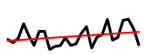
2019-2020 MLAA Quarter 1 Stocktake Scorecard - CLHIN Performance

Date Produced: November 2019; Date of Next issue: February 2020

LEGEND: Achieved Target | Within 10% of Target | >10% from Target

	Indicator Name	Provincial Target	Indicator Movement (Better is Higher or Lower)	Performance: Central LHIN Actual	Performance: Provincial Performance	Better than ON?	Rank (1 is best, 14 is worst)	Trend over time	Overall Improve since 2013/14?	Comments & CLHIN Initiatives Focused on Improving Performance
PERFORMANCE INDICATORS										
Home and Community: Reduce wait time for home care (improve access); More days at home (including end of life care)										
PSS	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 (2019Q1)	95.00%	Higher	**94.50%**	**86.20%**	✓	**3**		**YES**	Central LHIN consistently performs better than the province and is the third highest LHIN in performance on this indicator. Central LHIN has worked closely with Service Providers in clarifying wait-time policies, collaborating on root cause investigations and ensuring adequate follow up. The LHIN will continue to monitor this indicator on a weekly basis to ensure that the performance is sustained.
NURSE	Percentage of home care clients who received their nursing visit within 5 days of the date they were authorized for nursing services (2019Q1)	95.00%	Higher	**96.20%**	**95.80%**	✓	**6**		**YES**	Central LHIN has consistently met the target for thirteen straight quarters and will continue to meet the target. Central LHIN continues to monitor this indicator on a weekly basis to ensure that the performance is sustained.
CCAC_LTC	90th percentile wait time from community setting to first home care service (excluding case management) (2019Q1)	21 days	Lower	**21**	**26**	✓	**4**		**YES**	Central LHIN consistently performs better than the provincial average and has met the target in the last three quarters. The LHIN is ranked fourth in performance across all LHINs.
SERVICE	90th percentile wait time from hospital discharge to service initiation for home and community care (2019Q1)	TBD	Lower	**5**	**8**	✓	**1**		**N/A**	Performance has remained stable between 5 and 6 days over the past three years. Although there currently is no target, Central LHIN has been performing better than the provincial average and is the highest performing LHIN in the province. The LHIN continues to work with our hospitals to discharge patients to home as quickly as possible to ease congestion.
System Integration and Access: Provide care in the most appropriate setting; Improve coordinated care; Reduce wait times (specialists, surgeries)										
COM	90th percentile emergency department (ED) length of stay for complex patients (2019Q2)	8 hours	Lower	**9.80**	**10.80**	✓	**7**		**NO**	Central LHIN's 90th percentile ED length of stay for complex patients performance has steadily declined for the past three quarters and ranked 7th in the province. Central LHIN's performance is now below provincial average despite continued increase in ED volumes. 4 out of the 5 large community hospitals in Central LHIN ranked in the top ten hospitals in the province for highest ED volumes for complex patients, and three ranked in the top five hospitals in the province. The 'Time to Inpatient Bed' component of the length of stay for Admitted patients is the main contributor impacting Central LHIN's performance. The non-admitted complex patients are meeting the provincial target of 8 hours. All Central LHIN hospitals continue to implement initiatives targeted at improving patient flow and bed flow optimization (eg. Reducing Hallway Medicine). As the 'Time to Inpatient Bed' component of the length of stay for admitted patients is the main contributor to the performance on this indicator, solutions focused to improve flow and capacity include: 1. Implementation of iPlan (which assists with the early identification, engagement and management of patients) to support patient flow across several Central LHIN facilities . Central LHIN is supporting the full implementation of iPlan across all remaining hospitals and has just completed a refresh in partnership with hospitals. 2. Launch of the Reactivation Care Centers (RCC) Finch and Church sites creating capacity within the Central LHIN hospitals. 3. The LHIN continues to host bi-monthly ED working group meetings for the purpose of planning, implementing, and evaluating performance measures to improve the delivery of emergency services in the Central LHIN hospitals, as well as a forum for knowledge exchange on best practices. 4. Ongoing work with partners in the development, implementation and monitoring of new models of care to support patients within the community/home and divert from EDs.

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MINC	90th percentile ED length of stay for minor/uncomplicated patients (2019Q2)	4 hours	Lower	**4.18**	**4.93**	✓	**2**		**NO**	Although Central LHIN's performance has improved from the previous quarter and is second best in the province. Central LHIN's performance has experienced a decline over the past year and a half, a change mirrored at the provincial level. Central LHIN will continue to monitor and follow up with hospitals to address ED pressures and issues that may impact wait times. Of note, Central has a rate of 1.1 visits/1000 population aged 1-74 of emergency visits best managed elsewhere, well below the provincial rate of 3.0. Central continues to work with partners across multiple sectors to identify opportunities and support initiatives which will positively impact this indicator i.e. Central LHIN continues to with our long-term care homes and Health Quality Ontario to develop strategies to reduce the need for LTC emergency visits and share best practices amongst homes.

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HIP	Percent of priority 2, 3 and 4 cases completed within access target for hip replacement (2019Q2)	90% P2: 42 days P3: 84 days P4:182 days	Lower	**93.68%**	**80.06%**	✓	**2**		**NO**	Central LHIN continues to meet the provincial target, and is consistently one of the top performing LHINs in the province, ranking second highest performer at Q2. All Central LHIN hospitals are completing more cases than funded by QBP funding in order to address the high demand, forecasting to perform 455 cases ($4.1M) over QBP bundle funding. Capacity, however, remains limited. Patient choice of surgeon continues to contribute to timely completion of procedures (with patients opting to delay the procedure in favour of a specific site or surgeon). Central LHIN hospitals continue to implement the Centralized Intake and Assessment model of care and referral process for hip and knee replacement surgeries. As hospitals transition to the new model, Central LHIN anticipates continuing to meet the provincial target.
KNEE	Percent of priority 2, 3 and 4 cases completed within access target for knee replacement (2019Q2)			**90.05%**	**76.56%**	✓	**4**		**NO**	
PERA	Percentage of alternate level of care (ALC) days (2019Q1)	9.46%	Lower	**18.46%**	**16.70%**		**9**		**NO**	The Percentage of ALC Days in Central LHIN improved from 19.64% in Q4 FY 18/19 to 18.46% in Q1 FY 19/20. Performance on this indicator was driven by a 4% decrease in the reportable ALC Days between Q4 FY 18/19 (34,642 ALC Days) and Q1 FY 19/20 (33,232 ALC Days). Over this same time period, there was a 4.3% decrease in the volume of ALC separations (1659 separations in Q4 FY 18/19; 1588 separations in Q1 FY 19/20), indicative of fewer ALC patient discharges from hospitals. It is also important to note that the addition of the Reactivation Care Centre (RCC) sites (i.e. RCC-Finch site and RCC-Church site) increase the volume of both ALC days and ALC separations in the Central LHIN. Since 100% patients at the RCC sites are designated ALC, all discharges from these facilities result in accumulation of reportable ALC days and contribute to performance on this indicator above the provincial target. In Q1 FY 19/20, the overall Throughput Ratio for ALC was 0.97, with only 1 Central LHIN hospital achieving a Throughput Ratio above 1.0. These outcomes are, collectively, indicative of higher volumes of newly added vs. discharged ALC Cases in Central LHIN hospitals and the RCC. ALC continues to be a challenge in Central LHIN despite numerous investments and strategies. Central LHIN has the fasted pull from the hospital as demonstrated by the 90th percentile wait time from hospital discharge to service initiation for home and community care, to support flow related to ALC. Please see ALC Rate comments below regarding strategic initiatives in the Central LHIN to improve ALC performance, support patient flow and transitions to care, reduce delivery of care in unconventional bed spaces (e.g. "Hallway Medicine").***Please note that ALC Rate performance for Central LHIN does not include open ALC cases at the Reactivation Care Centres (Finch and Church sites).***
ALCF	ALC rate (2019Q2)	12.70%	Lower	**11.76%**	**16.99%**	✓	**3**		**NO**	The ALC Rate in Central LHIN increased slightly from Q1 FY 19/20 (11.12%) to Q2 FY 19/20 (11.76%). Overall LHIN performance remained below the provincial target of 12.70% for this indicator, with 4 of 6 Central LHIN hospital achieving ALC Rate performance below the Provincial Target during this reporting period. The top discharge destinations for ALC patients in Central LHIN continue to be Long-Term Care (LTC), Inpatient Rehabilitation, home with Home and Community Care services and Supervised or Assisted Living. The Central LHIN has supported the development and implementation of the following strategic initiatives to improve ALC performance, support patient flow and transitions to care, reduce delivery of care in unconventional bed spaces (e.g. "Hallway Medicine"): 1. Launch of the Reactivation Care Centres (Finch and Church sites) - Capital project involving collaboration between the Ministry, Central LHIN and neighbouring GTA LHIN and hospitals to increase acute care bed capacity by introducing more than 360 new acute care beds to the system. 2. Behavioural Support Transition Resource - provides transitional support services to hospital inpatients with cognitive and/or responsive behaviours. 3. iPlan and Discharge Planning Pathway - development and implementation of an electronic ALC dashboard (iPlan) at 5 of 6 Central LHIN hospitals. iPlan provides real-time situational awareness of patient discharge/transition status, and is supported by a standardized discharge planning pathway. 4. Transitional Care at Home - Central LHIN's Short Term Transitional Care Model program that provides restorative and personal care services to patients in their homes, and facilitates transitions from acute care. 5. Assess and Restore - includes programs implemented at 3 Central LHIN hospitals and provides support to seniors to regain and maintain functional independence, and facilitate return to home and assist patients to remain in the community for as long as possible. 6. Hospital Transitional Care Coordinator - Central LHIN Home and Community Care pilot project to develop a new in-hospital team to participate in case finding and consultation in support of early discharge planning and transitions to care for patients with complex transitional care needs. 7. North York General Hospital Transitional Care Program - 20 short-term transitional care beds within a congregate setting to deliver rehabilitative and restorative care services. 8. Southlake@Home - 16 week transitional care program that utilizes a Bundled Community approach that integrates care between hospital, community care providers, primary care and social support programs. Four Central LHIN hospitals (Mackenzie Health, Markham Stouffville Hospital , North York General Hospital, and Southlake Regional Health Centre) have received funding from the Ministry of Health under the Targeted Investments to Reduce Hallway Health Care strategy, including continuation of the North York General Hospital Transitional Care Program and Southlake@Home. The Central LHIN will continue to work with its hospital partners to support implementation/continuation of the 6 projects approved as part of this initiative.
Health and Wellness of Ontarians - Mental Health: Reduce any unnecessary health care provider visits; Improve coordination of care for mental health patients										

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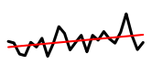
MH_E	Repeat unscheduled emergency visits within 30 days for mental health conditions (2019Q1)	16.30%	Lower	**19.28%**	**21.52%**	✓	**5**		**NO**	Repeat Unscheduled ED Visits within 30 Days for Mental Health Conditions declined slightly from FY2018/19 Q4 (19.25%) and decreased by 0.03 percentage points to 19.28% in FY2019/20 Q1. Central LHIN ranked 5th in the province and performed better than the provincial average of 21.52%. There continues to be a number of factors that contribute to the repeat visit rate, primarily: i) a small number of patients who are refractory to treatment who seek treatment in the emergency department, ii) community capacity, and iii) inpatient bed pressures. Hospitals indicate that there are a small number of patients that are refractory to treatment who seek treatment in the emergency room. For example, Mackenzie Health's two highest repeat visitors have a developmental delay and often come to the ED with various complaints, sometimes multiple times in a day. They have worked closely with community partners to put supports and plans in place to reduce the revisits to ED when not necessary. North York General Hospital (NYGH) is actively working on a post inpatient discharge virtual follow up clinic. They are also trying to increase the number of referrals to ARCS by the ED physicians. ARCS is a short term case management program that is provided in partnership between NYGH, COTA, TNSS , Bayview- Good Sheppard, and Humber. With respect to one of the top conditions presenting in the ED (schizophrenia and psychotic disorders), Central LHIN staff has spearheaded the adoption of the schizophrenia quality standard as a LHIN initiative, in partnership with HQO. With schizophrenia being one of the most complex conditions to manage, the adoption of care standards aims to improve the quality of care and help reduce frequent repeat visits to the ED. In Q1 of 2019/20, Central LHIN allocated $2,288,985 one-time and fiscal funding in 2019/20 and $2,674,000 annualized funding in 2020/21 in the community sector to enhance community mental health and addictions services. Funded initiatives include Peer Support, Early Psychosis Intervention, Priority Populations, Mental Health and Justin, and Addictions, all of which support patients in the communities and may help reduce repeat visits to the ED.
SA_E	Repeat unscheduled emergency visits within 30 days for substance abuse conditions (2019Q1)	22.40%	Lower	**24.58%**	**36.05%**	✓	**1**		**NO**	Repeat Unscheduled ED Visits within 30 Days for Substance Abuse Conditions worsened to 24.58% in Q1 from 22.29% in the prior Q4. Central LHIN performed better than the provincial average of 36.05%, and is the best performer in the province. Note that 13 out of 14 LHIN performed below 10% of the target. New initiatives that may be reducing repeat unscheduled emergency visits include the NYGH Rapid Access Addiction Medicine (RAAM) clinic that opened June 2019. As mentioned above, funded initiatives in Q1 2019/20 include Addictions (including Opioid Addiction Treatment services). Central LHIN will continue to work towards the target by increasing capacity for addictions counseling and case management, increasing access to youth residential treatment and youth withdrawal management, and increasing outreach and addiction services to underserviced communities.

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Sustainability and Quality: Improve patient satisfaction; Reduce unnecessary readmissions										
HIG	Readmissions within 30 days for selected Health Based Allocation Model (HBAM) Inpatient Group (HIG) conditions (2018Q4)	15.50%	Lower	**16.56%**	**16.87%**	✔	**6**	 More detail	**NO**	Readmissions within 30 days for selected HIG conditions decreased 0.68 percentage point in Q4 to 16.56% from the previous quarter (15.88%). Central LHIN performance better than the provincial average of 16.87%, and ranked 6th in the province. Initiatives implemented across Central LHIN to support improvement in performance include the following: 1. LHIN-wide access to the OTN Telehomecare (THC) program, focusing on COPD and CHF patients. 2. COPD clinics operational at two Central LHIN Community Health Centers (CHCs). 3. Community-based exercise and falls prevention classes for seniors, including designated "Breathe Better" classes tailored for seniors at risk of COPD and/or CHF. 4. Implementation of QBPs and the adoption of best practice pathways for patients with COPD, CHF, Pneumonia and Stroke. 5. Implementation of Interprofessional Primary Care Team (IPCT) expansions in 5 sub-regions (Northern, Western, Eastern, North York West, and North York Central) to increase access of primary care providers and their patients to allied health services. Since implementation began in June 2018, over 6,126 client referrals have been received from approximately 935 primary care providers for a variety of services. Additionally, the IPCT teams have established multiple partnerships with other providers and organizations for the delivery of services to underserved communities. 6. Implementation of Hospital to Home Program at Markham Stouffville Hospital, in partnership with Home and Community Care and York Region Paramedic Services, to support patients in better managing chronic disease in their homes by offering complex patients timely in-home, point-of-care testing/interventions and streamlined access to acute care services via a broader multidisciplinary team. 7. Moving forward, Central LHIN hospitals are planning to implement Bundled Care for Stroke Hemorrhage, Stroke Ischemic or Unspecified, and CABG procedures in FY 2020/21 to enhance coordination and integration of services through partnerships, as well as transition of care across the continuum of care. The goal of the initiatives is to promote collaboration across sectors, enable innovation in service delivery, and identify efficiencies to reduce IP LOS and hospital re-admission, and improve patient outcomes. 8. In collaboration with its Central LHIN Diabetes Education Program (DEP) Collaborative group, Central LHIN is working on its Diabetes strategy focusing on three areas identified as common challenges across DEP settings – Foot Care, Psychosocial Supports, and Program Awareness.