Central East **LHIN**

Central East LHIN Strategic Aims

2013-2016 Vascular Health Strategic Aim Update

June 24, 2015

Ontario
Local Health Integration Network

Agenda

- Overview of Central East LHIN Strategic Aim
- Aim Metrics Update
- Initiatives/Achievements
  - Regional Cardiovascular Rehabilitation and Secondary Prevention (CRSP)
  - Diabetes Education Programs (DEPs)
  - Stroke Report Card
- Risks and Mitigation Strategies
- Next Steps

Overview

Vascular Health Strategic Aim

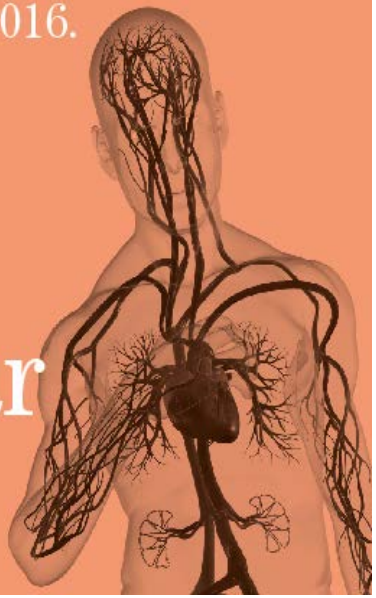
Overview : 2013-2016 Central East LHIN Integrated Health Service Plan

Community

FIRST

Help Central East LHIN residents spend more time in their homes and their communities.

Continue to improve the vascular health of residents so they spend 25,000 more days at home in their communities by 2016.



Vascular Health

Patient Story –Centre for Complex Diabetes Centre(CCDC)

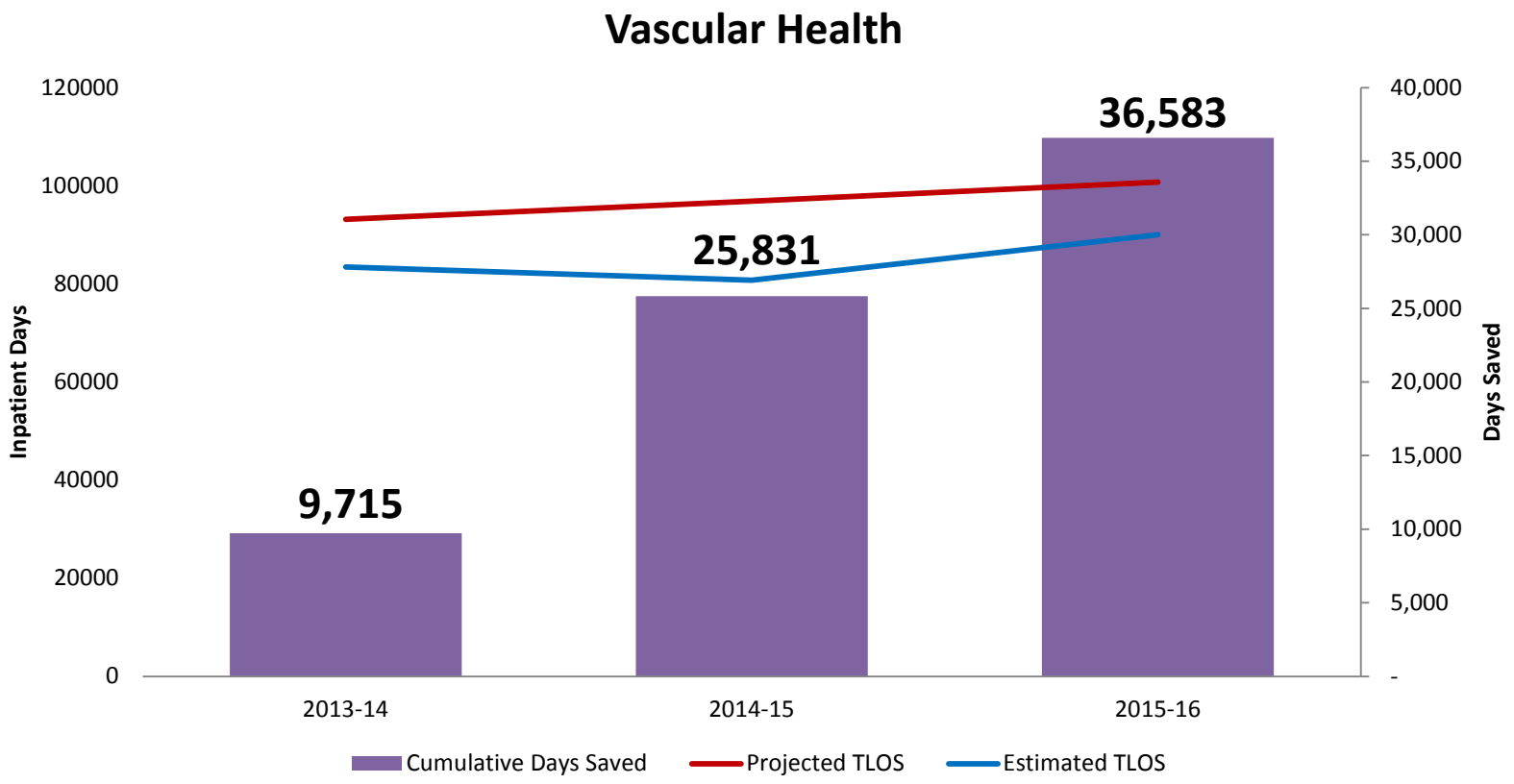
Ms. T was referred to Centralized Diabetes Intake (CDI) by The Scarborough Hospital's (TSH) Heart Function Clinic. Ms. T is single woman in her 40s with a teenaged son and has no other family. She immigrated to Canada from Asia 10 years ago and had been working in Canada running a food service business. She was diagnosed with type 2 diabetes 17 years ago. In addition, she also has hypertension, chronic kidney disease, hyperlipidemia, and congestive heart failure. The Central East Community Care Access Centre (CECCAC) CDI Care Coordinator completed a telephone assessment and deemed that the referral was appropriate for the CCDC. The referral package was forwarded to the CCDC at the TSH site. The patient presented at the TSH Centre for Complex Diabetes Centre (CCDC) as hypotensive with chest pain at her first CCDC visit and was quickly taken to the Emergency Department by the Nurse Practitioner . When she returned to the clinic for a follow up appointment other issues were revealed: Ms. T had been on a dangerously low calorie diet, and had not been taking her medication regularly due to concerns about cost. Ms. T had to shut her business down following a heart attack a year ago. Her savings were nearly depleted and she was faced with selling her home at a huge financial loss.

The CCDC pharmacist was able to supply Ms. T with sample medication on a temporary basis. The Registered Dietitian worked with Ms. T to make healthier diet choices and provided counseling regarding hypoglycemia awareness. The Social Worker provided crisis counseling, emotional support and assistance with advocating to receive financial assistance through the Ontario Disability Support Program. Ms. T is now no longer at risk of losing her home, and has coverage for her medication which she has started taking regularly. Her A1C and BMI have also reduced by one point since her initial visit to CCDC 5 months ago. Although her A1C is not yet within target range, Ms. T is encouraged to see progress and credits the CCDC team with helping her to move from a point of crisis to stability. She looks forward to continuing to work with the team to continue moving forward with her health goals. Ms. T asked to share her story. She stated that she found the "one stop shopping" approach from the full inter-professional team, helpful in managing her care.

Aim Metrics Update

Vascular Health Strategic Aim

Aim Metrics Update



Target = 25,000 days

Supporting Indicators – Definitions

Terms	Definition
Baseline	Where there is sufficient data, the baseline is the average of the two most recent fiscal years.
Central East LHIN Target	The formal Central East LHIN target for that indicator (typically developed for use in existing scorecards, such as the MLPA). This formal target is indicated by **bold formatting**. Where there is no formal target, the baseline less 10% is used as an informal Central East LHIN Target.
Current Performance	The Central East LHIN performance for the indicator using the most current data available.
Current Status	The current performance is compared with the CE LHIN target and the result is summarized by a colored dot following the parameters below: • A red dot indicates that the current performance deviates from the desired target by more than 10%. • A yellow dot indicates that the current performance is within 10% of the target • A green dot indicates that the current performance meets the target or is performing better than the desired target
Direction	The direction of the data uses all the data from the baseline and any additional data, up to and including the most current data available.
↘ ➡ ↗	A gray arrow indicates that there are at least 7 data points available to calculate the direction of the data.
↘ ⇨ ↗	A white arrow indicates that there are fewer than 7 data points available. The direction of data should be interpreted with caution.

Aim Metrics Update

Indicator	Baseline	CE LHIN Target	Current Performance	Current Status	Direction
30-Day Readmission for select CMG (Cardiovascular) (Goal: decrease)[1,4]	14.3%	*13.3%*	15.3%		
30-Day Readmission for select CMG (CHF) (Goal: decrease)[1,4]	23.0%	*18.3%*	23.2%		
30-Day Readmission for select CMG (COPD) (Goal: decrease)[1,4]	18.2%	*17.1%*	19.0%		
30-Day Readmission for select CMG (Diabetes) (Goal: decrease)[1,4]	13.2%	*7.7%*	10.2%		
Percentage ALC days (stroke) (Goal: decrease)[2]	23.7%	21.4%	19.0%		
Proportion of acute stroke (excluding TIA) patients discharged from acute care and admitted to inpatient rehabilitation (Goal: increase)[3]	36.2%	39.8%	38.1%		
Proportion of stroke/TIA patients treated on a stroke unit any time during their inpatient stay (Goal: increase)[3]	31.9%	35.0%	37.1%		

Note:
1 Most recent available data: 14/15 Q2
2 Most recent available data: 14/15 Q3
3 Most recent available data: Fiscal Year 13/14
4 Italicized font indicates a MOHLTC calculated target.

Summary

- The positive achievements of the Vascular Aim are a reflection of the continued improvement in the acute Length of Stay (LOS) for cardiovascular CMGs.
- The targets for the re-admission rates are not being achieved despite the overall accomplishment of the Vascular Aim.
- There is an opportunity for programs supporting vascular clients across the continuum of care to continue to work on transitions between the hospital, primary care and other community providers to minimize re-admissions.

Initiatives and Achievements

Vascular Health Strategic Aim

Regional Cardiovascular Rehabilitation and Secondary Prevention (CRSP)

Vascular Health Strategic Aim

Regional Cardiovascular Rehabilitation and Secondary Prevention (CRSP)

Strategic Context:

- CRSP provides a regional integrated service utilizing harmonized referral criteria, centralized referral, acceptance and booking for patients with established vascular disease (including those with diabetes, chronic renal disease, stroke, cardiac disease, congestive heart failure and peripheral vascular disease) who are at high risk for cardiovascular complications.

Description:

- CRSP is an evidence based strategy that has shown reduced morbidity and mortality related to cardiovascular disease.
- CRSP is a multi- factorial, integrated secondary prevention strategy approach for all vascular patients, including coronary artery disease, congestive heart failure, peripheral vascular disease, non-disabling stroke and high risk persons with diabetes

Expansion of the CRSP

Investment was awarded in December 2014 to continue to expand services and improve access in the Central East LHIN:

- Close the gap between current service level and estimated regional need of 5000 participants annually
- Establish new community based CRSP services into areas where travel time now exceeds 30 minutes
  - Cobourg: YMCA
  - Pickering: Pickering Soccer Club
  - Peterborough: Sports and Wellness Centre
  - Campbellford: Hastings Fieldhouse
  - Seaton 2016 to be determined
- Enhance support for CHF patients within CRSP
- Enhance linkages through integration within care pathways, order sets and communication to:
  - Primary care
  - Patients with vascular disease discharged from hospital
  - Care systems in Central East LHIN (i.e. CHF, Diabetes, Renal, Stroke, Vascular)

CRSP Sites

10 CRSP Existing Community Sites

- RVHS Centenary
- Pickering Soccer Club
- Ajax Community Centre
- Whitby Abilities Centre
- Oshawa Civic Complex
- Oshawa Legends Centre
- Bowmanville Indoor Soccer Facility
- Port Perry -Scugog Community Recreation Centre
- Lindsay Ross Memorial Hospital
- Cobourg YMCA

New Community Sites to be established:

- Campbellford Hastings Fieldhouse
- Peterborough Sports and Wellness Centre
- Seaton (to be determined)

Expansion of the CRSP (Continued)

Grand opening celebration- February 2015

The site at Rouge Valley Health System Centenary hospital was renovated and upgraded with new facility space, equipment and technology.

The event celebrated:

- 3 new catheterization labs- 2 renovated labs with new equipment, and 1 all-new lab;
- A new designated procedure room for pacemaker implants;
- An expanded cardiac short stay unit for preparation and recovery of patients;
- A new media room for videoconferencing and telemedicine; and
- A renovated main hallway and entrance to the cardiac centre

Applied Health Research Question (AHRQ)

The research question was approved by ICES

Proposed AHRQ Question

How can Ontario's health system better understand the impact of patients enrolled in the Central East LHINs Regional Cardiovascular Rehabilitation and Secondary Prevention Services on the following metrics:

- Emergency Department (ED) visits
- Cardiac related hospital admissions
- Cardiac related re-admissions rates of enrolled patients
- Non-routine visits to a cardiologist/specialist
- Cost per case

Purpose: This research will help identify a current and imperative knowledge gap. It will provide data, analyses and knowledge translation to help build a strong evidence-based foundation to inform and guide planning, policy and program development

Improving and Driving Excellence Across Sectors (IDEAS) Project

9 day Applied Learning Project- October 2014- April 2015

Goal: To increase access to diabetes and cardiac rehab services by harmonizing Centralized Diabetes Intake and Cardiac Rehabilitation Secondary Prevention programs' centralized processes.

Aims: By March 31st 2015:

- 50% of CDI patients who meet the criteria for CRSP program accept a referral to CRSP
- 30% of patients attending CRSP who have Diabetes and are not actively attending a DEP accept a referral to CDI

Results : Over the program duration (6 months) showed achievements of 50% increase in Cardiac Rehab patients accessing Centralized Diabetes Intake and 30% Centralized Diabetes Intake patients accessing Cardiac Rehab.

Diabetes Education Programs (DEPs)

Vascular Health Strategic Aim

Diabetes Service Coordination and Quality Improvement

- Each cluster of the LHIN established a Diabetes Network Committee
- Northeast and Scarborough cluster received funding to develop educational resources to be shared across the LHIN
- Ongoing increase in access to care and referrals through Centralized Diabetes Intake Referral program – Exceeded Targets
- Quarterly analysis for Diabetes Education Program (DEP) performance:
  - Wait times
  - No show rates
  - Supply and demand
- Preliminary analysis of data and reports showed :
  - Overall wait times for DEPs have decreased
  - Increased physician engagement
  - Increased community outreach and collaboration on initiatives

Teleopthalmology

Purpose: To engage individuals with Diabetes who live in the Scarborough region of Central East LHIN for the purpose of preventing complications and vision loss.

- Carefirst Seniors and Community Services Association received funding for a 2-year pilot project

Progress to date on initiative:

- Recruited staffing for the program (Nurse and Team assistant)
- Organized the camera for screening days.
- Ongoing outreach activities including production of program flyer, visiting family physicians, endocrinologists, and local family health teams
- Screening program to begin in June 2015

Stroke Report Card

Vascular Health Strategic Aim

Stroke Report Card and Progress Report

LHIN Stroke Report Card:

- Produced by the Ontario Stroke Evaluation Program which provides comprehensive evaluation of the Ontario Stroke System.
- Intentional selection of indicators across the care continuum with system level impact
- Interpretation to support identification of gaps and opportunities for collaboration with system stakeholders to drive improvement

LHIN Progress Report:

- Introduced in 2013/14
- Reviews LHIN performance relative to its past performance
- Compares 13/14 performance to the average of the previous 3 years
- Rates performance as progressing well, progressing or not progressing

Key Messages

The 2013/14 Stroke Report Card and Stroke Progress Report show ongoing progress in Central East LHIN for key performance indicators:

- Central East LHIN was a “top performer” in three indicators measuring above provincial benchmark in the following categories: prevention of stroke, acute stroke management, stroke rehabilitation
- Improvement in 10 of 16 indicators in year over year comparison to 2012/13
- No change or decline in performance for 6 of 16 indicators compared to 2012/13
- Statistically significant improvement in 4 indicators compared to the previous three years
- Performance not progressing in 5 indicators compared to previous three-years

Overall Central East LHIN Performance

Exemplary performance in 3 indicators:

- Inpatient admission rate for stroke/transient ischemic attack (TIA)
- Proportion of ischemic stroke patients who receive anti-thrombolytic therapy
- Median FIM efficiency for moderate strokes

Areas for improvement:

- Proportion of stroke/TIA patients who arrive by ambulance
- Proportion of ischemic stroke/TIA patients with atrial fibrillation prescribed or recommended anticoagulation therapy on discharge from acute care
- Proportion of ALC days to total length of stay in acute care
- Proportion of stroke/TIA patients discharged from acute care to LTC/CCC (excluding patients originating from LTC/CCC)

Risks and Mitigation Strategies

Vascular Health Strategic Aim

Risks and Mitigation Strategies - Vascular

Risk	Response/Mitigation
Identifying Key Priorities for Regional Improvements/Initiatives	• Vascular Coalition members collectively identify priorities and planning • Revised structure to ensure action/decision making items provide recommendations to the LHIN (i.e. approval of H-SIPs) • Identifying the gaps for Cardiac Rehabilitation and Secondary Prevention to service the region

Risks and Mitigation Strategies - Diabetes

Risk	Response/Mitigation
• DEP and CCDC unable to meet targets	• Targeted QI plans – Ongoing analysis to ensure standardized process optimizes use of DEPs
• Large variances within DEPs caseloads, capacity and resources	• Ongoing data analysis, identifies redundancies and opportunities for efficiencies and/or reinvestment into the community • Cluster specific to Diabetes Networks created to collaborate on cluster-based strategic improvements to access to care • Optimizing use of Centralized Diabetes Intake

Next Steps

Vascular Health Strategic Aim

Next Steps

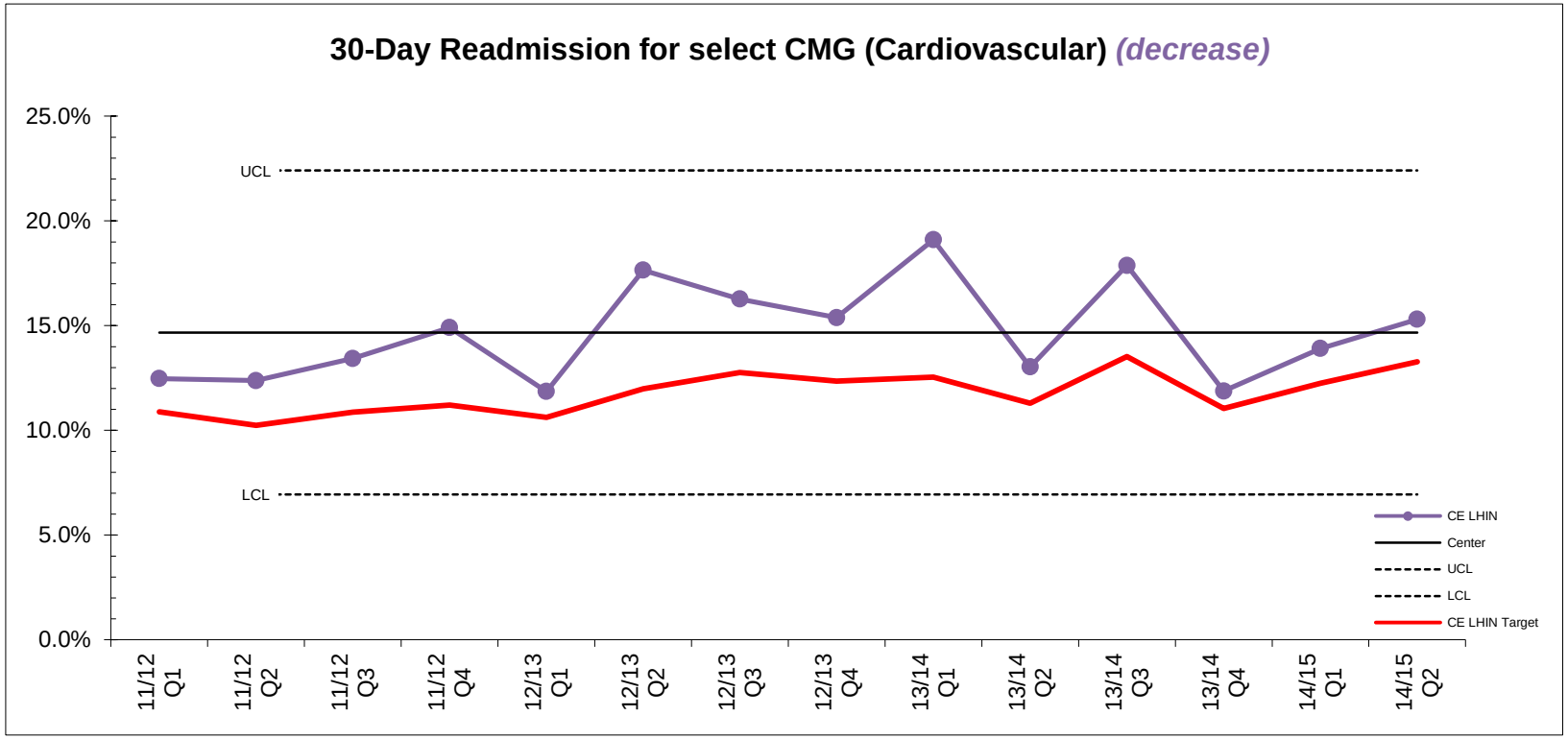
- To build on integrating the vascular network along the continuum of care through ongoing;
  - Accountability
  - Performance
  - Standardization
- To integrate specialized programs i.e. Health Links, French Language Services, First Nations, Metis and Aboriginal with diabetes and/or vascular programs
- Development of Vascular Aim and Improvement Priorities for IHSP 2016-2019
- Development of standardized diabetes patient experience survey for each cluster
- Align the Vision Care Strategy with diabetes care to improve screening
- Establishment of Vascular Surgical Services Steering Committee

Questions?

Vascular Health Strategic Aim

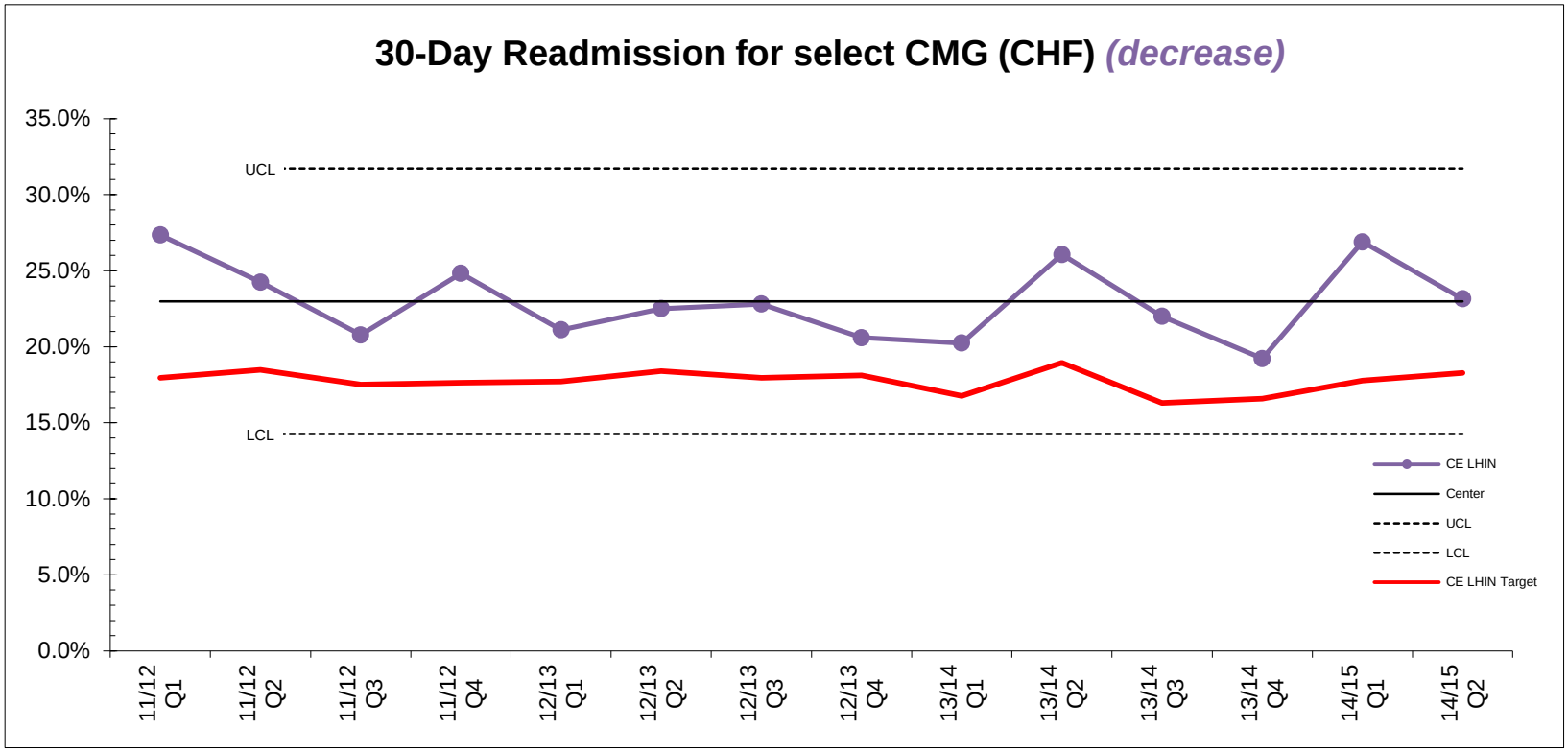
Appendix

Vascular Health Strategic Aim



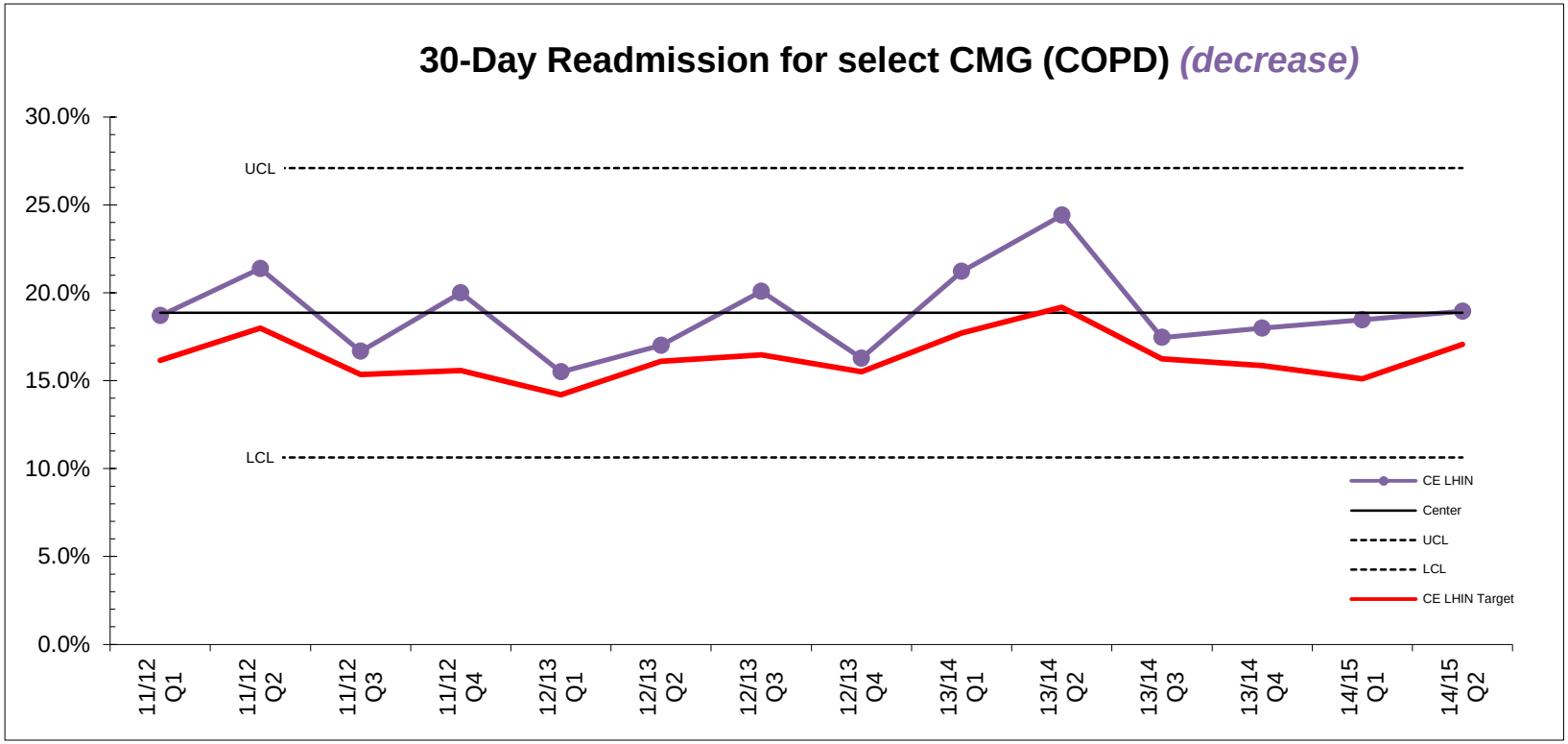
Analysis: Central East LHIN 30-day readmission for cardiovascular in Q2 14/15 were close to the 3- year average but remain higher than the target of 13.3 %. Review of the investments from the Central East LHIN within the Cardiovascular Rehabilitation and Secondary Prevention Services (CRSP) is underway to support the community based services. CRSP services is an evidence based strategy which supports the reduction/prevention of hospital readmissions however there is a request to reduce the needs gap.

Data Source: DAD, CIHI from MLPA Supplementary Data provided by MOHLTC



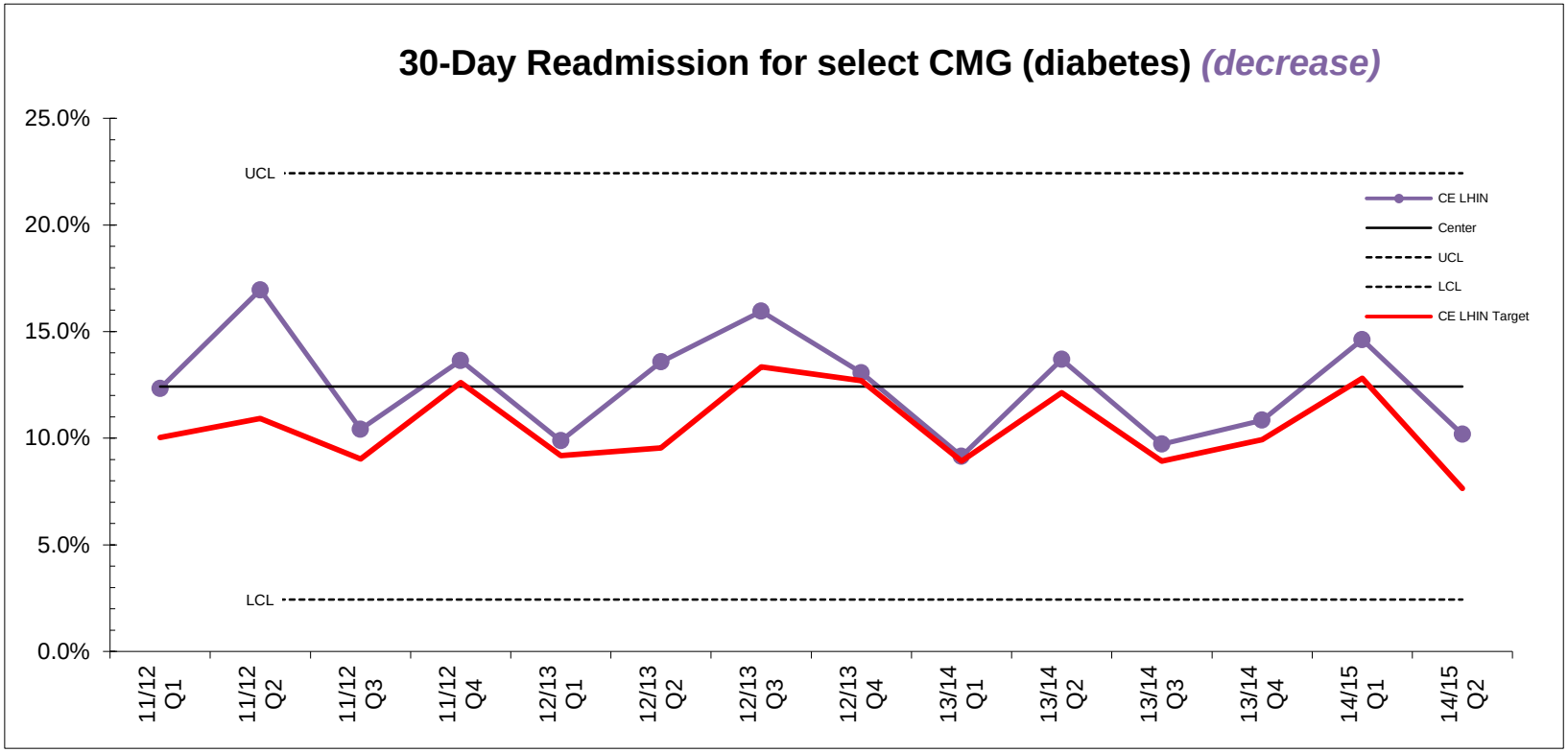
Analysis: While there has been some fluctuation in Central East LHIN Readmission rate for CHF in the last 4 quarters, the variation is within the upper and lower control limits. There has been increased awareness of other HF clinics in community and linkages with other Chronic Disease Management Groups. RMH created a Collaborative between Heart Function clinic and DEP, Mental Health and Metabolic Syndrome clinics and other Chronic Disease Management clinics.

Data Source: DAD, CIHI from MLPA Supplementary Data provided by MOHLTC



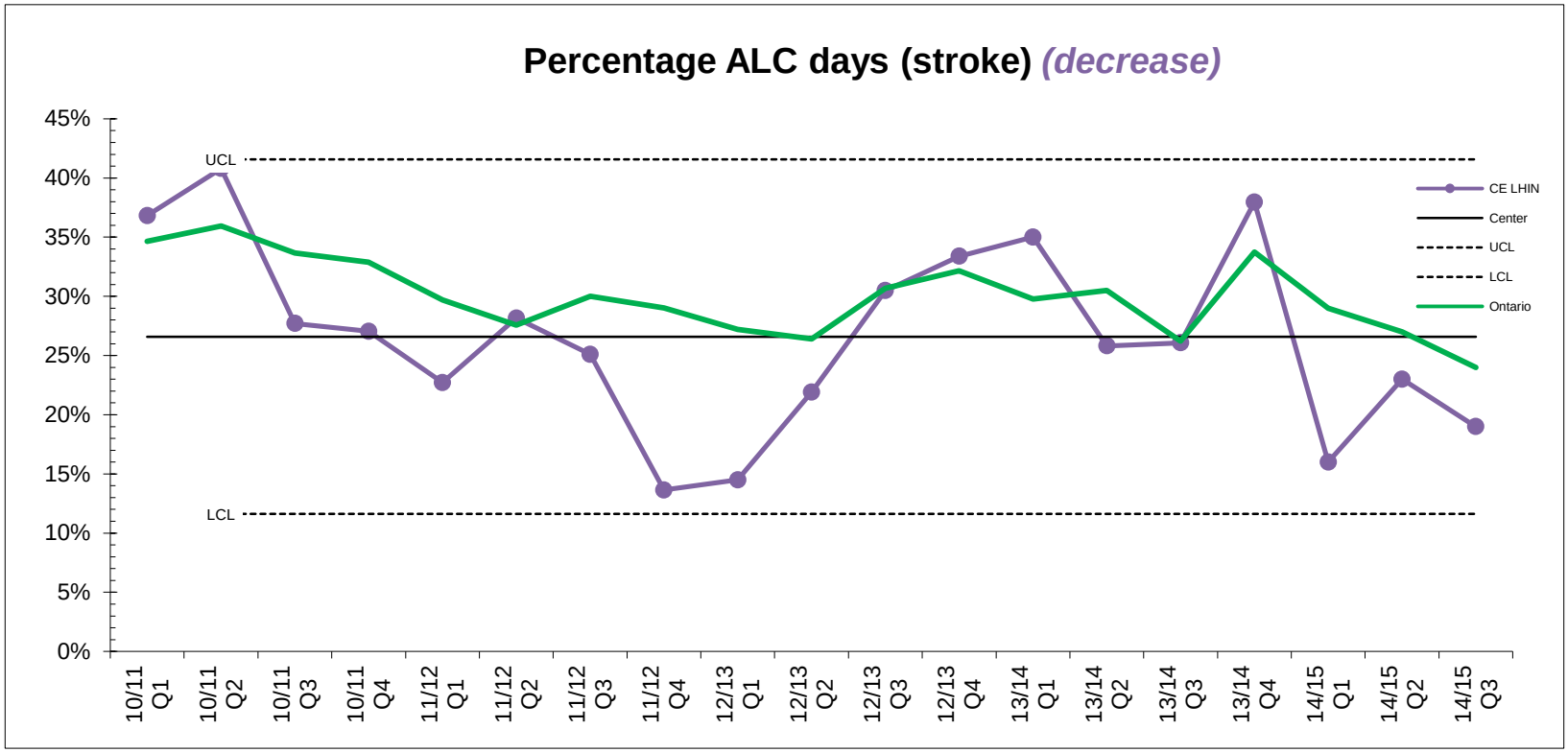
Analysis: The Central East LHIN 30-day readmission for COPD has increased slightly in the last 4 quarters from 17.5% in Q3 FY 13/14 to 19.0% in Q2 FY 14/15. There are three COPD/Respiratory clinics within the Central East Region that manage the referrals from hospital to community.

Data Source: DAD, CIHI from MLPA Supplementary Data provided by MOHLTC



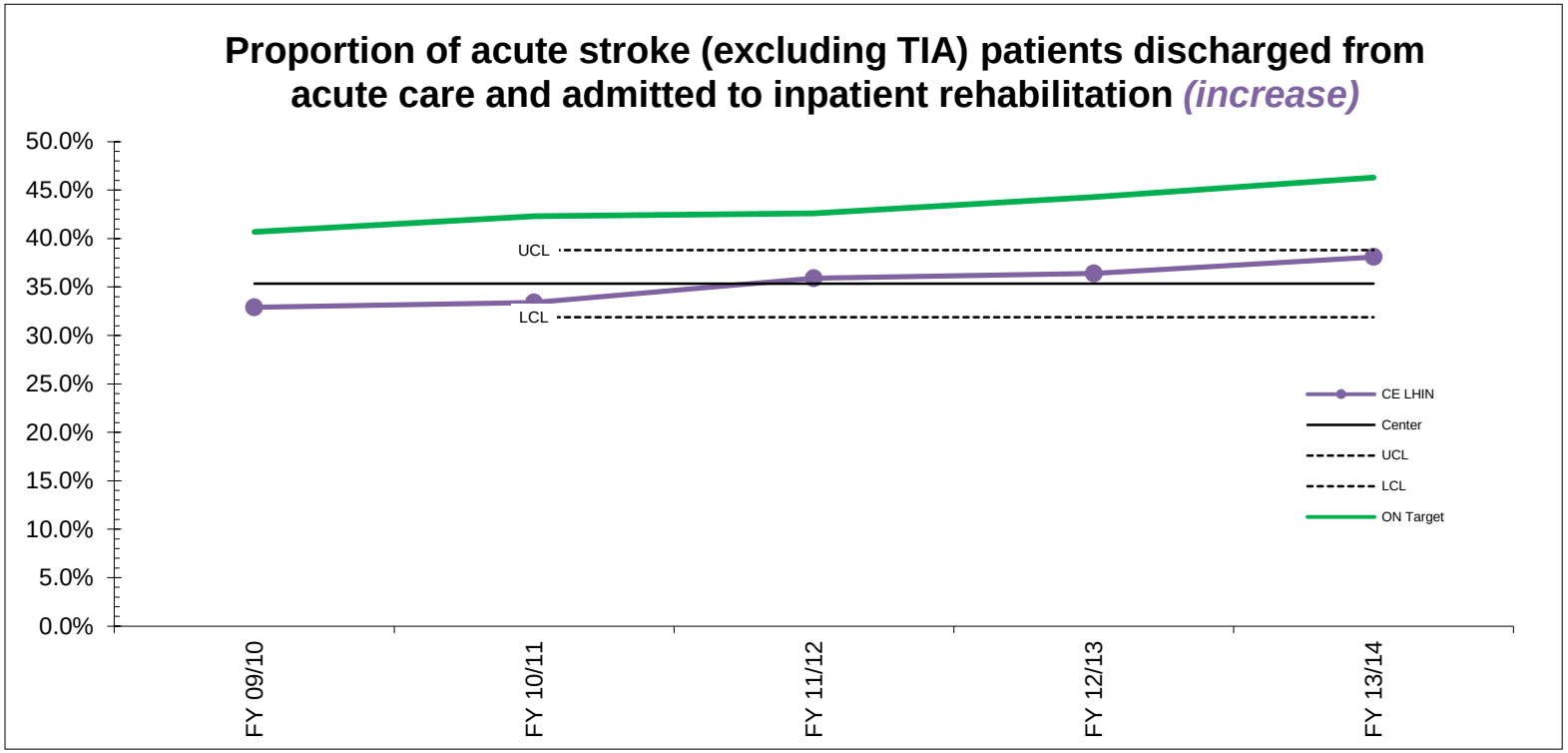
Analysis: The Central East LHIN Readmission rate for Diabetes is experiencing fluctuations similar to historical variation with a median of 12.5%. Centres for Complex Diabetes Care opened at three separate sites across the LHIN to provide intensive support for patients with complex presentations and diabetes. Access to Centralized Diabetes Intake also provides support directly to the patient.

Data Source: DAD, CIHI from MLPA Supplementary Data provided by MOHLTC



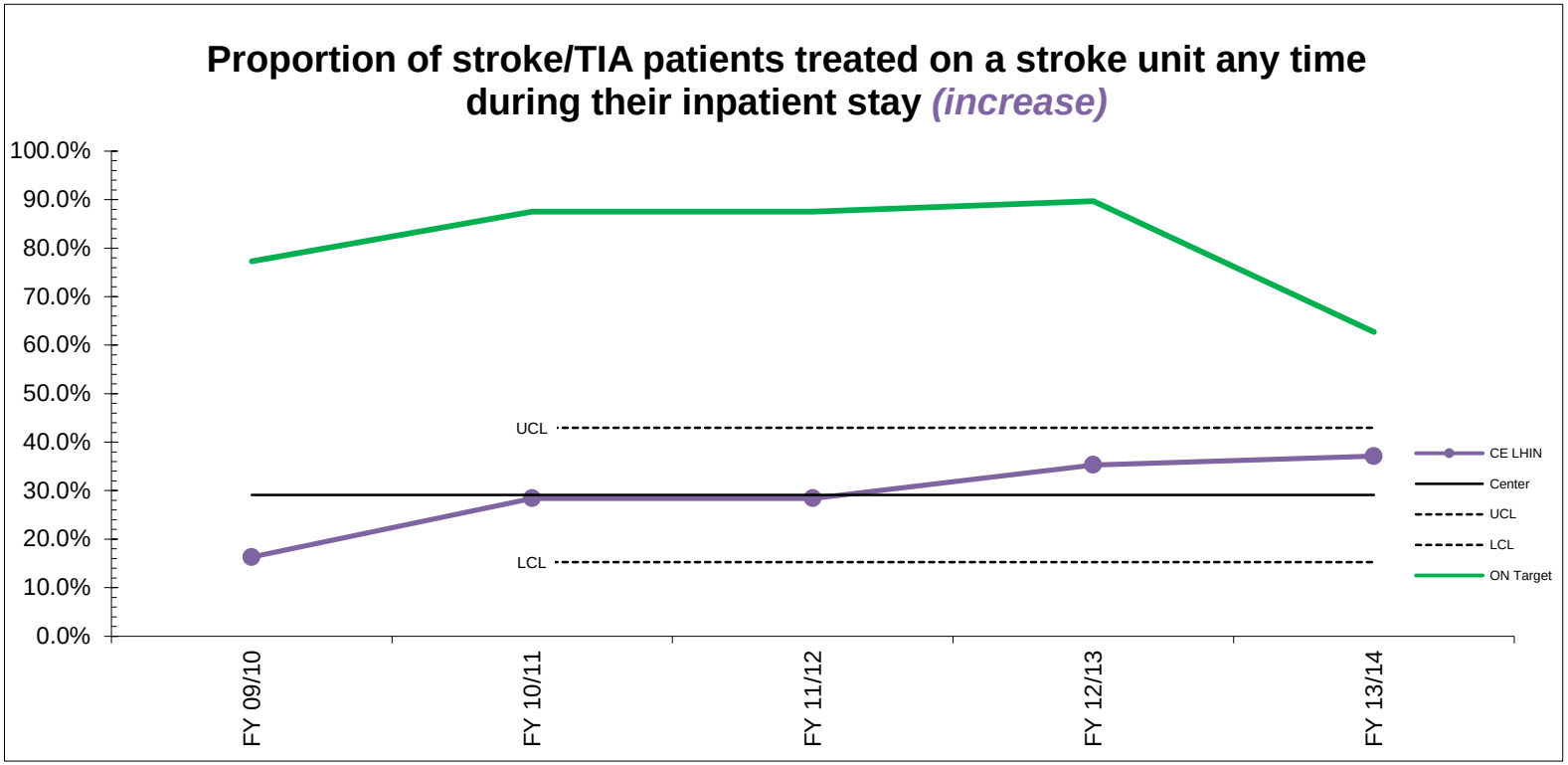
Analysis: Between Q4 FY 13/14 and Q1 FY 14/15, there was a decrease of 22% for ALC days (stroke patients) from 38.0% to 16.0% respectively. In Q2 and Q3 FY 14/15, there was an increase to 23.0% and then a slight decrease to 19.0%.

Data Source: DAD, CIHI from IntelliHealth, MOHLTC



Analysis: Since FY 09/10 there has been a gradual increase in proportion of acute stroke (excluding TIA) patients discharged from acute care and admitted to inpatient rehabilitation, from 32.9% to 38.1% in FY 2013/14. This may be due to improved coordination of data metrics to measure performance management of facilities referring to inpatient rehabilitation

Data Source: Stroke Progress Report 2013/14 from the Canadian Stroke Network and Ontario Stroke Network



Analysis: Between FY 11/12 and FY 13/14 there has been a 8.7% increase in proportion of stroke or TIA patients treated on a stroke unit any time during their inpatient stay, from 28.4% to 37.1%. A Vascular Aim Coalition identified priority was unifying a stroke system by district stroke coordination supporting increased communication among hospitals with MOUs. This resulted in enhanced utility of stroke units, as demonstrated by this indicator.

Data Source: Stroke Progress Report 2013/14 from the Canadian Stroke Network and Ontario Stroke Network

Stroke Report Card Indicators

20 indicators comprise the report card:

- Divided into care continuum categories: Public awareness, prevention, acute management, rehab, reintegration
- Types of indicators: 12 facility-based, 8 population-based,75% process indicators, 3 HSAA indicators
- Population based indicators reflect the importance of system wide access, efficiency, effectiveness, and integration

Provincial benchmarks:

- Calculated by achievable benchmark calculation (ABC) methodology
- Enable comparison within and across LHINs
- Colour coded to indicate performance against benchmark

Provincial, LHIN, sub-LHIN and facility level data available:

- Canadian Institute for Health Information
- NACRS, DAD and CIHI special projects

Stroke Report Card

Indicator No.	Care Continuum Category	Indicator[4]	LHIN FY 2013/14 (2012/13)	Variance Within LHIN[5] (Min–Max)
1	Public awareness and patient education	Proportion of stroke/TIA patients who arrived at the ED by ambulance.	57.7% (60.0%)	55.9–60.4%
2	Prevention of stroke	Annual age- and sex-adjusted inpatient admission rate for stroke/TIA (per 1,000 population).	1.1 (1.2)	1.2–1.5
3[§]	Prevention of stroke	Risk-adjusted stroke/TIA mortality rate at 30 days (per 100 patients).	11.9 (11.9)	4.2–25.4
4	Prevention of stroke	Proportion of ischemic stroke/TIA patients with atrial fibrillation prescribed or recommended anticoagulant therapy on discharge from acute care (excluding those with contraindications).	– (70.7%[‡])	–
5	Prevention of stroke	Proportion of ischemic stroke inpatients without atrial fibrillation who received carotid imaging.	74.3% (71.0%)	22.2–88.9%
6	Acute stroke management	Median door-to-needle time among patients who received acute thrombolytic therapy (tPA) (minutes).	58.0 (63.0[‡])	52.0–110.0
7[§]	Acute stroke management	Proportion of ischemic stroke patients who received acute thrombolytic therapy (tPA).	12.6% (13.8%)	10.2–14.0%
8[§]	Acute stroke management	Proportion of stroke/TIA patients treated on a stroke unit[8] at any time during their inpatient stay.	37.1% (33.1%)	18.2–49.2%
9	Acute stroke management	Proportion of stroke (excluding TIA) patients with a documented initial dysphagia screening performed during admission to acute care.	– (63.7%[‡])	–
10[§]	Acute stroke management	Proportion of ALC days to total length of stay in acute care.	31.4% (24.8%)	4.4–54.8%
11[§]	Acute stroke management	Proportion of acute stroke (excluding TIA) patients discharged from acute care and admitted to inpatient rehabilitation.	38.1% (36.4%)	26.6–47.6%
12	Stroke rehabilitation	Proportion of stroke (excluding TIA) patients discharged from acute care who received a referral for outpatient rehabilitation.	– (6.4%[‡])	–
13[§]	Stroke rehabilitation	Median number of days between stroke (excluding TIA) onset and admission to stroke inpatient rehabilitation.	6.0 (7.0)	5.0–30.0
14	Stroke rehabilitation	Mean number of minutes per day of direct therapy that inpatient stroke rehabilitation patients received.	–	–
15[§]	Stroke rehabilitation	Proportion of inpatient stroke rehabilitation patients achieving RPG active length of stay target.	61.8% (61.7%)	51.2–75.0%
16	Stroke rehabilitation	Median FIM efficiency for moderate stroke in inpatient rehabilitation.	1.2 (1.1)	0.9–1.3
17	Stroke rehabilitation	Mean number of CCAC visits provided to stroke/TIA patients in 2012/13 and 2013/14.	5.1 (5.3)	–
18	Stroke rehabilitation	Proportion of patients admitted to inpatient rehabilitation with severe strokes (RPG = 1100 or 1110).	46.9% (41.6%)	25.0–57.4%
19[§]	Reintegration	Proportion of stroke/TIA patients discharged from acute care to LTC/CCC (excluding patients originating from LTC/CCC).	8.1% (6.5%)	5.3–12.9%
20[§]	Reintegration	Age- and sex-adjusted readmission rate at 30 days for patients with stroke/TIA for all diagnoses (per 100 patients).	7.8 (8.1)	4.1–11.3

- Poor performance
- Acceptable performance
- Exemplary performance
- Data not available or benchmark not available