemented Ideas

- Assess post-discharge risk and activate appropriate community follow-up: 9
- Use of specialized teams like palliative and outreach teams: 7
- Technology enablers like telehomecare: 5
- Refer complex patients to health links or integrated funding models: 5
- Refer complex patients to health links or integrated funding model: 7
- Assess post-discharge risk and activate appropriate community follow-up: 6
- Audit and feedback: 5
- Technology like telehomecare and emergency medical service systems: 2
- Spreading quality initiatives: 2
- Rapid Response Nursing program for complex patients: 2

### QIP 2016/17 Workplan—Proposed Ideas
In Waterloo Wellington LHIN, organizations are working on change ideas such as *audit and feedback*, *staff education*, *early recognition of “at-risk” residents*, and *resident/patient education* (based on QIP 2016/17 Workplans).

Additionally organizations proposed change ideas related to *communication strategies to enhance resident care and transfers between providers*.
SPOTLIGHTS
Preventing Workplace Violence

North Wellington Health Care and Groves Memorial Community Hospital

- Introduced new emergency code ("Code Silver") to alert staff of an individual with a weapon
- Code Silver provides a course of action for should an individual with a weapon is present at the Hospital to prevent workplace violence and minimize risk to patients, staff, visitors and others
  - Developed a Policy and Procedure and a Violence Risk Assessment form to be completed for any appropriate Emergency Department patients
- OPP liaison contributed to the drafting of the actual code plan and the education package component
- Ethical education sessions were also held with staff to learn about the new code
- "Test drills" for this code are not performed, as the risk of something untoward occurring is too great
Improving Patient Experience and Access to Primary Care

Minto-Mapleton Family Health Team

Â Continue to monitor patients’ perception of access, and compare with provider appointment schedules through patient surveys

Â Process:

ï Administration from the Family Health Team, Emergency Department, and Family Health Organization (FHO) collect patient surveys
ï IT data management enter surveys into spreadsheet and FHO administration collate results
ï FHO administration to collect the third next available (TNA) appointment data from EMR schedule regularly
ï FHO administration distributes provider-specific data on TNA and patient surveys to each provider
Reducing Wait Times for Support

Waterloo Wellington CCAC

Using Root Cause Analysis (RCA) to impact 5 day wait times for access to Personal Support Workers (PSWs)

After RCA, the CCAC learned that families may delay initial visit first week (indicate they are not available) to prevent the patient from being overwhelmed by multiple new service providers

Idea: Created a new indicator to capture controllable factors in meeting MSAA target (the number of patients available for service who receive their first personal support visit within 5 days of authorization divided by the number of patients available for service who received first personal support visit)

Results: Personal Support & Homemaking: 2015/16 Q3 experience, MSAA/Quality Improvement Plan (QIP) results 91.3%; local (availability) 98.3%

Why this is important: By considering patient choice or preference to be included in the indicator report, the CCAC was able to meet the 5-Day Wait Time needs of the patients
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?