Looking Back and Looking Ahead
A Sneak Peek at Home Care Quality Improvement Plans (QIP) for 2017-2018

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Embrace Health Quality

A health system with a culture of quality is... stays true to these principles

- Safe
- Effective
- Patient-centred
- Efficient
- Timely
- Equitable

...and can only happen when we

- Engage patients and the public
- Redesign the system to support quality care
- Help professionals and caregivers thrive
- Ensure technology works for all
- Support innovation and spread knowledge
- Monitor performance with quality in mind
- Build a quality-driven culture

A just, patient-centred health system committed to relentless improvement. Let’s make it happen.

Read our vision for achieving a quality health system

Quality Matters: Realizing Excellent Care For All

www.hqontario.ca
Learning objectives

• Provide some preliminary guidance regarding the 2017/18 QIP submissions for home care
• Share learnings from the 2016-17 QIPs
• Prepare organizations for 2017-18 QIP submission by offering advance notice of changes
• Provide an overview of HQO resources to support organizations in meeting their goals and supporting change across the system
HOME CARE QIP SUBMISSIONS FOR 2017/18
Home Care QIPs

- CCACs have been submitting QIPs since 2014/15
- Changes proposed for CCACs as part of *Patients First* will result in changes to governance to the CCAC and the LHINs
  - What does this mean for home care QIPs?
  - How do we continue to focus on quality through the QIPs?
Home Care QIPs

Recommendations

• CCACs to submit a QIP by April 1, 2017
• CCACs will be encouraged to develop their QIP in collaboration with their LHIN
  — Guidance to this effect was sent to CCACs and LHINs in early October
• As changes proposed through *Patients First* are confirmed formally, additional guidance will be provided regarding board sign-off and other issues
• Home care QIP priorities will remain essentially stable to ease this transition
DISCUSSION
REFLECTIONS ON THE 2016-17 QIPs: LOOKING BACK ACROSS SECTORS
Key Observations – Overarching

• Reflecting back on their 2015/16 QIPs, of the 1042 submissions 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.
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.
Percentage of organizations that reported engaging patients and families in development of 2015/16 QIPs and 2016/17 QIPs across all four sectors

<table>
<thead>
<tr>
<th>Sectors</th>
<th>2015/16</th>
<th>2016/17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital</td>
<td>31</td>
<td>22</td>
</tr>
<tr>
<td>Primary care</td>
<td>19</td>
<td>9</td>
</tr>
<tr>
<td>Home care</td>
<td>36</td>
<td>14</td>
</tr>
<tr>
<td>Long-term care</td>
<td>14</td>
<td>12</td>
</tr>
</tbody>
</table>
Collaboration with each sector

HOSPITAL
- 70% CCAC
- 46% Primary Care
- 31% Long-Term Care
- 64% Hospital
- 56% LHIN

PRIMARY CARE
- 47% CCAC
- 43% Primary Care
- 9% Long-Term Care
- 80% Health Links

LONG-TERM CARE
- 59% CCAC
- 13% Primary Care
- 18% Long-Term Care
- 60% Health Links

CCAC
- 43% Primary Care
- 14% CCAC
- 7% Long-Term Care
- 93% Hospital
- 71% Health Links
Key observations: Equity indicators

1. Collecting and analysis of data, particularly surveys
2. Cultural competency training
3. Program planning
4. Access to Care
   - Poverty
   - Homelessness
   - Rural/Northern communities
Reflections on the 2016/17 QIPs

Looking Back

• 77% of CCACs reported progress in reducing ED visits
• 75% reported progress in reducing hospital readmissions

Moving Forward

• 100% working on at least 2 priority indicators
• 7/14 CCACs chose to try out the palliative indicator last year and are collecting baseline data
• References to involving patients in design of QI initiatives woven throughout QIPs
Progress was seen in performance for 50% or more Community Care Access Centres (CCACS) on indicators such as Unplanned Emergency Department Visits, Clients' Experience and Hospital Readmissions. Comparatively, a larger number of CCACs worsened in their performance between 2015/16 and 2016/17 for Five-Day Wait Time for Home Care: Nursing Visits, Five-Day Wait Time for Home Care: Personal Support for Complex Patients and Falls for Long-Stay Clients indicators.
More than 70% of community care access centres set an improvement target on all priority indicators for 2016/17. The highest number of CCACs with a target to maintain performance was seen for the Hospital Readmissions indicator at 23%, while Unplanned Emergency Department Visits and Clients' Experience indicators both saw 15% of CCACs selecting the indicators set a retrograde target in 2016/17.
EMERGENCY DEPARTMENT VISITS: PROGRESS AND CURRENT PERFORMANCE
Percentage of home care clients with an unplanned, less-urgent ED visit within the first 30 days of discharge from hospital (reporting period Q2 2013/14-Q2 2014/15)

Sources: Home Care database, CIHI DAD, CIHI NACRS, QIP Navigator (2016/17)
Reporting period: July 2014 – June 2015
Notes: Hamilton Niagara Haldimand Brant did not select the indicator.
Issue: Effective transitions

Common change ideas

- Assess post discharge risk
- Refer complex patients to Health Links or Integrated funding models
- Use of specialized outreach teams like palliative care
- Technology enablers like OTN/e-notifications

Current performance median and average values

- Reduce ED visits after discharge: median- 7.3% average- 6.8%
- Reduce hospital readmissions: median-18.4% average-17.2%
# A story of QI achievement: CE CCAC

<table>
<thead>
<tr>
<th>The topic</th>
<th>Change ideas</th>
</tr>
</thead>
</table>
| Reducing the number of unplanned Emergency Department visits and hospital readmissions | • Electronic alerts  
• Alerts trigger early engagement between CCAC and hospital staff  
• Actions aimed towards successful discharge back to community  
• Subsequent chart audits |

<table>
<thead>
<tr>
<th>Results/lessons learned</th>
<th>Next steps</th>
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<tbody>
<tr>
<td>• Currently reactive; want to move to a proactive approach</td>
<td>Focus on patient journey prior to hospital visit to better understand factors that increase likelihood of a hospital and/or emergency department visit, and may be responsive to proactive strategies; a critical shift in both strategy and approach</td>
</tr>
</tbody>
</table>
FALLS FOR LONG STAY PATIENTS: PROGRESS AND CURRENT PERFORMANCE
Percentage of CCAC Clients who had fallen, QIP 2016/17

Provincial Average (36.5)

Sources: Home Care database, inter-RAI for home care via Long-Stay Assessment Software, QIP Navigator (2016/17)
Reporting period: October 2014 – September 2015
Common change ideas, Falls

- Considering impact of recent delirium, infections, other conditions, and acting proactively
- Evaluating those with recent functional decline
- Identifying those at risk for falls. Having had a fall or multiple falls best predictor of falling again. (Compass)
- Evaluating medications
- Patient education
- Reducing safety hazards like rugs, lighting (Compass)
- Develop falls prevention programs targeted towards higher needs clients (Compass)
- Audit and feedback
- Staff education

Progress report - implemented change ideas
Work plan - proposed change ideas
Spotlight: CW CCAC: Promoting Falls Prevention and Exercise Programs for Seniors

Patient Experience Survey

**Most Significant Improvements Reported**

- Balance: 73%
- Muscular strength: 68%
- Mobility, ease of walking: 60%
- Endurance: 45%
- Decreased fear of falling: 36%
- Independence at home: 27%

**Client-Reported Goals of Exercise/Falls Prevention Program**

- Meet other seniors or socialize: 50%
- Maintain independence: 55%
- Improve balance: 86%
- Prevent falls: 91%
- Increase strength and endurance: 95%
The QIP consultation process

Initial issues and indicator matrix

Ongoing consultations

PFPAC
HQO QIP advisory
Ontario Association of CCACs and other sector associations
Ministry of Health and Long Term Care
LHINs

2017-2018 QIP Indicators
Advancing an Issue through the QIP

Example: Right care, right time, right place

Indicator: Dying in Preferred place of death (A)

- ✔ Important as evidence shows majority of people prefer to die at home or in hospice (Health Quality Ontario. Palliative Care at the End of Life. Toronto: Queen’s Printer for Ontario; 2016)

- ✔ Data is available from the CHRIS database

- ✔ Can be advanced through QIP.

- ✔ From an issues perspective, important that people cared for in right place at right time. Adding this to the QIP promotes sharing of ideas that work.
# Quality Issues and Indicators for the 2017/18 QIPs

<table>
<thead>
<tr>
<th>Issue</th>
<th>Hospital</th>
<th>Primary Care</th>
<th>Home Care</th>
<th>Long-Term Care</th>
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</thead>
<tbody>
<tr>
<td><strong>Effective</strong></td>
<td><strong>Transitions</strong></td>
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<tr>
<td></td>
<td>• Readmission for select conditions (A)</td>
<td>• Hospital readmissions for select conditions (A)</td>
<td>• Hospital readmissions (P)</td>
<td>• Potentially avoidable ED visits (P)</td>
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<tr>
<td></td>
<td>• Readmission for one of congestive heart failure, chronic obstructive</td>
<td>• 7-day post-discharge follow-up (physician) (P)</td>
<td>• Unplanned ED visits (P)</td>
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<tr>
<td></td>
<td>pulmonary disease, or stroke (QBP) (P)</td>
<td>• 7-day post-discharge follow-up (any provider) (A)</td>
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<td>• Readmission within 30 days for mental health and addiction (A)</td>
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<td></td>
<td>• Patient received enough information on discharge (P)</td>
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<td></td>
<td>• Discharge summaries sent within 48 h of discharge (A)</td>
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<tr>
<td><strong>Coordinating care</strong></td>
<td>• Narrative</td>
<td>• Identify complex patients (Health Links) (A)</td>
<td>• Narrative</td>
<td>• Narrative</td>
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<td></td>
<td>• Identify complex patients (Health Links) (A)</td>
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<tr>
<td><strong>Population health</strong></td>
<td>• Narrative</td>
<td>• Glycated hemoglobin testing (A)</td>
<td>• Narrative</td>
<td>• Narrative</td>
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<td></td>
<td></td>
<td>• Colorectal and cervical cancer screening (A)</td>
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<td><strong>Patient-centred</strong></td>
<td><strong>Palliative care</strong></td>
<td>• Home support for discharged palliative patients (P)</td>
<td>• End of life, died in preferred place of death (A)</td>
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<td></td>
<td>• Narrative</td>
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<tr>
<td></td>
<td>• Patient experience (P)</td>
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<td></td>
<td>• Patient involvement (P)</td>
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<tr>
<td><strong>Efficient</strong></td>
<td><strong>Access to right level of care</strong></td>
<td>• Narrative</td>
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<td></td>
<td>• Narrative</td>
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<tr>
<td></td>
<td>• Alternative level of care rate (P)</td>
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<td><strong>Safe</strong></td>
<td><strong>Medication safety</strong></td>
<td>• Medication reconciliation (admission) (P)</td>
<td>• Falls for long-stay clients (P)</td>
<td>• Pressure ulcers, (A) restraints (A), falls (A)</td>
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<td></td>
<td>• Medication reconciliation (discharge) (P)</td>
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<td></td>
<td>• Pressure ulcers (A), use of physical restraints in mental health patients (A)</td>
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<td></td>
<td>• Falls for long-stay clients (P)</td>
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<td><strong>Timely</strong></td>
<td><strong>Workplace safety</strong></td>
<td>• Narrative</td>
<td>• Potentially inappropriate prescribing of antipsychotic medications (P)</td>
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<td></td>
<td>• Narrative</td>
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<td><strong>Equitable</strong></td>
<td><strong>Timely access to care/services</strong></td>
<td>• Timely access to primary care (patient perception) (P)</td>
<td>• Wait time for home care (personal support worker, nurse) (P)</td>
<td></td>
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<td></td>
<td>• ED length of stay (complex) (P)</td>
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<td></td>
<td>• Narrative</td>
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<tr>
<td></td>
<td>• Narrative</td>
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*Legend*:
- *(P)*: Priority indicator
- *(A)*: Additional indicator
- *(QBP)*: Indicator related to quality-based procedures
2017-18 QIP Indicators: CCAC

- Falls for long-stay clients
- Unplanned ED visits
- Hospital readmissions
- 5 day wait times for home care: Nursing
- 5 day wait times for home care: Personal support for complex patients
- Clients’ Experience
- Identify complex patients (health links) (A)
- End of life, preferred place of death (A)

**RETIRED**

**MODIFIED**

**NEW**
- Identify complex patients (health links) (A)
- End of life, preferred place of death (A)
Determining the 2017/18 QIP priorities

• The Narrative
  – Is an executive summary of your QIP and is intended to introduce specific context for your QIP
  – Is a means for engaging your patients and staff in QI planning

• The Narrative is also a way to capture and understand emerging quality issues
  – For example, equity and workplace violence
Determining QIP priorities in Narrative

Example: Equity

**Priority:** Embedding an equity lens into QI initiatives

√ Important as vulnerable subpopulations may experience far different care than that demonstrated overall

X However there is no single indicator to advance this issue.

√ This issue is also important to all sectors.

√ Can be advanced through QIP, through QIP narrative.
## Narrative questions, 2017/18

### Building on existing questions
- Overview
- QI Achievements From the Past Year
- Integration and Continuity of Care
- Engagement of Leadership, Clinicians and Staff
- Engagement of Patients, Clients, and Residents

### New questions
- Staff Safety and Workplace Violence
- Population Health
- Equity
- Alternate Level of Care

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Did you know you can now upload shareable charts and pictures in your narrative?
PLANNING FOR 2017/18 QIPs: NAVIGATOR
Navigator key dates and timelines

• Navigator will launch by November 30, 2016
• Log in before March to ensure there are no surprises
• There will be Navigator training sessions this fall and winter to highlight the new functionalities
• Navigator closes briefly in February so that the indicator current performance values can be prepopulated
• Book your Board meetings now to ensure your submission is ready for April 1, 2017.
Our greatest accomplishment in the previous year has been the gains made in relation to patient flow as a result of the Bed Realignment project which culminated in December 2014. In preparation for Bed Realignment, guidelines were developed to promote the flow of patients across all HPHA sites to promote occupancy of 85% in all in-patient units. As of January 2015, Physician Leads, Team Leaders and Managers from each site meet with the VP Partnerships and Patient Experience and the Manager Patient Flow on a monthly basis. These meetings have enabled open discussion on patient admissions and transfers across all sites and have been instrumental in revising and enhancing decision making processes that result in appropriate decisions on patient destinations and the safe transfer of patients. Case reviews of admissions and transfers, review of data such as the number of off-service medical patients*, expected daily discharges by unit and number of transfers site to site are utilized to influence process improvement decisions at this forum. (*Off-service medical patients are those admitted to another unit such as surgery; an appropriate medical bed may be available at another HPHA site)
New this year: Type of indicator identified

The QIP Query Reports can be filtered by type of indicator
OTHER HQO SUPPORTS
What are HQO Quality Standards?

• **Concise:** five to 15 statements versus the hundreds that can appear in many practice guidelines

• **Accessible:** for clinicians to easily know what care they should be providing; and for patients to know what care to expect

• **Measurable:** each statement is accompanied by one or more quality measure

• **Implementable:** they come with quality improvement tools and resources targeted to each standard, to fuel adoption

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**Example:** Wound care (diabetic foot ulcers, venous/mixed ulcers, pressure injuries)

*(available spring 2017)*
HQO public reporting indicator review

HQO currently reviewing publically reported home care indicators using pre-determined selection criteria

Objectives of review

• Include patient/client voice in indicator selection (e.g. better measures of access, transitions, client/patient experience)

• Recommend indicators for public reporting at provincial, regional and/or service-provider level

• Identify potential areas for data advocacy and indicator development, recognizing numerous areas currently unreported (or underreported) due to limitations in indicator development or data availability
HQO public reporting indicator review II

• New set of indicators will be selected by an expert panel using modified Delphi process
• Indicators of informal or community home care delivery will not be in scope
• Patient and sector engagement ongoing. This far, we have heard that the following are top priorities for measurement:
  ♦ Transitions
  ♦ Effectiveness
  ♦ Appropriateness
  ♦ Patient satisfaction
  ♦ Pain and pain management
• Aim: to report new/modified set of indicators in 2017/18
HealthLink

Innovative Practices

Visit www.hqontario.ca to learn how to implement innovative practices used by Health Links.

• Innovative Practices Evaluation Framework
• Coordinated Care Management
• Transitions between Hospital and Home (September 28th)

Upcoming Areas of Focus:
• Mental Health & Addictions
• Webinar: Transitions between Hospital to Home  Part 1  
  Friday, October 14, 2016 from 12:00-1:00 pm
• Webinar: Transitions between Hospital to Home Community of Practice Part 2  
  Wednesday, November 16, 2016 from 12:00 - 1:00 pm.
• Upcoming Areas of Focus: Mental Health & Addictions

For more information: HLhelp@hqontario.ca
Planning for 2017/18 QIPs: Guidance Materials

Guidance materials launch
November 30, 2016

Package will include

- Annual Memo and “What’s New” Supplementation

- **Refreshed** guidance documents

- **Updated** indicator technical specifications

Please visit HQO’s website for additional resources or contact qip@hqontario.ca for assistance
Online Resources

Click on the hyperlinked pages or visit www.hqontario.ca
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<tr>
<th>Links to resources</th>
<th>Patient Engagement</th>
<th>Practice Reports</th>
<th>Quality Standards</th>
<th>Equity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Audience</td>
<td>Providers, Organizations, and Patients</td>
<td>Physicians and Interprofessional Teams</td>
<td>Community of Practice members collaborating to implement Quality Standards</td>
<td>All organizations interested in imbedding an equity lens in QI initiatives</td>
</tr>
<tr>
<td>Resources</td>
<td>Tools and resources to support patient engagement</td>
<td>For LTC and Primary Care, a resource to collect data from the practice for use in quality improvement</td>
<td>Toolkits and Guidance documents, Community of Practice for peer support</td>
<td>Frameworks and Guidelines</td>
</tr>
<tr>
<td>Integration with QIPS</td>
<td>Hospitals required to demonstrate how they engage Patients in developing QIPS</td>
<td>Clinicians access data and receive information about practice performance</td>
<td>There are three indicators in QIPS corresponding to Quality Standards.</td>
<td>Equity one of six quality dimensions measured in QIP (Narrative)</td>
</tr>
</tbody>
</table>