# MINISTRY-LHIN QUARTERLY STOCKTAKE REPORT

**LHIN:** **South West LHIN**

**REPORT DATE:** **May 2017**

Ontario

# GUIDE: QUARTERLY STOCKTAKE REPORT

| PERFORMANCE INDICATORS | DATA SOURCE | Page # |
|---|---|---|
| **HOME AND COMMUNITY CARE** | | |
| Percentage of home care clients with complex needs who received their personal support visit within 5 days of the date that they were authorized for personal support services | Home Care Database (HCD), Ontario Association of Community Care Access Centres (OACCAC) | Page 3 |
| Percentage of home care clients who received their nursing visit within 5 days of the date they were authorized for nursing services | | Page 3 |
| 90th percentile wait time from community for home care services: application from community setting to first home care service (excluding case management) | | Page 4 |
| 90th percentile wait time from hospital discharge to service initiation for home and community care | Discharge Abstract Database (DAD), Canadian Institute for Health Information (CIHI)<br>HCD, OACCAC | Page 4 |
| **SYSTEM INTEGRATION AND ACCESS** | | |
| 90th percentile emergency department (ED) length of stay for complex patients | National Ambulatory Care Reporting System (NACRS), Canadian Institute for Health Information (CIHI) | Page 5 |
| 90th percentile ED length of stay for minor/uncomplicated patients | | Page 5 |
| Percent of priority 2, 3 and 4 cases completed within access target for hip replacement | Wait Time Information System (WTIS) Access to Care, CCO | Page 6 |
| Percent of priority 2, 3 and 4 cases completed within access target for knee replacement | | Page 6 |
| Percentage of alternate level of care (ALC) days | DAD, CIHI | Page 7 |
| ALC rate | WTIS, HDB Bed Census Summary (BCS) | Page 7 |
| | | |
| **HEALTH AND WELLNESS OF ONTARIANS - MENTAL HEALTH** | | |
| Repeat unscheduled emergency visits within 30 days for mental health conditions | NACRS, CIHI | Page 8 |
| Repeat unscheduled emergency visits within 30 days for substance abuse conditions | | Page 8 |
| | | |
| **SUSTAINABILITY AND QUALITY** | | |
| Readmissions within 30 days for selected Health Based Allocation Model (HBAM) Inpatient Group (HIG) conditions | DAD, CIHI | Page 9 |
| | | |
| **MONITORING INDICATORS** | **DATA SOURCE** | **Page #** |
| **SYSTEM INTEGRATION AND ACCESS** | | |
| Percent of priority 2 and 3 cases completed within access target for computed tomography (CT) scan | WTIS, CCO | Page 10 |
| Percent of priority 2 and 3 cases completed within access target for magnetic resonance imaging (MRI) scan | | Page 10 |
| Percent of priority 2, 3 and 4 cases completed within access target for cataract surgery | | Page 10 |
| Wait times from application to eligibility determination for long-term care home (LTCH) placement: From community setting, and from acute-care setting | Client Profile (CPRO) Database | Page 11 |
| Rate of emergency visits for conditions best managed elsewhere | DAD, CIHI | Page 12 |
| Hospitalization rate for ambulatory care sensitive conditions | DAD, CIHI | Page 12 |
| Percent of acute care patients who have had a follow-up with a physician within 7 days of discharge | DAD, CIHI and Claims History Database (CHDB), MOHLTC | Page 12 |
| | | |
| **DEVELOPMENTAL INDICATORS** | **DATA SOURCE** | **Page #** |
| **HOME AND COMMUNITY CARE** | | |
| Percent of palliative care patients discharged from hospital with home support | DAD, CIHI | Page 13 |
| | | |
| **SUSTAINABILITY AND QUALITY** | | |
| Overall satisfaction with health care in the community | MOHLTC's Health Care Experience Survey | Page 13 |
| **APPENDIX** | | **Page #** |
| **SUMMARY OF PERFORMANCE INDICATORS** | | Page 14 |
| **NOTES** | | Page 15/16 |

## INTERPRETING PERFORMANCE INDICATORS

| Legend | Provincial Data | Provincial Target | LHIN Data |
|---|---|---|---|

| LHIN Data | | |
|---|---|---|
| Achieved Provincial Target | Within 10% of Provincial Target | >10% From Provincial Target |

**Note:**
The following will not be displayed in the figure:
NV: No volume or low volume (< 10 cases)
N/A: Not Applicable
NR: Not Reportable

Ontario

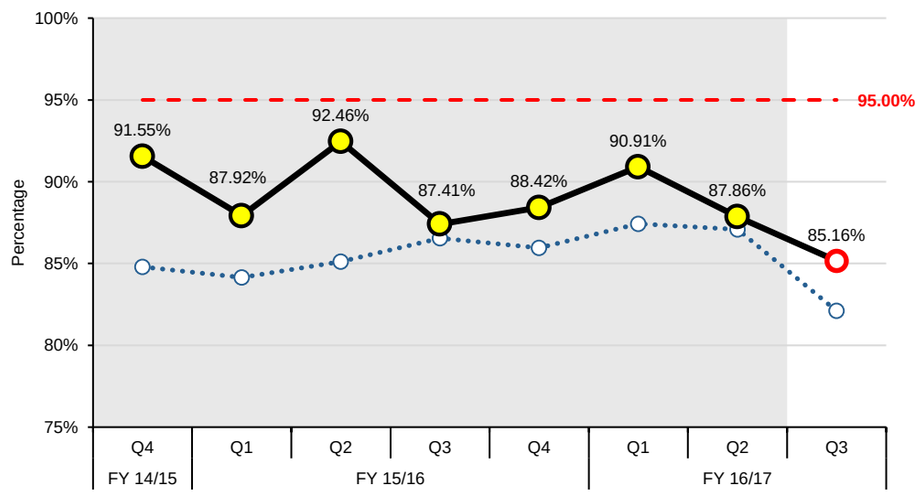
# South West LHIN

## PERFORMANCE INDICATORS: HOME AND COMMUNITY CARE

OBJECTIVES: 1. Reduce wait time for home care (improve access) 2. More days at home (including end of life care)

### Percentage of home care clients with complex needs who received their personal support visit within 5 days of the date that they were authorized for personal support services

| Summary (Q3 FY 16/17) | LHIN Performance | Provincial Performance | Provincial Target (FY 16/17) |
|---|---|---|---|
| | 85.16% | 82.10% | 95.00% |




#### LHIN COMMENTS

**What contextual factors explain current performance?**
Increase of complex referral over holiday season and limited staff capacity contributed to the performance in Q3 2016/17. The LHIN also has e-shift supports which is not provided by most LHINs. The E-shift services are subject to staffing shortages and annual increase in end of life palliative patients over the Christmas period. In addition, if we incorporate Patient Available Date into our reporting, the performance on this indicator is slightly better than otherwise.

**What initiatives are underway that are positively impacting current LHIN performance?**
Expand service provision to CCAC clients with complex care needs. Home and Community Care at the LHIN is receiving base funding to expand service provision for high needs clients. The LHIN is addressing service gaps and needs among the Home and Community Care clients, and is paying particular attention to services levels provided to clients with complex care needs

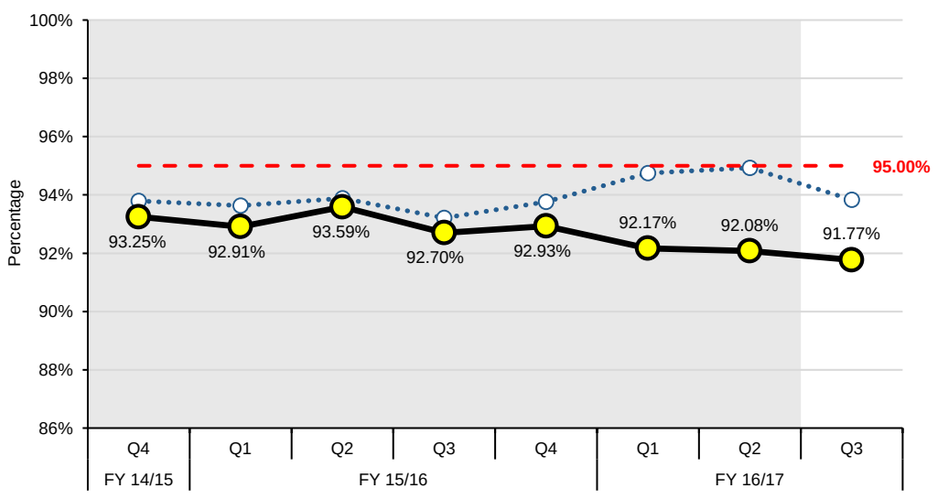
**What initiatives are underway that are expected to lead to improvement within the next 6 months to one year?**

The measure remains a key performance indicator and is monitored through the Service Accountability Agreement Quarterly Review Process. The LHIN staff work together to initiate follow-up requirements for root-cause investigation, improvement planning and reporting.

Measure remains a key performance indicator for Quality Improvement Plan and target set at 95%; the LHIN is also expecting to see the positive impact from PF investments on its performance. We continue to monitor.

### Percentage of home care clients who received their nursing visit within 5 days of the date they were authorized for nursing services

| Summary (Q3 FY 16/17) | LHIN Performance | Provincial Performance | Provincial Target (FY 16/17) |
|---|---|---|---|
| | 91.77% | 93.83% | 95.00% |




#### LHIN COMMENTS

**What contextual factors explain current performance?**
Increase of Out of Region Hospital referral over the holiday season and limited staff capacity contributed to the performance in Q3 2016/17. The LHIN also has e-shift supports which is not provided by most LHINs. The E-shift services are subject to staffing shortages and annual increase in end of life palliative patients over the Christmas period. In addition, if we incorporate Patient Available Date (PAD) into our reporting, the performance on this indicator is better than otherwise. Moreover, the South West LHIN is the only LHIN that provides Geriatric Resource Nursing (GRN) Services. The model adopted to this program is not designed for a visit within 5 days. Without GRN Services being considered, the performance on this indicator may increase by 1-2%.

**What initiatives are underway that are positively impacting current LHIN performance?**
Expand service provision to CCAC clients with complex care needs. Home and Community Care at the LHIN is receiving base funding to expand service provision for high needs clients. The LHIN is addressing service gaps and needs among the Home and Community Care clients, and is paying particular attention to services levels provided to clients with complex care needs.

**What initiatives are underway that are expected to lead to improvement within the next 6 months to one year?**
The measure remains a key performance indicator and is monitored through the Service Accountability Agreement Quarterly Review Process. The LHIN staff work together to initiate follow-up requirements for root-cause investigation, improvement planning and reporting.

Measure remains a key performance indicator for Quality Improvement Plan and target set at 95%; the LHIN is also expecting to see the positive impact from PF investments on its performance. We continue to monitor.

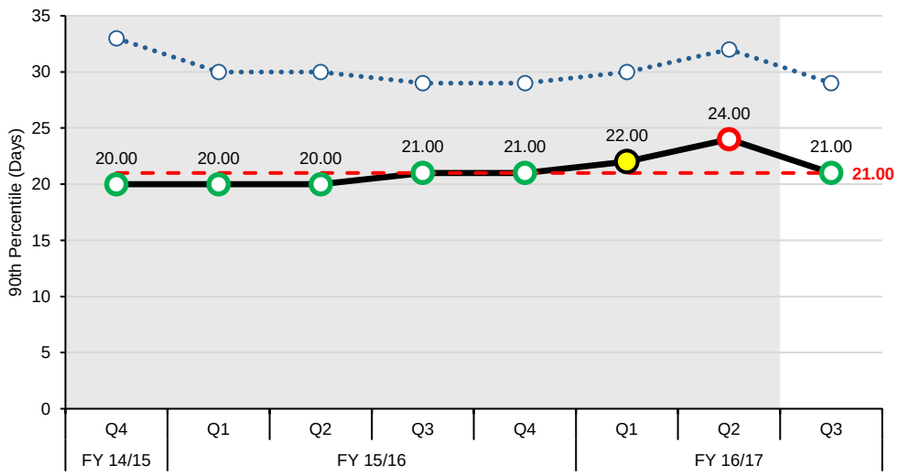
# South West LHIN

## PERFORMANCE INDICATORS: HOME AND COMMUNITY CARE

OBJECTIVES: 1. Reduce wait time for home care (improve access) 2. More days at home (including end of life care)

### 90th percentile wait time from community for home care services: application from community setting to first home care service (excluding case management)

| Summary (Q3 FY 16/17) | LHIN Performance | Provincial Performance | Provincial Target (FY 16/17) |
|---|---|---|---|
| | 21.00 Days | 29.00 Days | 21.00 Days |



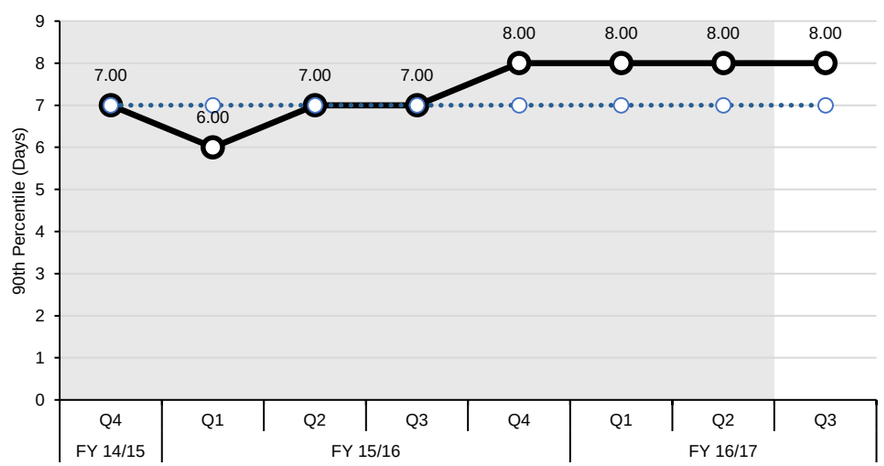

#### LHIN COMMENTS

**What contextual factors explain current performance?**

Increased demand contributed to the performance of Q1 and Q2 2016/17. The number of complex patients has increased consistently from Q1 2015/16 to Q3 2016/17, and the number of chronic senior clients also reached its peak in Q1 and Q3 2016/17. The pattern of the increased demand has been very consistent with the trend of the performance of the South West LHIN over Q1 and Q2 2016/17. In Q3 2016/17, total demand, including all clients, decreased by 5% and 7% from Q1 and Q2, respectively. As a result, the performance has been brought back to meet the provincial target.

### 90th percentile wait time from hospital discharge to service initiation for home and community care

| Summary (Q3 FY 16/17) | LHIN Performance | Provincial Performance | Provincial Target (FY 16/17) |
|---|---|---|---|
| | 8.00 Days | 8.00 Days | TBD |




#### LHIN COMMENTS

**What contextual factors explain current performance?**

Many referrals are completed between 7-10 days, which causes the overall all performance of the LHIN is not as good as provincial performance.

**What initiatives are underway that are expected to lead to improvement within the next 6 months to one year?**

Currently we don't see any potential risk for our clients currently, and our current performance is slightly worse than the provincial performance. After the Provincial target is released, we are going to take appropriate actions to improve our performance on this measure, if our performance is worse than the target.

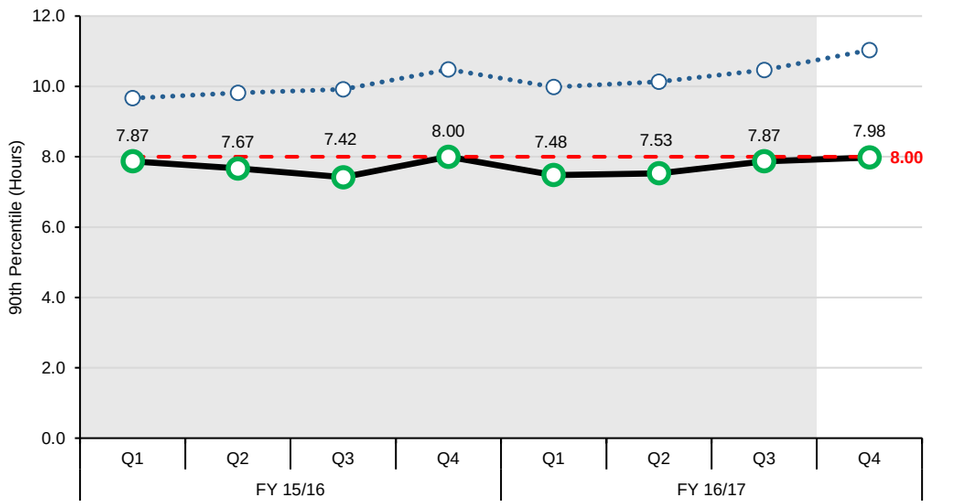
# South West LHIN

## PERFORMANCE INDICATORS: SYSTEM INTEGRATION AND ACCESS

OBJECTIVES: 1. Provide care in the most appropriate setting 2. Improve coordinated care 3. Reduce wait times (specialists, surgeries)

### 90th percentile emergency department (ED) length of stay for complex patients

| Summary (Q4 FY 16/17) | LHIN Performance | Provincial Performance | Provincial Target (FY 16/17) |
|---|---|---|---|
| | 7.98 Hours | 11.03 Hours | 8.00 Hours |




#### LHIN COMMENTS

**What contextual factors explain positive change in performance? negative change in performance?**

-In Q4, the South West LHIN had the best Emergency Department (ED) wait times for complex patients in the province, although experienced a slight increase in wait times over Q3 (8 hours, compared to 7.9 hours). Performance was slightly worse than Q4 2015-16, attributed to a more pronounces seasonal impact experienced this year. Overall, in Q4 we have seen a 2% increase in the volume of high acuity patients presenting at the Emergency Department.

**Hospital level** -Performance for this indicator is monitored at the hospital organizational level through our Service Accountability Quarterly Review Process and P4R and knowledge Transfer Learning Collaborative. Overall, South West LHIN performance has remained below provincial target for the past 8 quarters.

-5/13 of South West LHIN organizations are performing better than their respective service accountability targets. 7/13 are performing worse than their target but within their service accountability corridor. Only London Health Sciences Centre (LHSC) was performing worse than their performance corridor. Despite improvements in overall bed capacity due to a reduction in the total number of patients in ALC status occupying hospital beds, persistent inpatient capacity challenges remained (greater than 100% hospital occupancy) thus contributing to a worsening of wait times in the ED. A key contributor was the prevalence of mental health and addictions surge and capacity challenges.

**What initiatives are underway to explain current performance? (regional or key organizational)**

Our strategy includes the following key interventions currently targeting an improvement in this area:

**1**. ED Pay for Results - Targeted improvement and investment approach being implemented at high volume ED sites within the South West LHIN (focused on complex patients, and patients who are admitted to hospital). The Knowledge Transfer collaborative continues quarterly and supports sharing of successful strategies among high-volume sites. **2.** Other key interventions driving improvement locally at our high volume, teaching hospital (London Health Sciences) include evolvement of the Emergency Department System Transformation streams (the overall goal of this work is to promote patient flow from admission to discharge with standard work implementation and maintain and sustain 95% occupancy across the organization). **3.** Home First Refresh Learning Collaborative (implementation of ALC Avoidance approach) – launched with implementation teams in all South West LHIN hospitals in June 2017.

**4. Mental Health Surge Planning** - Hospitals with a high volume of ED visits – are focused on reducing access pressures related to an influx of patients with mental health conditions requiring admission to hospital. Surge huddles are facilitated by the London Hospitals as needed with other schedule 1 facilities, community partners, CCAC, and LHIN in order to decant patients to other appropriate destinations that have capacity.

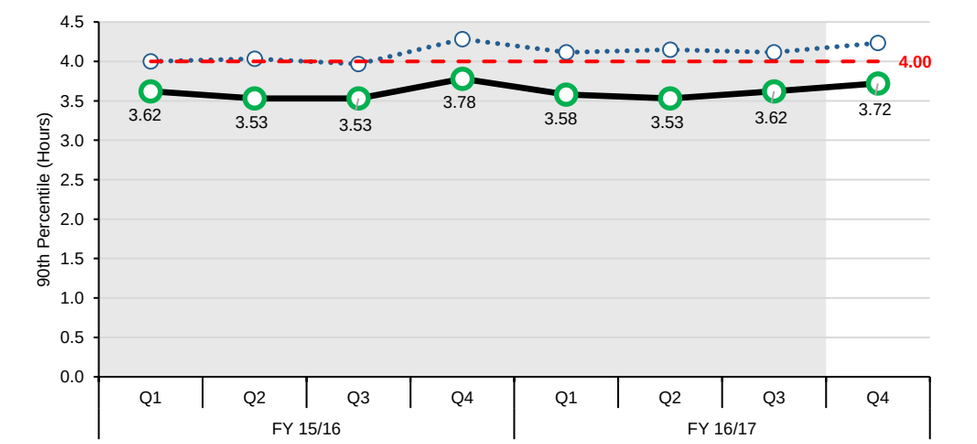
**5.** Regional Access and Flow and Holiday Surge planning

**What initiatives are underway that are expected to lead to improvement within the next 6 months to one year? (Longer-term (immediate impact is not expected as in development):** 1. Development of a Regional Access and Flow Memorandum of Understanding (MOU) and Policy/Protocol along in partnership with our Chief Nursing Executive Leadership Forum, and targeted Mental Health Capacity Planning.

2. Strategies for extraordinary needs patients leveraging provincial best practices and a learning collaborative format.

### 90th percentile ED length of stay for minor/uncomplicated patients

| Summary (Q4 FY 16/17) | LHIN Performance | Provincial Performance | Provincial Target (FY 16/17) |
|---|---|---|---|
| | 3.72 Hours | 4.23 Hours | 4.00 Hours |




#### LHIN COMMENTS

**What contextual factors explain positive change in performance? negative change in performance?**

-Performance has remained below provincial average and target historically for more than the past 8 quarters.

-For Q4 10/13 of the South West LHIN organizations are performing within their HSAA corridor. 3 Organizations The Alexandra Hospital, Stratford, London Health Sciences has seen a worsening of performance and are performing above the provincial target of 4 hrs. At LHSC, high demand scenarios with a backlog of admitted patients who cannot get access to inpatient beds does not allow the hospital to operate the ED using the new optimized and efficient Emergency Department System Transformation (EDST) model, thus having a negative impact on patient flow and wait times for patients.

**What initiatives are underway to explain current performance? (regional or key organizational):**

Strategically, all hospitals within the South West are focused on improving access, and patient flow within their organizations and regionally among organizations as a key priority. Performance for all ED wait time indicators including non-admitted are monitored through the South West LHIN SAA Quarterly Review Process.

LHSC: is focusing on decreasing time to consult in the ED as well as implementation of EDST (Implementation of individual Physician Scorecards; Driving front line and team accountability; Reducing care cycle times and admission avoidance for patients with mental health concerns who present to the ED)

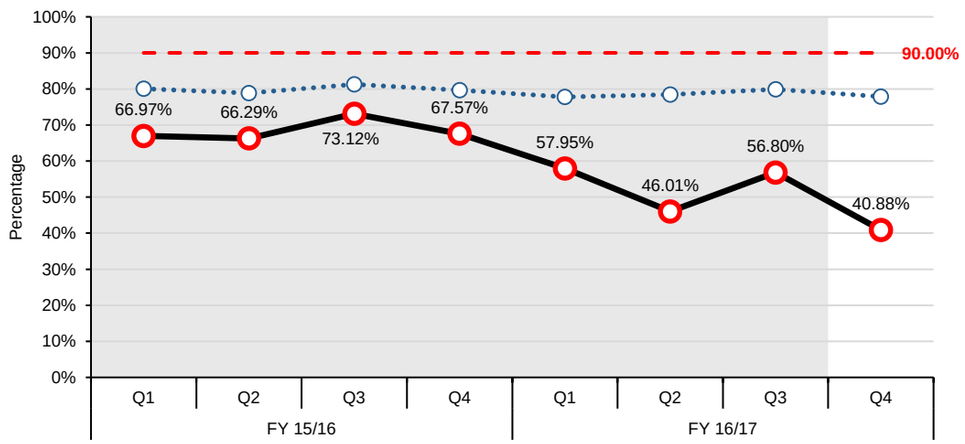
# South West LHIN

## PERFORMANCE INDICATORS: SYSTEM INTEGRATION AND ACCESS

OBJECTIVES: 1. Provide care in the most appropriate setting 2. Improve coordinated care 3. Reduce wait times (specialists, surgeries)

### Percent of priority 2, 3 and 4 cases completed within access target for hip replacement

| Summary (Q4 FY 16/17) | Provincial Target (FY 16/17) (Combined): 90.00% | | | | |
|---|---|---|---|---|---|
| | LHIN Performance | | | | Provincial Performance (Combined) |
| | Priority 2: 42 Days | Priority 3: 84 Days | Priority 4: 182 Days | Combined | |
| | 90.91% | 39.80% | 39.51% | 40.88% | 77.89% |




#### LHIN COMMENTS

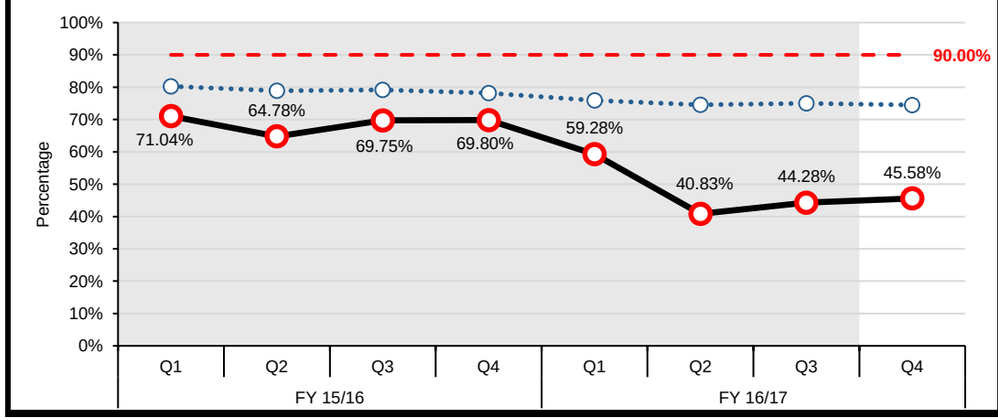
**What contextual factors explain positive/negative change in performance?**
Performance for hip replacement surgery in the South West LHIN has declined from the prior quarter. This was expected as we were closing longest waiting cases. At the start of Q4, 1378 cases were on open wait list, 480 hips cases were added and 564 hip surgeries were performed.

**What initiatives are underway to explain current performance? (regional or key organizational)**
1. Organizations performing hip replacement surgeries within the South West, are reinvesting efficiencies or global funding in order to complete additional procedures beyond their base allocation (~15%).
In addition, London Health Sciences received notification to target some of their 1% base investment increase to target a reduction in wait times for hip and knee replacement surgeries. This translated into an additional 90 hip, and 30 knee replacement surgeries completed above QBP allocations at LHSC in 2016/17.
2.Based on sustained demand pressures in the South West LHIN, the LHIN targeted additional investment (approximately a total of 90 additional hip/knee surgeries) to support expedited completion of hip and knee replacement surgeries for patients who had been waiting the longest for their surgery.
Regional and organizational data clean up action championed by the South West LHIN Decision Support Network continues in order to remove duplicates and ensure that we understand true demand for procedures. Work is underway to ensure that sustainable practices are put in place at all sites to monitor open case wait lists.
The South West LHIN manages performance through the Service Accountability Agreement Quarterly Review Process - which includes performance monitoring and escalation of follow up action.

**What initiatives are underway that are expected to lead to improvement within the next 6 months to one year? (Longer-term (immediate impact is not expected as in development):**
Working with the Orthopaedic Steering Committee to develop better mechanisms to share wait time information by organization and surgeon with primary care providers in the South West LHIN - leveraging lessons learned through implementation in Waterloo Wellington LHIN. It is expected that this will be implemented by Q2 2017-18.
Additionally, the team is working with the Orthopedic Steering Committee on developing a central intake and scheduling process in the South West LHIN for wait 1 and wait 2 with implementation aligned with the Provincial MSK strategy.

### Percent of priority 2, 3 and 4 cases completed within access target for knee replacement

| Summary (Q4 FY 16/17) | Provincial Target (FY 16/17) (Combined): 90.00% | | | | |
|---|---|---|---|---|---|
| | LHIN Performance | | | | Provincial Performance (Combined) |
| | Priority 2: 42 Days | Priority 3: 84 Days | Priority 4: 182 Days | Combined | |
| | NV | 40.96% | 46.32% | 45.58% | 74.50% |




#### LHIN COMMENTS

**What contextual factors explain positive/negative change in performance?**
Performance for hip replacement surgery in the South West LHIN has declined from the prior quarter. This was expected as we were closing longest waiting cases. At the start of Q4, 2302 cases were on open wait list, 759 knees cases were added and 1464 knee surgeries were performed.

**What initiatives are underway to explain current performance? (regional or key organizational)**
1. Organizations performing hip replacement surgeries within the South West, are reinvesting efficiencies or global funding in order to complete additional procedures beyond their base allocation (~15%).
In addition, London Health Sciences received notification to target some of their 1% base investment increase to target a reduction in wait times for hip and knee replacement surgeries. This translated into an additional 90 hip, and 30 knee replacement surgeries completed above QBP allocations at LHSC in 2016/17.
Based on sustained demand pressures in the South West LHIN, the LHIN targeted additional investment (approximately a total of 90 additional hip/knee surgeries) to support expedited completion of hip and knee replacement surgeries for patients who had been waiting the longest for their surgery .
Regional and organizational data clean up action championed by the South West LHIN Decision Support Network continues in order to remove duplicates and ensure that we understand true demand for procedures. Work is underway to ensure that sustainable practices are put in place at all sites to monitor open case wait lists.
As a compliment, the South West LHIN manages performance through the Service Accountability Agreement Quarterly Review Process - which includes performance monitoring and escalation of follow up action.

**What initiatives are underway that are expected to lead to improvement within the next 6 months to one year? (Longer-term (immediate impact is not expected as in development):**
Working with the Orthopedic Steering Committee to develop better mechanisms to share wait time information by organization and surgeon with primary care providers in the South West LHIN - leveraging lessons learned through implementation in Waterloo Wellington LHIN. It is expected that this will be implemented by Q2 2017-18.
Additionally, the team is working with the Orthopedic Steering Committee on developing a central intake and scheduling process in the South West LHIN for wait 1 and wait 2 with implementation aligned with the Provincial MSK strategy.

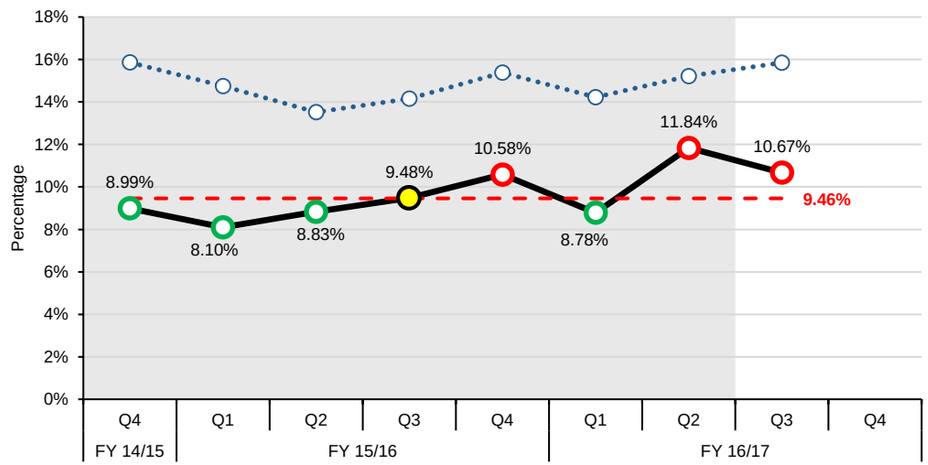
# South West LHIN

## PERFORMANCE INDICATORS: SYSTEM INTEGRATION AND ACCESS

OBJECTIVES: 1. Provide care in the most appropriate setting 2. Improve coordinated care 3. Reduce wait times (specialists, surgeries)

### Percentage of alternate level of care (ALC) days

| Summary (Q3 FY 16/17) | LHIN Performance | Provincial Performance | Provincial Target (FY 16/17) |
|---|---|---|---|
| | 10.67% | 15.85% | 9.46% |




#### LHIN COMMENTS

**What contextual factors explain current performance? Performance/Facility-level analysis/issues and supporting data (hospital, CCAC, LTCH) that explain the performance results**:

• There were 2 facilities whose percentage of ALC days were significantly higher than their performance in Q2 2016/17: Tillsonburg District Memorial Hospital, Wingham and District Hospital. At the same time, most of the facilities had better or keep the same performance compared to Q2 2016/17. As a result, the overall performance of the LHIN improved from last quarter.

• ALC days performance of the LHIN was still the second best across the province in Q3 2016/17, although it didn't meet the provincial target.

**What initiatives are underway that are positively impacting current LHIN performance?**

• Targeted investments to CCAC to support Home First patients and complex care patients

• Targeted investments in Assisted Living spaces

• BSO support for difficult-to-serve ALC populations

• Teaching hospital, LHSC, has made significant improvements as it has tested the William Osler approach to ALC avoidance (details below).

**What initiatives are underway that are expected to lead to improvement within the next 6 months to one year?**

• Chief Nursing Executives have made ALC and patient flow LHIN-wide priorities for improvement. An action plan has been developed based on successes achieved at William Osler Health System and includes:

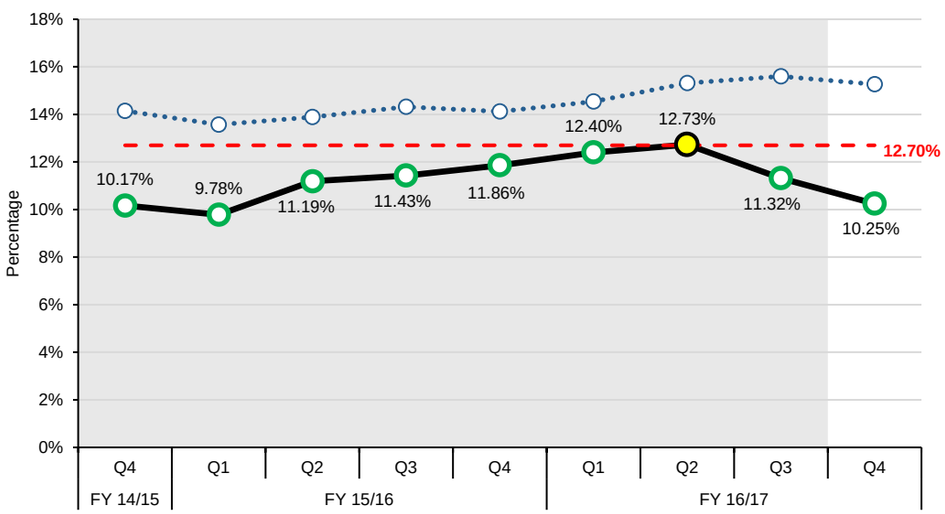
- the implementation of ALC avoidance practices
- a 'refresh' of Home First principles and practices
-a physician champion
-consultation/ access to a clinical ethicist
-key performance indicators
-collaborative learning opportunities
-development of a coordinated approach for patients with extraordinary needs

• Tillsonburg hospital representatives visited LHSC in early February 2017 for information sharing and to learn about ALC avoidance strategies as well as connect with a physician champion

• Performance for ALC is monitored through our Service Accountability Agreement Quarterly Review Process at the hospital level and with CCAC. An escalating series of follow-up requirements is initiated with any hospital (and CCAC) that falls outside of its allowed corridor on this indicator requiring explanation, improvement planning, and further reporting.

### ALC rate

| Summary (Q4 FY 16/17) | LHIN Performance | Provincial Performance | Provincial Target (FY 16/17) |
|---|---|---|---|
| | 10.25% | 15.27% | 12.70% |




#### LHIN COMMENTS

**What contextual factors explain current performance? Performance/Facility-level analysis/issues and supporting data (hospital, CCAC, LTCH) that explain the performance results:**

• PF Investments were made to enhance assisted living services, which helped achieve better ALC performance.

• There were 2 facilities whose percentage of ALC days were significantly higher than their performance in Q3 2016/17: Clinton Public Hospital, Strathroy Middlesex General Hospital. At the same time, most of the facilities had better or kept the same performance compared to Q3 2016/17. Particularly, London Health Sciences Centre, the largest facility in the LHIN, further improved their performance on ALC rate by 24%. As a result, the overall performance of the LHIN was better than last quarter.

• ALC rate performance of the LHIN was the third best across the province in Q4 2016/17 and it was better than the provincial target.

What initiatives are underway that are positively impacting current LHIN performance?

• Targeted investments to CCAC to support Home First patients and complex care patients

• Targeted investments in Assisted Living spaces

• BSO support for difficult-to-serve ALC populations

• Teaching hospital, LHSC, has made significant improvements as it has tested the William Osler approach to ALC avoidance (details below).

**What initiatives are underway that are expected to lead to improvement within the next 6 months to one ye**ar?

• Chief Nursing Executives have made ALC and patient flow LHIN-wide priorities for improvement. An action plan has been developed based on successes achieved at William Osler Health System and includes:

- the implementation of ALC avoidance practices and a 'refresh' of Home First principles and practices
-a physician champion
-consultation/ access to a clinical ethicist
-key performance indicators
-collaborative learning opportunities and development of a coordinated approach for patients with extraordinary needs

• Tillsonburg hospital representatives visited LHSC in early February 2017 for information sharing and to learn about ALC avoidance strategies as well as connect with a physician champion

• Performance for ALC is monitored through our Service Accountability Agreement Quarterly Review Process at the hospital level and with CCAC. An escalating series of follow-up requirements is initiated with any hospital (and CCAC) that falls outside of its allowed corridor on this indicator requiring explanation, improvement planning, and further reporting.

• ALC data is shared broadly via the South West LHIN Report on Performance to promote awareness at the system level for this shared accountability measure and portfolio team members continue to monitor "number of open ALC cases" for more timely data in order to action planning and follow-up.

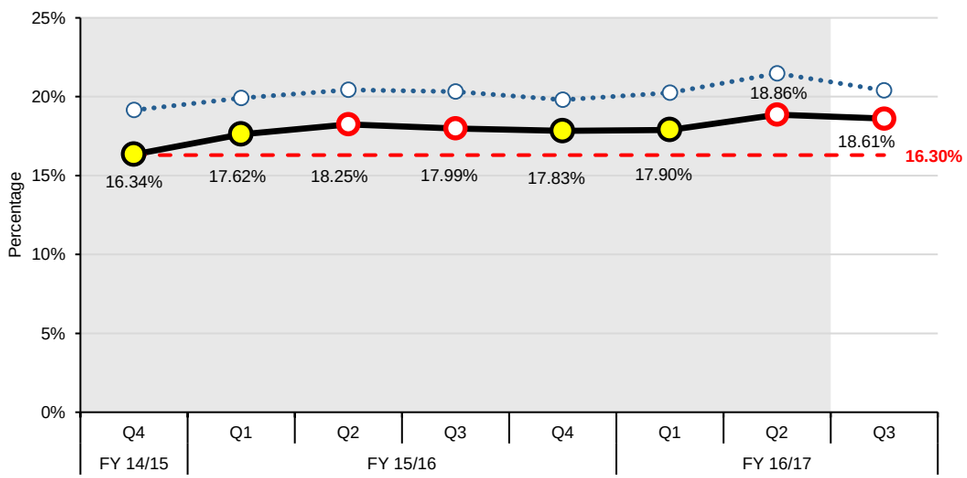
# South West LHIN

## PERFORMANCE INDICATORS: HEALTH AND WELLNESS OF ONTARIANS - MENTAL HEALTH

OBJECTIVES: 1. Reduce any unnecessary health care provider visits 2. Improve coordination of care for mental health patients

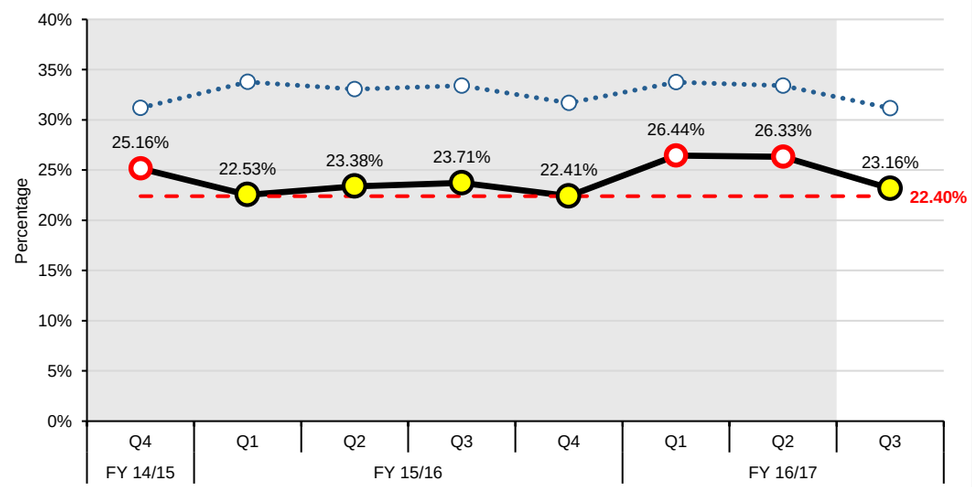
### Repeat unscheduled emergency visits within 30 days for mental health conditions

| Summary (Q3 FY 16/17) | LHIN Performance | Provincial Performance | Provincial Target (FY 16/17) |
|---|---|---|---|
| | 18.61% | 20.39% | 16.30% |




### Repeat unscheduled emergency visits within 30 days for substance abuse conditions

| Summary (Q3 FY 16/17) | LHIN Performance | Provincial Performance | Provincial Target (FY 16/17) |
|---|---|---|---|
| | 23.16% | 31.15% | 22.40% |




### LHIN COMMENTS

**What contextual factors explain current performance?**

**Mental Health:**

The mental health revisit rate for the South West LHIN in Q3 2016/17 was 18.61% which is slightly lower than the Q2 result of 18.86%. In general, the slight decrease can be attributed to three of our Schedule 1 sites, London Health Sciences Centre (LHSC) - Victoria Hospital, Grey Bruce Health Services (GBHS) - Owen Sound, and Stratford General Hospital. These three hospitals had a combined decrease in the number of mental health revisits of 58 revisits (about 15% fewer visits than in Q2 2016/17). Because LHSC-Victoria Hospital and GBHS-Owen Sound are our largest two Schedule 1 facilities, a reduction in visits in these two hospitals was able to outweigh the increases in revisit rates seen at some of our smaller hospitals.

LHSC has indicated that the high rates seen in Q2 may have been potentially due to less timely follow-up with family doctors or other community resources due to the increased amount of vacation time used during the summer months. GBHS also has looked at the population that is utilizing their ED for mental health concerns. They found that they have a large number of their mental health and substance abuse ED visits are for medication renewals and visitors to the area utilizing their ED. They have begun implementing changes to their service delivery to address these populations. Their crisis team is now offering single session appointments for transient individuals. They've opened walk-in clinics across Grey Bruce and the hospital has implemented a discharge checklist. These changes will hopefully work to lower the revisit rate seen at GBHS.

**Substance Abuse:**

The substance abuse revisit rate within the South West LHIN decreased from Q2 to Q3 2016/17 (26.33% to 23.16% respectively). Our Q3 result now falls within corridor.

The decreased rate this quarter can be attributed to decreases in rates at each of our six Schedule 1 hospitals. The combined revisit rate at these six sites dropped from 31.5% in Q2 to 24.7% in Q3. Our Schedule 1 sites generally account for ~75% of all revisits in the LHIN, so it fits that the overall South West LHIN revisit rate mirrors the trend in the Schedule 1 revisit rate.

GBHS has indicated that they have been working to address their substance abuse revisit rate by increasing availability of their Rapid Access Addiction Medicine clinics and by moving towards continuous intake for their Community Addiction Treatment Services program.

**What initiatives are underway that are positively impacting current LHIN performance?**

**Crisis Centre/Stabilization Beds -** CMHA Middlesex is the third stage of Capital approval to move five stabilization beds in London to be co-located at the Crisis Centre. When the beds are moved, they will also expand to ten beds. This is also expected to help lower our revisit rates as we will have more capacity to be able to keep people that do not need to be at the hospital out of the hospital. In March and April 2017, CMHA Middlesex had to refuse service to more than 20 people per month because the stabilization beds were already at capacity. Over the last six months, on average ~86% of stabilization bed clients were likely diverted from the ED, ~29% have no fixed address, and ~13% were students (high school, college, and university-level). In terms of the Crisis Centre, over the past six months, on average 54% of visitors each month were visiting the Crisis Centre for the first time, 6% reported no fixed address, 10% had attended the ED in the previous month, and 26% were students.

**Supportive Housing Units -** Increasing access to stable housing for people with MH conditions as part of the 1,000 unit provincial initiative. Year 3 funding which would increase capacity in London Middlesex by 17 units.

**Coordinated Access -** Continued engagement in Oxford, Elgin and Middlesex (Thames Valley) to improve coordination and access to MH&A service providers throughout the Thames Valley area. As part of Coordinated Access, "Reach Out" launched in August 23, 2016. Reach Out is a 24/7 bilingual information, support and crisis line for people with mental health or addiction needs for Thames Valley and is designed to provide individuals better community supports (when possible). Reach Out is currently receiving upwards of 1000 calls per month and more bookings are being directly made with community organizations than we had previously seen.

**Mental Health and Addictions Capacity Planning -** This is a project aimed at developing solutions to patient access and flow in Schedule 1 and tertiary mental health hospitals in the South West LHIN. A committee has been struck to better understand utilization in these settings and to develop and test clinical protocols with respect to patient flow (including transfers and discharge planning) and surge. It is expected that if there is better flow in to and out of Schedule 1 and tertiary mental health beds, not only will patients be able to access the care they need more quickly, but patients will also be connected with the services they need in their communities and need to seek care in the ED less often. Work on procuring project resources is currently underway to further advance this initiative.

**Peer Support Integration -** The South West LHIN has been working with relevant partners since December 2015 to integrate peer support programs in to lead mental health and addictions organizations in each sub-region. The goal is to strengthen and expand peer support services within our LHIN and the integrations in each sub-region are expected to be completed in 2017. Enhancing access and availability of peer support could help contribute to keeping individuals out of the Emergency Department.

The South West LHIN monitors performance on these indicators through our SAA Quarterly Review Process. An escalating series of follow-up requirements is initiated with any hospital that falls outside of its allowed corridor on this indicator requiring explanation, improvement planning, and further reporting.

**What initiatives are underway that are expected to lead improvement within the next 6 months to one year?**

It is believed that the opening Crisis Centre in London and continued Coordinated Access work in Middlesex, Elgin, and Oxford will help us move towards the provincial target. Because the Crisis Centre only opened in January 2016, and is working through the Capital process in order to become fully functional, it is challenging to specify a date when the Capital improvements may start to make an impact. Also, our Capacity Planning project has a project end date of March 2018, so hopefully we will see the impacts of the improved protocols regarding access and flow soon after.

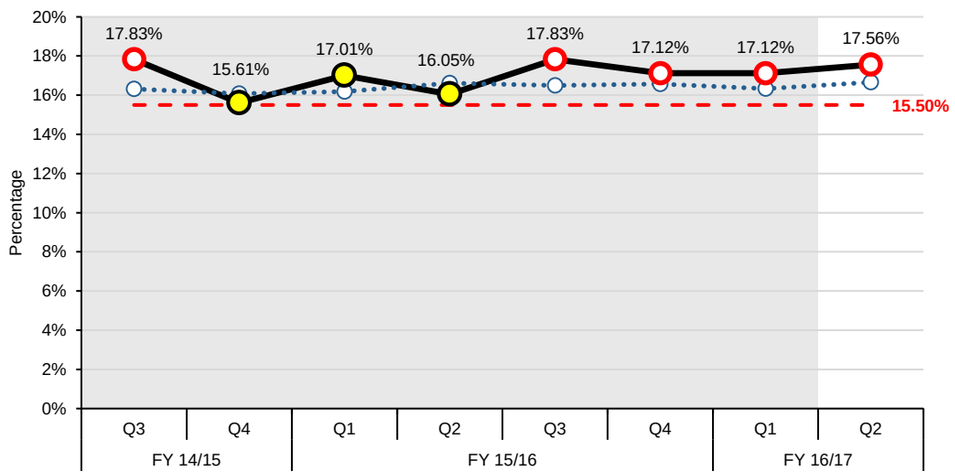
# South West LHIN

## PERFORMANCE INDICATORS: SUSTAINABILITY AND QUALITY

OBJECTIVES: 1. Improve patient satisfaction 2. Reduce unnecessary readmissions

### Readmissions within 30 days for selected HIG conditions

| Summary (Q2 FY 16/17) | LHIN Performance | Provincial Performance | Provincial Target (FY 16/17) |
|---|---|---|---|
| | 17.56% | 16.66% | 15.50% |




### LHIN COMMENTS

**What contextual factors explain current performance?**

In Q2 16/17, the South West LHIN did not meet the province wide performance target of 15.5% for readmissions within 30 days for selected HIG grouper conditions, ranking 11th amongst the 14 LHINs. The LHIN's adjusted rate of readmission was 17.6%, a 4% deviation above the LHIN's expected rate.

Readmission rates in Q2 16/17 were above expected for stroke (+42%), diabetes (+20%), and congestive heart failure (+15%). Excess readmissions in Q2 were primarily attributable to 20 excess readmissions indexed for diabetes and congestive heart failure at London Health Sciences Centre (LHSC), and an increase in readmitted stroke cases which accumulate across the district stroke centers located in Grey, Bruce, and Oxford Counties. The rate of readmission for stroke at LHSC - the regional stroke center - was equal to expected.

In Q2 16/17, readmissions rates for chronic obstructive pulmonary disease were 11% below the LHIN's expected rate, attributable to a decreased number of readmissions for COPD at LHSC and Grey Bruce Health Services. This finding is the expected impact from concentrated efforts of the London-Middlesex and Grey Bruce Health Links, the Integrated Funding Model Project, and Telehomecare.

**What initiatives are underway that are positively impacting current LHIN performance?**

Readmissions in the South West LHIN are actively monitored and followed-up through HSP Service Accountability Agreements (SAAs) and included in their organizations' Quality Improvement Plans (QIPs). In addition to these processes, the following interventions are directly targeting improvement in readmissions in the South West. Each of the interventions have resulted in a small, but limited impact on LHIN level readmissions, due to limited numbers of clients supported in each intervention:

1) Health Links: All six Health Links are now active in the South West LHIN, coordinating care for residents. At the close of Q4 16/17, over 1,500 coordinated care plans (CCPs) had been completed, covering 3.5% of the estimated target population (+1.5% from Q3 16/17). On Q2 16/17 close, 800 CCPs were in place during the timeframe reflected in the readmissions data above. Early utilization data suggests a 15% reduction in emergency department visits, a 22% reduction in unplanned admissions to hospital, and a 47% reduction in hospital days stayed within 6 months of the initial care conference for residents in the South West LHIN supported by a Coordinated Care Plan (CCP).

2) Diabetes Education Programs: By the end of Q2 16/17, nine funded diabetes education programs provided support to 11,993 residents with diabetes self management. These programs have been successful in helping clients to self-manage their diabetes outside of hospital; however, together they only provide support to an estimated 14% of the South West LHIN's known diabetic population. This is the first quarter readmissions for diabetes have been above expected since FY 15/16.

3) Telehomecare: 503 clients were enrolled in Telehome care by the end of Q4 16/17, exceeding its fiscal target by 24%. This initiative is currently holding at maximum funded capacity. Readmission rates for the South West LHIN in Q2 16/17 were 11% below expected for COPD, and 15% above expected for congestive heart failure - the two conditions primarily supported through Telehomecare monitoring.

4) Integrated Funding Model "Connecting Care to Home": 109 residents chronic obstructive pulmonary disease (COPD) and three residents with congestive heart failure (CHF) were enrolled in the IFM model in London by the end of Q4 16/17. Outcomes suggest an estimated 50% of inpatient days and 50% of acute hospital and community care costs could potentially be diverted by supporting clients with mild-to-moderate COPD and CHF through bundled care.

5) IDEAs Spread Project - The South West LHIN Clinical Quality Lead continues to engage key Medical Advisory Committees throughout the LHIN to promote adoption of policy regarding timely discharge summary communication (80% of summaries sent within 48 hours of discharge). Timely discharge summary communication has been integrated into the 2017/18 Hospital QIP Template.

**What initiatives are underway that are expected to lead to improvement within the next 6 months to one year?**

• Increased education of and referrals to Health Links is key to reducing avoidable hospital admissions and readmissions. The South West LHIN has assembled a working group to begin exploring strategies for Health Links scale up and spread; planned initiatives include integrating coordinated care planning processes into existing community-based service programs (memory clinics, adult day/falls prevention programs) and use of Health Partner Gateway to enable enhanced secure exchange of client health information between community-based care partners including primary care.
• Consideration of Priority-for-Investment funding in FY 17/18 to support an Indigenous-led early test of change for culturally safe coordinated care planning

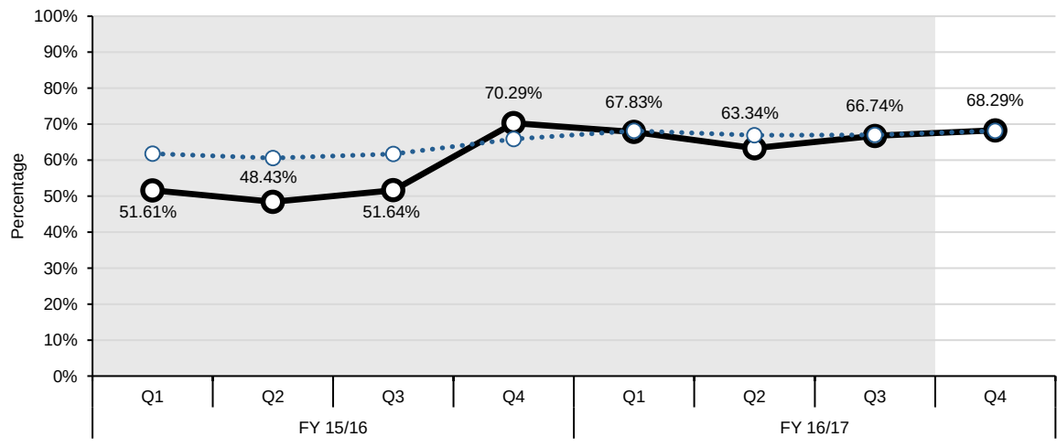
# South West LHIN

## MONITORING INDICATORS: SYSTEM INTEGRATION AND ACCESS

OBJECTIVES: 1. Provide care in the most appropriate setting 2. Improve coordinated care 3. Reduce wait times (specialists, surgeries)

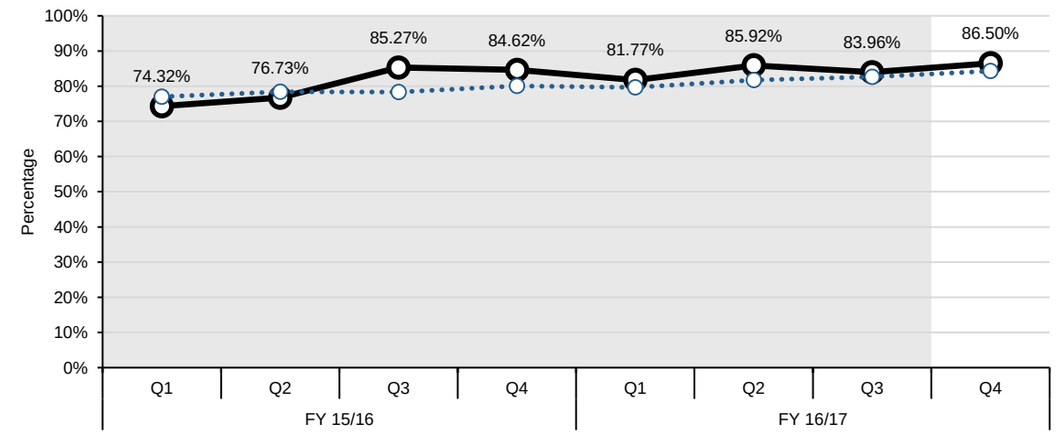
### Percent of priority 2 and 3 cases completed within access target for MRI scan

| Summary (Q4 FY 16/17) | LHIN Performance | | | Provincial Performance (Combined) |
|---|---|---|---|---|
| | Priority 2: 2 Days | Priority 3: 2-10 Days | Combined | |
| | 71.14% | 66.51% | 68.29% | 68.17% |



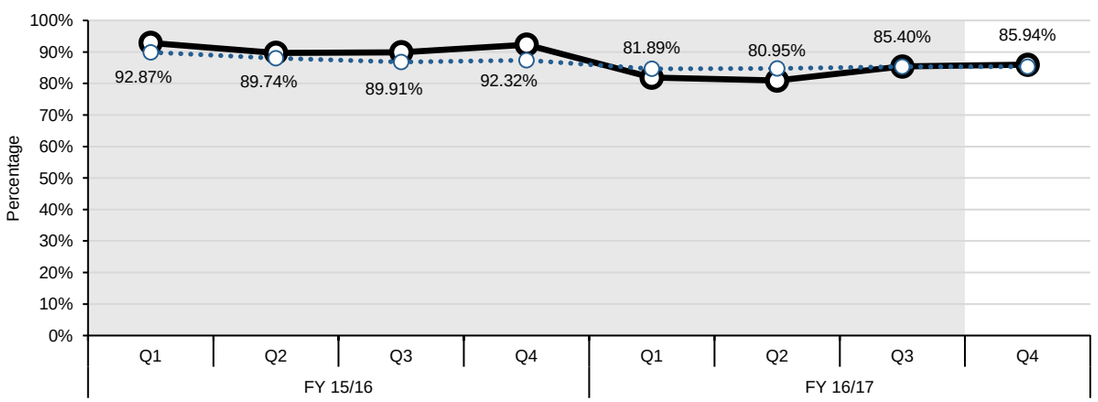

### Percent of priority 2 and 3 cases completed within access target for CT scan

| Summary (Q4 FY 16/17) | LHIN Performance | | | Provincial Performance (Combined) |
|---|---|---|---|---|
| | Priority 2: 2 Days | Priority 3: 2-10 Days | Combined | |
| | 94.40% | 77.88% | 86.50% | 84.30% |




### Percent of priority 2, 3 and 4 cases completed within access target for cataract surgery

| Summary (Q4 FY 16/17) | LHIN Performance | | | | Provincial Performance (Combined) |
|---|---|---|---|---|---|
| | Priority 2: 42 Days | Priority 3: 84 Days | Priority 4: 182 Days | Combined | |
| | NV | 68.05% | 87.19% | 85.94% | 85.32% |



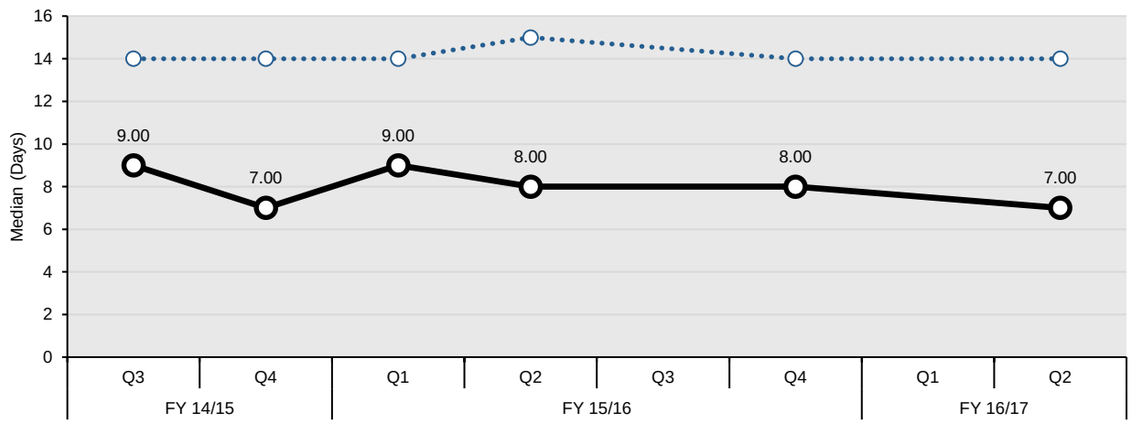
# South West LHIN

## MONITORING INDICATORS: SYSTEM INTEGRATION AND ACCESS

OBJECTIVES: 1. Provide care in the most appropriate setting 2. Improve coordinated care 3. Reduce wait times (specialists, surgeries)

### Wait times from application to eligibility determination for long-term care home (LTCH) placement: From community setting

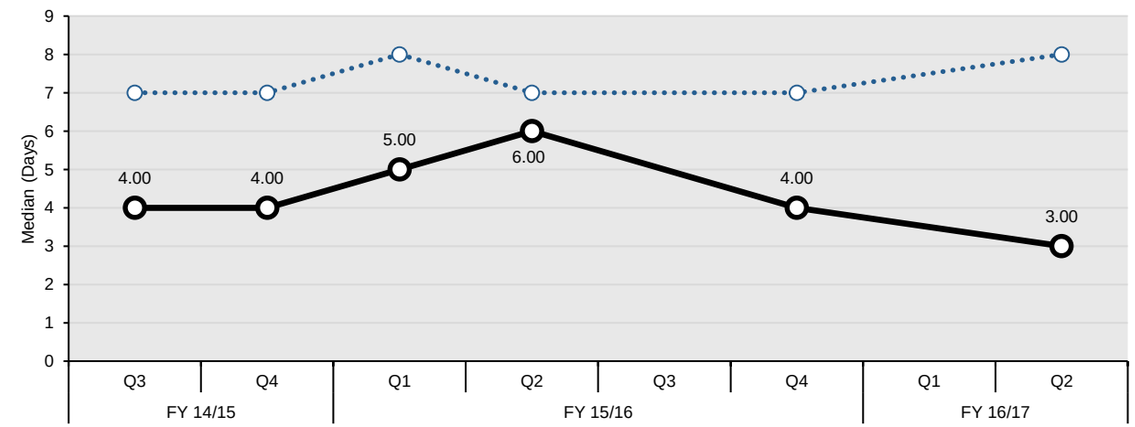
| Summary (Q2 FY 16/17) | LHIN Performance | Provincial Performance |
|---|---|---|
| | 7.00 Days | 14.00 Days |




Note: Q3 15/16 and Q1 16/17 data are not reported due to data quality issues.

### Wait times from application to eligibility determination for long-term care home (LTCH) placement: From acute-care setting

| Summary (Q2 FY 16/17) | LHIN Performance | Provincial Performance |
|---|---|---|
| | 3.00 Days | 8.00 Days |




Note: Q3 15/16 and Q1 16/17 data are not reported due to data quality issues.

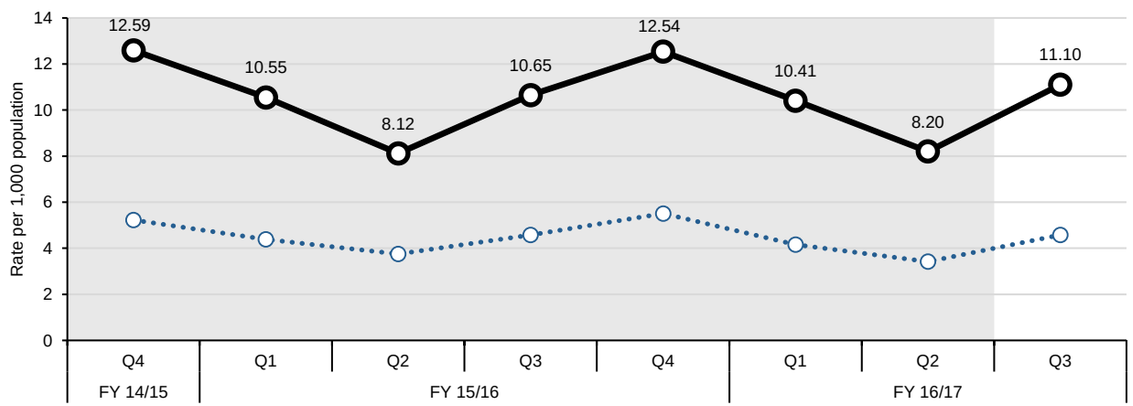
# South West LHIN

## MONITORING INDICATORS: SYSTEM INTEGRATION AND ACCESS

OBJECTIVES: 1. Provide care in the most appropriate setting 2. Improve coordinated care 3. Reduce wait times (specialists, surgeries)

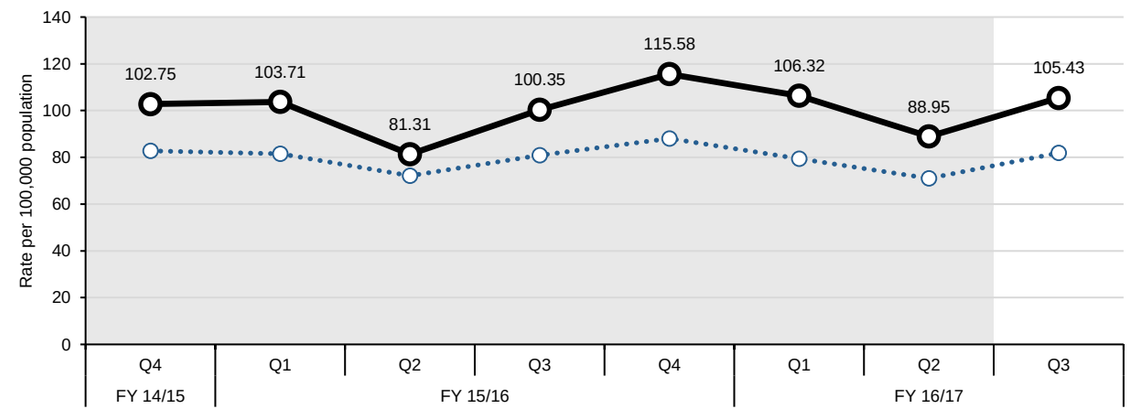
### Rate of emergency visits for conditions best managed elsewhere

| Summary (Q3 FY 16/17) | LHIN Performance | Provincial Performance |
|---|---|---|
| | 11.10 | 4.58 |



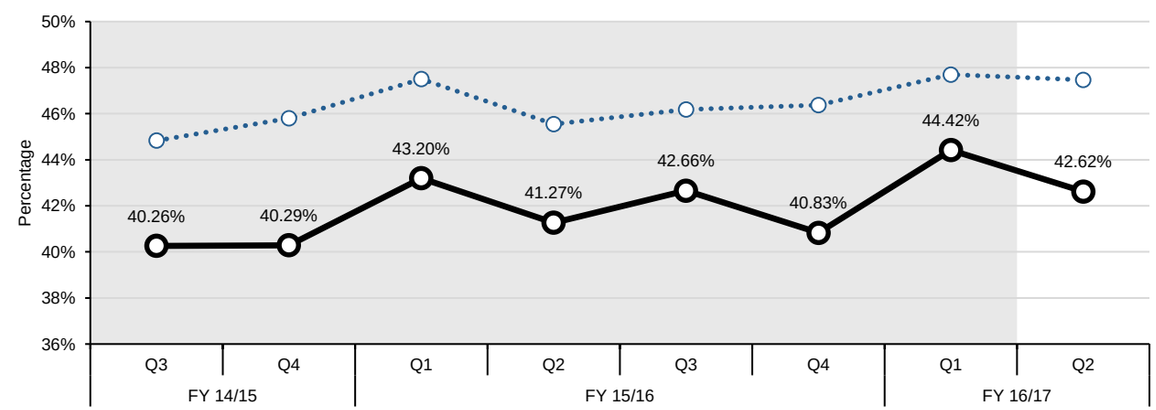

### Hospitalization rate for ambulatory care sensitive conditions

| Summary (Q3 FY 16/17) | LHIN Performance | Provincial Performance |
|---|---|---|
| | 105.43 | 81.88 |




### Percent of acute care patients who have had a follow-up with a physician within 7 days of discharge

| Summary (Q2 FY 16/17) | LHIN Performance | Provincial Performance |
|---|---|---|
| | 42.62% | 47.46% |



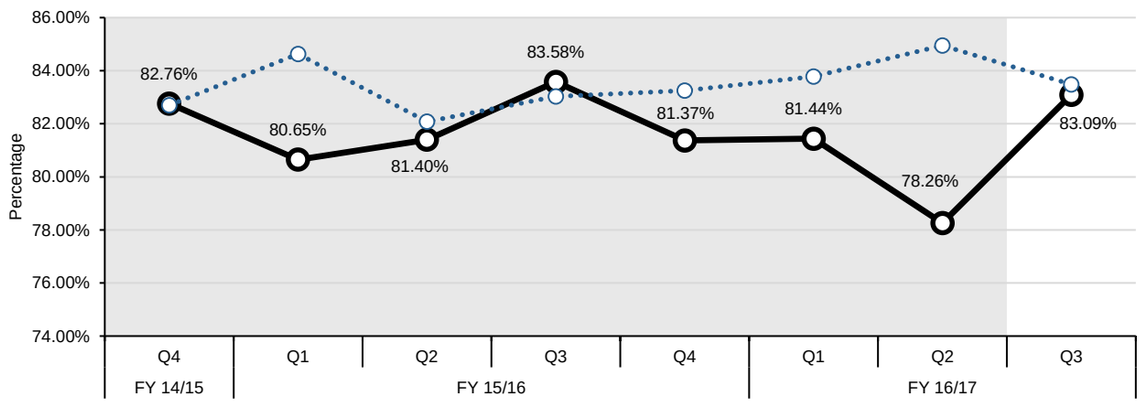
# South West LHIN

## DEVELOPMENTAL INDICATORS: HOME AND COMMUNITY CARE

OBJECTIVES: 1. Reduce wait time for home care (improve access) 2. More days at home (including end of life care)

### Percent of palliative care patients discharged from hospital with home support

| Summary (Q3 FY 16/17) | LHIN Performance | Provincial Performance |
|---|---|---|
| | 83.09% | 83.48% |



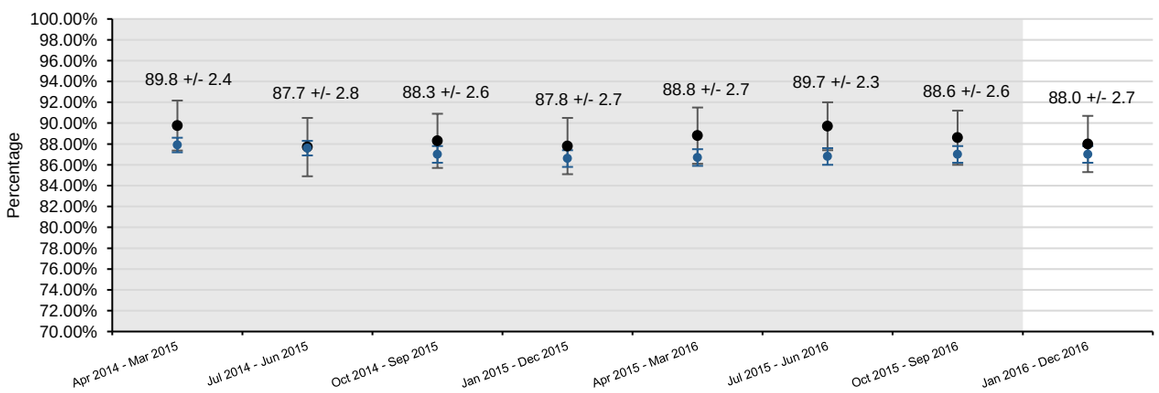

This indicator relies on the DAD data only; linking to other data sources such as the Home Care Database may more accurately capture all supports that are provided to patients after discharge from hospital.

## DEVELOPMENTAL INDICATORS: SUSTAINABILITY AND QUALITY

OBJECTIVES: 1. Improve patient satisfaction 2. Reduce unnecessary readmissions

### Overall satisfaction with health care in the community

| Summary (Jan 2016 - Dec 2016) | LHIN Performance | Provincial Performance |
|---|---|---|
| | 88.0% +/- 2.7% | 87.0% +/- 0.8% |



Ontario

# PROVINCIAL

## SUMMARY OF PERFORMANCE INDICATORS

| LEGEND | | |
|---|---|---|
| Achieved Provincial Target | Within 10% of Provincial Target | >10% From Provincial Target |

| PERFORMANCE INDICATORS | Reporting Quarter | PROV. TARGET | PROV. | LHIN | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | ESC | SW | WW | HNHB | CW | MH | TC | C | CE | SE | CHMP | NSM | NE | NW |
| **HOME AND COMMUNITY CARE** | | | | | | | | | | | | | | | | | |
| Percentage of home care clients with complex needs who received their personal support visit within 5 days of the date that they were authorized for personal support services | Q3 16/17 | 95.00% | 82.10% | 90.99% | 85.16% | 83.72% | 89.02% | 86.21% | 87.20% | 86.05% | 87.21% | 85.50% | 87.41% | 29.68% | 86.45% | 80.75% | 61.90% |
| Percentage of home care clients who received their nursing visit within 5 days of the date they were authorized for nursing services | Q3 16/17 | 95.00% | 93.83% | 96.08% | 91.77% | 94.02% | 94.66% | 93.78% | 94.99% | 93.86% | 95.32% | 93.27% | 93.15% | 93.03% | 92.09% | 93.72% | 91.48% |
| 90th percentile wait time from community for home care services: application from community setting to first home care service (excluding case management) | Q3 16/17 | 21.00 Days | 29.00 | 24.00 | 21.00 | 13.00 | 27.00 | 23.00 | 37.00 | 24.00 | 27.00 | 56.00 | 21.00 | 31.00 | 51.00 | 43.00 | 31.00 |
| 90th percentile wait time from hospital discharge to service initiation for home and community care | Q3 16/17 | TBD | 7.00 | 5.00 | 8.00 | 5.00 | 6.00 | 8.00 | 13.00 | 7.00 | 5.00 | 8.00 | 7.00 | 7.00 | 7.00 | 6.00 | 5.00 |
| **SYSTEM INTEGRATION AND ACCESS** | | | | | | | | | | | | | | | | | |
| 90th percentile emergency department (ED) length of stay for complex patients | Q4 16/17 | 8.00 Hours | 11.03 | 9.97 | 7.98 | 8.35 | 16.83 | 11.48 | 11.75 | 13.35 | 10.83 | 10.82 | 9.70 | 12.25 | 9.30 | 9.05 | 10.32 |
| 90th percentile ED length of stay for minor/uncomplicated patients | Q4 16/17 | 4.00 Hours | 4.23 | 4.30 | 3.72 | 4.67 | 4.68 | 3.70 | 3.75 | 4.67 | 3.48 | 4.17 | 4.38 | 4.87 | 4.25 | 4.20 | 4.27 |
| Percent of priority 2, 3 and 4 cases completed within access target for hip replacement | Q4 16/17 | 90.00% | 77.89% | 91.13% | 40.88% | 39.00% | 69.19% | 75.96% | 62.61% | 93.65% | 98.54% | 90.15% | 75.00% | 93.09% | 76.43% | 84.74% | 75.64% |
| Percent of priority 2, 3 and 4 cases completed within access target for knee replacement | Q4 16/17 | 90.00% | 74.50% | 69.73% | 45.58% | 38.93% | 60.86% | 62.12% | 45.77% | 92.45% | 96.32% | 88.73% | 81.30% | 88.68% | 83.55% | 80.62% | 82.39% |
| Percentage of alternate level of care (ALC) days | Q3 16/17 | 9.46% | 15.85% | 16.50% | 10.67% | 12.36% | 16.57% | 6.67% | 17.62% | 12.21% | 16.88% | 17.89% | 15.92% | 13.99% | 16.14% | 26.50% | 31.12% |
| ALC rate | Q4 16/17 | 12.70% | 15.27% | 15.06% | 10.25% | 9.85% | 14.69% | 7.46% | 14.29% | 11.53% | 15.98% | 26.27% | 17.05% | 14.17% | 13.95% | 22.95% | 30.86% |
| **HEALTH AND WELLNESS OF ONTARIANS - MENTAL HEALTH** | | | | | | | | | | | | | | | | | |
| Repeat unscheduled emergency visits within 30 days for mental health conditions | Q3 16/17 | 16.30% | 20.39% | 18.95% | 18.61% | 18.58% | 20.27% | 24.37% | 15.42% | 27.78% | 18.58% | 20.52% | 19.28% | 18.35% | 16.30% | 18.09% | 21.05% |
| Repeat unscheduled emergency visits within 30 days for substance abuse conditions | Q3 16/17 | 22.40% | 31.15% | 28.84% | 23.16% | 22.60% | 28.48% | 36.27% | 25.57% | 42.43% | 21.60% | 27.75% | 21.63% | 25.36% | 22.39% | 29.74% | 40.60% |
| **SUSTAINABILITY AND QUALITY** | | | | | | | | | | | | | | | | | |
| Readmissions within 30 days for selected HIG conditions | Q2 16/17 | 15.50% | 16.66% | 16.36% | 17.56% | 15.76% | 16.64% | 14.92% | 15.48% | 17.57% | 15.91% | 16.90% | 18.02% | 16.83% | 15.83% | 16.69% | 17.88% |

## NOTES

### *Key Changes - Effective May 2017 Stocktake Report*

1. Revised Indicator Names in the Ministry LHIN Accountability Agreement (MLAA)
    a. 90th Percentile Wait Time from community for Home-Care Services: Application from community setting to first Home Care service (excluding case management)
        *Previously: 90th percentile wait time from community for community care access centres (CCAC) in-home services: application from community setting to first CCAC service (excluding case management)*
    b. Wait times from Application to Eligibility Determination for Long-Term Care Home Placement: From community setting, and from acute-care setting
        *Previously: CCAC wait times from application to eligibility determination for long-term care home (LTCH) placement: From community setting, and from acute-care setting*
2. Revised Indicator and Indicator Category in the MLAA
    a. The MRI and CT wait time indicators have been moved from performance to monitoring category and the indicators no longer include Priority 4 cases (Priority 2 and 3 only).
3. Removed Indicators from the MLAA
    a. The Cardiac and Cancer wait time indicators
4. New Indicators Added to the MLAA
    a. 90th Percentile Wait time from Hospital Discharge to Service Initiation for Home and Community Care has been added as a new Home and Community Care performance indicator. The target is TBD.

### Indicator Specific Notes

**All Indicators**

Historical data is not refreshed (unless otherwise specified in the below notes), so the current report does not include any resubmissions for previously reported data in the Quarterly Stocktake reports.

**Repeat unscheduled emergency visits within 30 days for mental health conditions**

1. Beginning August 2013, the time period for reporting of the indicator changed to include visits occurring within the first 60 days of the reported quarter plus the last 30 days of the previous quarter.

**Repeat unscheduled emergency visits within 30 days for substance abuse conditions**

1. Beginning August 2013, the time period for reporting of the indicator changed to include visits occurring within the first 60 days of the reported quarter plus the last 30 days of the previous quarter.

**Overall satisfaction with health care in the community**

1. As these results are based on survey data, lower confidence intervals (LCIs) and upper confidence intervals (UCIs) have been provided. Sometimes referred to as margin of error, these provide the probability that an estimate falls with a stated range (an interval). A 95 percent CI indicates that the 'true' value falls between the upper and lower limits of the stated range 19 times out of 20.

**Percent of palliative care patients discharged from hospital with home support**

1. This indicator relies on the DAD data only; linking to other data sources such as the Home Care Database may more accurately capture all supports that are provided to patients after discharge from hospital.

**Readmissions within 30 days for selected Health Based Allocation Model (HBAM) Inpatient Group (HIG) conditions**

1. This indicator is based on the 2015 case mix and will differ from results previously provided. For historical trends, please refer to results in the MLAA supplementary file and not to earlier versions of the supplementary or MLAA files.
2. Beginning Q3 FY 2015/16, an updated reference readmission ratio was calculated to adjust for the most recent 4 years incl. FY 2011/12-FY 2014/15; previous quarters were based on FY 2010/11-FY 2013/14.

**ALC Rate**

1. Please note that Sunnybrook Health Sciences Centre and St. John's Rehab have amalgamated in 2012. For ALC rate, this information is reflected in FY16/17 Q1 onwards with both sites being reported under Toronto Central LHIN. Previous quarters will contain St. John's Rehab information within Central LHIN.

## NOTES

### Indicator Specific Notes

**Wait times from application to eligibility determination for long-term care home (LTCH) placement: From community setting, and from acute-care setting**

1. Please note that Q3 2015/16 data will not be included in this quarterly release of Stocktake due to data quality issues in the CPRO dataset.

2. Please note that Toronto Central LHIN Q4 2015/16 data will not be reported in this quarterly release of Stocktake due to data quality issues in the CPRO dataset.

3. Please note that Q1 2016/17 data will not be reported in this quarterly release of Stocktake. In November 2016 a data quality issue was identified in the Client Profile monthly data submission received from the Ontario Association of Community Care Access Centres (OACCAC). The issue is related to the priority category assignment resulting in the Waitlist, Wait-times, Placements etc. being incorrectly reported.