North East 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 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

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 East LHIN Overview

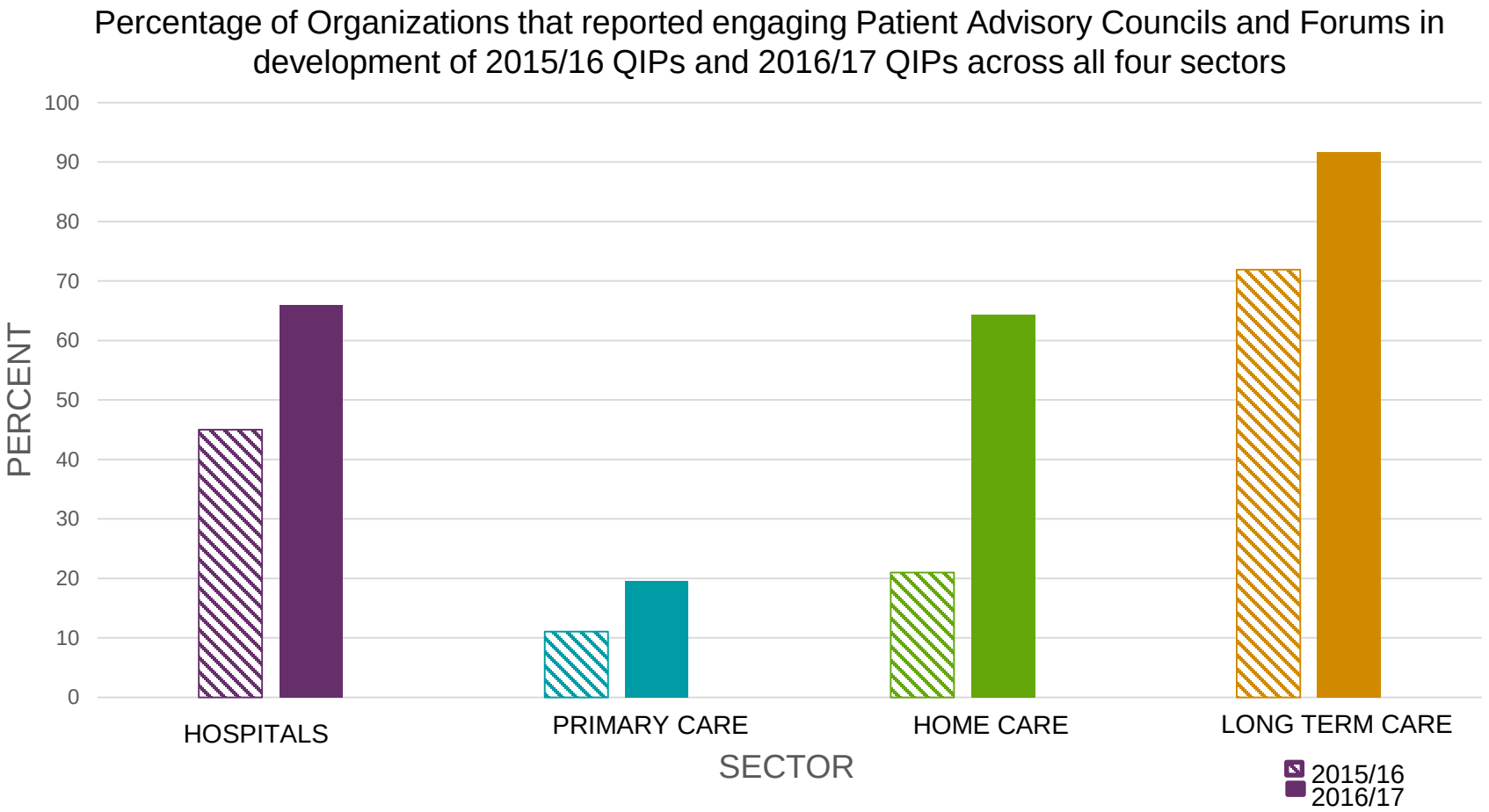
Sector	QIP Count	Description
Hospital	22	• 1 acute teaching hospital • 4 large community hospitals • 16 small community hospitals • 1 CCC/ rehabilitation hospital
Primary care	41	• 26 Family Health Teams • 6 Community Health Centres • 3 Aboriginal Health Access Centres • 6 Nurse Practitioner Led Clinics
Community care	1	• CCAC
Long-Term care	43	• 16 not-for-profit homes • 18 for-profit homes • 9 municipal homes
Multi-sector*	3	• 3 hospitals • 1 primary care • 3 long-term care

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

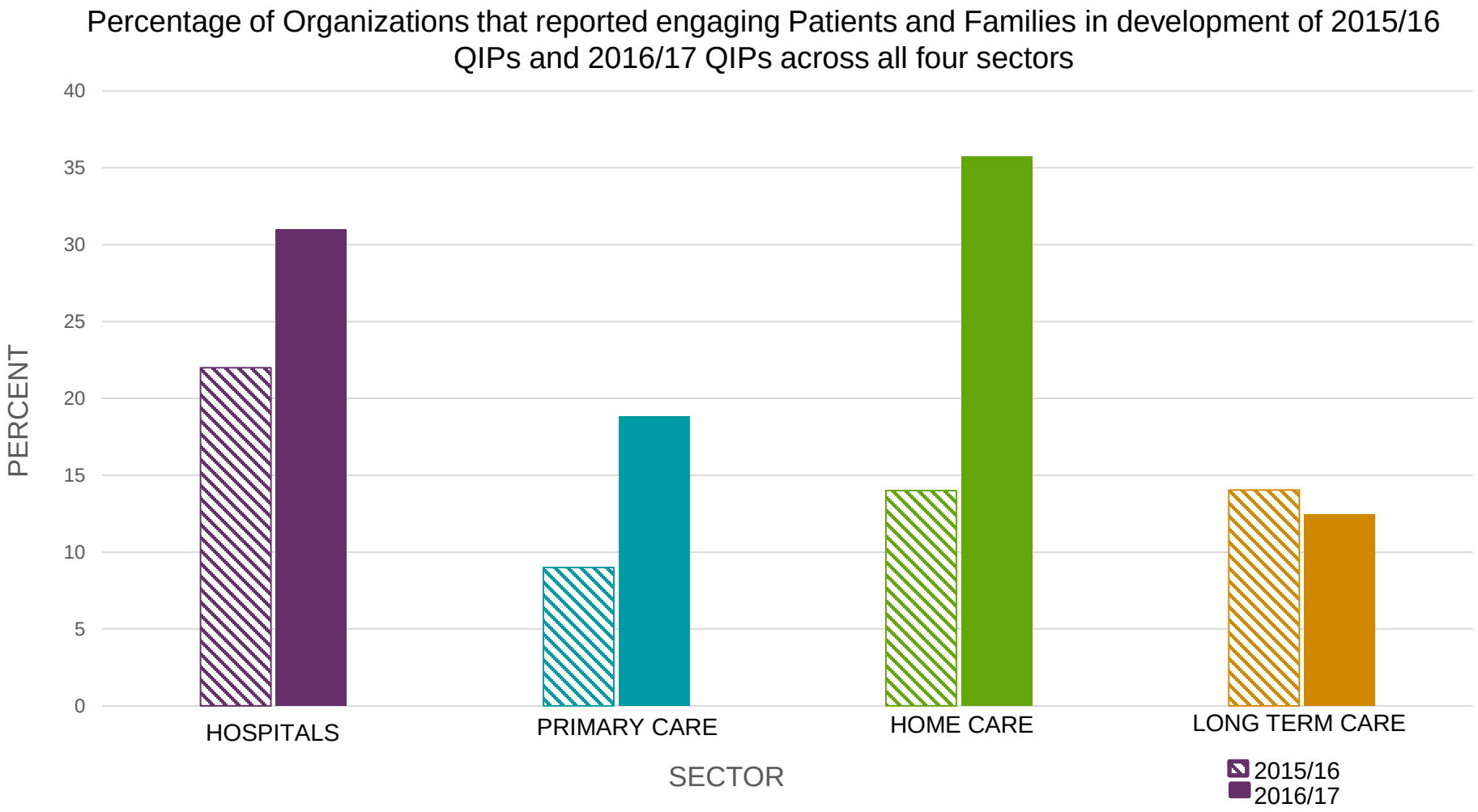
Key Observations – Overarching

- 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



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



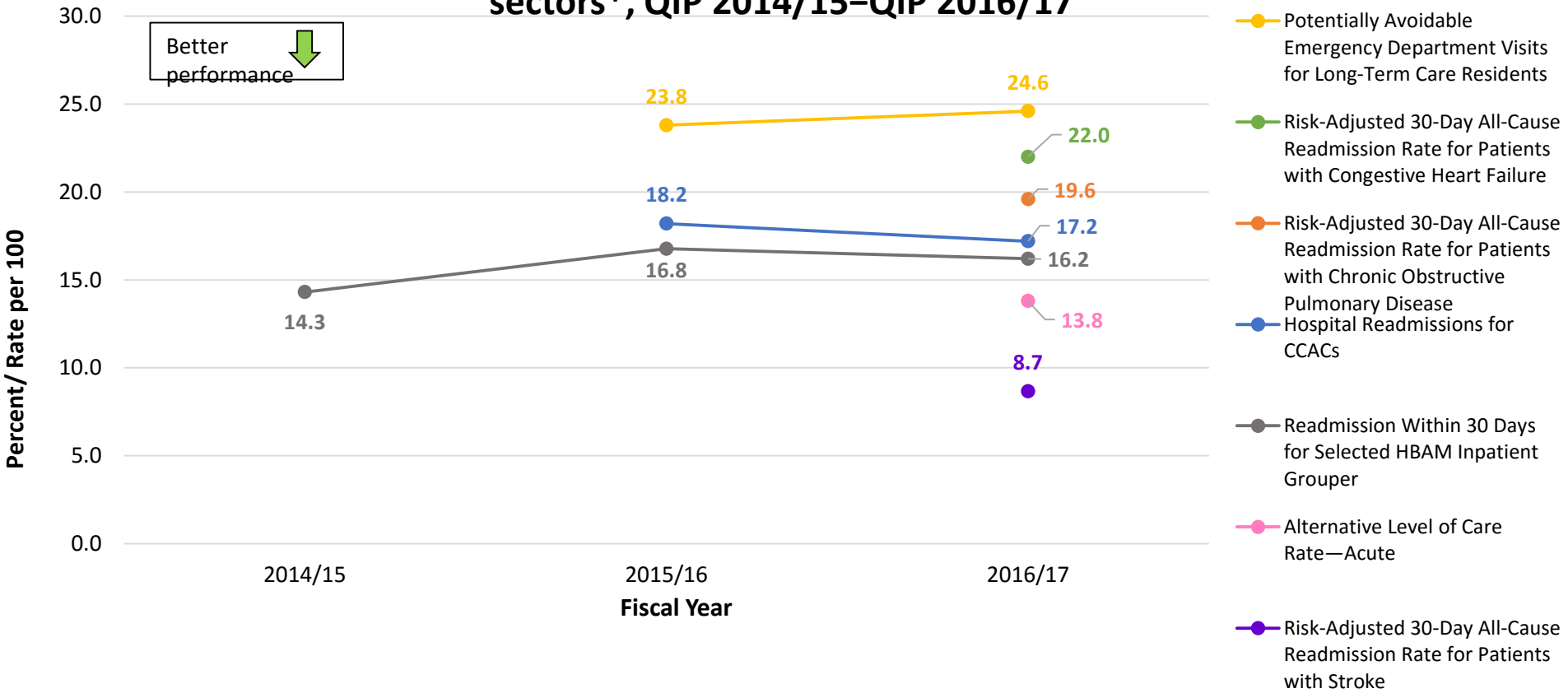
Key Observations – Per Sector

- **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.

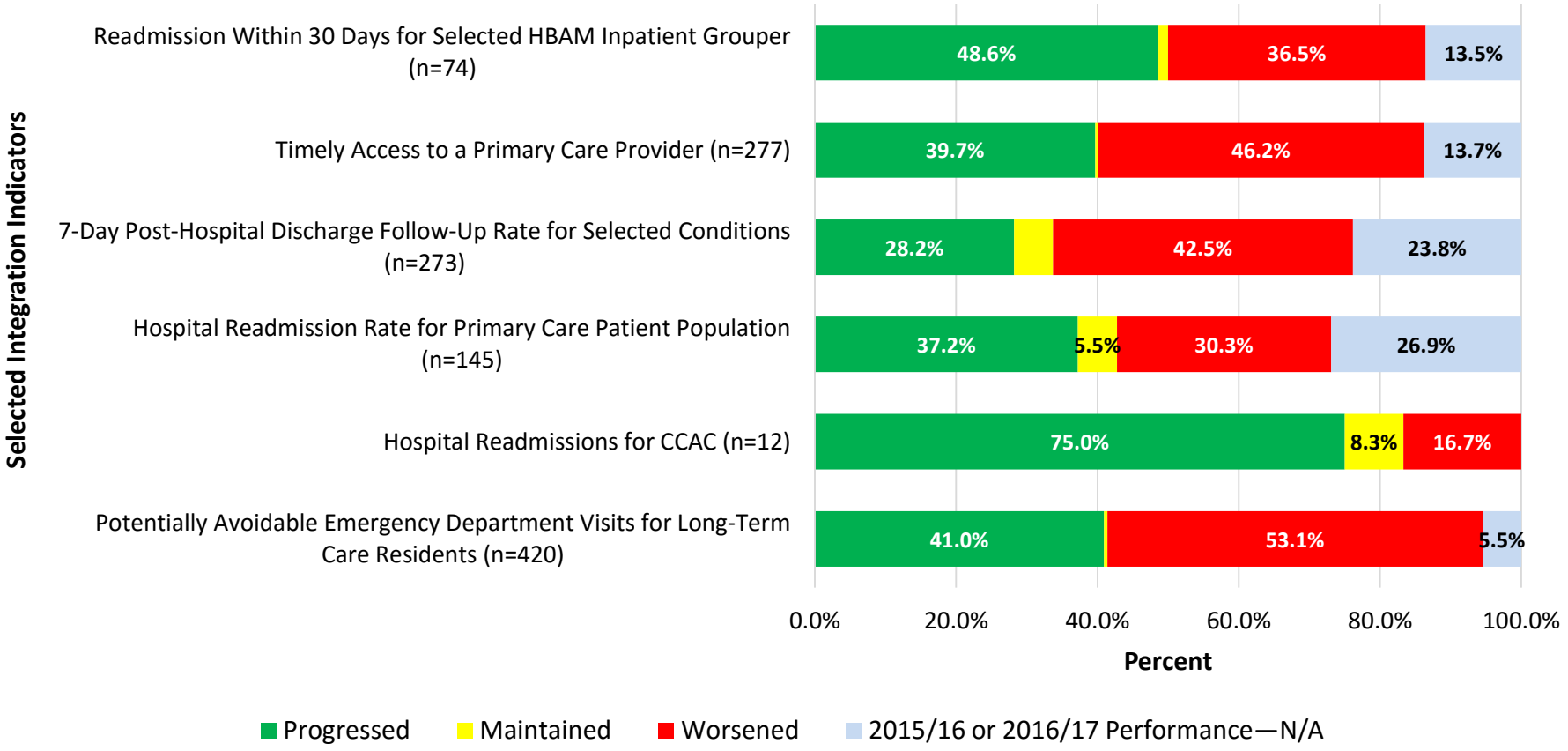
Risk-Adjusted 30-Day All-Cause Readmission Rate for Patients with Congestive Heart Failure; Risk-Adjusted 30-Day All-Cause Readmission Rate for Patients with Chronic Obstructive Pulmonary Disease, Readmission Within 30 Days for Selected HBAM Inpatient Groupers, Risk-Adjusted 30-Day All-Cause Readmission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

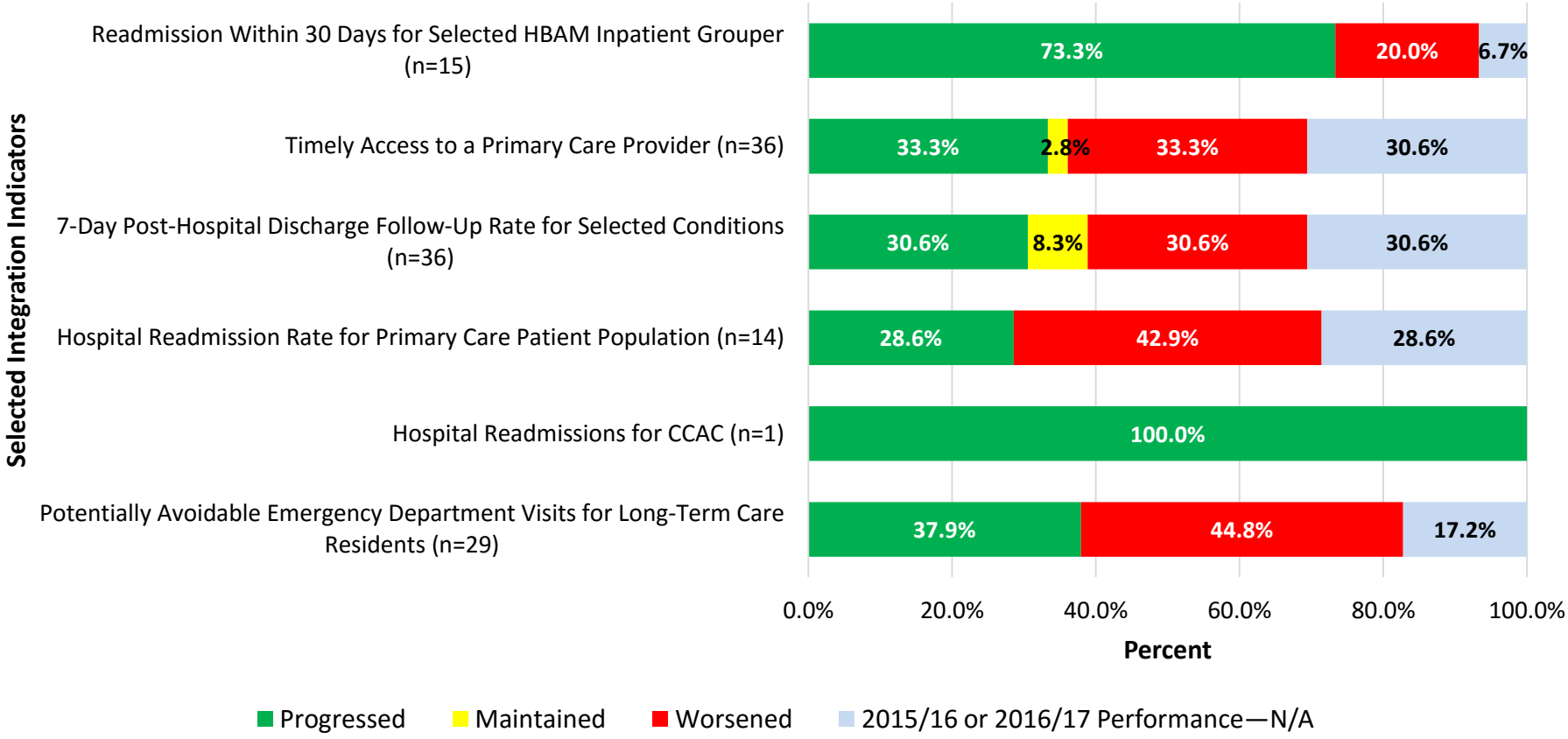
Looking back: Percentage of organizations in Ontario that progressed, maintained or worsened their performance between the 2015/16 QIP and the 2016/17 QIP on selected integration indicators, as reported in the QIP 2016/17 Progress Report



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 East LHIN QIP Data: Progress Made in 2016/17

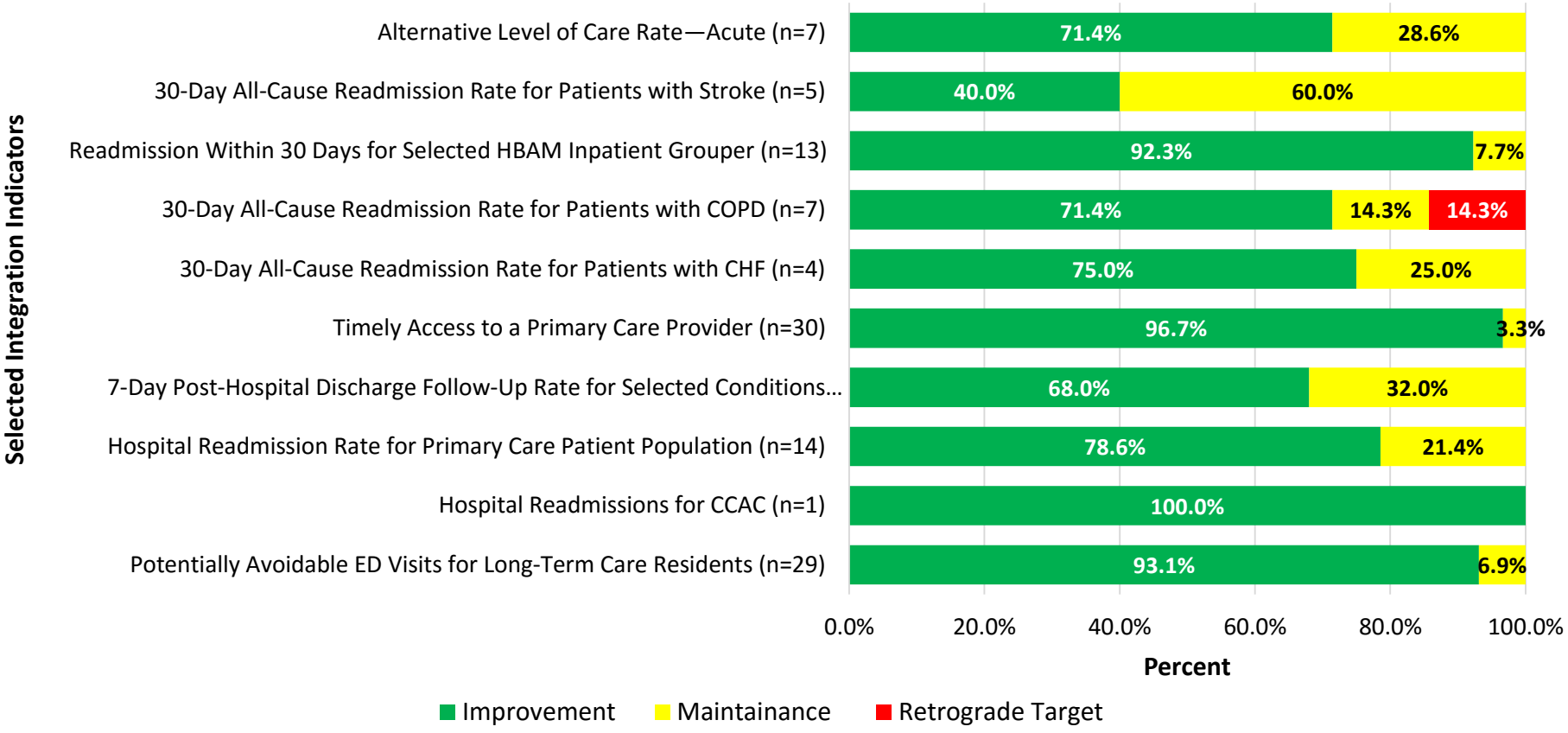
Looking back: Percentage of organizations in North East LHIN that progressed, maintained or worsened in their performance between the 2015/16 QIP and the 2016/17 QIP on selected integration indicators, as reported in the 2016/17 QIP Progress Report



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.

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

Looking forward: Percentage of organizations in North 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.

North East LHIN QIP Data: 2016/17 Indicator Selection

Sector	General Areas of Focus: Integration Indicators	Current Performance NE 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)	23.90%	22.00%	7/25
	ii. 30-Day All-Cause Readmission Rate for Patients with Chronic Obstructive Pulmonary Disease (QBP)	19.15%	19.60%	9/25
	iii. 30-Day All-Cause Readmission Rate for Patients with Stroke (QBP)	8.93%	8.67%	7/25
	iv. Readmission Within 30 days for Selected HBAM Inpatient Grouper (HIGs)	16.86%	16.19%	13/25
	v. Alternate Level of Care Rate – Acute (ALC Rate)	19.27%	13.84%	13/25
Primary Care	i. 7-day Post-hospital Discharge Follow-Up Rate for Selected Conditions	N/A**	N/A**	37/41
	ii. Access to primary care (survey-based)	N/A**	N/A**	41/41
	iii. Hospital Readmission Rate for Primary Care Patient Population	N/A**	N/A**	22/41
Community Care Access Centres	i. Hospital Readmissions	18.33%	17.23%	1/1
Long Term Care	i.ED visits for Ambulatory Care Sensitive conditions	25.20%	24.55%	32/45

* 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 NE LHIN:

- 1 Hospital selected a custom indicator related to *30- Day Readmission Rate* (A combined designation for all four 30-Day Readmissions indicators)
- 3 Hospitals selected a custom indicator related to *Alternate Level of Care Rate*
- 1 Primary Care Organization selected a custom indicator related to *Hospital Readmission Rate for Primary Care Patient Population*

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

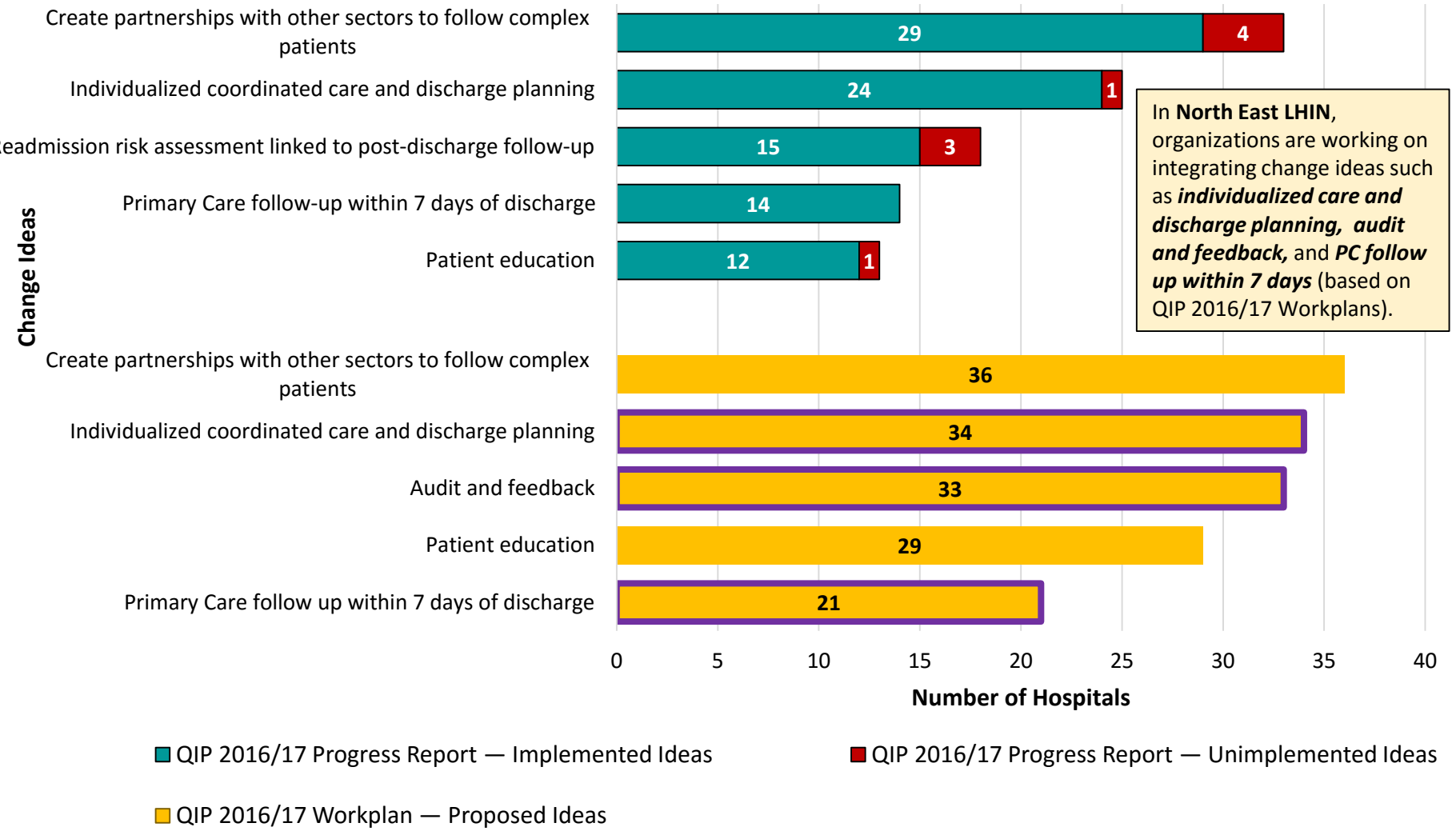
Note: Interpret data with caution; please refer to Technical Specifications; for instance, the three QBP indicators and the Readmissions HIG indicator are risk-adjusted, while the rest are not risk-adjusted.

MOST COMMON CHANGE IDEAS FROM 2015/16 AND 2016/17

Common Change Ideas

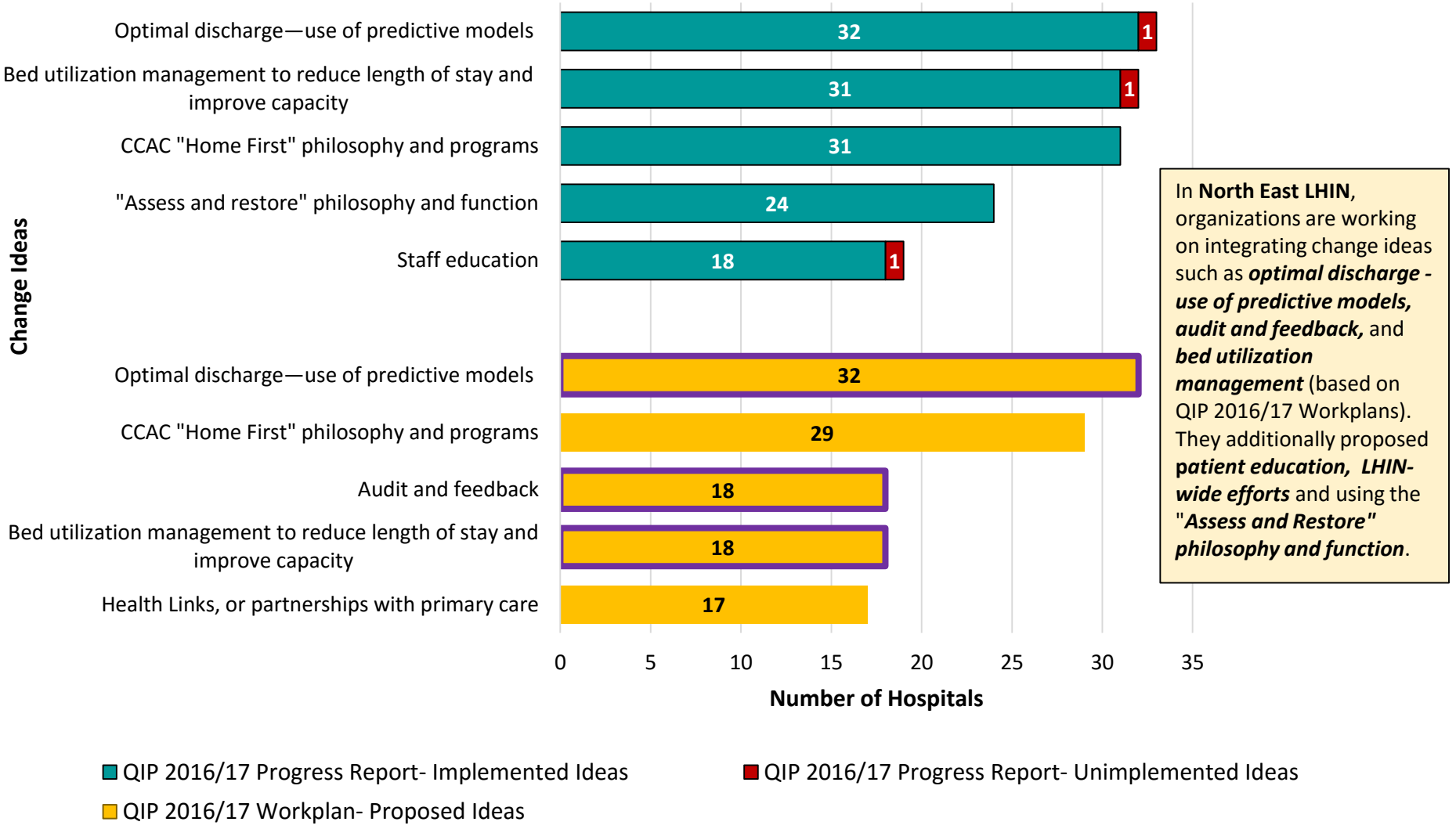
- The following slides show common change ideas at the provincial level; ideas have been categorized by theme
- Graphs display change ideas by indicator and show:
  - The most common change ideas included in the 2016/17 QIPs (Progress Report), and a look back at progress made in implementing change ideas
  - 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



* 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.

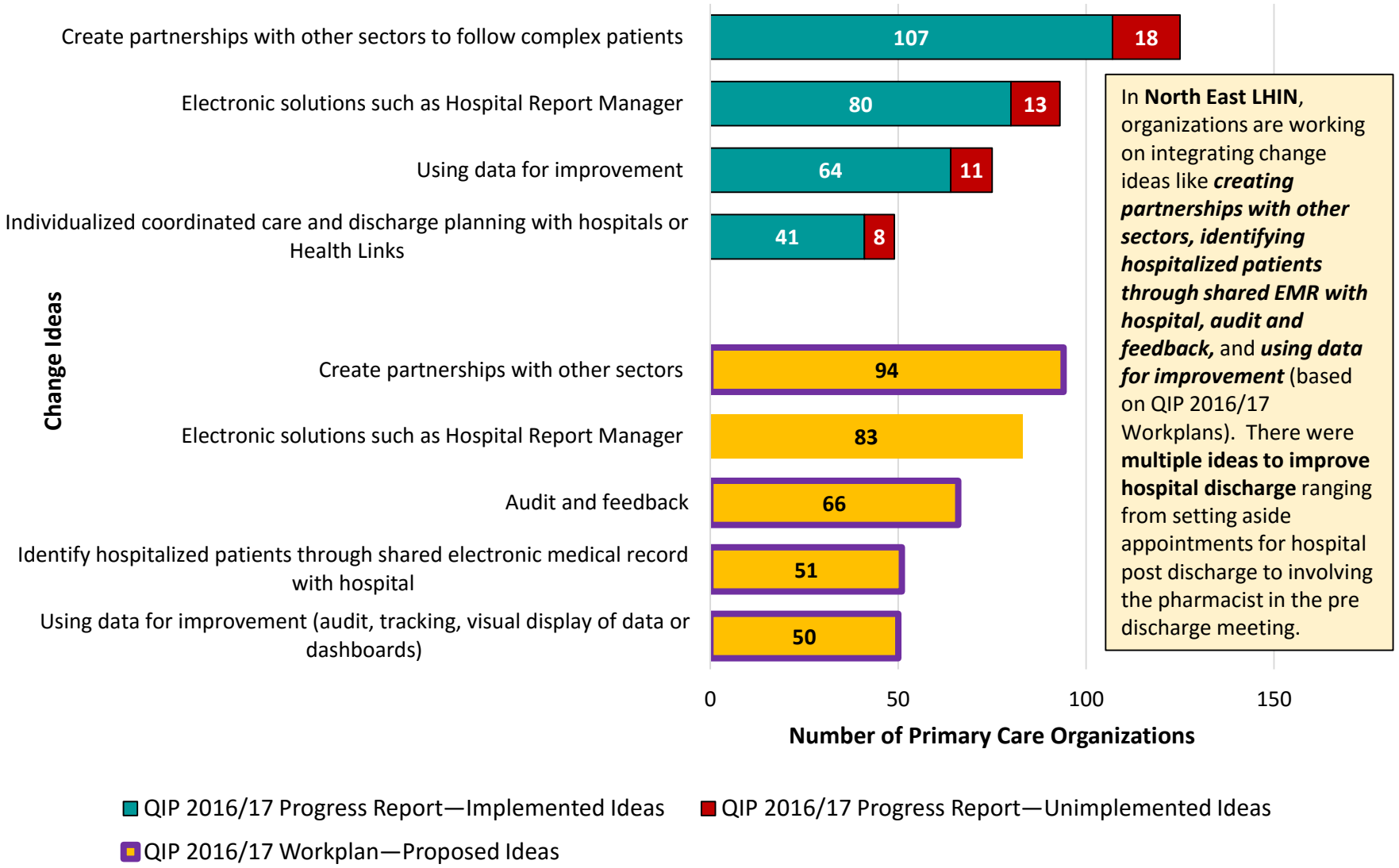
Most common change ideas in Ontario from 2015/16 and 2016/17 hospital QIPs for Alternative Level of Care,* as reported in the 2016/17 QIPs



In **North East LHIN**, organizations are working on integrating change ideas such as ***optimal discharge - use of predictive models, audit and feedback,*** and ***bed utilization management*** (based on QIP 2016/17 Workplans). They additionally proposed ***patient education, LHIN-wide efforts*** and using the "***Assess and Restore" philosophy and function***.

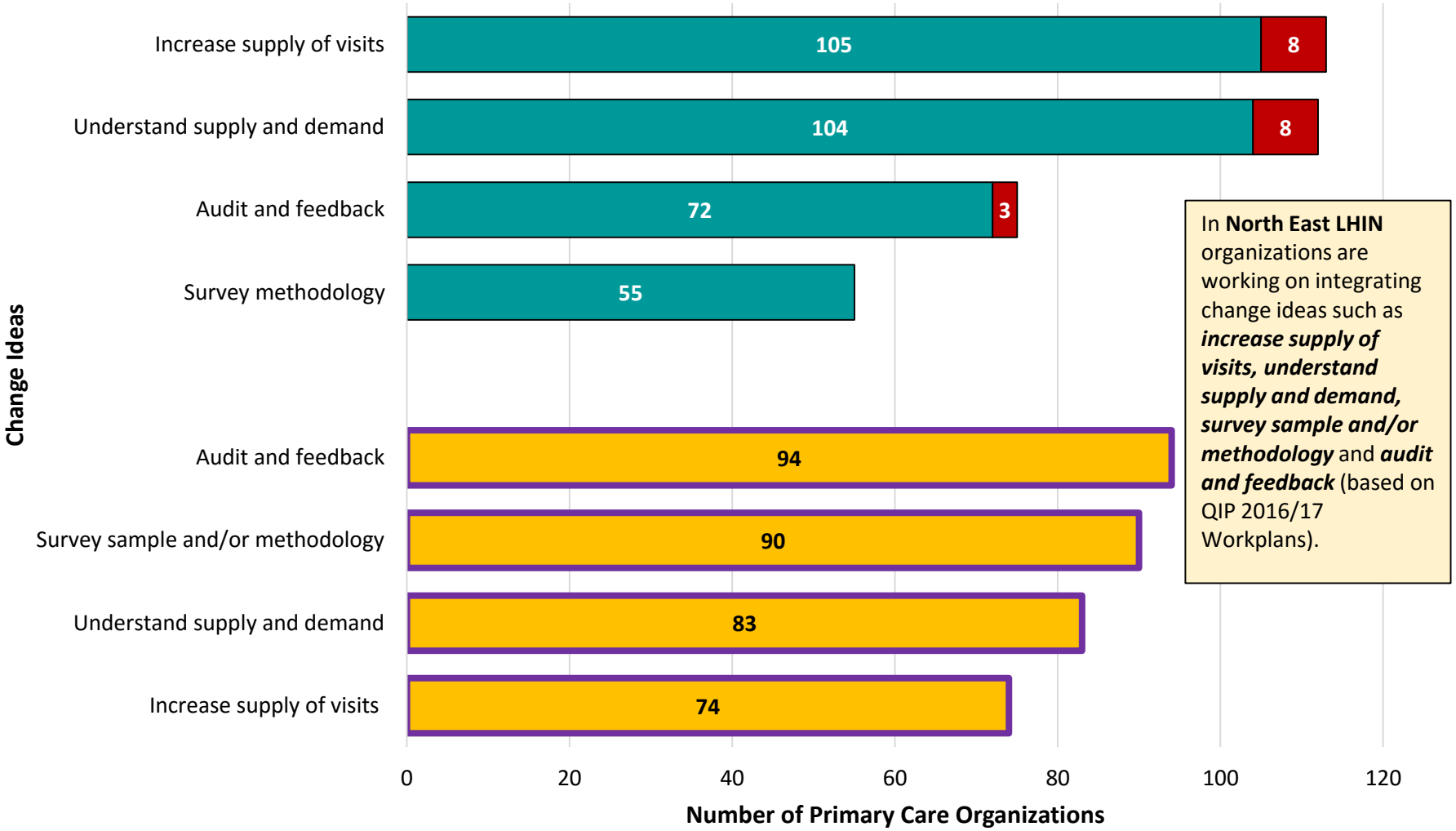
* The information presented combines data submitted by organizations on the following alternative level of care indicators: Alternative Level of Care Rate—Acute, and Percent Alternative Level of Care Days.

Most Common Change Ideas in Ontario from 2015/16 and 2016/17 Primary Care QIP for 7-day Post-Hospital Discharge Follow-Up Rate for Selected Conditions, as reported in 2016/17 QIP



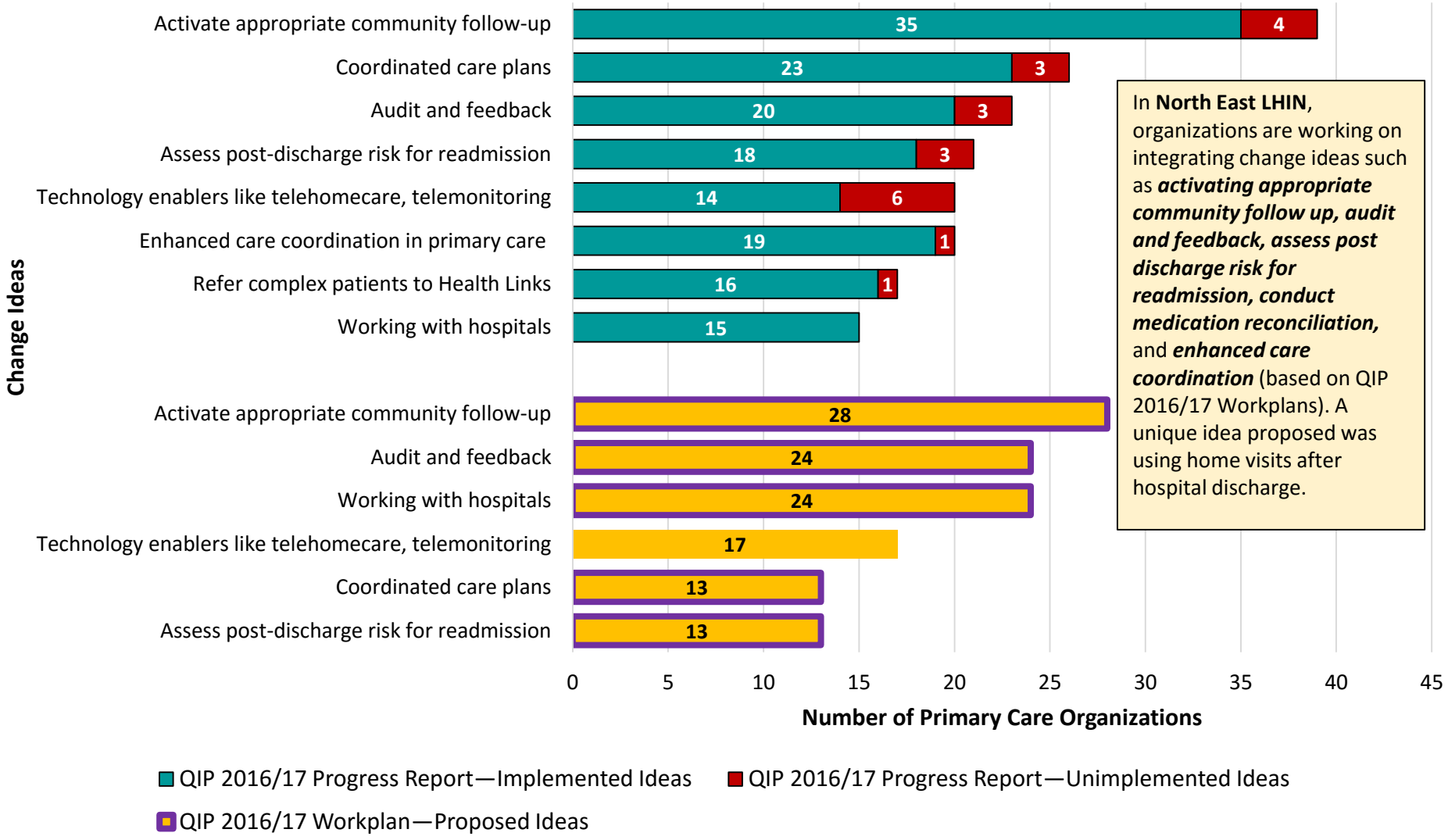
In **North East LHIN**, organizations are working on integrating change ideas like ***creating partnerships with other sectors, identifying hospitalized patients through shared EMR with hospital, audit and feedback,*** and ***using data for improvement*** (based on QIP 2016/17 Workplans). There were **multiple ideas to improve hospital discharge** ranging from setting aside appointments for hospital post discharge to involving the pharmacist in the pre discharge meeting.

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

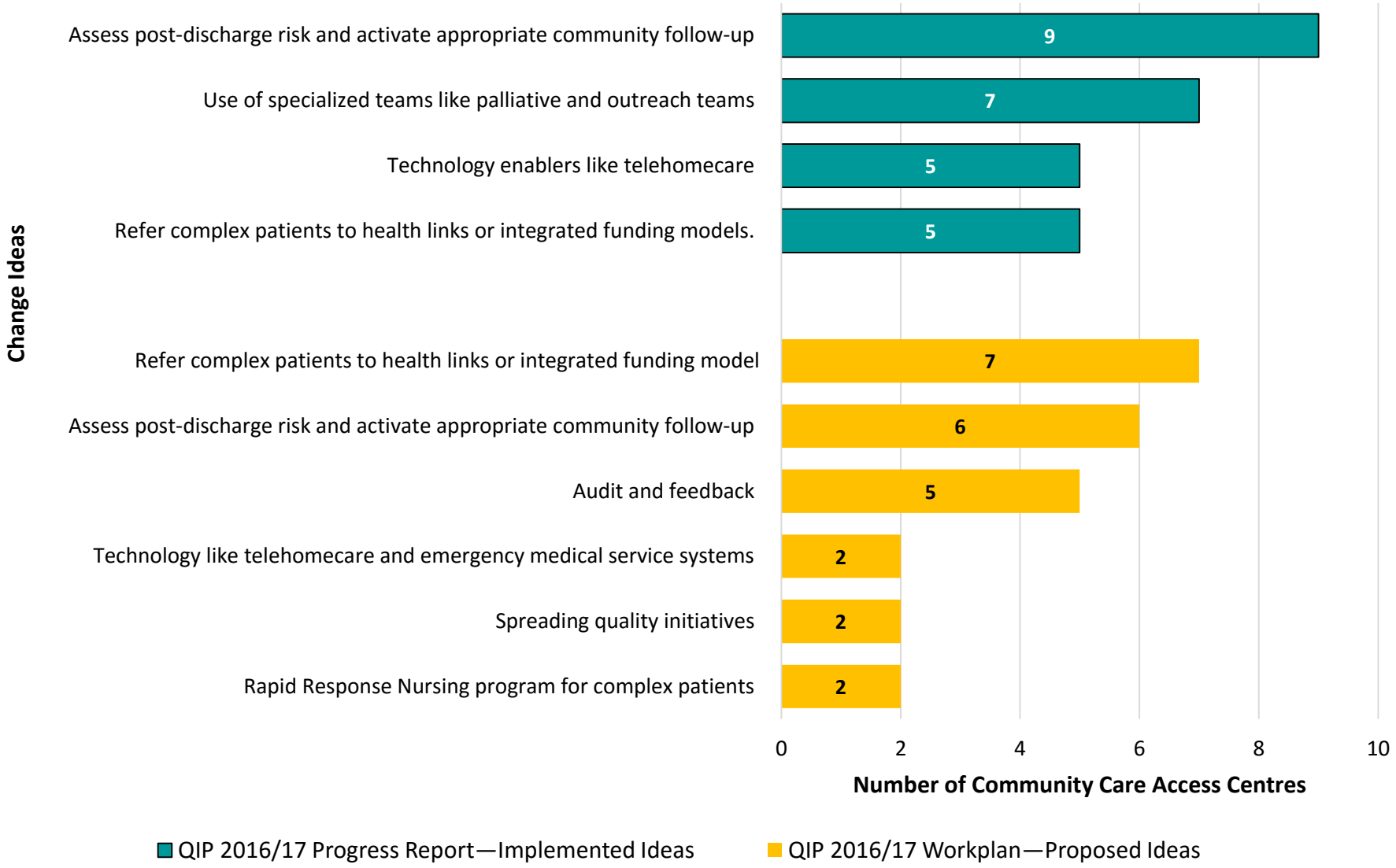


In **North East LHIN** organizations are working on integrating change ideas such as ***increase supply of visits, understand supply and demand, survey sample and/or methodology*** and ***audit and feedback*** (based on QIP 2016/17 Workplans).

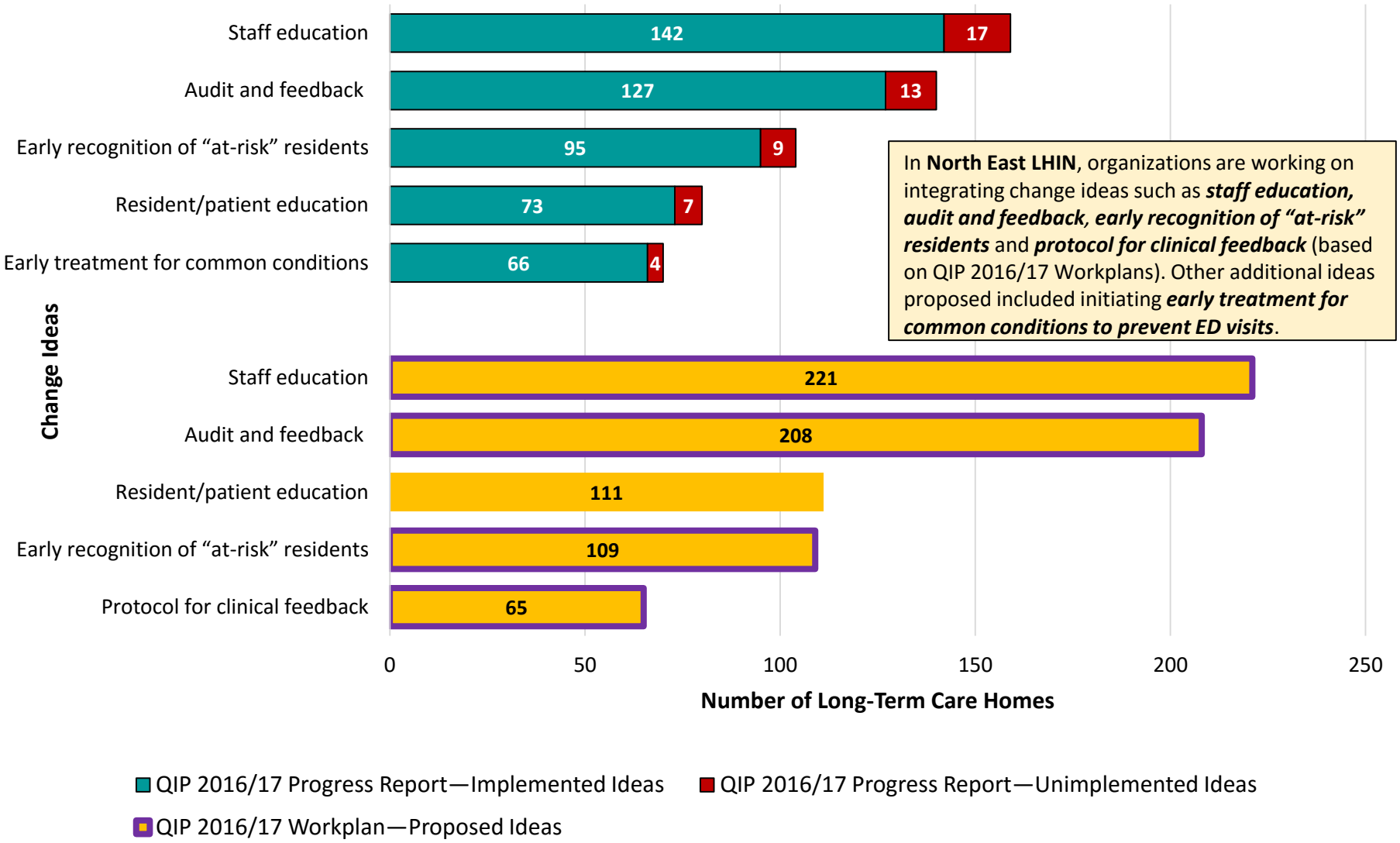
Most common change ideas in Ontario from 2015/16 and 2016/17 primary care QIPs for Readmission Within 30 Days for Selected HBAM Inpatient Groupers, as reported in the 2016/17 QIPs



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

Hospital and Primary Care Partnership

Espanola General Hospital – Improve Transitions

- Prior to discharge from hospital, a follow-up appointment is made with the patient's primary care provider and shared with them at the time of discharge.
- The hospital has partnered with their Family Health Team (FHT) to support those patients who do not have a regular family physician. Unattached patients are given an appointment with the RN at the FHT so they have contact with a health care provider who can help them navigate care should they need assistance.
- The Family Health Team started a clinic for unattached patients; when high risk patients are seen by the RN in the FHT, every attempt is made to have them more closely followed via the unattached patient clinic

Navigator roles

Noojmowin TEG Health Centre

- Their Aging at Home Navigator and Primary Care Manager are leads in a collaborative partnership with local health centre sites, Family Health Teams, hospitals and health authorities.
- The partnership addresses transitions primarily through discharge planning at regularly scheduled meetings/contacts with our local hospital and committee meetings.

CCAC – Utilizing Telehomecare for COPD/CHF

- Patient's **vitals are monitored remotely** by a nurse, using equipment placed in the patient's home. When required, actions initiated by the nurse to address any patient vitals that fall outside of their parameters.
- **Each care plan individualized and health coaching provided** to ensure patients are able to understand and recognize and prevent exacerbations.
- **OTN** produces and provides Program Leads with a **monthly report** from the THC database.
- Report details # of patient's in program who have received first visit. **Data reviewed regularly by program leads** and shared as needed.
- **Results:** 550 patients supported in this program (budgeted level)

Reducing ED visits

Wikwemikong Nursing Home

- Develop care path for residents with fever, potential dehydration, acute change in mental status, change in behavior, gastrointestinal symptoms, possible UTI and other ambulatory care sensitive conditions.

Au Chateau

- Change in ‘on call after hours’ availability of physicians
- Residents who require after hours assessment are visited by the ‘on call’ physician rather than sending the resident to the local Emergency Department

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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