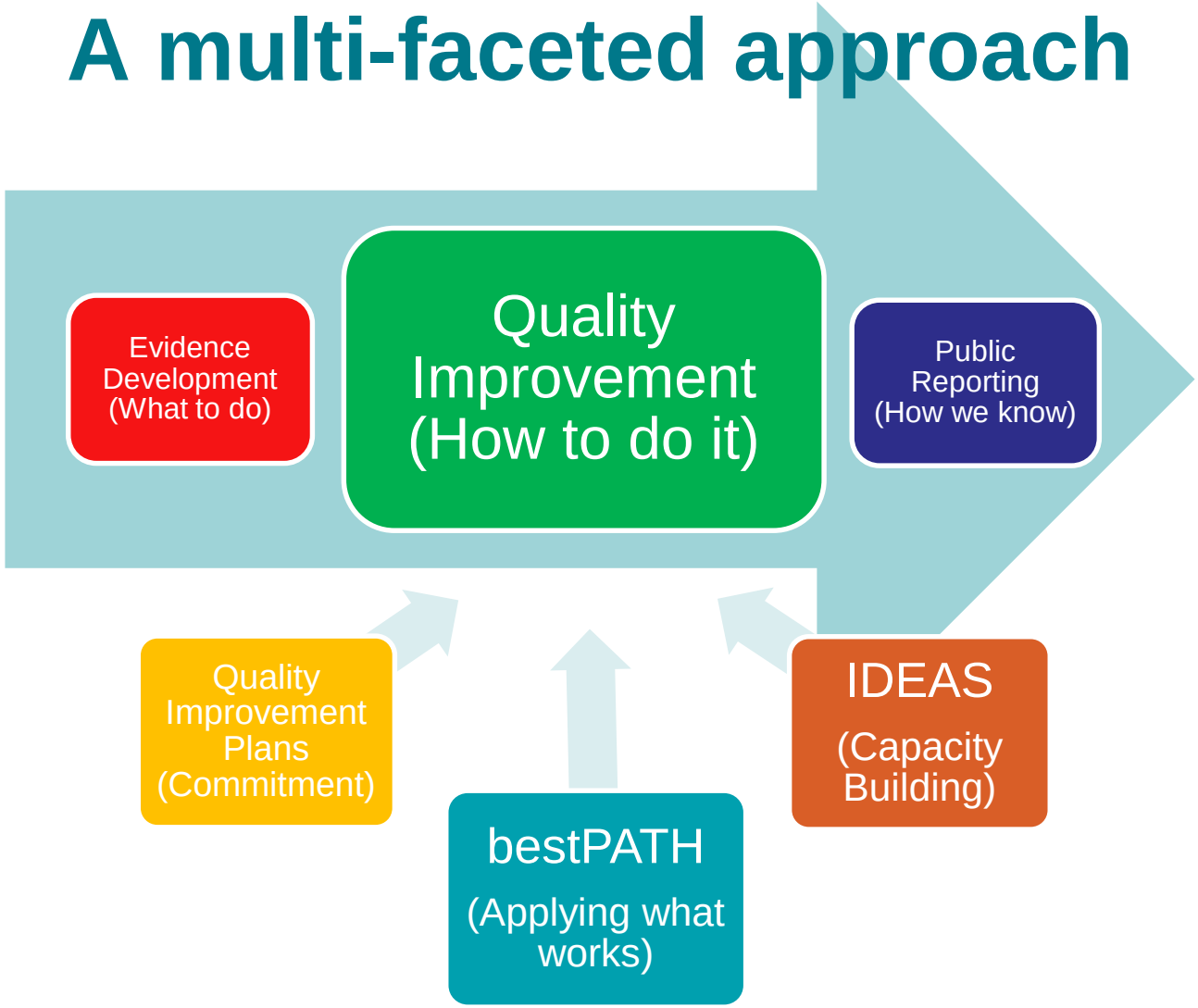
Quality Improvement Support to Health Links

Transformation Secretariat Roundtable
February 26, 2014

Ontario
Health Quality Ontario

Quality Improvement: A multi-faceted approach



Health Link Indicators of Success

Moving the needle

1. Reduce the time from primary care referral to specialist
2. Reduce the number of 30 day readmissions to hospital
3. Reduce the number of avoidable ED visits for patients with conditions best managed elsewhere
4. Reduce time from referral to home care visit
5. Reduce unnecessary admissions to hospitals
6. Faster primary care follow-up after discharge from an acute care setting

Setting the stage for coordinated care straight away

1. All complex patients will have a coordinated care plan
2. Complex patients and seniors will have regular and timely access to a primary care provider

How you'll know you've arrived

1.Enhance the health system experience for patients with the greatest health care needs

2.Reduced ALC rate

3.Reduce the average cost of delivering health services to patients without compromising the quality of care

Source: MOHLTC, Transformation Secretariat

bestPATH

FOCUS

WHAT TO DO

HOW TO DO

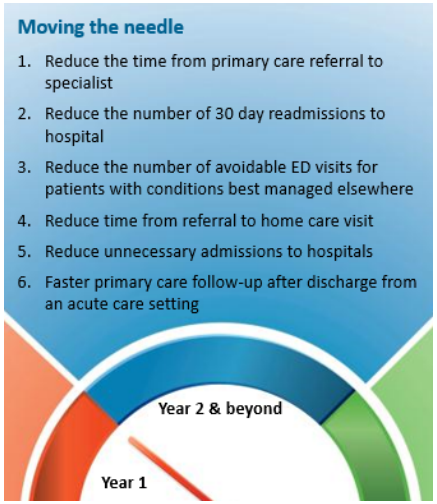
MEANINGFUL ENGAGEMENT

bestPATH supports Health Links:

- Priority setting and developing action plans
- Evidence informed improvement ideas and best practices
- Developing QI capacity through education and mentoring in QI science and methodology
- Leadership in patient engagement and activation

bestPATH

- Services/tools offered:
  - Educate and mentor Health Link leaders and teams in QI science, application, change management, and team building
  - Guide teams through the HQO Quality Improvement Framework (a systematic approach to process improvement)
  - Value stream analysis events
  - Implementation of evidence informed improvement packages
  - Experience based patient and family co-design
  - Connect teams with experts and innovators
  - Web-based repository of best practices
  - Data analysis e.g. defining patient population
  - Best practice implementation
  - Access to IHI Open School



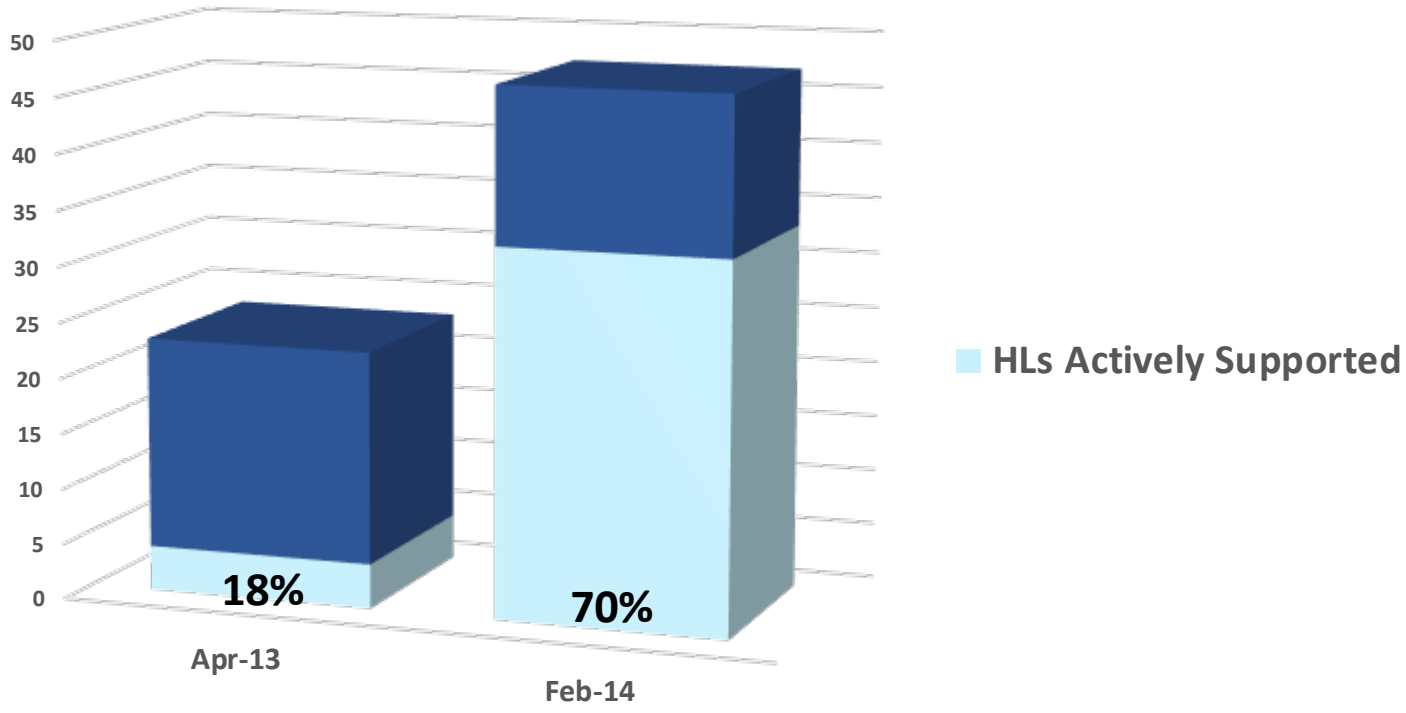
bestPATH

Active in 33 Health Links in 11 LHINs

28 system level Value Stream Analysis (VSA) events with 670 participants resulting in:

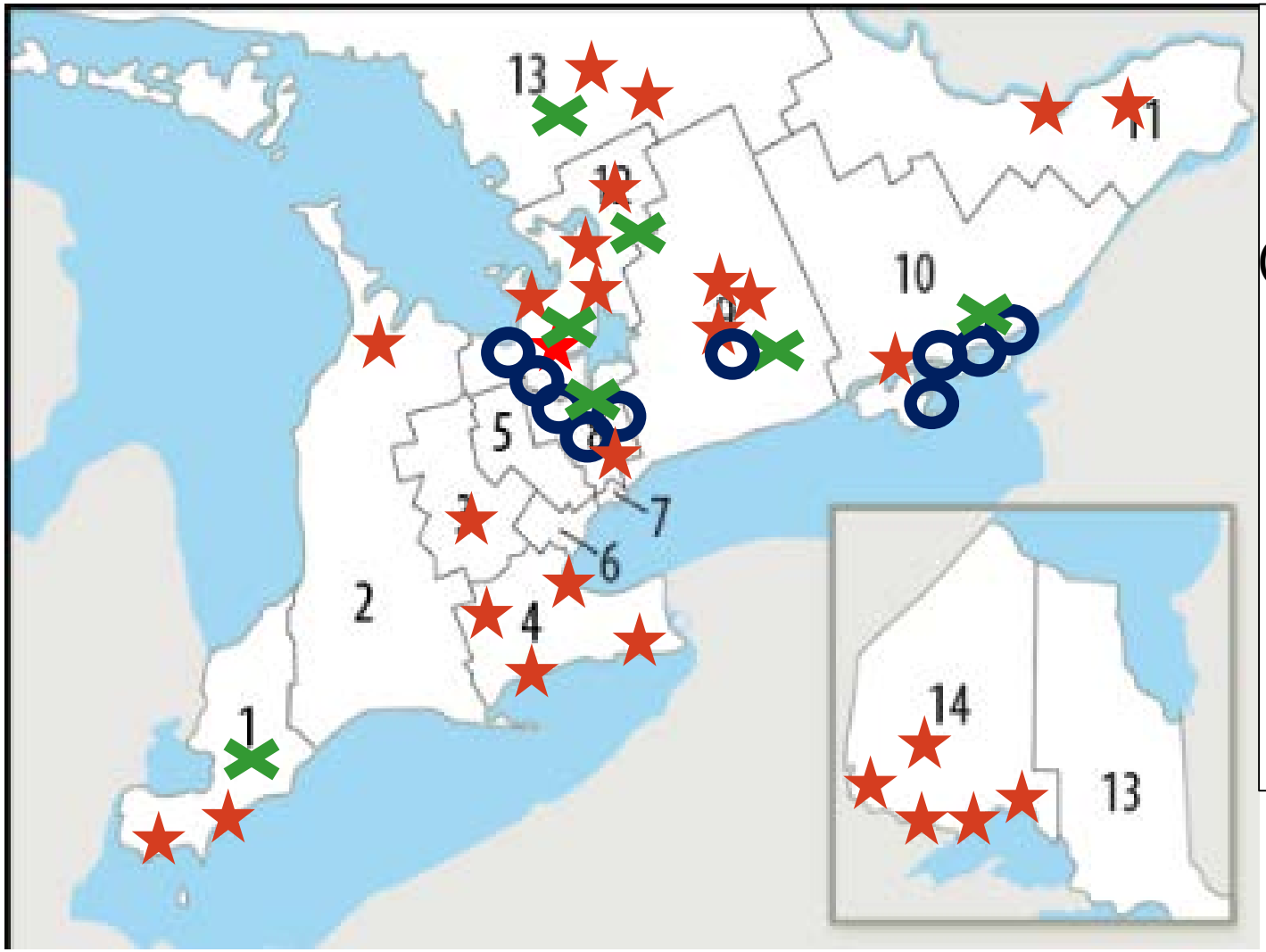
- Shared visions for the Health Links
- Identification of opportunities for improvement
- Action plans developed and incorporated in business plans
- Tests of change initiated
- 5 Improvement Facilitator (IF) Education Sessions preparing 147 IFs
- IF Community of Practice developed in ESC LHIN
- 10 Patient Engagement workshops
- Advanced Access supporting Health Links in two LHINs

Growing bestPATH adoption in Health Links



- As of April 2013, actively supported four of 22 Health Links
- As of February 2014, actively supporting 33 of 47 Health Links, with **growing engagement in another 22 formed or forming Health Links**

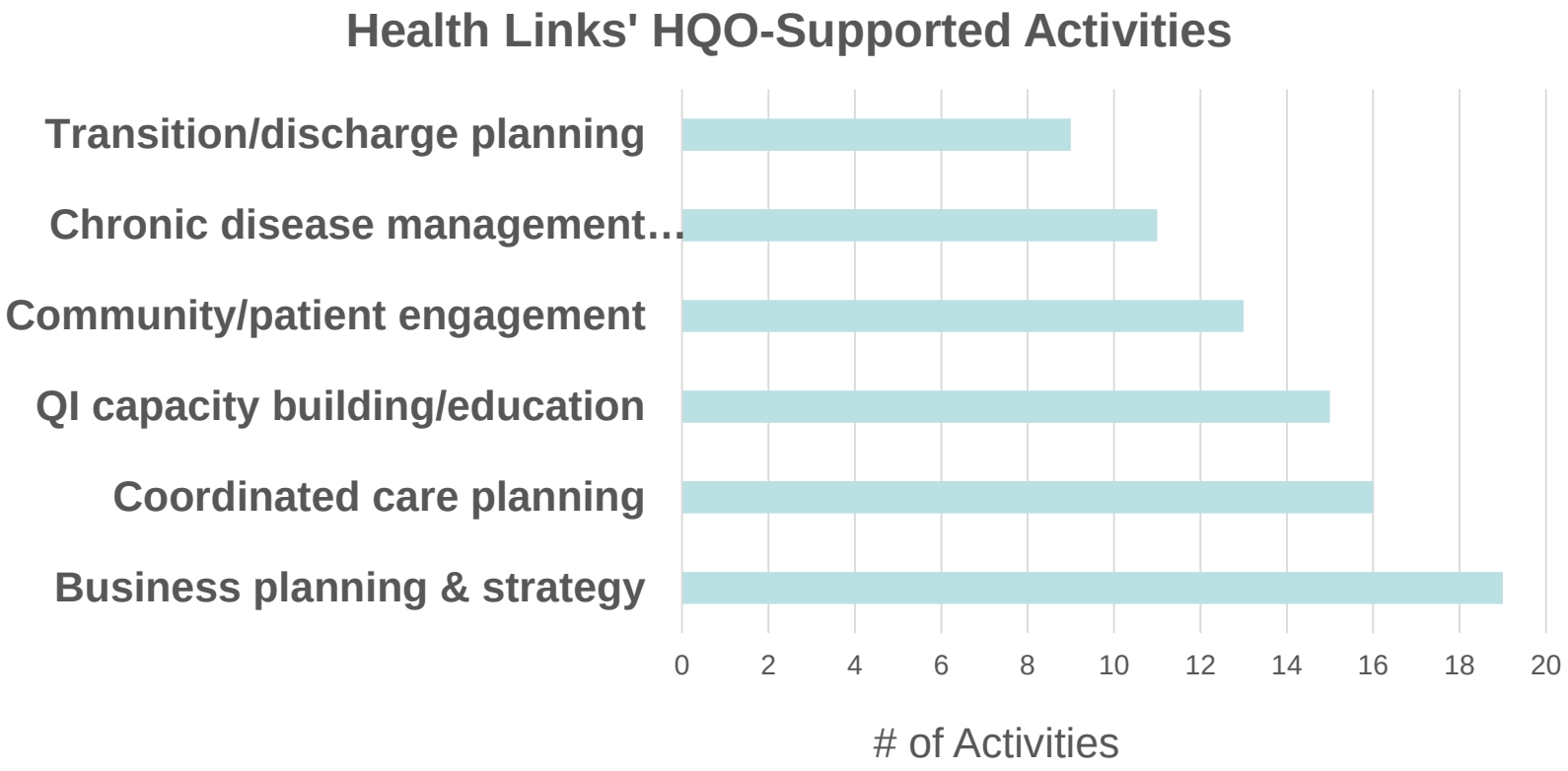
bestPATH Reach



Legend

- VSA (28) (670 participants)
- IF Training (6 LHINs) 147 IFs prepared
- Patient Engagement Workshops (10)

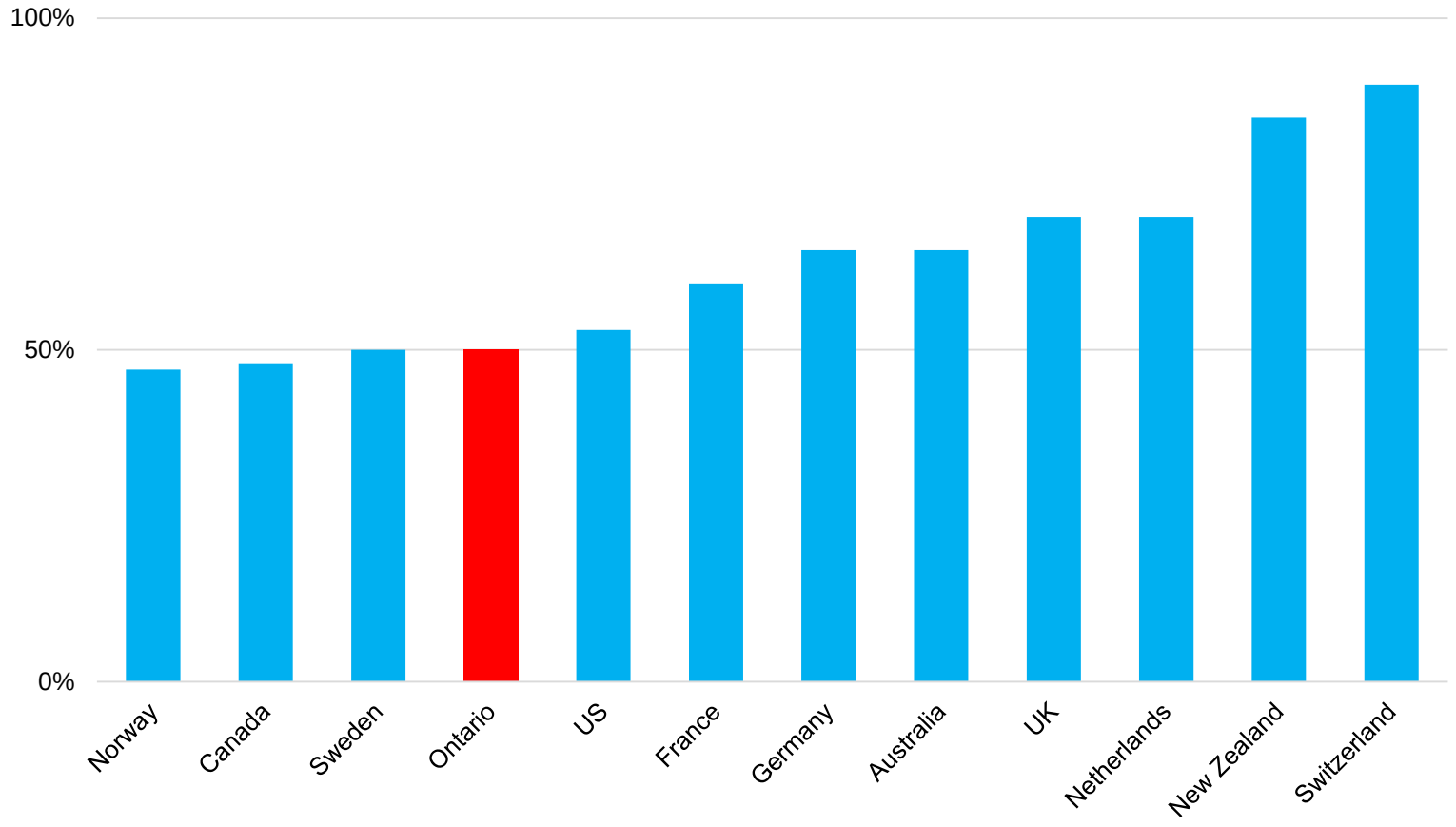
What Activities are emerging?



Other activities include: access, patient privacy, patient education, falls prevention, mental health, palliative care, and advance care planning

Access to Primary Care – a "must-have" feature of Health Links

Percentage of adults able to see their GP same or next day



Quality Monitor 2011

Advanced Access & Efficiency: What it is

- Assist primary care providers to improve access
- Patients calling to schedule a visit are offered an appointment with their primary care provider on the same day, or on a day of their choice
- Primary care teams learn how to implement change concepts and evidence-informed care
- End result is improved patient experience

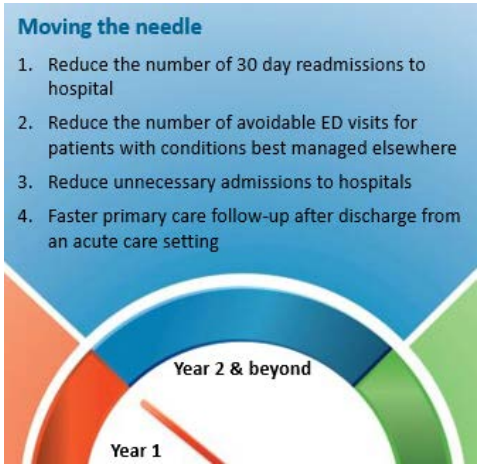
Advanced Access & Efficiency: The Payoff

Beyond access and reduced wait times:

- Improved patient, provider and staff experience
- Improved efficiency and patient flow
- Improved organization of care processes and continuity of care
- Assistance in addressing access priorities in annual Quality Improvement Plans (QIPs)
- Preparation for meeting performance targets in Health Links

Transition Planning

- In May 2013, the Transformation Secretariat asked HQO to start a consensus building process aimed at improving and standardizing approaches to discharge care planning
- Reviewed by HL, MOH, OHA, OMA, AFTHO, RNAO, AOHC, OACCAC, OCSA
- 9 practices
- The guide is ready!!



Transition Key Practices

- The guide summarizes 9 key practices grounded in a set of foundational principles:

1. Pre-transition planning practices
2. Transition planning practices
3. Practices to support smooth transitions post discharge

Transition Planning Guide

Transition Planning

- Feedback so far:
  - "This document captures the things that are required when looking at the issue of good, effective discharge planning. We very much appreciate the parts of the document that address patient understanding of each facet of the plan, particularly the inclusion of the 'teach back' method… it is an effective technique."

    – OMA

  - "This document and the development of best practice goals for discharge planning are essential steps in improving the coordination and integration of care for our complex patients."

    – AFHTO

  - "We are pleased the framework is a patient-centred guide to help transition care after acute needs have been met."

    – OHA

Coordinated Care Planning

- Partnered with e-Health Liaison and Special Projects Branches in development of the business case for an electronic “solution” to coordinated, individualized plans of care; continuing to support working groups to advance best practices in coordinated care planning and patient engagement

HQO’s contribution to this process has focused most on:

- Identifying leading practices in care planning through literature review and emerging trends
- Keeping the focus on a patient-centred approach
- Emphasizing the need for a patient portal

Coordinated Care Plan

HealthLink <<PATIENT NAME>>'s Coordinated Care Plan (<<HEALTH LINK NAME>>) v5-7SF

My identifiers	Last updated:	Last updated by:
Given name:	Preferred name:	Surname:
Date of birth:	OHIP insured: Choose an item.	Health card #:
Telephone #:	Mother tongue:	Preferred official language: Choose an item.
Marital status: Choose an item.		People who live with me: Choose an item.
Where I currently live: Choose an item.		Ethnicity/culture:
Substitute decision maker (SDM):		**SDM telephone #:**
Emergency contact:		**Emergency contact telephone #:**

My plan to achieve my goals for care	Last updated:	Last updated by:	
What is most important to me right now:			
What concerns me most about my healthcare right now:			
What I hope to achieve	What we can do to achieve it	Who will be responsible	Barriers and challenges
My plan for future situations			
When my heart/breathing stops, if someone is close by, I would want them to: Choose an item.			
If my condition(s) get worse and it looks like I might not survive, I would like to: Choose an item.			

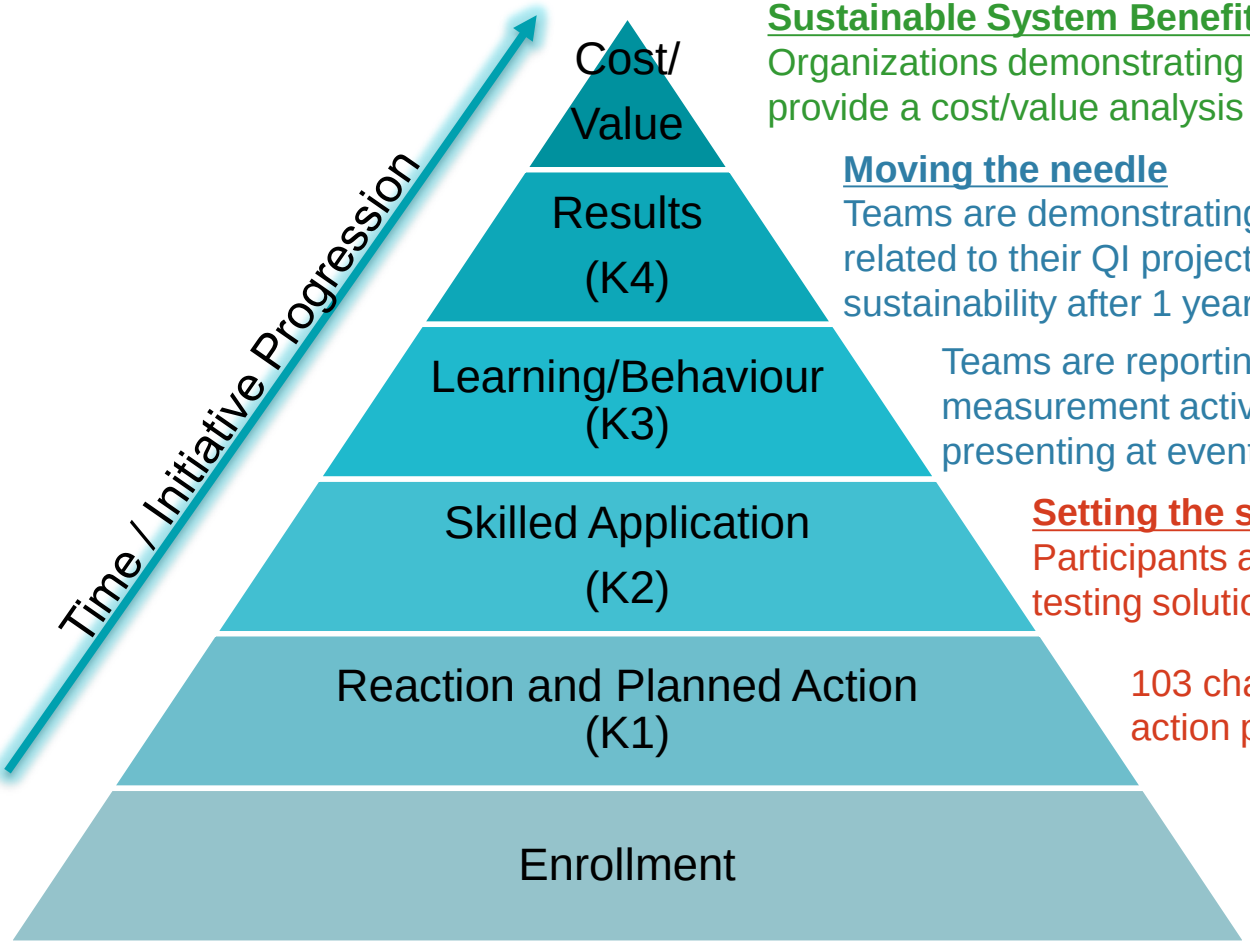
My care team	Last updated:		Last updated by:	
Name	Role or relationship	Telephone #	Lead care coordinator	I rely on most at home
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
The people I rely on at home are: Choose an item.				

1

- Example of the short form front page

Evaluation Stages

Health Quality Ontario: QI Evaluation Model



Sustainable System Benefit
Organizations demonstrating use of tools or measures that provide a cost/value analysis of their QI efforts

Moving the needle
Teams are demonstrating significant improvement on measures related to their QI project. Evidence of spread; evidence of sustainability after 1 year

Teams are reporting progress on their QI projects: measurement activity, use of QI team progress scale, presenting at events

Setting the stage
Participants are actively engaged in developing and testing solutions

103 change ideas that are included in action plans

28 Value Stream Analyses with 670 participants
5 Improvement Facilitator training sessions with 147 participants
10 Patient Engagement Sessions

Other Supports

- Quality Improvement Plans - opportunity for collaboration through aligned QIPs
- IDEAS - applied learning opportunity to build capacity within Health Links
- QI RAP is a flexible and scalable, web-based measurement and management tool to support improvement work
- Performance measurement collaboration
- Evidence-based practices; continuously renewable resource
- QI compass

Next Steps for HQO Support of Health Links – Emerging Activities of Interest

- Expanding the Transitions in Care improvement package to include best practices for Emergency Department discharge
- Best practices in patient co-development care planning
- Patient experience
- Best practices in Mental Health and Addiction
- Governance best practices

Future HQO Directions for QI that will further support Health Links

- Shift to a Regional Model focused on system level cross-sector work, spread and scale e.g. increase local capacity to support growing volume of health links
- In collaboration with system partners, establish communities of practices that link local and provincial resources to help with implementation, spread and sustainability
- Increased patient, family, caregiver engagement for improved experience and outcomes
- Increased Clinical Engagement
- Regionally based QI and KTE Specialist support to help Health Links customize innovations, implement evidence based practices, achieve common quality agenda targets and other aligned improvement efforts

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