Excellent Care for All

Quality Improvement Plans (QIP): Progress Report for 2017/18 QIP

The Progress Report is a tool that will help organizations make linkages between change ideas and improvement, and gain insight into how their change ideas might be refined in the future. The new Progress Report is mostly automated, so very little data entry is required, freeing up time for reflection and quality improvement activities.

Health Quality Ontario (HQO) will use the updated Progress Reports to share effective change initiatives, spread successful change ideas, and inform robust curriculum for future educational sessions.

ID	Measure/Indicator from 2017/18	Org Id	Current Performance as stated on QIP2017/18	Target as stated on QIP 2017/18	Current Performance (Jan – Dec 2017)	Comments
1	90th %ile ED LOS – Non-admitted CTAS I-III (hours) (Hours; Non-admitted ED patients; 2016; SMS (In-house registration system))	958	8.25	8.00	8.35	Target was not achieved. The change ideas were implemented as intended, however, there are many different variables affecting performance on this indicator thereby making it challenging to capture the direct impact of this initiative.

Realizing that the QIP is a living document and the change ideas may fluctuate as you test and implement throughout the year, we want you to reflect on which change ideas had an impact and which ones you were able to adopt, adapt or abandon. This learning will help build capacity across the province.

Change Ideas from Last Years QIP (QIP 2017/18)	Was this change idea implemented as intended? (Y/N button)	Lessons Learned: (Some Questions to Consider) What was your experience with this indicator? What were your key learnings? Did the change ideas make an impact? What advice would you give to others?
TOH-wide implementation of orange dot moves	YES	This change idea was an extension of our previous year's QIP initiatives focused on moving patients from the ED to in-patient beds in the most efficient and effective manner. For the period between June – Sept 2017, a total of 376 patients have been sent to the inpatient unit on the orange dot. This represents 188 hours of saved stretcher time. This initiative was a good start towards decreasing length of stay in the ED and presents opportunities to send patients on the yellow dot (a step before the orange dot) and to apply this concept to patients at triage to be even more efficient. There are many different variables affecting performance on this indicator thereby making it challenging to capture the direct impact of this initiative. **Lessons learned/ advice for others:** Change in a large organization is only successful with clear communication

to all stakeholders. Stakeholder engagement with a focus on the “why” was key to success. A supportive management team was also a key driver of change.

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2	CDI rate per 1,000 patient days: Number of patients newly diagnosed with hospital-acquired CDI during the reporting period, divided by the number of patient days in the reporting period, multiplied by 1,000. (Rate per 1,000; All inpatients; January 2016 - December 2016; Publicly Reported, MOH)	958	0.42	0.40	0.4	Target was achieved. See change idea for details.

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Standardize and implement environmental control systems (Care Environment)	YES	This project followed the TOH Innovation framework which provided tools and structure that helped guide the project. For example, an approved project charter helped define scope and shape the project. While the development of a current state process map helped the team identify gaps and allowed for the design of a future state process map. Changes were made to the audit process as the audit team looked to integrate the audit tool into an electronic capturing system (REDCap). The new auditing process is working well, but we are discovering more gaps and errors. This was expected as the process implementation was delayed, and we have seen employees reverting to old habits in the meantime. Although the audit tool has been developed, there is still work to be done to increase engagement and enhance data accessibility.

ID	Measure/Indicator from 2017/18	Org Id	Current Performance as stated on QIP2017/18	Target as stated on QIP 2017/18	Current Performance (Oct 2016 – Sep 2017)	Comments
3	Cost per weighted case - Total acute/DS ($/HIG) (Dollars; All acute IP and DS; Oct/15-Sep/16; CIHI NACRS, MedAssets.)	958	6240.00	5900.00	6353	Target was not achieved. The change ideas were implemented as intended, however there are many different variables affecting performance on this indicator thereby making it challenging to capture the direct impact of this initiative.

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Surgical Supply Costing	YES	The initial phase of the project went live successfully October 16, 2017. All teams have worked very well together and progressed through the learning curve sharing 'lessons learned and tips and tricks' along the way. This project kept to its timeline, came in well under budget, and had a successful implementation. The Steering Committee is now in the process of identifying what types of reports will be useful and how they will be disseminated. Following this information efforts toward standardization of supplies can commence.

ID	Measure/Indicator from 2017/18	Org Id	Current Performance as stated on QIP2017/18	Target as stated on QIP 2017/18	Current Performance (Q1 FY 2017/2018)	Comments
4	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? (%; Survey respondents; April - June 2016 (Q1 FY 2016/17); CIHI CPES)	958	61.90	65.00	63.1	Target was not achieved however, performance has improved. See change ideas for details.

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Systematic implementation of Patient Engagement Framework	YES	This change idea is a continuation from previous year's work and is continuing to gain traction as it expands. As of Q3 2017, an ongoing advisor recruitment process was established, and several new patient advisors were on-boarded. Building an infrastructure for advisor recruitment, onboarding and support has helped integrate patient advisors into meaningful activities such as quality improvement projects and decision-making. Patient advisors have also been involved in the co-design of an advisor orientation program. Use of tools, such as SharePoint, have enabled development of a collaboration site to support the recruitment onboarding and integration of advisors. Further enhancements to this SharePoint tool are being launched in Q4 which will include supportive tools, request forms, evaluation forms, success stories, videos to further promote engaging patients in QI projects. Overall the program is progressing as planned. Challenges observed include engaging vulnerable populations for representation into patient advisory activities.

ID	Measure/Indicator from 2017/18	Org Id	Current Performance as stated on QIP2017/18	Target as stated on QIP 2017/18	Current Performance (Nov 2016 – Oct 2017)	Comments
5	Hospital Standardized Mortality Ratio (HSMR - 2015) (Ratio (No unit); All inpatients; Nov/15-Oct/16; CIHI DAD)	958	83.30	80.00	83.1	Target was not achieved; however, performance has improved. See change ideas for details.

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Drug stewardship	YES	A significant amount of work has been accomplished towards the goals of measuring the value of the Antimicrobial Stewardship Program (ASP), communicating the results, increasing efficiency by building a monitoring system and developing an understanding of the roles and functions of the program. There continues to be a need to find ways to communicate successes more broadly (ex. IT/web design, Communications, reach administrators and Dept./Division Heads). Lessons learned: The ASP has a wide variety of projects/strategies/interventions ongoing, but need to focus efforts to ensure: 1 - we are measuring outcomes arising from these change interventions 2 - we are communicating our successes and value broadly 2017 QIP focused mainly on improving efficiency and visibility of ASP program; in the future the ASP may serve as an example for the broader issues of drug and resource stewardship. Work in this area will continue as part of our HIS design and configuration efforts in 2018/19.

ID	Measure/Indicator from 2017/18	Org Id	Current Performance as stated on QIP2017/18	Target as stated on QIP 2017/18	Current Performance (Apr 2017 – Nov 2017)	Comments
6	Overall Rating of Experience Inpatient survey (% Top Box) (%; All inpatients; Apr/16 - Nov/16; CPES-IC)	958	68.60	72.00	70.1	Target was not achieved; however, performance has improved. See change ideas for details.

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Enhance audit and feedback mechanisms	YES	Performance based goals based on performance data were successfully implemented into the annual re-credentialing process for physicians. While recognizing that many factors influence patient satisfaction, our overall patient Experience score remains elevated compared to last year. Next steps are to consult Division Heads and identify barriers to engagement and seeking feedback on use of metrics for re-credentialing. We will

continue to work with Patient Experience Reps to encourage feedback of metrics.

Lessons learned**:** Effective communication is challenging. Many staff have not heard about this initiative despite extensive communication efforts. Accountability was a key driver and should be maintained going forward. Support from senior management was also key to success.

Patient centered-communication strategy

Significant progress was made in rolling out a patient centered-communication strategy and training for transportation workers and clerks, in addition to campaigning all staff to the take the #HelloMyNameIs pledge.

Lessons learned: It is challenging to coordinate in-class training for a large group of staff that work shifts and do not have access to relief time for training. It is very time consuming to rollout an initiative with such a wide scope. The coaching model may need to be reviewed and re-examined. The model has great potential, but training may need to be moved to an online format due to challenges for staff to attend in-person training sessions.

ID	Measure/Indicator from 2017/18	Org Id	Current Performance as stated on QIP2017/18	Target as stated on QIP 2017/18	Current Performance (Apr 2016 – Mar 2017)	Comments
7	Percent of palliative care patients discharged from hospital with the discharge status "Home with Support". (%; Discharged patients; April 2015 – March 2016; CIHI DAD)	958	91.67	90.50	91.42	Target achieved. See change idea for details.

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Optimize palliative support	YES	This project followed the TOH Innovation framework which provided tools and structure that helped guide the project. Highlights of this change idea include: A completed and approved project charter. Two pilot units were selected to implement discharge checklist. Education and use of PPDT with PC team was completed in September. Education to pilot units was rolled out Dec/Jan 2018. Discharge follow up phone call document prepared and in use by Palliative Care team as of end of June 2017. Process Mapping for discharge process completed on November with key internal and external Stakeholders. This process was implemented during the education and pilot of the PPDT on two units at TOH in January 2018. Although the tool to optimize palliative support was well supported and backed with supporting evidence, the actual uptake and use of the tool was less than anticipated. Further education will be required. The team remains committed to continuing these improvement efforts into 2018/19.

ID	Measure/Indicator from 2017/18	Org Id	Current Performance as stated on QIP2017/18	Target as stated on QIP 2017/18	Current Performance (Q3 FY 2017-2018)	Comments
8	Percentage of patients identified with multiple conditions and complex needs (Health Link criteria) who are offered access to Health Links approach (%; Patients meeting Health Link criteria; Most recent 3-month period; Hospital collected data)	958	CB	CB	90%	Baseline and targets were not set for this indicator because we first needed to secure a data sharing agreement. This is near completion and more complete Health Links data will be available going forward.

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Population health strategy for health links	It has not been implemented as intended. TOH has been providing health link services for some time, however the process for collecting the data was never well established. Much of the work this year was to revaluate the criteria and implement processes to capture the data correctly.	The goals for this change idea were to define the process, collect preliminary data, analyze data and engage physicians. The project team met with VPs to review options to optimize opportunities to expand early in the fiscal year. However, due to the lack of standard approach, no data has been collected. We realized that without proper forms for documentation, the metrics for this indicator would not be reliable. As a result, data agreement forms were submitted to enable sharing across connected organizations. Anticipated efforts post systematic analysis of the shared data include greater education and awareness for providers involved. Lessons learned: Engagement is difficult without data to support our change ideas.

ID	Measure/Indicator from 2017/18	Org Id	Current Performance as stated on QIP2017/18	Target as stated on QIP 2017/18	Current Performance (Jan – Dec 2017)	Comments
9	Proportion of Admitted Patients whose ED LOS was less than 24 hours (%) (%; Admitted ED patients; 2016; SMS (In-house registration system))	958	76.20	83.00	76.1	Target was not achieved. The change ideas were implemented as intended, however there are many different variables affecting performance on this indicator thereby making it challenging to measure the direct impact of this initiative.

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TOH-wide implementation of orange dot moves	YES	See comments in the other section.

ID	Measure/Indicator from 2017/18	Org Id	Current Performance as stated on QIP2017/18	Target as stated on QIP 2017/18	Current Performance (Dec 2016 – Nov 2017)	Comments
10	Readmissions - 30 day unplanned (%) (%; ; Dec/15-Nov/16; SMS (In-house registration system))	958	10.00	9.50	9.7	Target was not achieved; however, performance has improved. See change ideas for details.

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Planning and execution of new Health Information System platform and program delivery	YES	A successful project kick-off was held with over 500 participants from the partner organizations. Project execution began immediately. Last quarter was active with certification of Project Fusion team, recruitment and education of key stakeholders. Phase 0 - Groundwork - where information was gathered across organizations was successfully completed at the end of November. Organizations were responsive to project needs. Direction began in December. This phase focuses on understanding large directional decisions which will guide the team in the build and adoption phase. This phase will be completed at the end of January. Alliance organizations working very well together towards a common and collaborative goal. Lessons learned: We benefited from participating in the go-live at St. Joseph Hamilton to understand their lessons learned.
Optimize use of ambulatory care clinics to avoid ED visits and readmission (Rapid Referral Clinic)	NO	This change initiative was an expansion of a previous year's QIP initiative starting in the Internal Medicine department at the General Campus. The change idea for this year's QIP was to adapt this clinic service into General Surgery. The current state analysis of general surgery rapid referral clinic was mapped out but through the investigation, the results indicated that there is not a strong need for expanding this concept to General Surgery.

ID	Measure/Indicator from 2017/18	Org Id	Current Performance as stated on QIP2017/18	Target as stated on QIP 2017/18	Current Performance (Jan – Dec 2016)	Comments
11	Risk-adjusted 30-day all-cause readmission rate for patients with CHF (QBP cohort) (Rate; CHF QBP Cohort; January 2015 - December 2015; CIHI DAD)	958	20.98	20.00	20.80	Target was not achieved; however, performance has improved. See change ideas for details.

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Implementation of Ottawa Smoking Cessation Model	YES	To date in Q3, a total of 288 (an estimated 14.8% of expected) smoking cessation consultations were completed (282 at the Civic and 6 at the General). It is to be noted that this data is only for October and November of Q3 as December data is not yet available. The Smoking Cessation Specialist positions were to be filled at both of our TOH campuses, however, the position at one of the campuses was still not filled in Q3. As such, smoking cessation activities for inpatients at that Campus have been minimal. To assist in addressing the needs of inpatients at the General campus, the Smoking Cessation Specialist from another area (Cancer Centre) has started to complete smoking cessation consultations on the 4 inpatient oncology units at the General campus. In Q3, questions surrounding smoking and smoking cessation treatment were added to the prevalence day screening. Results from this are not yet available. Quit cards were offered again to TOH patients and staff through UOHI until October 31, 2017. Activities that helped with the spread in one of the campuses included: - Holding meetings with the COPD outreach program to discuss incorporating OMSC into their processes and how to additionally assist patients. - Developing a Smoking Cessation Community of Practice - Holding meetings with all inpatient oncology unit managers at the General Campus to finalize process for the Smoking Cessation Specialist from the Cancer Centre to be flagged

for smoking cessation consultations on their units.
- Holding Lunch and Learns on the inpatient oncology units at the General to educate staff on the new process and smoking cessation medications
- Holding Surgery Grand Rounds focused on Smoking Cessation speaker

At our campus with a dedicated smoking cessation specialist (Civic campus), inpatient tobacco users are still not being well identified by front line staff and the Smoking Cessation Specialist is still having to spend valuable time identifying the patients that require consultations rather than completing consultation.

Next steps for the group involve:
- Reviewing results of prevalence day screening and disseminate information.
- Hire a Smoking Cessation Specialist at the General for inpatient or determine plan for address tobacco use in inpatients at the General campus.
- Set up meetings with all inpatient managers/CCLs/Educators to discuss process for identifying patient smokers for specialist
- Explore data entry options for smoking cessation consultations for inpatients into the OMSC database.

ID	Measure/Indicator from 2017/18	Org Id	Current Performance as stated on QIP2017/18	Target as stated on QIP 2017/18	Current Performance (Jan – Dec 2016)	Comments
12	Risk-adjusted 30-day all-cause readmission rate for patients with COPD (QBP cohort) (Rate; COPD QBP Cohort; January 2015 – December 2015; CIHI DAD)	958	20.97	19.50	20.80	Target was not achieved; however, performance has improved. See change ideas for details.

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Implementation of Ottawa Smoking Cessation Model	YES	This is repeated change idea. See comments for Risk-adjusted 30-day all-cause readmission rate for patients with CHF (QBP cohort) field for details.

ID	Measure/Indicator from 2017/18	Org Id	Current Performance as stated on QIP2017/18	Target as stated on QIP 2017/18	Current Performance (Jan – Dec 2016)	Comments
13	Risk-adjusted 30-day all-cause readmission rate for patients with stroke (QBP cohort) (Rate; Stroke QBP Cohort; January 2015 - December 2015; CIHI DAD)	958	10.16	0.00	8.60	This indicator was not tracked in alignment with our corporate workplan

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This indicator will not be tracked in alignment with our corporate workplan.		

ID	Measure/Indicator from 2017/18	Org Id	Current Performance as stated on QIP2017/18	Target as stated on QIP 2017/18	Current Performance (Nov 2016 – Oct 2017)	Comments
14	Staff incidents - Total reportable workplace incidents per month (Count; All staff from TOH; Nov/15-Oct/16; Parklane)	958	43.70	41.00	46.75	An increase on this indicator can be explained by the heightened awareness and focus on staff incidents resulting from training efforts and the improved ease of reporting due to improvements to the reporting system.

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Implementation of Just Culture within processes and culture	YES	Progress has been made to create the approach to all-staff training and manager support. This approach has been discussed with broad stakeholders across TOH with the release of all staff and leader key messages and the completion and release of 'All Staff' education materials. To date, the majority of Leaders have been trained in the just culture philosophy and application of the decision-making algorithm tool. We have also incorporated this training into our new leader onboarding curriculum to ensure sustainability. As well, enhancements have been made to the patient safety and staff safety incident investigation process including the development and launch of a front-line leader level Incident Investigation Training course and accompanying toolkit. This approach is aligned with our new method for investigation incorporating Just Culture principles, decision algorithm and enhanced ‘cause-and-effect' rigour in analysis. Other notable accomplishments include the implementation of staff safety reporting within the rebranded *Safety Learning System* and the implementation of privacy incident reporting within this system. A Just Culture SharePoint site was created and launched

		to enable all Leaders to readily access key education, tools and communications materials As we continue with ongoing enhancements to our incident investigation process, we are sharing learnings more broadly across the organization. We also plan to circle back to the Leaders to obtain feedback thus far in the tools, education and resources made available to them to support the broader roll-out of Just Culture. We will continue our strategic efforts into 2018/19 and will focus on: 1) assessment of culture shift; 2) continued enhancements to the incident investigation process and learning systems.
Violence in the workplace initiatives	YES	As part of the initiative outlined in the method, this specific phase of the QI initiative was focused on improving violence risk assessments (VRA) and the timelines for completing a final report. We looked to incorporate more pre-assessment staff survey information and quantitative data on staff incidents and security activity when conducting a VRA. This information could provide context for the assessment and report, resulting in more meaningful reporting and follow up recommendations. An identified barrier was that current risk assessments were not conducted at a frequency that allows for quick implementation, evaluation and monitoring of progress. Working with recommendations from JHSC, the team has agreed to simplifying risk assessment report, which will assist with more timely completion. To address this, will we reduce the number of steps in the report drafting process from 3 to 2; & simplify contexts of reporting and focus on recommendations. Other accomplishments in 2017 specific to preventing workplace violence include: • Upgraded our personal alarm system for all mental health areas, and initiated system design to expand this to all Emergency Department areas. Staff in Mental Health can all now summon assistance from Security and their other team members at the touch of a button. • Partnered with Algonquin College and Ottawa Police Services to deliver new, enhanced violence response and prevention training to our security team members.

- Implemented a standardized approach for team debrief after a violent incident to ensure staff health is being addressed and we learn from what worked well and what could be done better.

- Enhanced our flagging system to distinguish between verbal and physical violence and to ensure that this information is being communicated to teams who do not always use the centralized patient information system.

Lessons learned: The project followed the TOH Innovation Framework which provided the structure and tools to keep the project on track. The timeframe to complete our PDSAs is long as this project focuses on infrequent events. This initiative has laid the groundwork for the mandatory workplace violence indicator on this year's workplan.

ID	Measure/Indicator from 2017/18	Org Id	Current Performance as stated on QIP2017/18	Target as stated on QIP 2017/18	Current Performance (Q2 FY 2017-2018)	Comments
15	Total number of alternate level of care (ALC) days contributed by ALC patients within the specific reporting month/quarter using near-real time acute and post-acute ALC information and monthly bed census data (Rate per 100 inpatient days; All inpatients; July – September 2016 (Q2 FY 2016/17 report); WTIS, CCO, BCS, MOHLTC)	958	14.34	12.50	14.47	Target was not achieved. The change ideas were implemented as intended, however there are many different variables affecting performance on this indicator thereby making it challenging to measure the direct impact of this initiative.

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Patient flow optimization and discharge enhancements	YES	This project experienced some delays in initial launch due to organizational changes. Once initiated several accomplishments were noted in a short period of time (Sep- Dec 2017): • Developed project plan with tasks, MRPs and timelines • Process Change for Right Bedding- PDSA Cycles • Data Management Plan executed and currently tracking as of December 8, 2017 • Predictive Discharge • Clinical Care Leader Current State Assessment • Clinical Care Leader Tasks to optimize flow identified • Implemented Accountability Framework amongst medicine Clinical Manager. Each Manager is currently leading one of several projects identified to transform patient flow.

ID	Measure/Indicator from	Org	Current	Target as	Current	Comments

	2017/18	Id	Performance as stated on QIP2017/18	stated on QIP 2017/18	Performance (Jan – Dec 2017)	
16	Urgent surgical cases (A-E) performed within target (%) (%; All urgent surgeries; 2016; SIMS (In-house surgical system))	958	76.70	85.00	75.2	Target was not achieved. See change ideas for details.

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Organizational redesign of urgent surgery	NO	Annual case hours in the OR have grown by 17% over the past six years resulting in a need to identify opportunities for improving efficiencies. Extensive data analysis and modeling has been performed with this goal in mind. Significant analysis as to the causes of current performance has been undertaken in 2017/18. Given the complexity of the process more analysis and recommendations within existing resources (I.e. cost neutral) are necessary. Moving forward, areas of focus include enhancing accountability structures; reviewing enhanced data, system changes and consulting with the Institute for Healthcare Optimization (IHO) to review our most current data and make recommendations for practice, policy and resource change to senior management.