

Toronto Central 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

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

Toronto Central LHIN Overview

Sector	QIP Count	Description
Hospitals	14	<ul style="list-style-type: none"> • 5 acute teaching hospitals • 5 CCC & Rehab • 2 large community hospitals • 1 ambulatory care • 1 mental health facility
Primary Care	31	<ul style="list-style-type: none"> • 17 Community Health Centre • 14 Family Health Teams
Community	1	<ul style="list-style-type: none"> • CCAC
Long-Term Care	34	<ul style="list-style-type: none"> • 14 for-profit • 16 not-for-profit • 4 municipal
Multi-sector*	2	<ul style="list-style-type: none"> • 2 hospitals • 2 long-term care

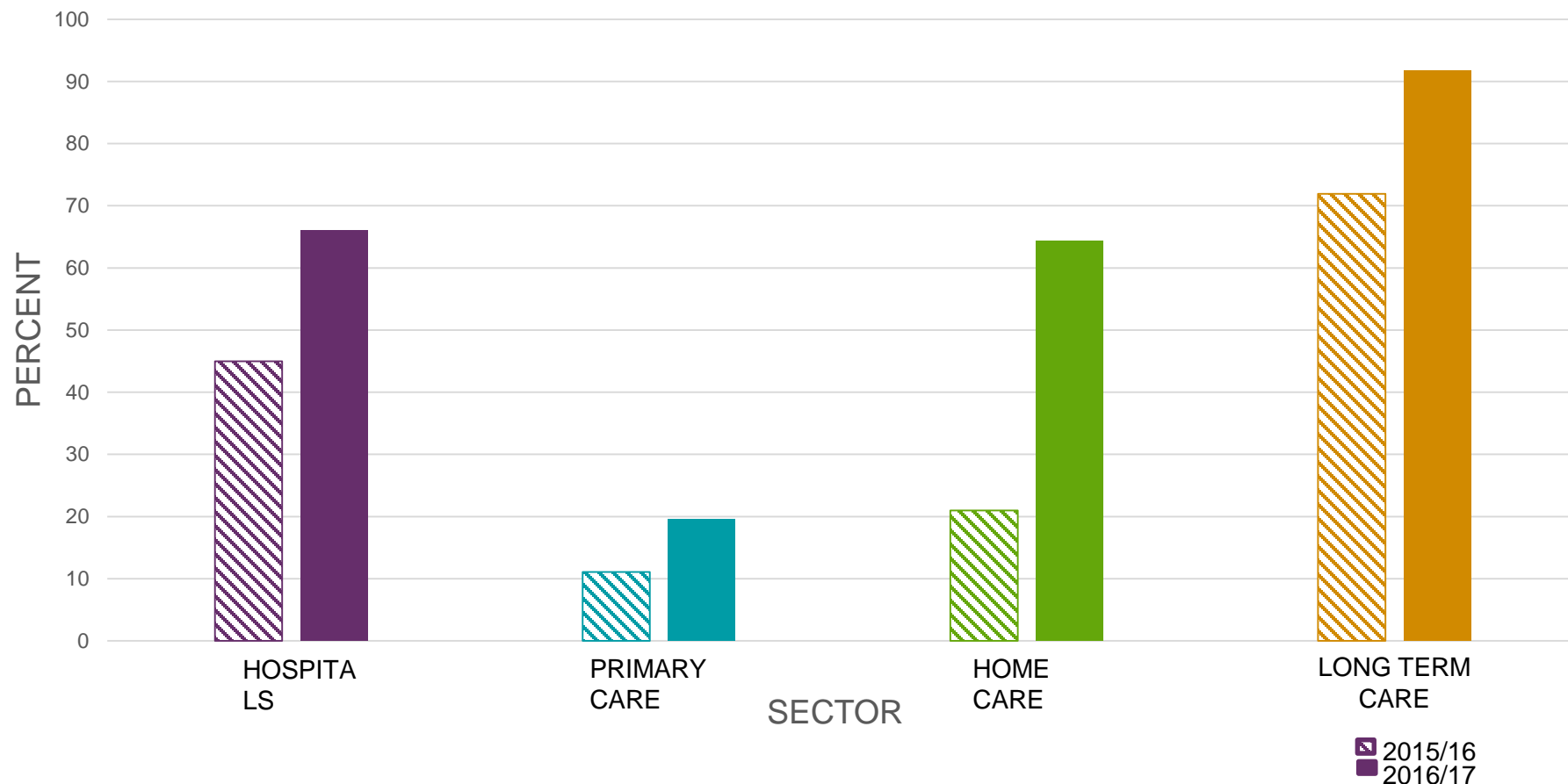
*Please note that multi sector sites are already included in the sector totals, above.

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.

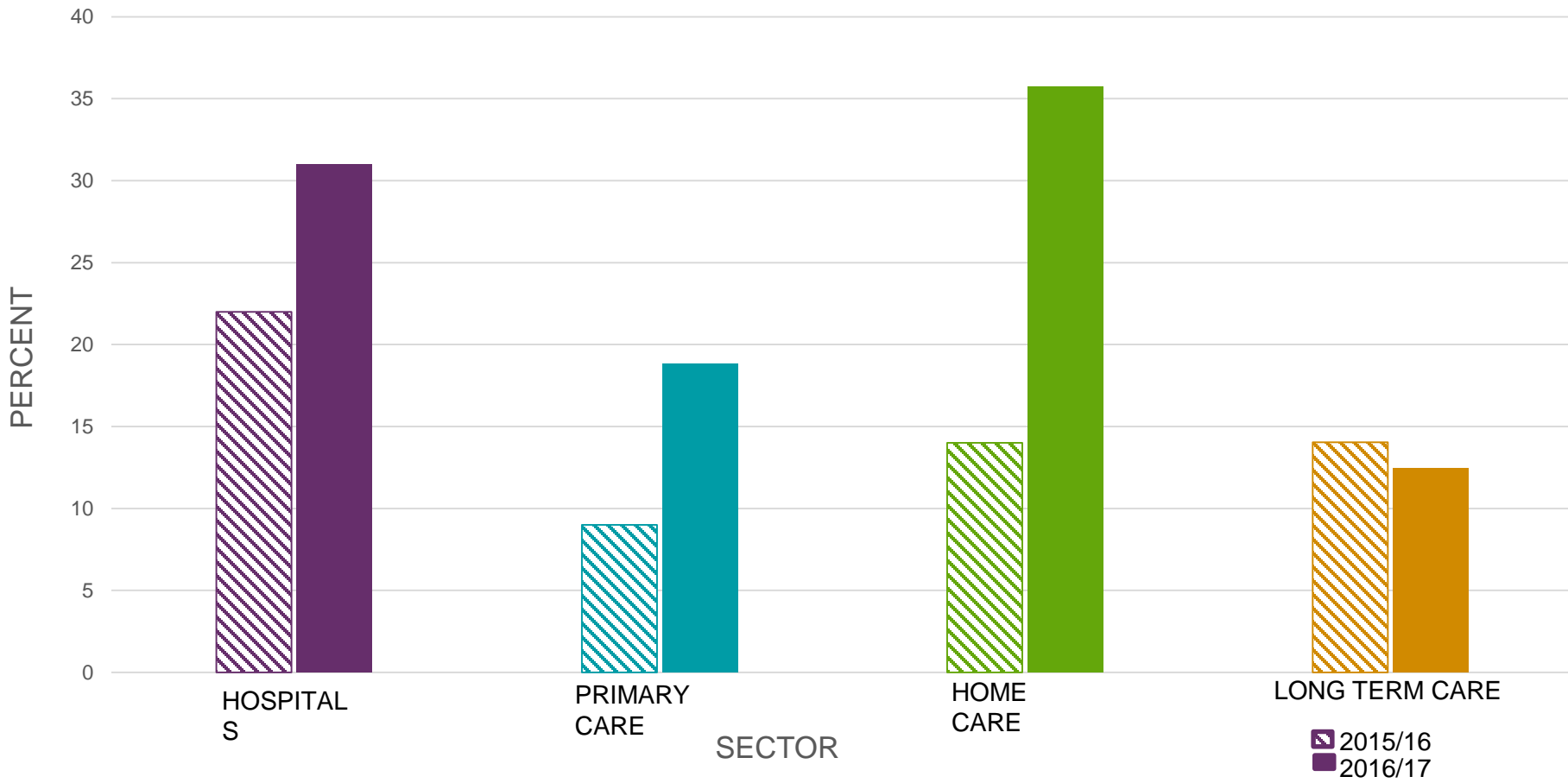
All sectors described an increased use of Patient and Family Advisory Councils and Forums in the development of their QIPs

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



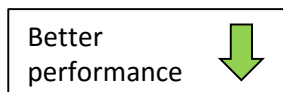
Key Observations – Per Sector

- **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).

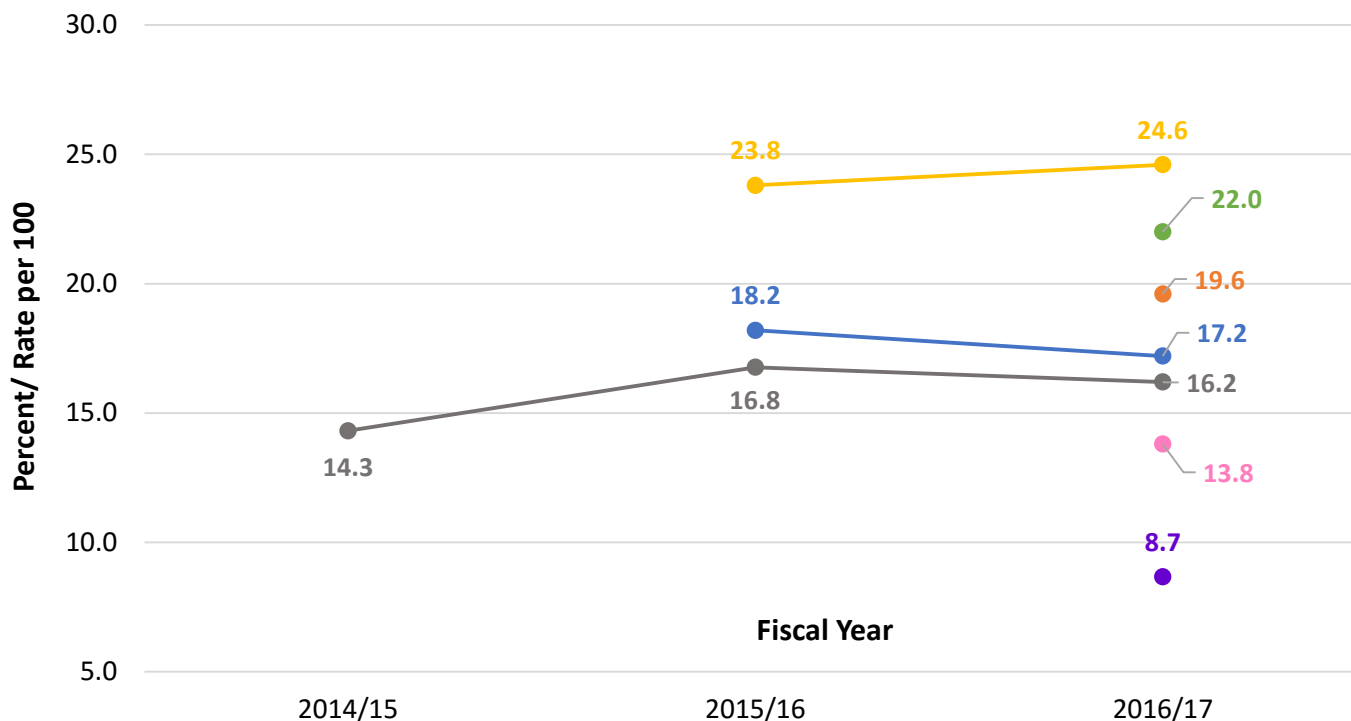
QUALITY IMPROVEMENT PLAN DATA

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 Grouper
- Alternative Level of Care Rate—Acute
- Risk-Adjusted 30-Day All-Cause Readmission Rate for Patients with Stroke



Fiscal Year

*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.

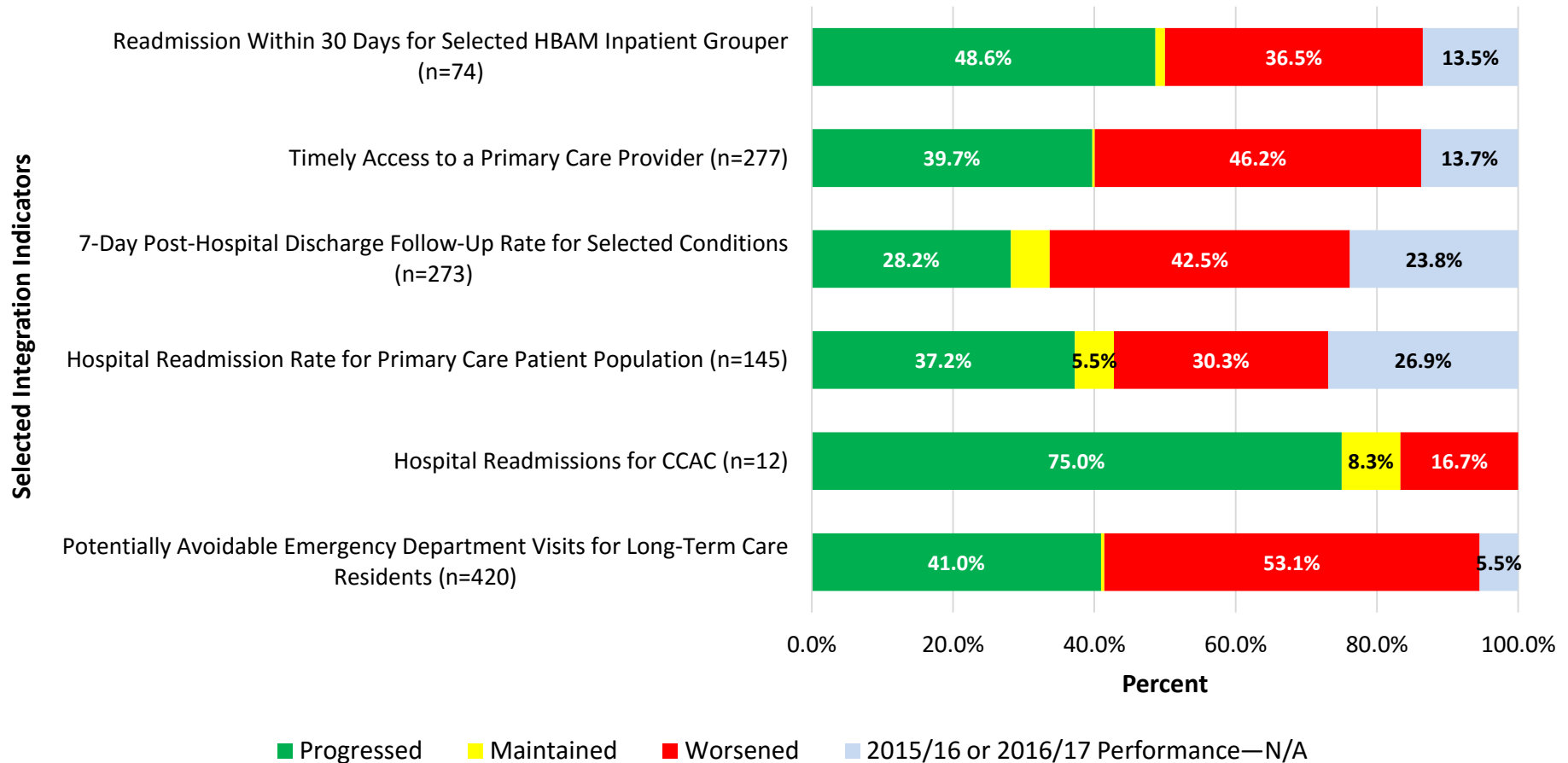
Risk-Adjusted 30-Day All-Cause Readmission Rate for Patients with Congestive Heart Failure; Risk-Adjusted 30-Day All-Cause Readmission Rate for Patients with Chronic Obstructive Pulmonary Disease, Readmission Within 30 Days for Selected HBAM Inpatient Groupers, Risk-Adjusted 30-Day All-Cause Readmission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

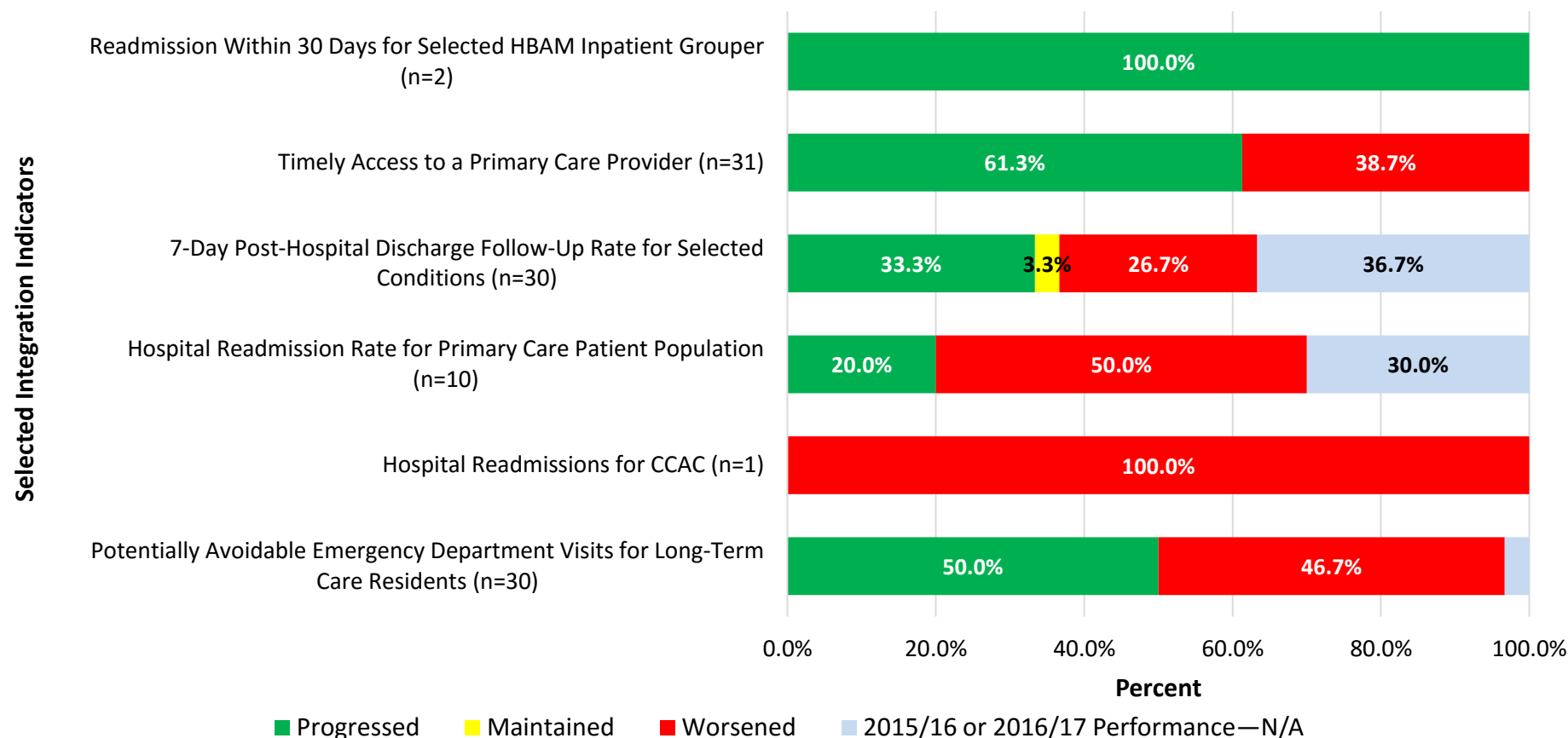
Looking back: Percentage of organizations in Ontario that progressed, maintained or worsened their performance between the 2015/16 QIP and the 2016/17 QIP on selected integration indicators, as reported in the QIP 2016/17 Progress Report



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.

Toronto Central LHIN QIP Data: Progress Made in 2016/17

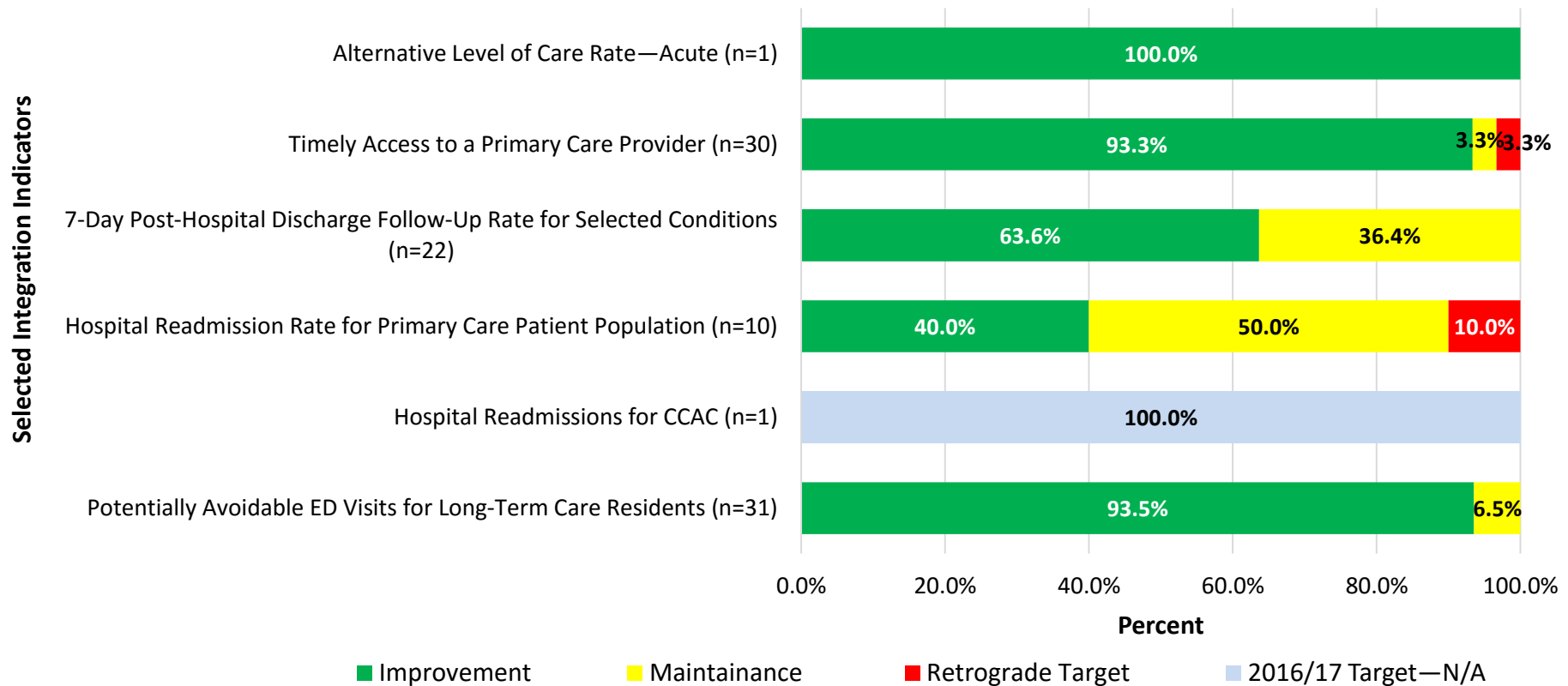
Looking back: Percentage of organizations in Toronto Central LHIN that progressed, maintained or worsened in their performance between 2015/16 QIP and 2016/17 QIP on selected integration indicators, as reported in QIP 2016/17 Progress Report



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.

Toronto Central LHIN QIP Data: Target Setting in 2016/17

Looking forward: Percentage of organizations in Toronto Central 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.

Toronto Central LHIN QIP Data: 2016/17 Indicator Selection

Sector	General Areas of Focus: Integration Indicators	Current Performance TC 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)	22.97%	22.00%	0/16
	ii. 30-Day All-Cause Readmission Rate for Patients with Chronic Obstructive Pulmonary Disease (QBP)	20.36%	19.60%	0/16
	iii. 30-Day All-Cause Readmission Rate for Patients with Stroke (QBP)	9.80%	8.67%	0/16
	iv. Readmission Within 30 days for Selected HBAM Inpatient Grouper (HIGs)	17.40%	16.19%	0/16
	v. Alternate Level of Care Rate – Acute (ALC Rate)	11.47%	13.84%	1/16
Primary Care	i. 7-day Post-hospital Discharge Follow-Up Rate for Selected Conditions	N/A**	N/A**	27/31
	ii. Access to primary care (survey-based)	N/A**	N/A**	30/31
	iii. Hospital Readmission Rate for Primary Care Patient Population	N/A**	N/A**	12/31
Community Care Access Centres	i. Hospital Readmissions	20.71%	17.23%	1/1
Long Term Care	i. ED visits for Ambulatory Care Sensitive conditions	27.20%	24.55%	31/36

* 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 TC LHIN:

- 2 Hospitals 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*
- 1 Primary Care Organization selected a custom indicator related to 7-day Post-hospital Discharge Follow-Up 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.

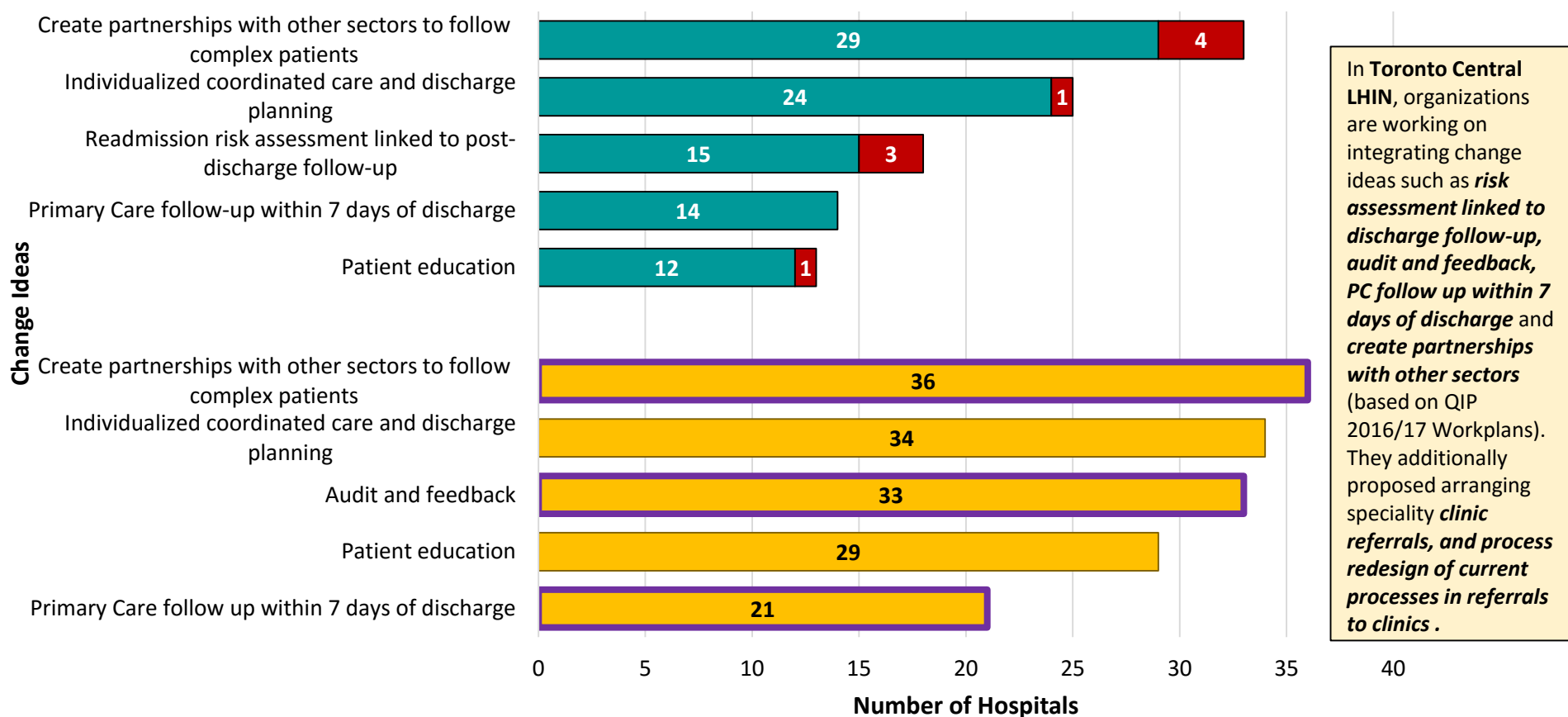
MOST COMMON CHANGE IDEAS FROM 2015/16 AND 2016/17

Common Change Ideas

On following slides, provincial view is provided and changes have been categorized into themes

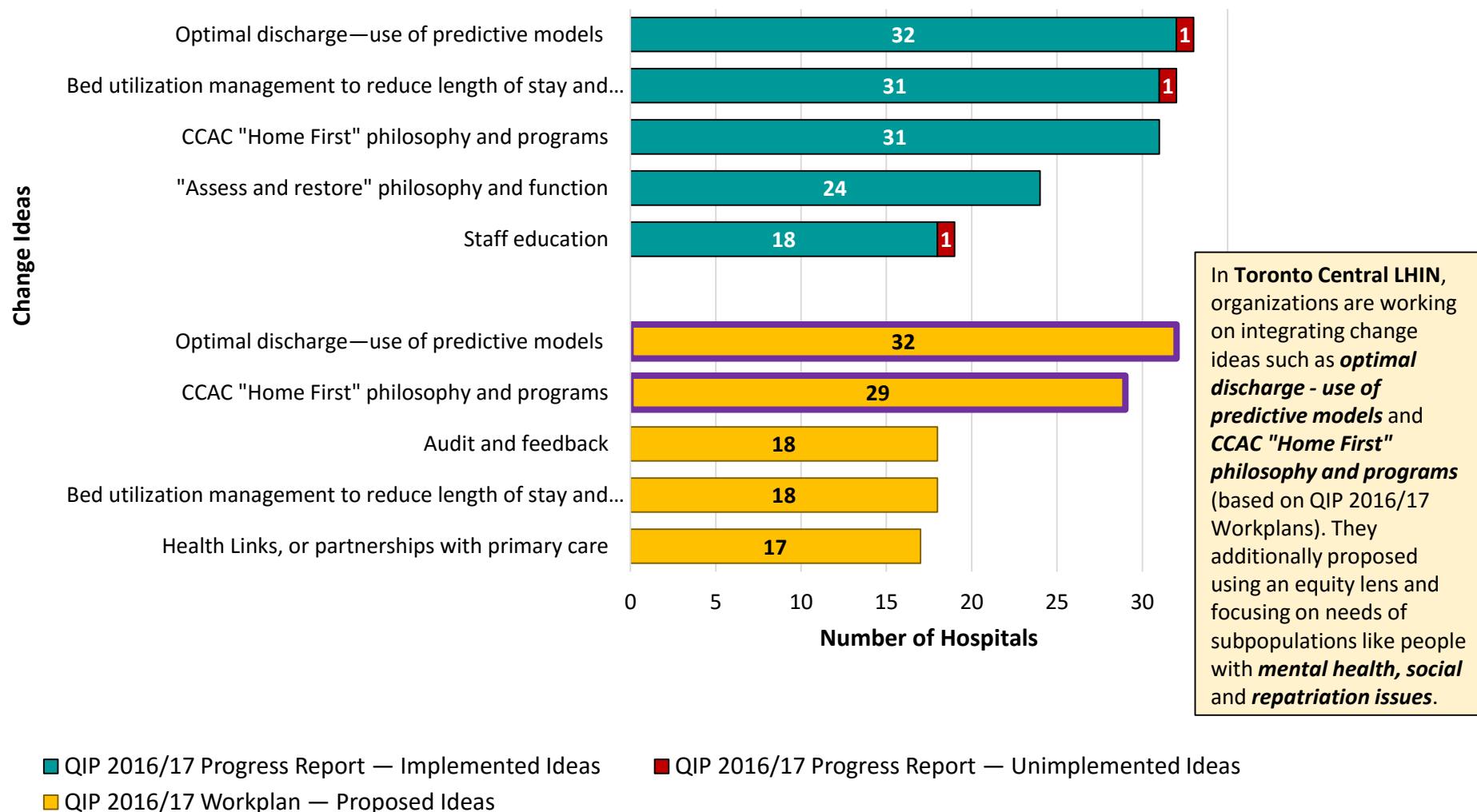
- Graphs display change ideas by each indicator and show
 - Most common change ideas included in the 2016-2017QIPS submissions (progress report); provides a retrospective look at progress of implementing change ideas
 - Extent to which these change ideas also included in QIP work plans
 - LHIN specific notes to capture regional change ideas, unique ideas in work plan.

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



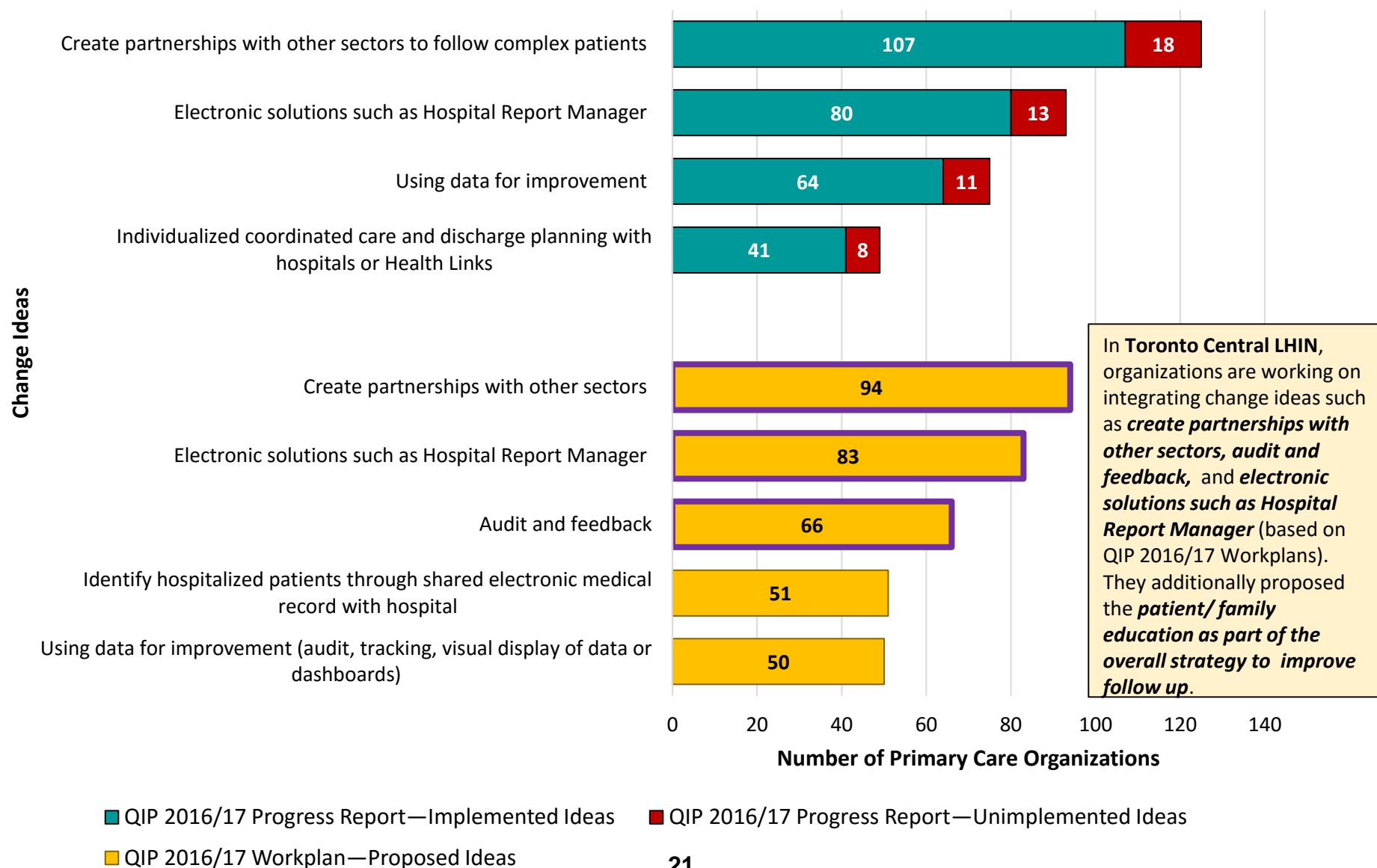
* The information presented combines data submitted by organizations on the following four 30-Day Readmission indicators: 30-Day All-Cause Readmission Rate for Patients with Congestive Heart Failure, 30-Day All-Cause Readmission Rate for Patients with Chronic Obstructive Pulmonary Disease, 30-Day All-Cause Readmission Rate for Patients with Stroke and Readmission Within 30 Days for Selected HBAM Inpatient 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

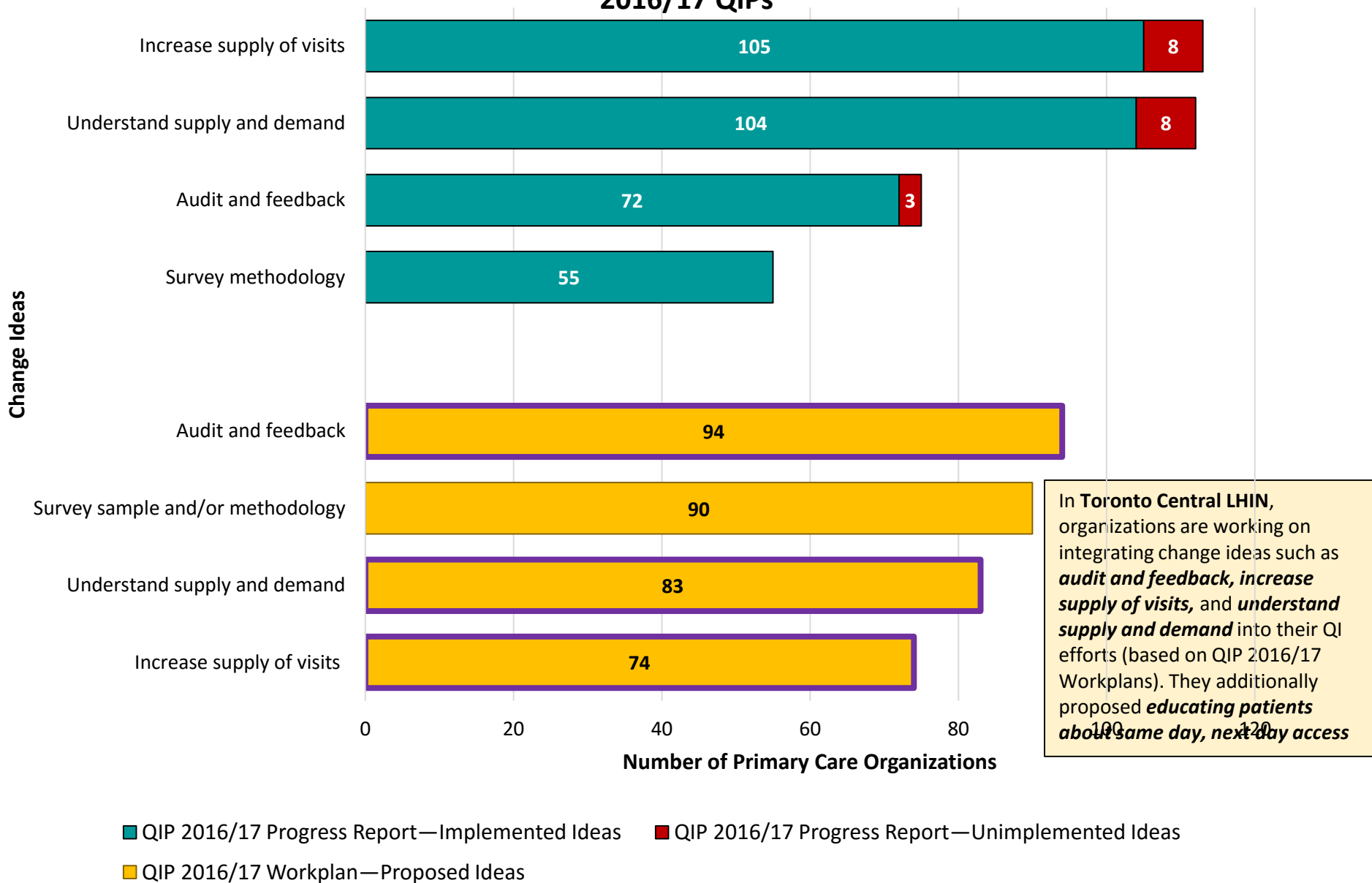


* The information presented combines data submitted by organizations on the following Alternative Level of Care indicators: Alternative Level of Care Rate—Acute, and Percent Alternative Level of Care Days.

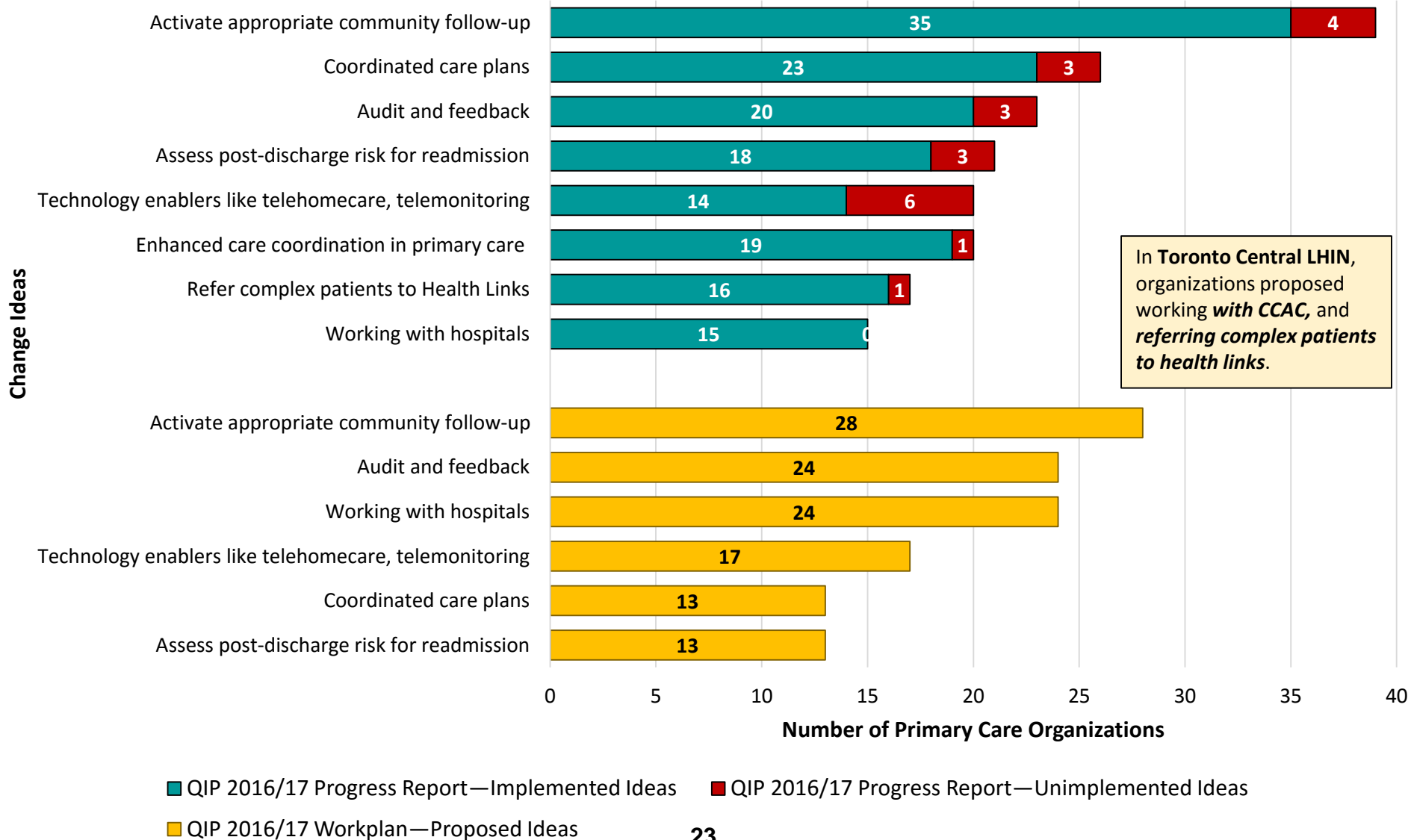
Most common change ideas in Ontario from 2015/16 and 2016/17 primary care QIPs for 7-Day Post-Hospital Discharge Follow-Up Rate for Selected Conditions, as reported in the 2016/17 QIPs



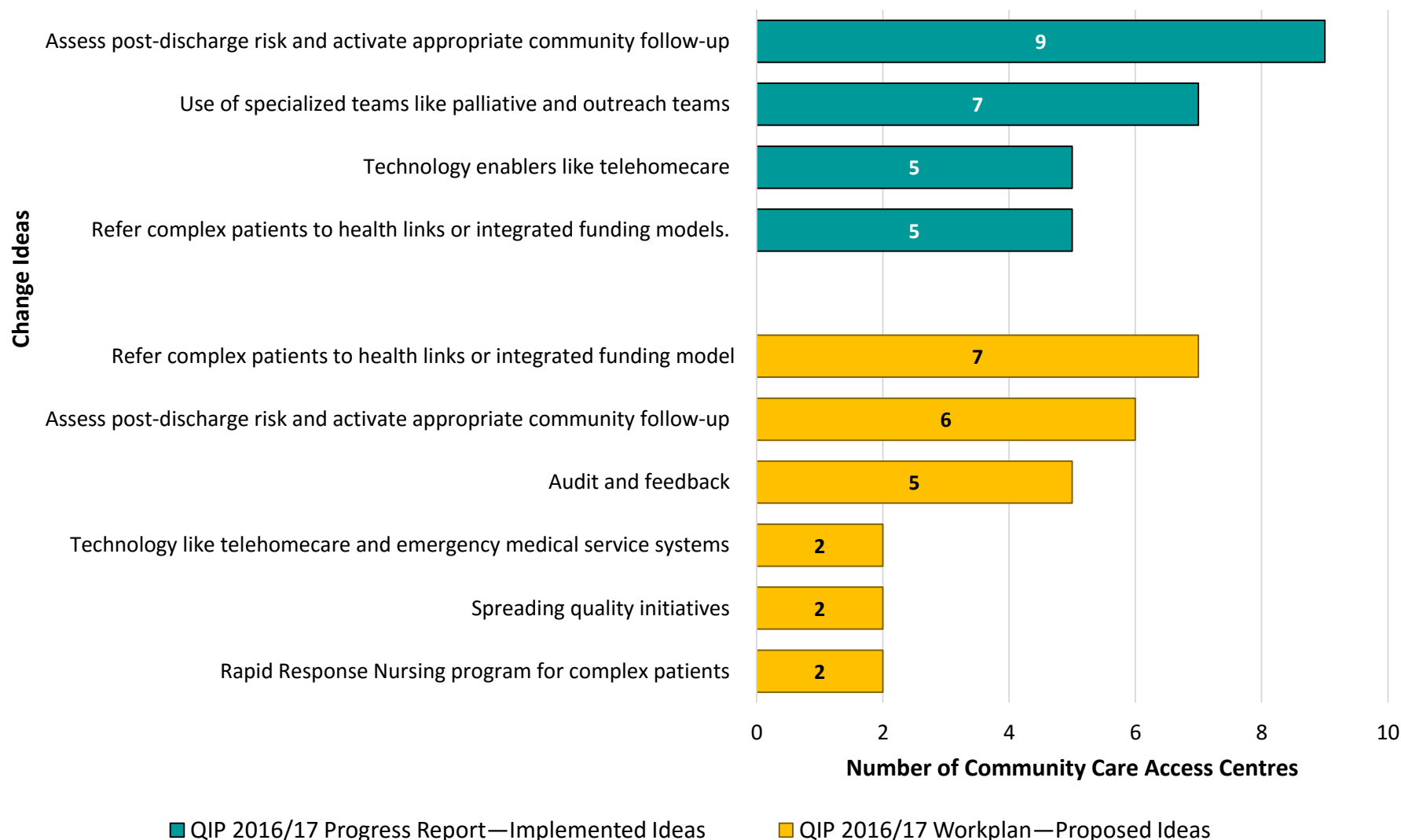
Most common change ideas in Ontario from 2015/16 and 2016/17 primary care QIPs for Timely Access to a Primary Care Provider, as reported in the 2016/17 QIPs



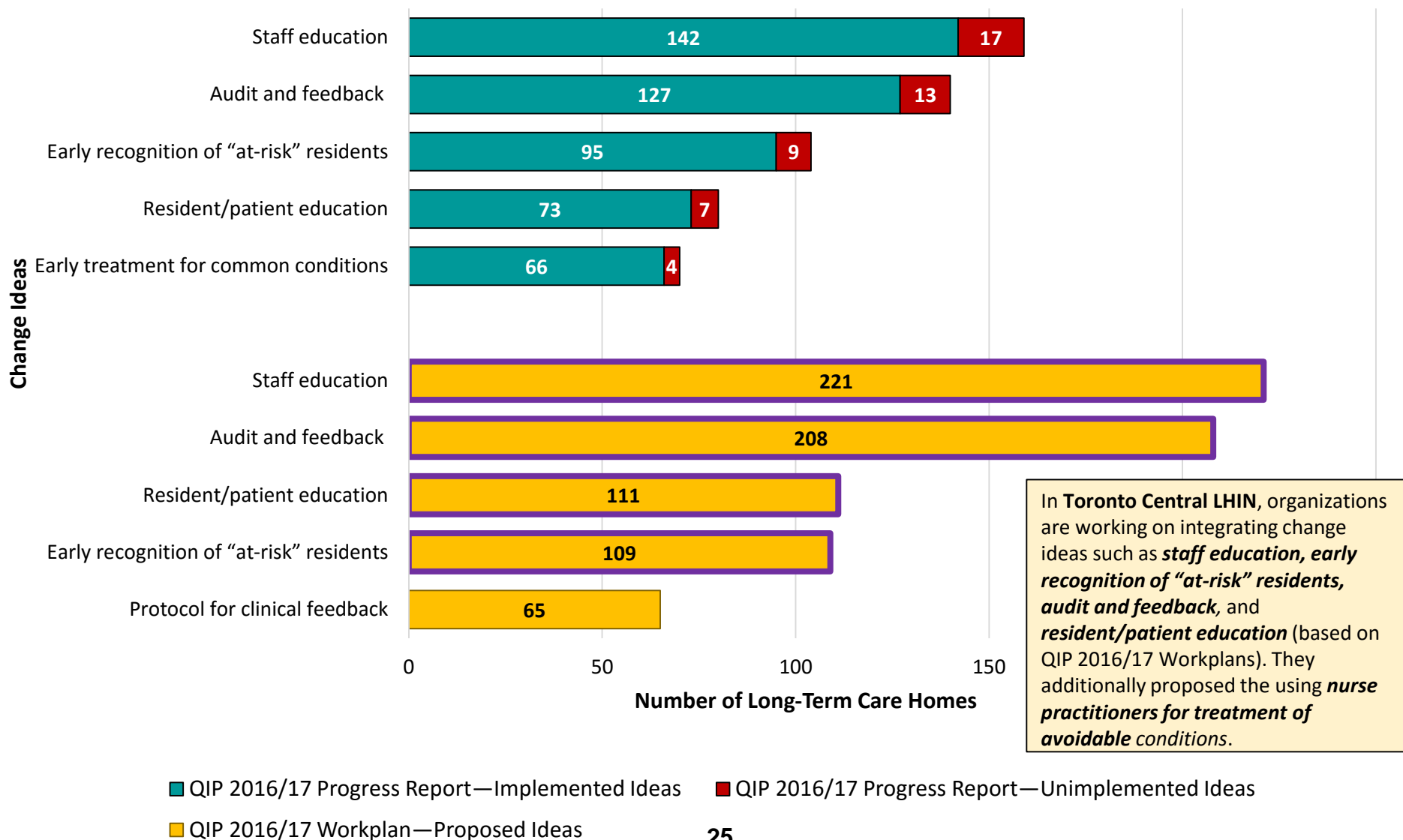
Most common change ideas in Ontario from 2015/16 and 2016/17 primary care QIPs for Readmission Within 30 Days for Selected HBAM Inpatient Groupers, as reported in the 2016/17 QIPs



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

Reducing Readmissions

St. Michael's Hospital (SMH)

- Developed SMH Risk of Readmission Tool based on previous tools (such as LACE), but including additional factors specifically designed for SMH's patient population, such as:
 - Does patient have family physician (MD)?
 - Are they homeless?
 - How many ED visits has there been in the last 6 months?
- Tool includes identification of supports patient may require, including Family MD referral, CCAC referral, Smoking Cessation and Puffer Support
- This model was implemented in General Internal Medicine, and was demonstrated to be accurate at predicting SMH readmission
- Next steps are to determine how best to use the model effectively and enable supports for at-risk patients

Optimizing Transitions in Care

Holland Bloorview Kids Rehab Hospital and The Hospital for Sick Children (SickKids)

- Change idea: improve the flow of children with medical complexity to Holland Bloorview's Complex Continuing Care (CCC) unit, and ultimately to home communities
- Added SickKids Average Length of Stay as a process measure for this change idea in the 2016/17 Quality Improvement Plan
- While organizations continuously partner in many initiatives, this is first formal Quality Improvement Plan initiative managed jointly
- A Joint Working Group will be established to:
 - Identify patient populations that could be cared for in a lower acuity setting (CCC unit)
 - Confirm gaps/barriers to transferring these patients
 - Develop a plan to address these gaps
 - Develop a jointly approved project plan that includes at least two improvement initiatives aimed at improving flow of complex medical patients from SickKids to Holland Bloorview's CCC unit by December 2016
 - Use and build on previous efforts (such as the FLO collaborative and earlier work with long-term ventilation population)

Improving Patient Flow and Improving Access to Care

South Riverdale Community Health Centre

Improving Patient Flow:

- Introduced full-time Clinic Assistant role to improve patient flow and coordination of care for individuals with complex needs
- Lessons learned: this is a larger role than we had originally anticipated and requires more staff for this role

Improving Access:

- Exploring the feasibility of group medical visits to streamline access (focusing on improving chronic pain management for physiotherapy patients)
- Individuals with chronic pain were found to have a high number of repeat visits to nurse practitioners and/or physicians. This program may reduce demand for access to clinical services

Improving Patient Experience

Toronto Central CCAC

Patient-Centred Care:

- Toronto Central CCAC and Hamilton Niagara Haldimand Brant LHIN have been engaged in research on client and caregiver experience
- Staff received training in a patient-centred approach to care planning and delivery called “Changing the Conversation”
 - In 5 year period, Toronto Central CCAC’s scores on the survey question “Would you recommend the CCAC to your family or friends if they needed help?” have jumped from 88% to 98%
 - Scores for overall satisfaction were above 90% and have stayed at that level
 - This approach was recognized as a Leading Practice by Accreditation Canada in 2015

Improving Patient Experience

Toronto Central CCAC

Integrated Palliative Care:

- In 2015/16, the CCAC achieved its goal to increase the number of patients supported by integrated palliative program by 10%
- Work included creating a more integrated palliative care model, including launching client and family Palliative Advisory Council, and planning for the launch of an integrated electronic health record in 2016/17 to allow all members of the palliative team across organizations to share communications and work more effectively as a team
- This will be the first fully integrated electronic health record for home care and primary care in Ontario

Improving Communication and Teamwork

Fairview Nursing Home

- Using a hospital tracking tool that is working well to understand and improve emergency department transfers
- Working to engage the nurse-led outreach team, including weekly visits and contacting them before sending a resident to the ED
- Lessons learned:
 - It is important to have regular care conferences to update residents' Advance Directives to reflect patient and family wishes, quality of care, and life decisions
 - It is also important to educate families about aging principles with support of doctor
- Currently establishing a palliative care team with active involvement of the social worker to liaise with palliative physician and provide support to families, residents, and team

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?



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