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

AIM		Measure					Change Ideas			
Quality dimension	**Issue**	**Measure/Indicator**	**Type**	**Source / Period**	**Current performance**	**Target**	**Planned improvement initiatives (Change Ideas)**	**Methods**	**Process measures**	**Target for process measure**
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	CIHI CPES / April - June 2017(Q1 FY 2017/18)	63.1	65	**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 and clear design) and patient involvement) are followed for each document or media type. 1c) Gather and/or develop training resources (online, in-person workshops) and then train staff on best practices and on the process for creating/revising patient education information and involving patient advisors.**	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 practices and on the process for creating/revising patient education information and involving patient advisors.	1a) by end of Q1. 1b) Revise/update 100% of patient education documents by June 2019. 1c) Gather and/or develop training resources (online, face to face workshops) by end of Q1. Train 1 person from each division by end of Q2.
							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 training by end Q3. Remaining content build ongoing.
		Readmissions - 30 day unplanned (%)	C	SMS (In-house registration system) / Dec/16-Nov/17	9.7	9.4	**Continued optimization of Post-Discharge Phone Calls Program**	**See above**	**See above**	**See above**
		Risk-adjusted 30-day all-cause readmission rate for patients with CHF (QBP cohort)	P	CIHI DAD / January - December 2016	21.07	20.9	**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 cessation follow up. 2) Hospital wide prevalence audits will be carried out in April, November via NPPD. Results will be shared with management teams, with ongoing education provided. 3) Incorporate Patient identification of smoking status and screening into HIS (EPIC).	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 Database). 3)Establish work group to build workflows and support content. 4) Define system requirements and define process changes.	TOH is to provide the Ottawa Model for Smoking Cessation to 80% of expected inpatient smokers. This is in alignment with the LHIN HSAA with TOH, where a target of 80% is used. Testing environment completed by end of Q3. Trial testing environment training by end of Q3. Remaining content build ongoing.
		Risk-adjusted 30-day all-cause readmission rate for patients with COPD (QBP cohort)	P	CIHI DAD / January - December 2016	20.8	20.1	**Continued implementation of Ottawa Smoking Cessation Model**	See above	See above	See above
Efficient	**Access to right level of care**	**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**	P	WTIS, CCO, BCS, MOHLTC / July - September 2017	14.47	12.5	**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 impact and consider systematic spread by end of Q4.
Patient-centred	**Person experience**	**"Would you recommend this emergency department to your friends and family?"**	P	EDPEC / April - June 2017 (Q1 FY 2017/18)	68.5	70	**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 triage and throughout the ED) b. Changes to physical environment c. Wait time communication 3. Conduct trials and evaluate success of implemented change ideas.	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	CIHI CPES /Nov/16-Oct/17	69.8	72	**Continued Implementation of Patient and Family Engagement Framework**	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 of the patient and family engagement framework will be developed. Which encompasses: 1. Involving patient advisors in decision making related to strategic direction impacting clinical care. 2. Ensuring staff education and training is informed by patient and family advisors. 3. Improving patient and family education material based on patient and family input. 4. Engagement in clinical and non-clinical processes. 5. Embedded patient advisors within research activities and promoting and sustaining the ASK ME about research campaign.

	Palliative care	**Percent of palliative care patients discharged from hospital with the discharge status "Home with Support".**	P	CIHI DAD / April 2016 - March 2017	91.42	90.5	**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 current TOH discharge process against the OPCN performance indicators. 3. Evaluate the impact of the PPDT. 4. Spread of PPDT as a standard of care if applicable.	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. Spread to be completed by the end of Q3.
Safe	**Safe care/Medication safety**	**The number of antimicrobial-free days (both antibacterial and antifungal) in ICU for the reporting period**	A	CCIS / Most recent quarter available	518.45	565	**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 patterns of Ab usage) d) Incorporate real-time feedback opportunities for pre-defined Abs/syndromes and potentially ad-hoc requests	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.**	**M**	**Local data collection / January - December 2017**	**228**	**251**	**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.**
							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 incident learning system. 3) Continue efforts to integrate principles and methods into culture and develop systematic evaluation approach to measure effect of cultural shift.**	**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 and implement method for sharing lessons learned. 3) Develop and employ a comprehensive evaluation method.**	**1a) 100% of leaders completing Incident Investigation for leaders education by end of Q3. Every new leader will complete Just Culture for Leaders education within 6 months of joining TOH/starting a leadership role. 1b) 100% of frontline staff by end of Q3. 2) Final enhancements completed by end of Q2. Complete communication across Q3 and Q4. 3) Develop a comprehensive evaluation method by end of Q2. Aim to initiate evaluation according to plan starting in Q3.**
Timely	**Timely access to care/services**	**Proportion of Admitted Patients whose ED LOS was less than 24 hours**	C	SMS (In-house registration system) / Jan/17-Dec/17	76.1	80	**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 begin pilot by end of Q1. 2) Q2-Q3 3) Q4
							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 Managers to design optimal workflow. 3. Evaluate continuous PDSA cycles with the goal of optimizing parallel processes related to patient flow. 4. Develop standard work and KPI for clinicians and leaders. 5. Measure impact of initiative on flow metrics related to ED.	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 evaluation (3) by end of Q2 .
		90th %ile ED LOS – Non-admitted CTAS I-III (hours)	C	SMS (In-house registration system) / 2017	8.35	8	**TOH-wide Implementation of the yellow dot moves**	See above	See above	See above
		Urgent surgical cases (A-E) performed within target (%)	C	SIMS (In-house surgical system) / 2017	75.2	85	**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 monitoring processes and tools and governance structures.	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 through case flagging and review; Implement governance structures to oversee performance; Revise and implement standard operating procedures.	1) By end of Q1, 2018 2) By end of Q2, 2018

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)

Types of Indicators

- **CPS Indicators**
- **HQO Mandatory/Priority/ Additional Indicators**
- Custom Indicators