Focus on Follow Up

Aligning QIPs for 2019-20

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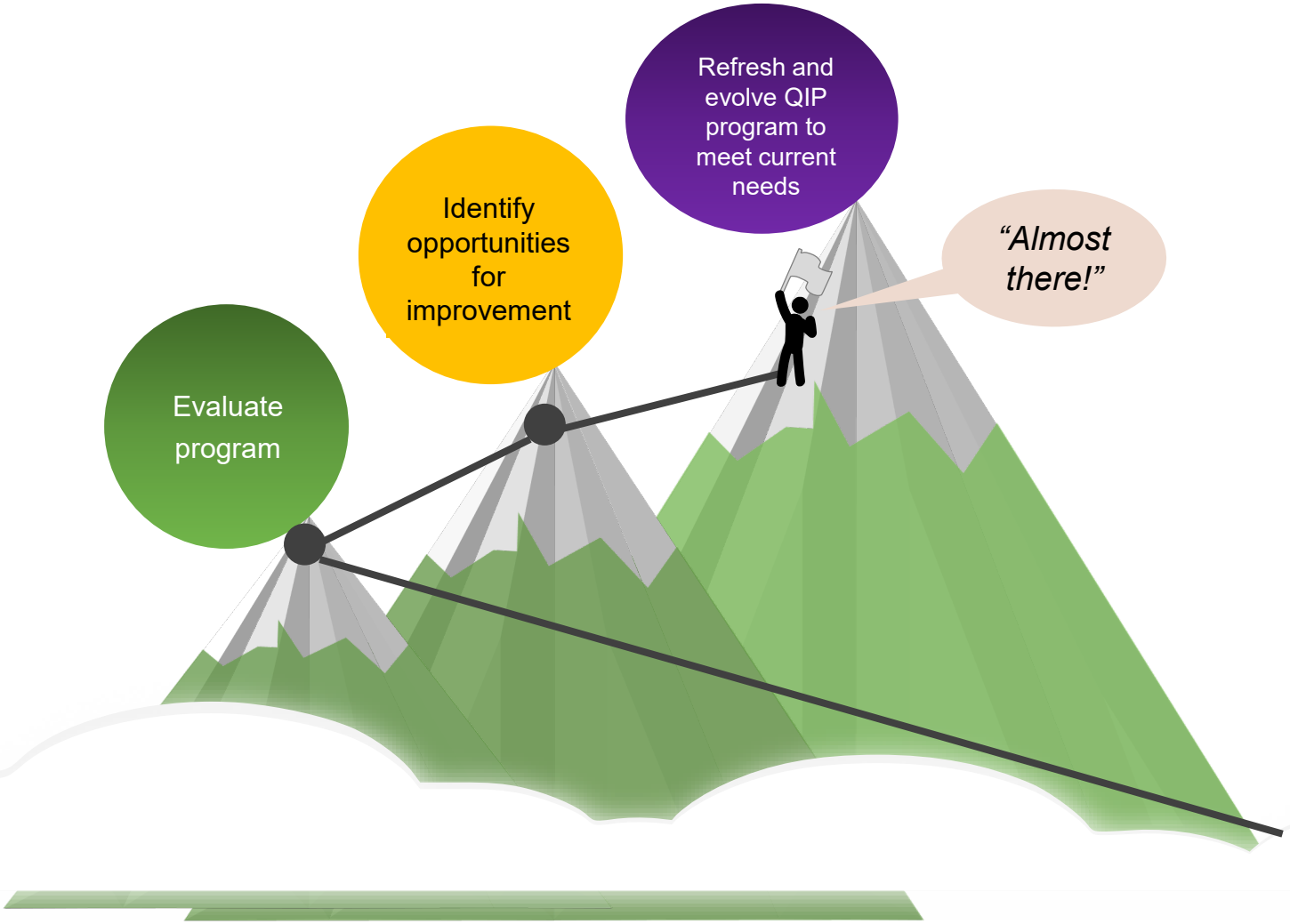
Session Objectives

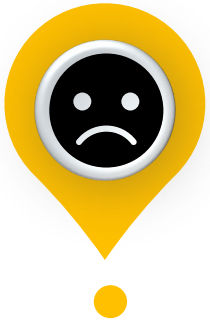
- Recap recent communication from HQO about the QIP Program (Webinars Oct 19 & 23)
  - QIP evaluation and HQO planned response
  - Future direction of the QIP Program
- Overview of NE LHIN QIP 2019-20 Recommendations
- Opportunities to leverage NEOFHT Indicators
- Next steps re: QIP Planning

Health Quality Ontario: Evaluation of the QIP program



Key Themes From the Evaluations

HQO's Plan



1. Priorities

- Too many indicators/ competing priorities
- **Focus & simplify**: a few key themes/ indicators

2. Collaboration

- The emergence of collaboratives, networks, and regional QI work
- Support cross sector collaboration with initial focus on **access to appropriate level of care and transitions**
- Adjust QIP to reflect collaborative QI goal setting

3. Implementation

- QI teams need more support
- Wrap around implementation **support for QI teams** working on key themes (i.e. change management know-how, community of practice, help organizations to improve & showcase what is working well)

NE LHIN QIP Memo: Guidance for 2019-20 QIPs (Nov '18)

The Regional Quality Table's goal is to improve the overall health status of Northerners through aligning and spreading initiatives. Through collaboration and consultation, the RQT has recently developed its first Integrated Regional Quality Plan, which identifies '**Transitions from Hospital to Home**' as a key priority.

QIP Indicator Selection:

- When preparing your 2019-20 QIP, we request all organizations identify an area for improvement related to improving transitions in care. Organizations are then encouraged to collaborate with new and existing local partners to develop change ideas and select indicators to measure improvement.

NE LHIN QIP Memo: Guidance for 2019-20 QIPs (Nov '18)

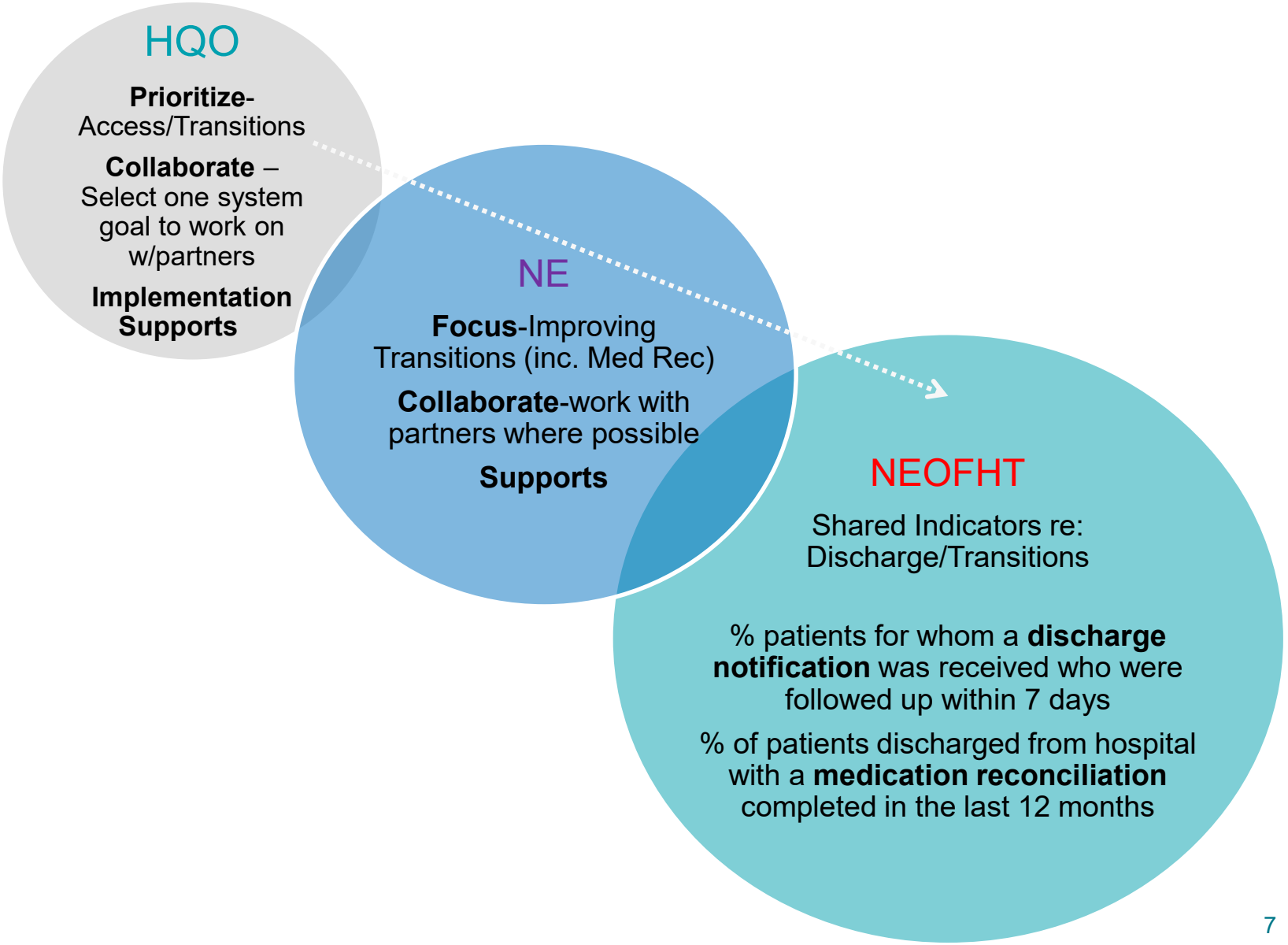
- Performance across all sectors in areas related to 'effective transitions' continue to be a challenge for providers in the NE LHIN
  - QIP Snapshot Report
  - Measuring Up 2018
  - MLAA Indicators

NEOFHT Indicators

Indicators related to hospital discharge (transitions) that align with both D2D and QIP measures:

- ✓ % patients for whom a **discharge notification** was received who were followed up within 7 days of discharge, by phone or in-person visit with any clinician
- ✓ % of patients discharged from hospital with a **medication reconciliation** completed in the last 12 months

A Common Thread



What organizations can do now

2018/19 QIP:

- Continue to focus on implementing the change ideas in your 2018/19 QIP
- Look for potential opportunities for collaboration, spread/scale, adjusting targets
- Consider QI education for current or future QIP team members (FREE)

What organizations can do now

2019/20 QIP:

- Reflect on your progress and targets from your 2018/19 QIP and use these as a starting point for your 2019/20 QIP
- Review NE QIP Memo & NEOFHT Indicators
- Given the focus on transitions/access & prioritization and collaboration:
  - Identify one organizational indicator for in-house QI work and one system indicator for collaboration with partners
  - Consider reaching out to your local partners to identify any opportunities to work together
  - Together, define quality improvement activities that will impact how patients transition between care environments or timely access to services in the care setting that is most appropriate.
  - Look for additional supports from HQO and NE in December/January
  - **New for 2019/20 QIP Submissions: For transitions issues/indicators:** Organizations will be able to identify in their QIP submission who they are collaborating with in Navigator

Examples

2018/19 Indicators
Where are our opportunities?

Readmissions? Med Rec?
Care Coordination? ALC?
ED Visits? Follow up?

PRIMARY CARE Percent of patients/clients who see their primary care provider within 7 days **after discharge** from hospital for selected conditions.

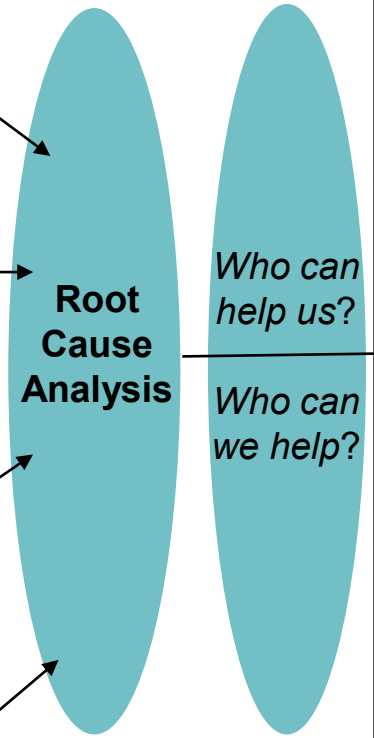
% patients for whom a discharge notification was received who were followed up within 7 days of discharge, by phone or in-person visit with any clinician

ACUTE CARE **Readmission** rate for patients with CHF/COPD/Stroke/MHA; Did you receive enough information from hospital staff about what to do if you were worried about your condition or treatment **after you left the hospital**?

HCC Percentage of home care clients who experienced an unplanned **readmission** to hospital within 30 days of discharge from hospital.

LTC Number of **ED visits** for modified list of ambulatory care–sensitive conditions* per 100 long-term care residents.

MULTI Number of complex patients identified/offered access/have completed **coordinated care plan**; **Medication Reconciliation**



Collaborative Change Ideas
What can we do?

Patient Oriented Discharge Summary (PODS)

Process for follow up appointments/referrals

Electronic notifications / shared data/reporting

Care pathways

Audit & Feedback

Quality Standards

Staff/Patient Education

Collaborative approach to rounds/discharge planning conferences/coordinated care planning

Collaborative communication protocols (checklists, SBARD, discharge phone calls)

Use of triage/risk assessment tools (i.e. LACE)

High level quality goal: Improve transitions of care and care coordination for the CHF population by becoming a top performer in CHF readmissions.

AIM (A)					GOALS (B)	CHANGE (C)	
Dimension	Issue	Big Dot Measure	Current Performance	Target			
					rganizations	Change Ideas and Methods	Process Measures
					WWCCAC	Rapid Response Nurse (RRN) completes full medicaiton reconcilation in the home	% Medication reconcilations completed in the home
						Develop process to have hospital pharmacist be able to share discharge med rec details with the community pharmacist and next care provider. Then primary care to confirm with patient.	% medication reconciliation at discharge (CHF population)

Change concept	Organizations	Change Ideas and Methods	Process Measures
7 day follow-up	Grandview FHT, Langs, Two Rivers FHT	Rapid Response Nurse (RRN) completes full medicaiton reconcilation in the home	% Medication reconcilations completed in
		Primary care prioritize booking appointments for CHF patients.	% of patients with CHF seen within 7 days
	Cambridge Memorial Hospital	Faxed discharge lists, including diagnosis, faxed to primary care.	% of discharged patients that have notification provided to primary care
		Implement notification system to alert CCAC RRN of high risk CHF patient discharge	% CHF patients flagged for CCAC involveme
		Send discharge summary to primary care, and LTC when applicable, within 48 hours (CHF population)	% discharge summaries sent from hospita to community care provider within 48 hou of discharge
	Independent Living Centre Waterloo Region	Support transportation concerns to access to primary care follow-up	
	Grandview FHT, Langs, Two Rivers FHT	Explore process for patients to secure a booked appt within 7 days of hospital discharge	
		pports connections and lore - MOW	asking them to look for. Possible linkages to volunteer drivers reporting back concerns as well.
			Transportation for primary care follow-up visits prioritized for CHF. Requires referral pathway changes/education to ensure clients are prioritized appropriately. he check in education piece to our driver training as well	% post discharge rides provided
			Implementation and evaluation of CHF telehomecare pilot.	
		WWCCAC	Referrals to RRNs for patients with CHF and complex medical needs discharged from CMH.	% of CHF clients who receive RRN visit withir 48 hours
		r care- Two Rivers	CORE" physician education to local primary care teams	% of primary care teams with CORE education

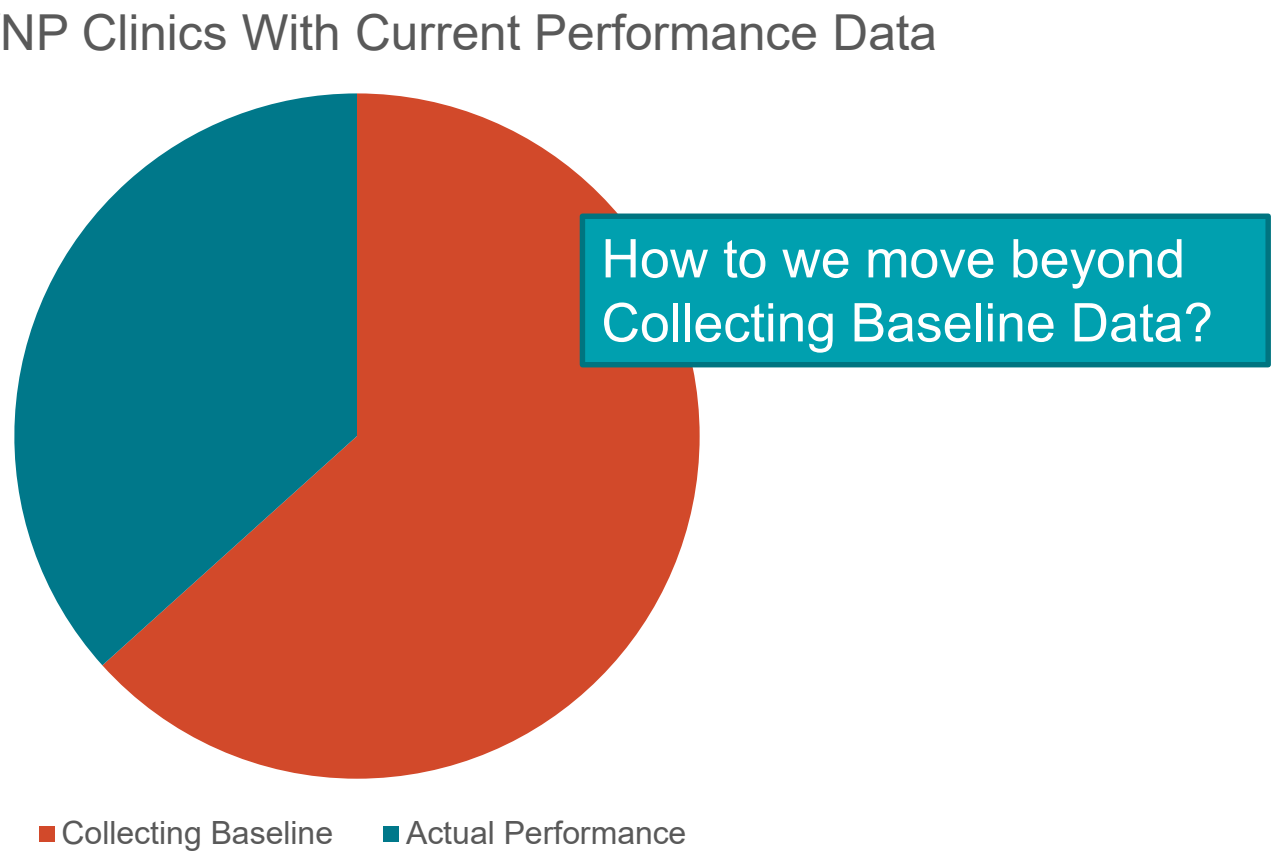
Effective	Effective transitions	Risk-adjusted 30-day all-cause readmission rate for patients with congestive heart failure (QBP cohort)	22% (calendar year 2015)	15% To meet the top performer large community hospital (St. Mary's General, Grand River, Orillia Soldiers' Memorial)

Thinking ahead…..

	Big Dot? (2018-19 Indicator)	Root Cause(s)?	Partners?	Change Ideas?
"In-House" Indicator TBD			n/a	
"System" Indicator Improving Transitions (NE/HQO)				

Workshop

% patients for whom a discharge notification was received who were followed up within 7 days of discharge, by phone or in-person visit with any clinician

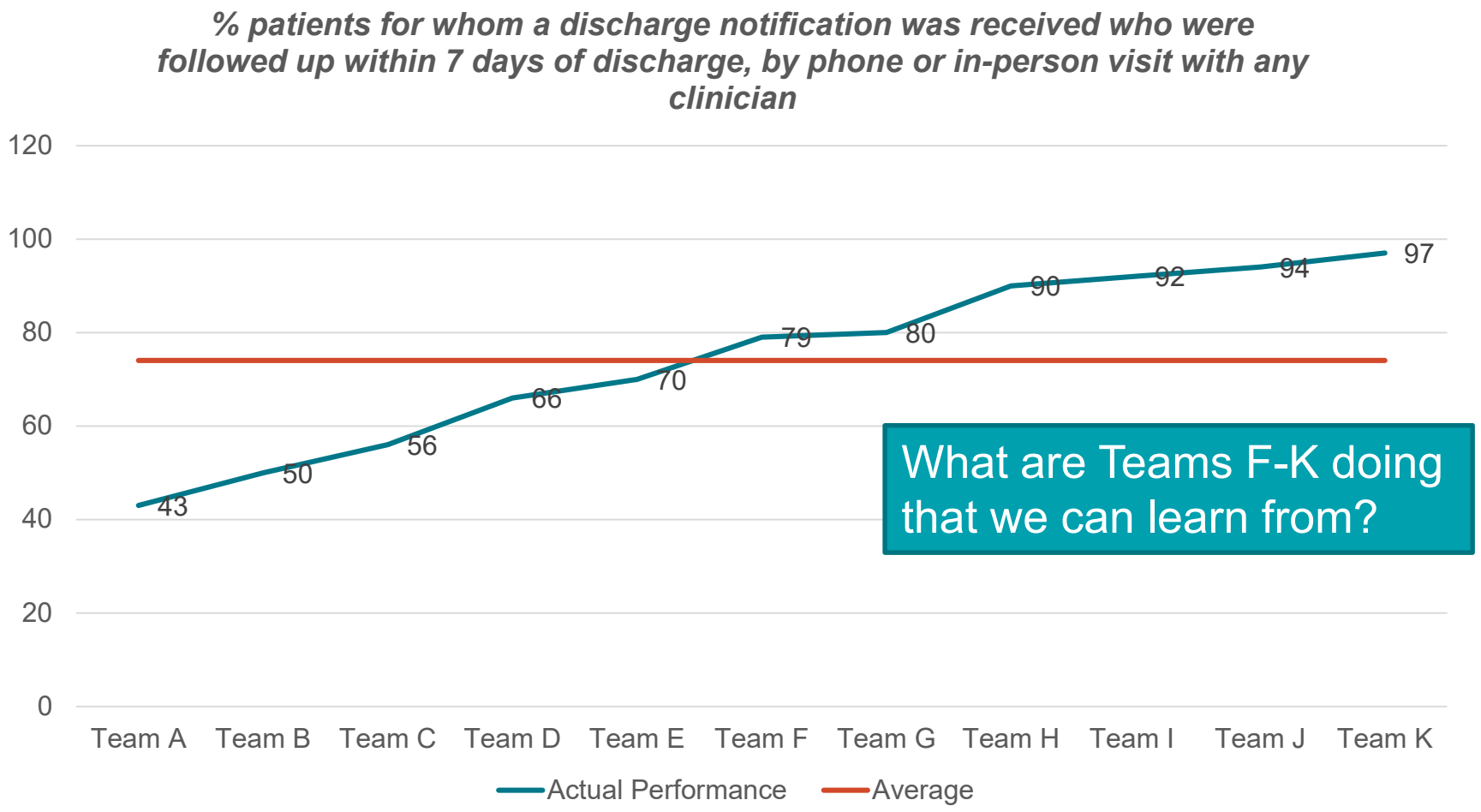


Data is retrieved from publicly posted QIP Reports on the QIP Navigator for 2018/19

Workshop

- 23 Team discussed the process in which they are notified of a hospital discharge
  - Electronic Notification (ie. HRM)
  - Discharge summary received daily from hospital
  - FHT staff attends discharge rounds
  - Hospital faxed discharge instruction sheet daily
  - Hospital calls the FHT
  - Hospital provides daily report of all discharges
  - Meditech/Citrix Report

Workshop


% patients for whom a discharge notification was received who were followed up within 7 days of discharge, by phone or in-person visit with any clinician
120
100
80
60
40
20
0
43
50
56
66
70
79
80
90
92
94
97
Team A
Team B
Team C
Team D
Team E
Team F
Team G
Team H
Team I
Team J
Team K
Actual Performance
Average
What are Teams F-K doing that we can learn from?

Workshop

- How can we share our stories?
- Are there any success stories?
- Are there other teams that have collaborated with partners that have had successes? Can we R&D?
- Is there a common theme?
- How can we translate our learnings today into our 2019/20 QIP?

Coming soon….

- New for 2019/20 QIP Submissions: For transitions issues/indicators: Organizations will be able to identify in their QIP submission who they are collaborating with in Navigator
- Additional Supports
    - QIDSS
    - IDEAS QI Primer / IDEAS Foundations
    - HQO QIP Guidance Documents, Webinars, etc.
    - NE LHIN Supports: Toolkit, Webinars, etc.

Change Concepts/Change Ideas Resources

- QIP Navigator
- Quality Standards
- Best Path
- Quorum
- Measuring Up
- Choosing Wisely
- RNAO Best Practice Guidelines

Thank you.

LET'S CONTINUE THE CONVERSATION:

- hqontario.ca
- @HQOntario
- HealthQualityOntario
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Health Quality Ontario

Let's make our health system healthier