2018/19 Quality Improvement Plan
"Improvement Targets and Initiatives"

Ottawa Hospital 501 Smyth Road

AIM		Measure								Change				
Quality dimension	Issue	Measure/Indicator	Type	Unit / Population	Source / Period	Organization Id	Current performance	Target	Target justification	Planned improvement initiatives (Change Ideas)	Methods	Process measures	Target for process measure	Comments
M = Mandatory (all cells must be completed) P = Priority (complete ONLY the comments cell if you are not working on this indicator) A= Additional (do not select from drop down menu if you are not working on this indicator) C = custom (add any other indicators you are working on)														
Effective	**Effective transitions**	Did you receive enough information from hospital staff about what to do if you were worried about your condition or treatment after you left the hospital?	P	% / Survey respondents	CIHI CPES / April - June 2017(Q1 FY 2017/18)	958*	63.06	65.00	Target set for 3% improvement. We are doing better than the provincial average of 57.5% but the 90%ile value of 73% would be	1)Systematic improvement of patient education information	1a) Standardize and streamline processes for creating and/or revising patient education information and involving patient advisors. 1b) Ensure best practices (AODA compliance, principles of adult education, health literacy (i.e. plain language	1a) Processes for creating and/or revising education information and involving patient advisors have been standardized and streamlined. 1b) Number of documents revised/updated in accordance with best practices. 1c) Number of staff trained on best	1a) by end of Q1. 1b) Revise/update 100% of patient education documents by	Multi-year Initiative
										2)Continued optimization of Post-Discharge Phone Calls Program	1) Incorporate and enhance transitions for discharge patients through post-discharge call program into new HIS (Epic)	1a)Establish work group to build workflows and support content 1b) Define system requirements and define process changes 1c) Plan testing development once system build complete 1d) End user Training in test environment	Testing environment completed by end of Q3. Trial testing environment	
		Risk-adjusted 30-day all-cause readmission rate for patients with CHF (QBP cohort)	P	Rate / CHF QBP Cohort	CIHI DAD / January - December 2016	958*	21.07	20.90	Target set for a 1% reduction that builds on the success of previous year's	1)Continued implementation of Ottawa Smoking Cessation Model	1) The Ottawa Model Smoking Cessation team will continue ongoing audits to assess rates of: a) identification of smoking status of all admitted patients; b) completion of smoking cessation consultation forms; c) enrollment in smoking	1) percent of patients being asked about smoking status on admission (determined through audits). 2) Number (%) of inpatient smokers who receive a smoking cessation consultation while at TOH (tracked through data entry into Smoking Cessation	TOH is to provide the Ottawa Model for Smoking Cessation to 80% of expected	
		Risk-adjusted 30-day all-cause readmission rate for patients with COPD (QBP cohort)	P	Rate / COPD QBP Cohort	CIHI DAD / January - December 2016	958*	20.8	20.10	We will aim for of 3.5% improvement. This is based off of our previous	1)Continued implementation of Ottawa Smoking Cessation Model	1) The Ottawa Model Smoking Cessation team will continue ongoing audits to assess rates of: a) identification of smoking status of all admitted patients; b) completion of smoking cessation consultation forms; c) enrollment in smoking	1) percent of patients being asked about smoking status on admission (determined through audits). 2) Number (%) of inpatient smokers who receive a smoking cessation consultation while at TOH (tracked through data entry into Smoking Cessation	TOH is to provide the Ottawa Model for Smoking Cessation to 80% of expected	
		Readmissions - 30 day unplanned (%)	C	% / Discharged patients	SMS (SMS (In-house registration system) / Nov/16-Oct/17	958*	9.7	9.40	Target represents a 3% improvement over the baseline	1)Continued optimization of Post-Discharge Phone Calls Program	1) Incorporate and enhance transitions for discharge patients through post-discharge call program into new HIS (Epic)	1a)Establish work group to build workflows and support content 1b) Define system requirements and define process changes 1c) Plan testing development once system build complete 1d) End user Training in test environment	Testing environment completed by end of Q3. Trial testing environment	
Efficient	**Access to right level of care**	Total number of alternate level of care (ALC) days contributed by ALC patients within the	P	Rate per 100 inpatient days / All inpatients	WTIS, CCO, BCS, MOHLTC / July - September 2017	958*	14.47	12.50	Target set at the HSAA agreement value. We are the lowest	1)Optimization of patient flow	Design Integrated Discharge Planning Model		1) Design Model and approach to pilot. 2) Pilot Model. 3) Evaluate impact and consider systematic spread.	1) Design Model and being pilot by end of Q1. 2) Pilot Model by end Q2-Q3. 3) Evaluate	Multi-year Initiative
Patient-centred	**Palliative care**	Percent of palliative care patients discharged from hospital with the discharge status	P	% / Discharged patients	CIHI DAD / April 2016 - March 2017	958*	91.42	90.50	We continue to be the best performer among our bench marked	1)Optimization of palliative support	1. Pilot Palliative Patient Discharge Tool (PPDT), which includes the checklist, a telephone follow-up and data collection on 2 units (internal medicine and oncology). 2. Categorize data according to goals of care in order to accurately measure performance of	Number of completed PPDTs (only complete with 30-day follow-up).	Pilot to be completed by end of Q2. Evaluation to be completed by end of Q2	
	Person experience	"Would you recommend this emergency department to your friends and family?"	P	% / Survey respondents	EDPEC / April - June 2017 (Q1 FY 2017/18)	958*	68.5	70.00	Target set for 2% improvement. This is the first year we have	1)Enhancing patient satisfaction in the Emergency Department	1. Conduct root causes analysis, patient and staff focus groups and systematic analysis of patient complaints to determine improvement opportunities. 2. Prioritize improvement trials anticipated to focus around: a. Communication (at	1) Complete analysis of root cause and patient complaints. 2) Identify and prioritize opportunities for improvement. 3) Conduct trials and evaluate success of implemented change ideas.	Complete 1 & 2 by end of Q1. Complete 3 by end of Q4.	
		Overall Rating of Experience Inpatient survey	C	% / All inpatients	CIHI CPES / Nov/16 - Oct/17	958*	69.8	72.00	Average performer. Aim for 3 % increase over baseline. Set as per CPS	1)Continued Implementation of Patient and Family Engagement Framework	1) Systematic development and implementation plans to be developed for each aspect of TOH's Patient Engagement Framework.	Completion and rollout of each aspect of the TOH's Patient Engagement Framework	By end of Q1 a detailed plan with actions and milestones for each component	Multi-year initiative
Safe	**Safe care/Medication safety**	Medication reconciliation at discharge: Total number of discharged patients	P	Rate per total number of discharged patients / Discharged	Hospital collected data / October – December (Q3) 2017	958*	86.16	86.16	Current efforts are focused on maintaining baseline performance as	1)-	-	-	-	This indicator will not be tracked on our QIP in alignment with our
		The number of antimicrobial-free days (both antibacterial and antifungal) in ICU	A	Rate per 1,000 patient days / ICU patients	CCIS / Most recent quarter available	958*	518.45	565.00	This is a new additional indicator on the HQO QIP. Data in the CCIS	1)Continued implementation of an Antimicrobial Stewardship Program	Leverage design and development phase in Fusion/Epic to: a) Standardize order sets for Ab use b) Incorporate data capture and reporting for DOTS c) Increase compliance (and access to compliance data) to order sets for Ab use (enabling a look at	a) Number of order sets standardized b) Percent complete c) Compliance rate d) Percent complete	a, b, c, d to be completed by end of Q4	

	Workplace Violence	**Number of workplace violence incidents reported by hospital workers (as by defined by OHSA) within a 12 month period.**	**MANDATORY**	**Count / Worker**	**Local data collection / January - December 2017**	**958***	**228**	**251.00**	**We expect to see an increase driven by heightened awareness and focus on incidents of workplace violence incidents resulting from training efforts, improved ease**	**1)Continued implementation of violence in the workplace initiatives**	**1) Enhance our violence and prevention training strategy and delivery. 2) Improve ease of reporting for frontline staff.**	**1) Number of staff who received enhanced training above their current training baseline. 2) Number of in-services provided on requirement and mechanisms for incident reporting.**	**1) 600 staff; 300/year over 2 years. 2) 20 in-services per year.**	**FTE=10929 Multi-year Initiative**
										2)Continued implementation of a Just Culture	1) Continued rollout of a) leader education incorporating Just Culture principles as part of our onboarding processes and incident investigation methods as well and b) frontline staff education in Just Culture principles. 2) Continue to enhance our	1a) % of leaders educated (Incident Investigation for Leaders and Just Culture for Leaders). 1b) % of frontline staff educated (Just Culture Principles for all staff). 2) Incorporate enhanced status tracking and accountability for improvement actions and design	1a) 100% of leaders completing Incident Investigation for	
Timely	**Timely access to care/services**	90th %ile ED LOS – Non-admitted CTAS I-III (hours)	C	90th percentile / Non-admitted ED patients	SMS (In-house registration system) / 2017	958*	8.35	8.00	Represents a 4% improvement target. Previous year's target of	1)TOH-wide Implementation of the yellow dot moves	1. Design and implement a program and communication plan executed through PDSA cycles to maximize efficiency of patient flow (on yellow dot). 2. Collaborate with all in patient programs, housekeeping, transportation, admitting, and Flow	1) Disposition decision to inpatient bed time. 2) Number of admitted patients in ED at 07:00hrs, 12:00hrs, 16:00hrs, 00:00hrs.	Complete 1 by end of Q1. Complete 2 by end of Q1. Complete initial	
		Proportion of Admitted Patients whose ED LOS was less than 24 hours	C	% / Admitted ED patients	SMS (In-house registration system) / 2017	958*	76.1	80.00	Target represents 5% improvement over baseline. We are a low performer. More aggressive target set.	1)Optimization of flow	Design Integrated Discharge Planning Model	1) Design Model and approach to pilot 2) Pilot Model 3) Evaluate impact and consider systematic spread	1) Design Model and being pilot by end of Q1 2) Q2-Q3 3) Q4	
										2)TOH-wide Implementation of the yellow dot moves	1. Design and implement a program and communication plan executed through PDSA cycles to maximize efficiency of patient flow (on yellow dot). 2. Collaborate with all in patient programs, housekeeping, transportation, admitting, and Flow	1) Disposition decision to inpatient bed time. 2) Number of admitted patients in ED at 07:00hrs, 12:00hrs, 16:00hrs, 00:00hrs.	Complete 1 by end of Q1. Complete 2 by end of Q1. Complete initial	
		Urgent surgical cases (A-E) performed within target (%)	C	% / All urgent surgeries	SIMS (In-house surgical system) / 2017	958*	75.2	85.00	This was a multi-year initiative. The target from last year will be retained as	1)Improve access to urgent surgery through use of operations research analytics and quality improvement methods	1) Leverage operations research methodology to confirm urgent surgery demand, assess current capacity and utilization based on urgent classification scheme, allocate necessary resources to meet demand. 2) Design and implement performance	1) Confirm urgent surgery classifications and designated urgent resources; conduct modeling to determine necessary capacity to meet demand; determine method to achieve necessary capacity. 2) Improve and implement performance data reporting	1) By end of Q1, 2018 2) By end of Q2, 2018	