Quality Improvement Planning and Implementation for Ontario Health Teams

How you can leverage the QIP and Quality Standards to support your OHT

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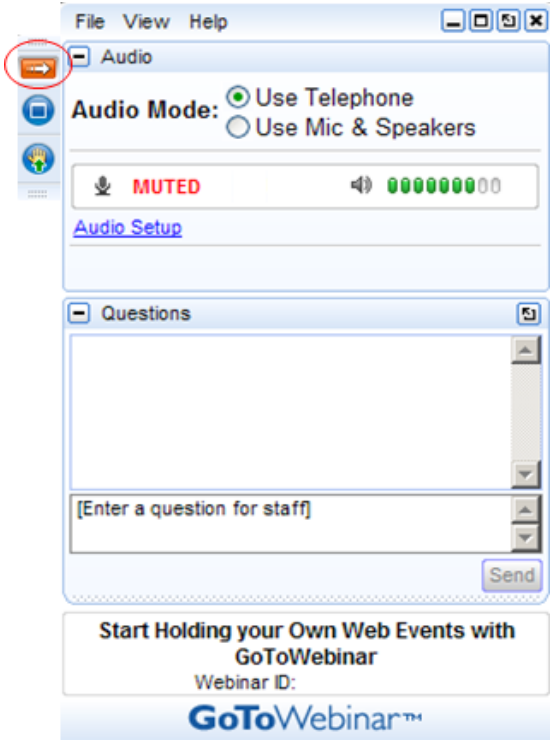
How to participate in the discussion

- Click the arrow to minimize the control panel
- Call in on your phone (*recommended*)
- Enter your Audio PIN so you can be unmuted
- Note that the webinar is being recorded



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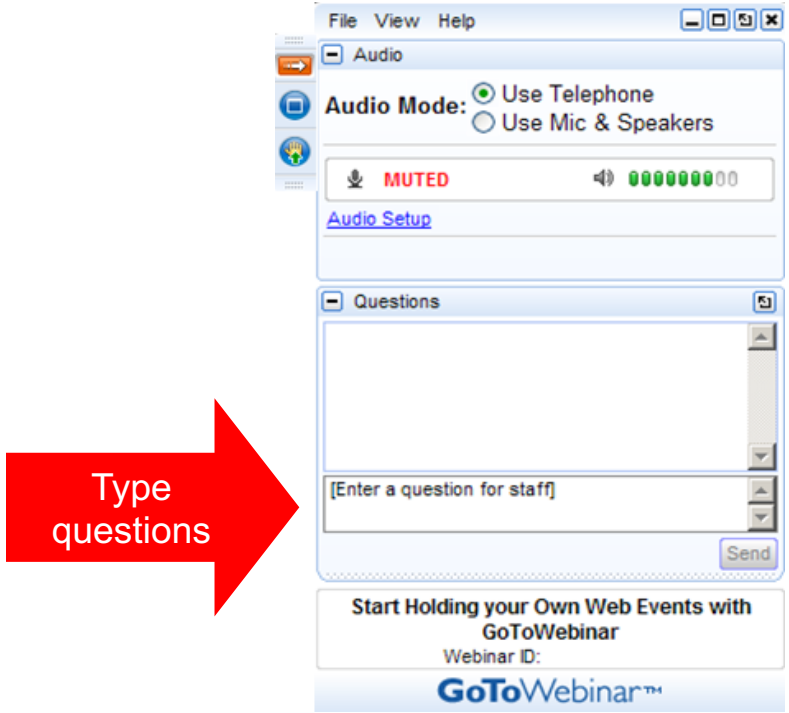
How to participate in the discussion

Options

1. Select the “raise hand” icon if you wish to speak and we will unmute you (*preferred*)
2. Type your comments in the Questions box



Webinar Objectives

By the end of this session, participants will:

- Learn about the connection between the Quality Improvement Plan, Quality Standards and Ontario Health Teams
- Learn how Quality Standards can support Ontario Health Team integration work
- Learn about OHT implementation resources available from RISE

Poll Question

What stage is your organization at in regards to OHT?

- Self – assessment
- In discovery
- In development
- OHT candidate
- Other / I don’t know

OHTs

- OHTs are a new way of organizing and delivering care that involves all health providers (including home and community care providers, primary-care providers, and hospitals, among others) working together in one coordinated team to achieve the quadruple aim of improving care experiences and health outcomes at manageable per capita costs, and with positive provider experiences
- As OHTs develop and mature, they will become clinically and fiscally accountable for delivering a full and coordinated continuum of care to a defined population
- OHTs may one day be seen as a landmark in the development of Ontario's health system as the introduction of universal coverage for hospital-based and physician-provided care

RISE

- As part of the Ministry's OHT Central Program of Supports, and inspired by the platforms that supported the development and maturation of accountable-care organizations in the U.S., RISE provides evidence-based support to OHTs, using a 'rapid learning and improvement' lens
- Rapid learning and improvement involves six steps:
  - Identifying a problem (or goal) through an internal and external review
  - Designing a solution based on data and evidence generated locally and elsewhere
  - Implementing the plan (possibly in pilot and control settings)
  - Evaluating to identify what does and does not work
  - Adjusting, with continuous improvement based on what was learned from the evaluation (and from other OHTs' evaluations)
  - Disseminating the results to improve the coverage of effective solutions across the health system
- RISE supports rapid learning and improvement among OHTs both in
  - 'Moving the needle' on quadruple-aim metrics for their year 1 priority populations (as a key first step in laying the groundwork for moving the needle for their entire attributed population)
  - Putting in place the eight OHT building blocks (e.g., digital health solutions such as e-consultations)

RISE
Rapid-Improvement Support and Exchange

OHTs' Connections to Quality Standards & QIPs

OHT building blocks #1 to #8
(which cover 58 domains)

1) Defined patient population:
Who is covered, and what does 'covered' mean?

2) In-scope services:
What is covered?

3) Patient partnership and community engagement:
How are patients engaged?

4) Patient care and experience:
How are patient experiences and outcomes measured and supported?

5) Digital health:
How are data & digital solutions harnessed?

6) Leadership, accountability and governance:
How are governance & delivery arrangements aligned, and how are providers engaged?

7) Funding and incentive solutions:
How are financial arrangements aligned?

8) Performance measurement, quality improvement, and continuous learning:
How is rapid learning & improvement supported?

Examples of the 18 domains related to **OHT building block #4**

Domains addressed by the many Quality Standards related to year 1 priority populations

- Proactive patient identification
- Individualized care planning
- Care pathways
- Self-management planning and support (including digital self-care)
- Shared decision-making
- Virtual-care services
- Proactive chronic-disease management
- Integrated-care models

Domain addressed by the Transitions Playbook

- Transition services

Example of the 6 domains related to **OHT building block #8**

a) OHT-focused rapid learning and improvement, including **Quality Improvement Plans**
b) Guidelines (or Quality Standards) and other sources of best evidence
c) Rapid learning and improvement competencies
d) Performance measurement across the quadruple aim and across sectors, including detection of inappropriate variation, provider feedback, and public reporting

OHTs and Quality Improvement Plans

- There is alignment between QIP priorities and OHT priorities of integrated care
- The existing structure of the Ontario Health QIP can be helpful to support OHTs to establish collaborative quality goals and document and advance these goals through the QIP
  - The QIP is rooted in engaging patients and caregivers in the process of improvement focusing on integrated care

OHTs and Quality Standards

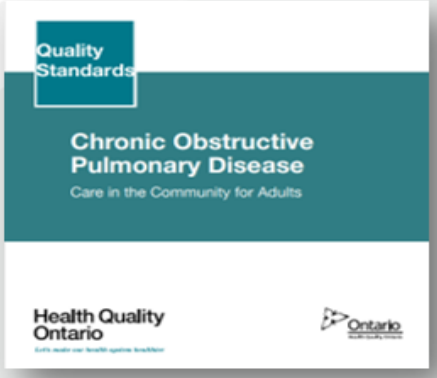
- The ***Performance Measurement, Quality Improvement, and Continuous Learning*** requirement in the OHT model states that Ontario Health Teams should demonstrate progress to reduce variation and implement clinical standards:
  - Each Quality Standard specifies an area that is critical to the high-quality care — areas where care needs to be improved and/or where variation exists among regions based on evidence
  - Each statement includes indicators teams can use to measure whether their PDSA (Plan-Do-Study-Act) cycle is improving the quality of care for each area of focus
  - Incremental improvements in these areas, in the long term, also positively impact the overall measures of success for transitions in care from hospital to home
- As OHTs look to standardize and improve care, the Quality Standards are a key resource for clinical teams to review and reflect upon

Quality Standards

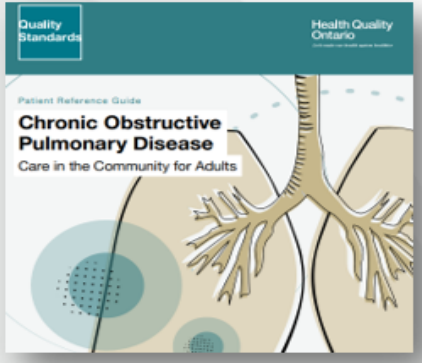
Quality Standards

- Inform clinicians and patients what quality care looks like
- Focus on conditions or processes where there are large variations in how care is delivered, or where there are gaps between the care provided in Ontario and the care patients should receive
- Are grounded in the best available evidence

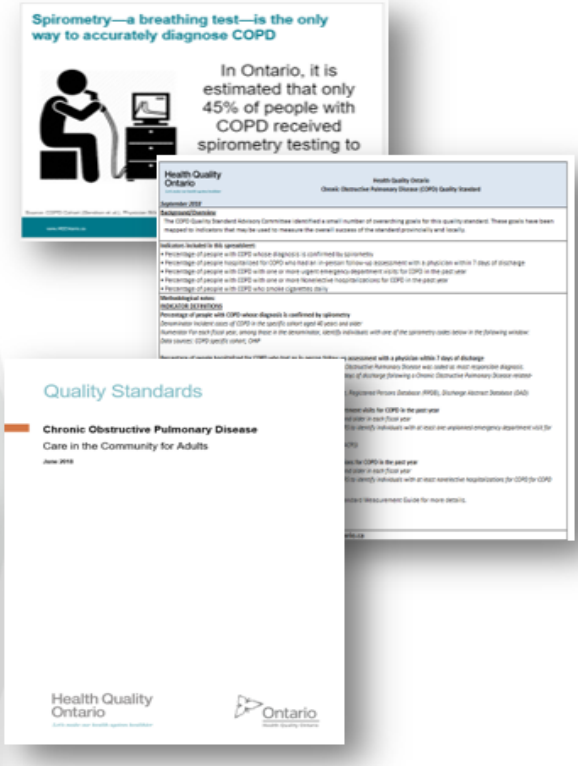
Each quality standard focuses on a certain health care issue and consists of:



Quality Standard



Patient Conversation Guide



Data and Reporting Products

Recommendations for Adoption

Getting Started Guide

Quality Standards for OHT Priority Populations

YEAR 1 PRIORITY POPULATIONS	People with enhanced mental health needs and/or substance use disorders	Older adults with greater needs, including 'at risk,' co-morbidities & chronic conditions, complexity, frailty, and high service users	People with chronic conditions, including CHF, COPD, dementia, diabetes & those with complex-care needs	People at the end of life and/or needing palliative care
ALIGNMENT TO QUALITY STANDARDS	• Anxiety disorders • Major depression • Obsessive-compulsive disorder • Opioid use disorder • Schizophrenia (care in the community) • Schizophrenia (care in hospital) • Problematic Alcohol Use and Alcohol Use Disorder	• Behavioural symptoms of dementia • Chronic pain • Opioid prescribing for chronic pain • Diabetic foot ulcers • Dementia • Hip fracture • Low-back pain • Osteoarthritis • Pressure injuries • Venous leg ulcers	• COPD • Dementia • Behavioural symptoms of dementia • Diabetic foot ulcers • Diabetes in pregnancy • Diabetes type 1 • Diabetes type 2 • Heart failure • Transition Between Hospital and Home	• Palliative care

Priorities for Patients & Caregivers when Transitioning from Hospital to Home

1. There are not enough publicly funded home care services to meet the need
2. Home care support is not in place when patients arrive home from hospital
3. Patients have to advocate to get enough home care
4. Patients are not being involved in discharge planning
5. Once home, patients do not have contact numbers for people to call if there is a problem
6. During discharge planning, hospital providers assume family and friends will provide care
7. There are long waits for follow-up appointments with family doctors and specialists
8. Patients receive unclear or inconsistent communication about their health status

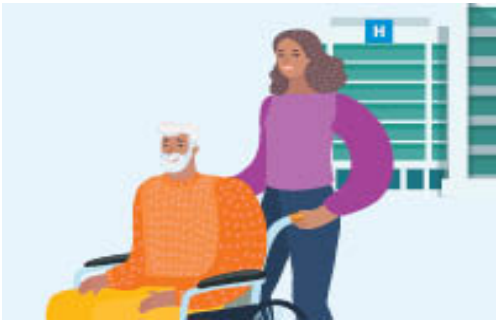
Kiran T, Wells D, Okrainec K, *et al* Patient and caregiver priorities in the transition from hospital to home: results from province-wide group concept mapping *BMJ Quality & Safety* Published Online First: 05 January 2020.

Transitions Between Hospital and Home Playbook: *A Tool Designed for OHTs*

Quality Standards

Transitions Between Hospital and Home

Care for People of All Ages



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Appropriate and Timely Support for Home and Community Care

People transitioning from hospital to home are assessed for the type, amount, and appropriate timing of home care and community support services they and their caregivers need. When these services are needed, they are arranged before people leave hospital and are in place when they return home.

[Transitions Between Hospital and Home Quality Standard]

[Transitions Between Hospital and Home Playbook]

Polling Question

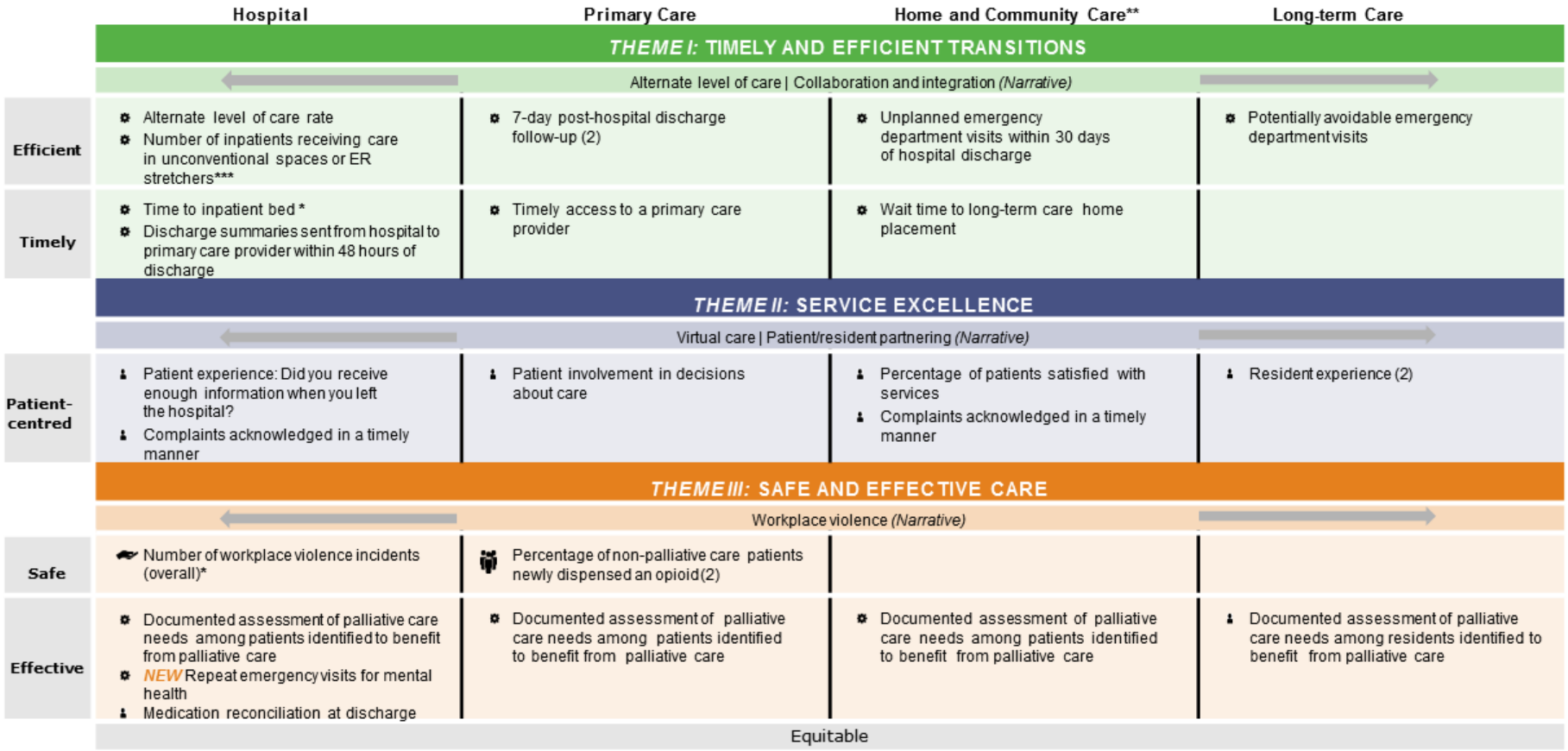
- **What would be most helpful to you in using Quality Standards for OHT quality improvement planning? (choose one)**
  - Examples of how Quality Standards link to OHT populations
  - Education/training for implementation of Quality Standards
  - Coaching to support implementation

Quality Improvement Plans

The Goals of the Current QIP Program are to:

- ✓ Set and advance priorities for quality improvement, both provincially and locally
- ✓ Make a difference. Achieve improvements in the quality of care across sectors through an approach that is systematic, collaborative, integrated and demonstrates impact
- ✓ Promote quality as a strategic focus, and imbue a culture of quality within organizations and among providers of care
- ✓ Accelerate organizations' ability to improve quality of care by analyzing improvement plans, sharing evidence and results that inspire further activity and results
- ✓ Foster community and patient engagement in quality

Quality Priorities for the 2020/21 QIPs



*Mandatory indicator (hospital sector only)

**These indicators will continue to be a priority focus for LHIN home and community care services. Additional guidance will be provided to LHIN home and community care services around expectations regarding the 2020/21 QIPs

***This indicator technical specification may be amended; see indicator technical specifications document for more information

Quadruple Aim

Value and Efficiency | Patient Experience | Provider Experience | Population Health

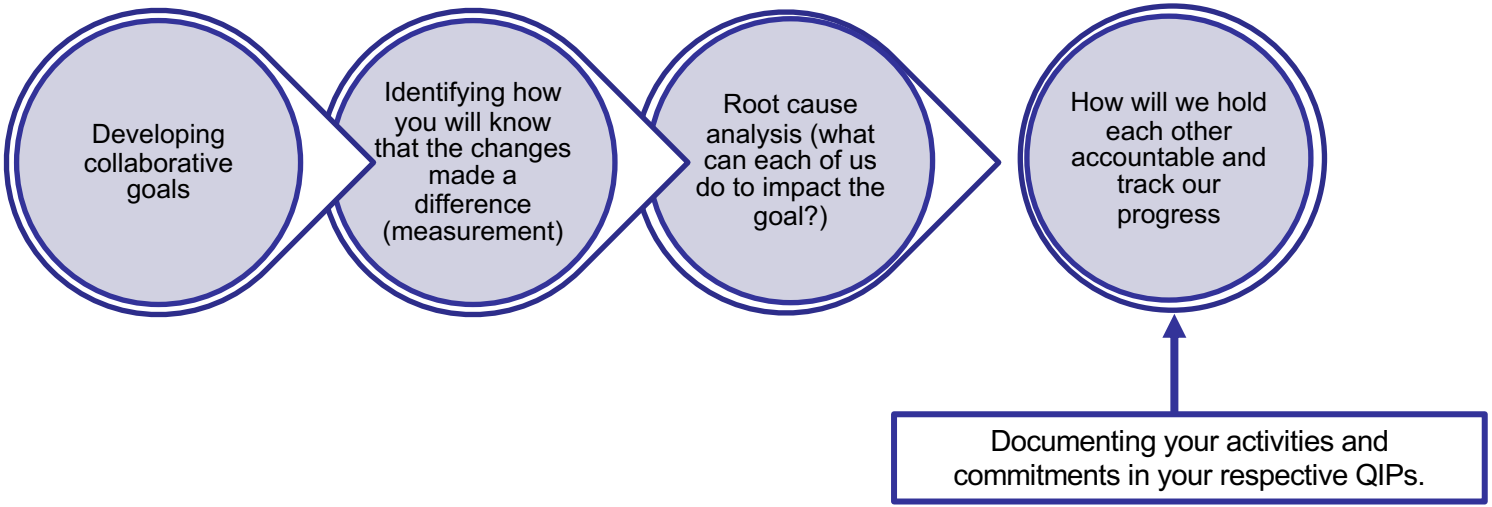
Updated 2019 Nov 20

What have we learned from collaborative QIPs?

Key Steps in Collaboration Efforts

Start with a vision.

Example:
East Toronto OHT Vision: ‘A system without discharges. Characterized by a seamless continuum of care. Focused on population health. Programs tailored to our 21 local neighborhoods. Grounded in the quadruple aim.



Tips for working with partners on collaborative QI goals

Lessons learned from previous collaborative initiatives

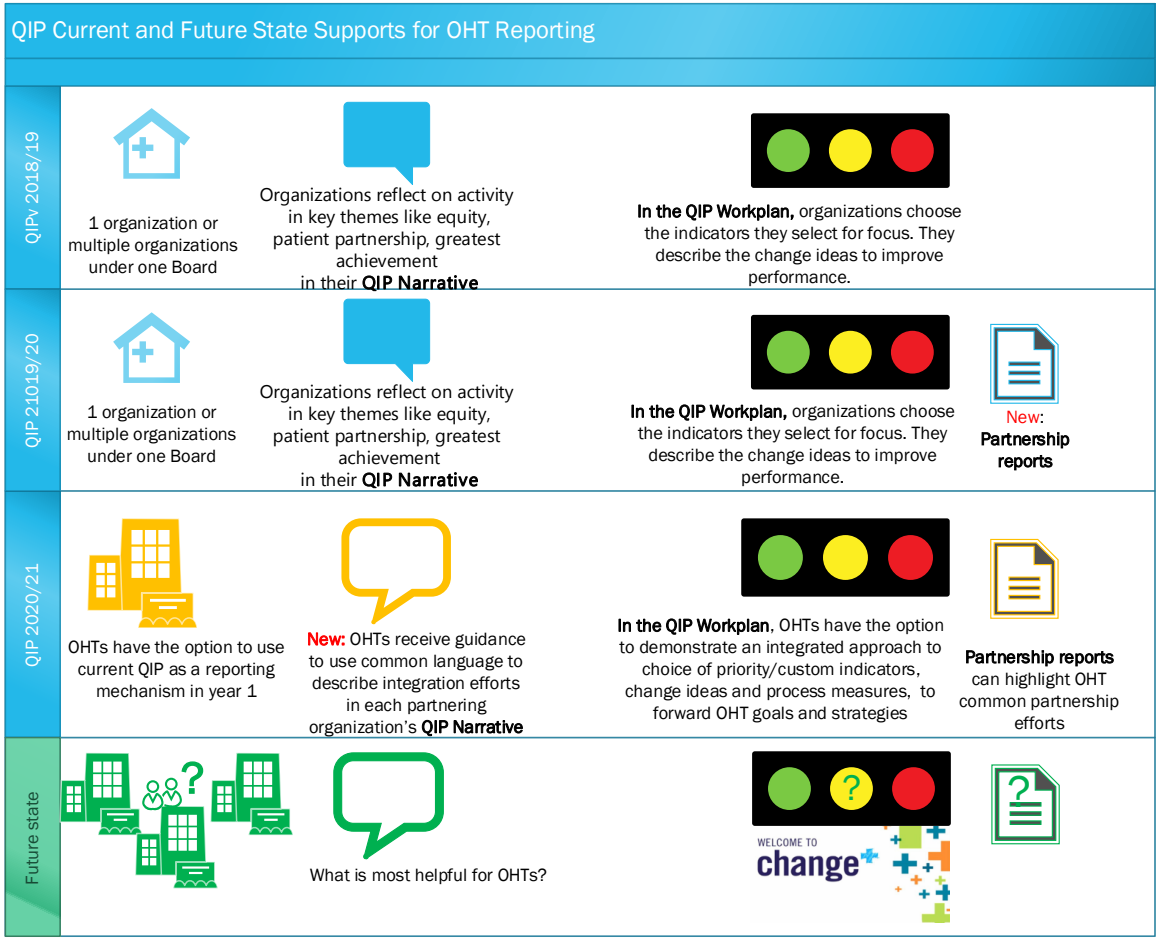
- Organizations found that the QIP was a convenient forum and structure for collaboration – most organizations were familiar with the language and expectations and it helped them break down their QI goals
- It is important to engage and get support from senior leaders and boards – both within your organization, but also at the overall OHT level. Previous organizations found it helpful to use common messaging (e.g., standardized briefing notes) and timing for updates
- Relationship building takes time but it is critical for success – get to know each other and what each organization does and doesn't do

Tips for working with partners on collaborative QI goals

Lessons learned from previous collaborative initiatives

- Quality improvement is iterative - don't get bogged down by trying to find "perfect" measures (but try to always move forward - even if it means just picking a small action item at the end of a meeting)
- Successful teams established a strong structure to manage and support their QI activities - e.g., regular meetings, clear accountability from meeting to meeting, common orientation and update. Consider having a champion or leader to coordinate and keep things on track and moving ahead
- Several collaborative teams have taken advantage of the HQO Community of Practice resources to share files, message and engage in improvement

Organizations are Reflecting More Collaboration in their QIPs



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Reflecting this work in your organization-level QIP

2020/21 QIP cycle

- For the 2020/21 cycle, all organizations (hospital, primary care and long-term care) are required to submit an individual organization-level QIP

- Organizations can describe in their respective QIPs how they are partnering with others to improve performance on the QIP indicators. This would also apply to organizations who are part of an OHT

Capturing Collaboration and Integration in the Narrative

- Describe who your organization is working with to improve integration and continuity of care as patients/residents move across the health system
- If you are an organization that is part of an OHT, you could describe the collaborative quality goals of your OHT
- You can also include the name of your OHT and each of your partners

Tip: You may also consider developing common language for this section of your narrative that all organizations can use.

Capturing Collaboration and Integration in the Workplan

- In the *Change Ideas* section, you could describe any *shared* change ideas
- In the *Comments* section, you could include any additional comments about your collaborative quality improvement initiatives
- In the *Collaboration* Status section, let us know the names of the organizations you are partnering with on specific issues or indicators
- Should your OHT be focusing its quality efforts on a sub-population (e.g. youth mental health and wellness), custom indicators could be used to reflect this work
  - For example, your OHT may have selected to work on reducing repeat ED visits for youth with mental health needs – a custom indicator would work well here

Connecting the dots...

Transitions Case Study

- The Lindt OHT has chosen to focus on transitions in care because transitions are critical and vulnerable points for patients and families in the provision of health care
- They reviewed the Quality Standard on Transitions and learned that there are opportunities for improvement in Ontario to ensure that all patients, as well as their families and caregivers, receive the support and information they need for a successful transition from hospital to home
- When they reviewed their data, they identified that only 30% of seniors and their caregivers are satisfied with the amount of information they are receiving before discharge from hospital. They also know from the concept mapping that was part of the Transitions Quality Standard that one of the priorities for patients is knowing what to do if there is a problem after they leave the hospital
- Recognizing the importance of involving patients and caregivers during transitions, the partners of the OHT decide to work on communication during the discharge process. They decided to reflect this work in their organization-level QIP, using the indicator ***"Did you receive enough information when you left the hospital?"*** Organizations will reflect their work on this indicator in the narrative section in the organization-level QIP and tag their partners in the indicator field in the workplan.
- The Lindt OHT will use the Transition Between Hospital and Home Quality Standard, and the Quality Standards Playbook to identify change ideas for their QIPs

Palliative Care Case Study

- The Great Lakes OHT has chosen to focus on early identification of palliative care for complex frail seniors because of the chronic disease trajectory and high ED visit rate for these patients. This impacts care and support for both the patients and the families.
- They reviewed the Quality Standard on Palliative Care and learned that there are opportunities for improvement in Ontario to ensure that all patients, as well as their families and caregivers, receive the support and information they need for an improved palliative care experience as the patient moves from hospital to home.
- When they reviewed their data, they identified that of the 63,380 people who received palliative care, 46.8% of those received palliative care in the last month of life in 2017/2018.
- Recognizing the importance of involving patients and caregivers in the conversation about early palliative care, the partners of the OHT decide to work on "**the percentage of people identified with palliative care needs who have a documented assessment**“, which is an indicator in the QIP. Organizations will reflect their work on this indicator in the narrative section in the organization-level QIP and tag their partners in the indicator field in the workplan.
- The Great Lakes OHT will use the Palliative Care Quality Standard and will join the Community of Practice to inform the change ideas in their QIPs.

What RISE supports are available to help Ontario Health Teams?

RISE
Rapid-Improvement Support and Exchange

RISE Supports (Organized By RISE Objective)

- Develop and iteratively improve over time packages of support that respond to evolving OHT developmental priorities
  - Waves 1 (13 RISE briefs), 2 (18 regional sessions) & 3 (6 webinars) completed
  - Wave 4 (learning & improvement collaboratives will focus on four year 1 priority populations)
- Deliver 'on demand' (or facilitate the delivery of) a suite of activities (e.g., upcoming 'learning and improvement' collaborative forum) and products (e.g., RISE briefs on assets and resources to support 'moving the needle' on year 1 priority populations)
- Build and engage an OHT community of practice among teams on an OHT readiness path
- Build and engage a RISE community of practice among those who can support local teams
- Maintain a website (www.OHTrise.org | www.ESOrise.org) and disseminate a monthly e-newsletter to provide a structured 'way in' and disseminate 4 types of resources
  - RISE resources (e.g., RISE brief on population-health management)
  - Resources prepared by other partners (e.g., Ontario Health's quality-improvement assets and resources)
  - Resources prepared by the Ministry (e.g., digital health playbook)
  - Systematic reviews and economic evaluations on topics for which no OHT-specific resources are yet available

Questions and Discussion

Poll Question

How likely are you to implement at least one idea or concept from this webinar?

- Very Likely
- Likely
- Neither Likely nor Unlikely
- Unlikely
- Very Unlikely

Thank you

Where to go for more information?

- Visit the QIP website and QIP Navigator:
  - https://www.hqontario.ca/Quality-Improvement/Quality-Improvement-Plans
  - https://qipnavigator.hqontario.ca/Account/Login.aspx
- Visit the Quality Standards webpage:
  - https://www.hqontario.ca/Evidence-to-Improve-Care/Quality-Standards
  - View the Transitions Between Hospital and Home Playbook: https://quorum.hqontario.ca/Portals/0/Users/116/00/10100/Transitions%20Between%20Hospital%20and%20Home%20Playbook%20EN.pdf?ver=2019-12-05-150210-130
- Questions?

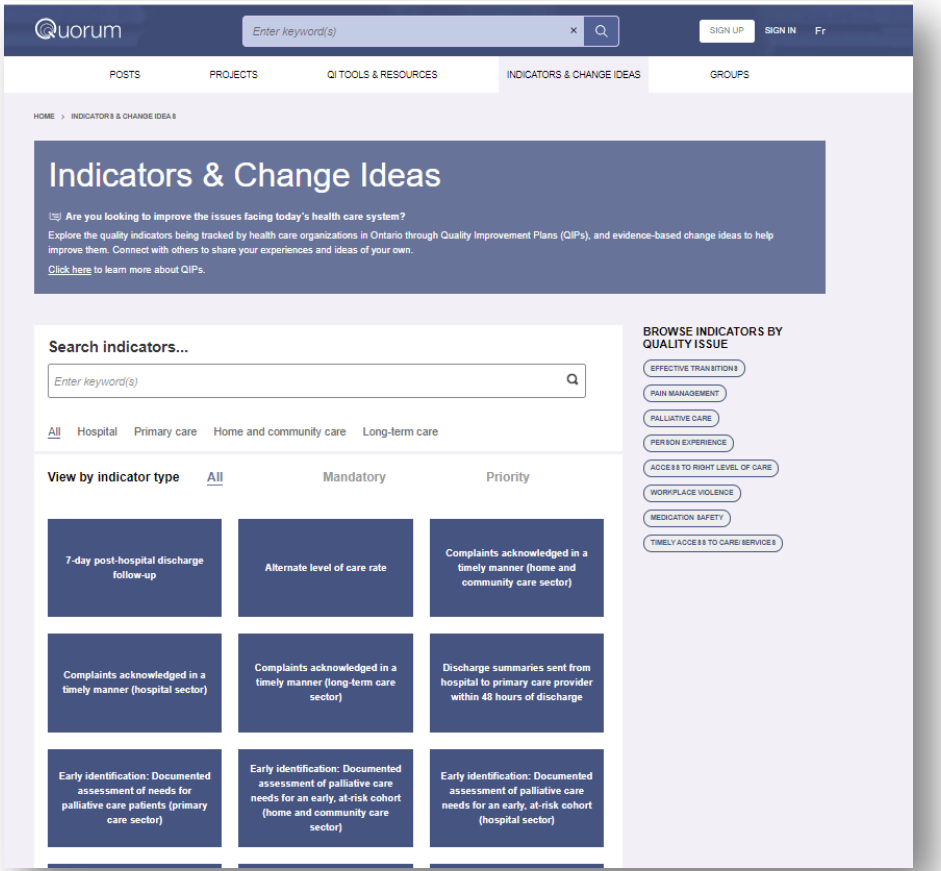
  QIP@HQOntario.ca

  Qualitystandards@HQOntario.ca

Quorum

- Ontario Health's online platform where users learn, share, and collaborate to improve health care quality in Ontario

- Contains:
  - QI tools and resources
  - Indicators and Change ideas
  - Specific links to change ideas for QIP indicators



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2020/21 Quality Improvement Plans

Support & Training

More information:

bit.ly/QIPsupport

Webinars:

Hear about what's new in the 2020/21 QIPs

Help Sessions:

Focused and interactive guidance on key topics related to the 2020/21 QIPs

Drop-In Sessions:

A QI specialist will answer questions and offer advice on developing or implementing your QIP

Videos:

Acquire QI basics and tips and tricks to help you create and submit a QIP

Quality Improvement Plans