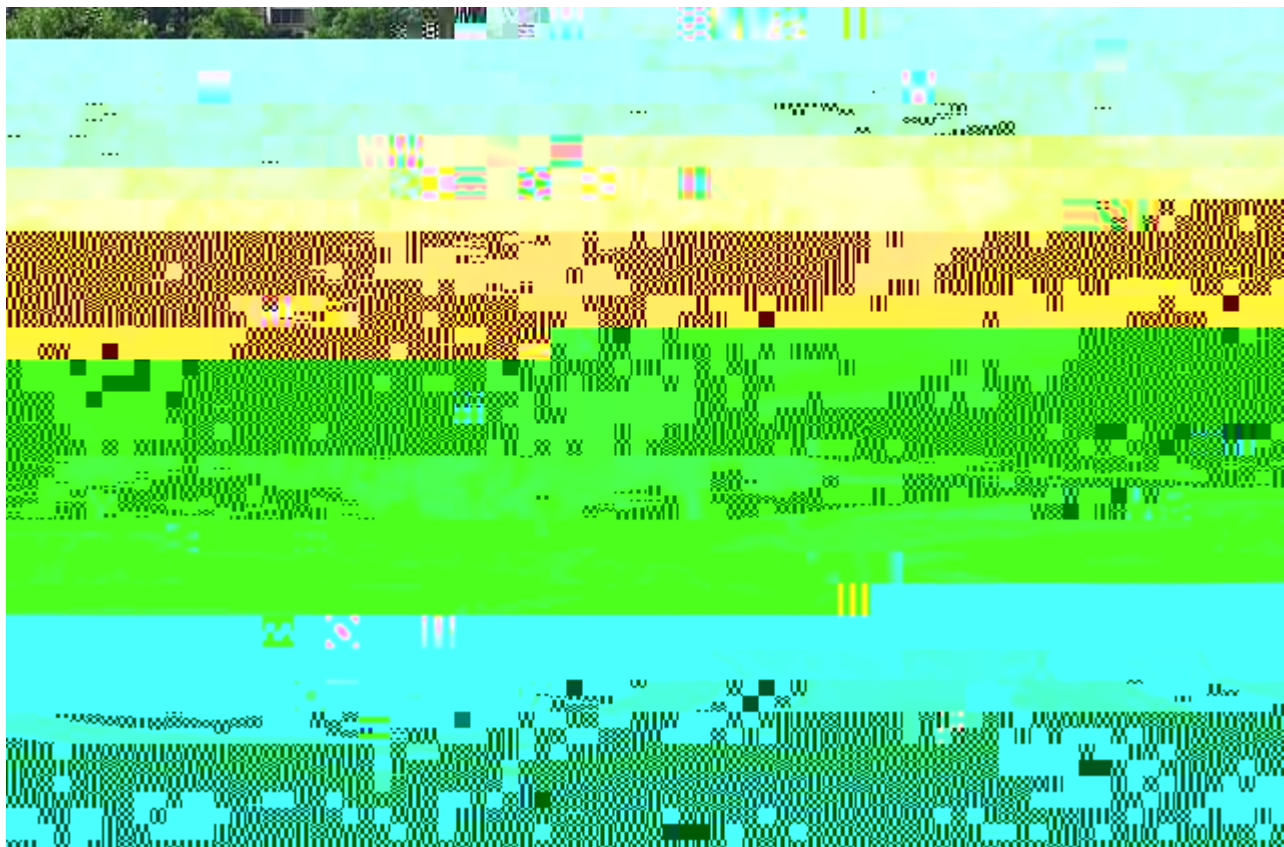
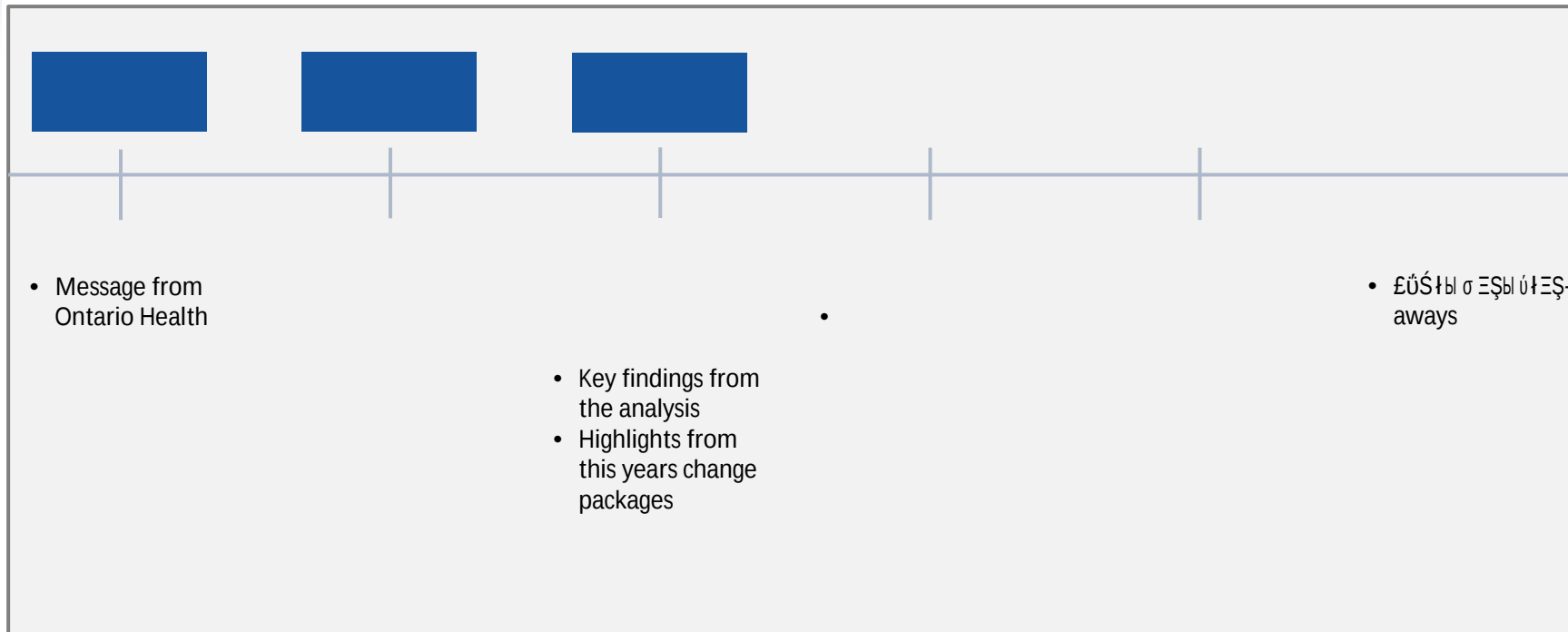






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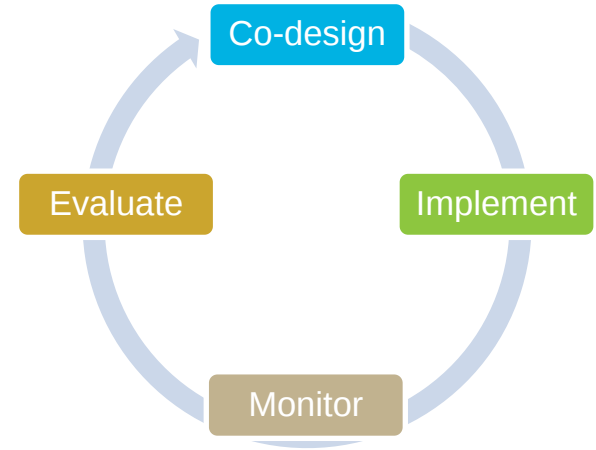
, Executive, Population Health and Value Based Health System

Background, structure, and areas of focus and indicators

- *, Manager, OHT Implementation*

The collaborative quality improvement plan (cQIP) is a population health management improvement plan that aligns provincial and local health system priorities with the Quadruple Aim, and considers populations most at risk.

The cQIP is a process that Ontario Health teams



The cQIP structure is based on the Model for Improvement and includes:

- A **Narrative**, where OHTs reflect on their change initiatives over the past year, including successes, challenges, and lessons learned
- A **Context**, where OHTs provide context for their quality improvement work by describing their OHT and the population they serve. The Narrative is also the place to capture and analyze emerging quality issues
- A **Plan**, where OHTs will set improvement targets for the quality indicators



Builds on the success of the 2022/2023 cQIP (continued learning)



Supports improved collaboration over time



Focuses on the same key areas of focus, with additional flexibility for local priorities



Provides additional supports (e.g., use of Navigator, use of OHT Data Dashboard, applying upstream thinking to the areas of focus)

Overall observations

Key messages from the analysis

- , *Senior Specialist, Clinical Institutes and Quality Programs*

About half of OHTs described _____ in their approach, developing _____ and teams, process mapping, trying to understand available sources and setting

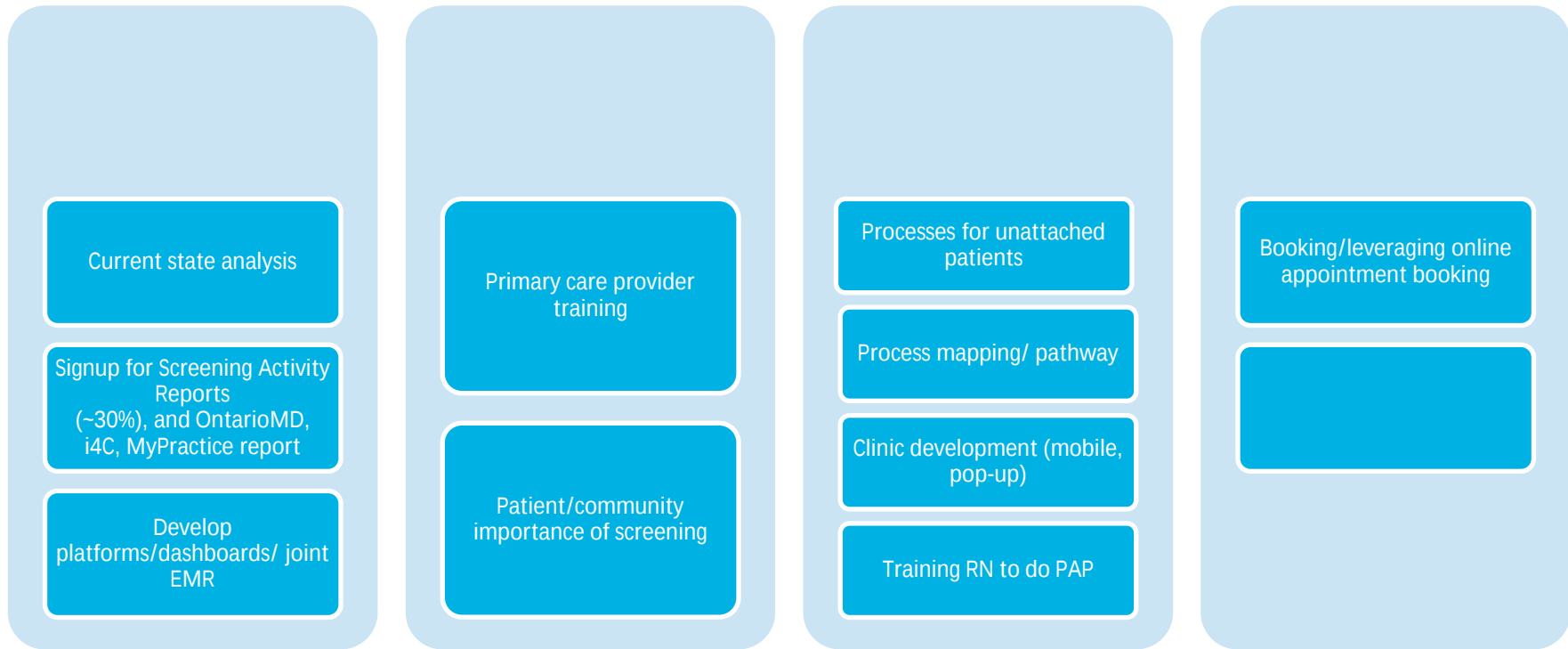
Nearly half of OHTs describe using a _____ approach in selecting specific population _____ to focus their improvement work

Collaboration and partnerships

- For the alternate level of care (ALC) and mental health and addictions (MHA) indicators, most OHTs identified _____, including organizations outside of traditional health care (e.g., _____)
- For preventative care indicator, _____ focused on _____
- There remains an opportunity for OHTs to consistently engage patients/families/community members in the _____ of initiatives

Guest Speaker:

- , *Director, Clinical Programs, Mental Health and Addiction Centre of Excellence*



Guest Speaker:

-

Outlining improved data and analytics support provided in the cQIP report on the OHT Data Dashboard

, Director, Population Health Data Strategy and Implementation

Introducing streamlined submission and progress reporting using the QIP Navigator Platform

Key timelines and key supports available

, Senior Specialist, Clinical Institutes and Quality Programs

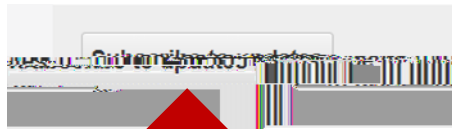
Data now available via the OHT Data Dashboard:
cQIP data added November 18, 2022

- Available to OHTs through eReports
- Tool is linked from Navigator platform
- Current performance will be pre-

Joining is as easy as 1, 2, 3!

1. Visit the [OHT Shared Space](#) and click the [Join](#) button.
2. Visit the [cQIP Community of Practice](#) button. You will receive an email into the group.

Note: You are automatically accepted into the “[General Discussion](#)” Group.



Why participate?

Get your questions answered in a space dedicated to quality improvement in OHTs

Access specific resources and supports to assist in your cQIP development, submission and progress reporting

Get notified of any upcoming relevant cQIP events, webinars, or educational opportunities

Share local best or leading practices, and adapt resources to advance your quality plan

Identify emerging opportunities and address common barriers with cross-OHT collaboration

Learn more about some of the indicators

- Get questions answered QIP@ontariohealth.ca
- Drop-in Sessions
 - When: 1 hour weekly, starting January 18 to March 31, 2023
 - What: support for cQIP submission including demonstration of how to use new Navigator tool
 - Click [HERE](#) for drop-in session dates



-

, Population Health and Value Based Health System





cQIP Main Messages



The provincial areas of focus and indicators were chosen to assist **with critical COVID-19 recovery challenges**. Our

via transitions from home or hospital to post-acute care, long-term care, or residential care within priority populations.

Rationale

The ALC Data Indicator includes acute care, long-term care, and residential care. The ALC Data Indicator is used to track the number of individuals who are discharged from hospital to post-acute care, long-term care, or residential care within priority populations. The ALC Data Indicator is used to track the number of individuals who are discharged from hospital to post-acute care, long-term care, or residential care within priority populations.

Associated Indicator: Allomato Level of Care

Additions (MHA) services

This includes a focus on reducing inequities for individuals within priority populations.

Rationale

- Every year, more than one million people in Ontario experience a mental health or addictions challenge requiring care. Often, supports are difficult to find where and when they are needed. Care in the community is often not available, and many people are not able to access the services they need.

Associated Indicator: ED first point of contact

2. Increase overall access to preventative care

Rationale

Reported March 12, 2021: According to statistics gathered by Ontario Health, almost a million fewer colorectal, breast and cervical cancer screenings were conducted between March and December than was planned.

Associated Indicator: Number of patients in to date with a mammogram

Available on our [cQIP CoP shared space](#):

cQIP Guidance Document

cQIP Technical Specifications

Coaching Tool

Change Packages

Available on Quorum:

[Quality Improvement Tools and Resources](#)

