Excellent Care for All

Quality Improvement Plans (QIP): Progress Report for 2016/17 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 2016/17	Org Id	Current Performance as stated on QIP2016/17	Target as stated on QIP 2016/17	Current Performance 2017	Comments
1	"Overall, how would you rate the care and services you received at the hospital?" (inpatient), add the number of respondents who responded "Excellent" and divide by number of respondents who registered any response to this question (do not include non-respondents). (%; All patients; October 2014 - September 2015; NRCC survey, CPES-IC survey.)	958	48.80	52.00	68.60	The patient experience survey was switched to the new CPES-IC Survey in April 2016. All numbers (baseline and target) were adjusted up by an absolute 18% to reflect increase in %top box due to changes in measurement method. Current Performance as stated on QIP2016/17 was revised to 66.8%. Target as stated on QIP 2016/17 was revised to 70.00% Current performance 2017 is now 68.6% which contains all the survey data to-date from April – Nov 2016.

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Change Ideas from Last Years QIP (QIP 2016/17)	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?
Develop, implement and evaluate Phase 1 of the Patient and Family Communication Program	Yes	• Training of champions has been completed for physician and for other clinical and non-clinical staff; strategies to support these individuals in broader coaching and culture changes is underway. •Indicators measures changed; many

using a train-the trainer model		factors influence this indicator and we have discussed the need for an overall evaluation framework for patient experience. •Improved communication is not solely related to providing physicians and staff with education but is linked to a much broader cultural change; we need to bring out the innate passion in individuals; importance of broader corporate communication related to our work. •Advice for others is to engage patients and families as well as other champions; harness the enthusiasm of key individuals and support of senior leaders.
Identify Framework to Optimize Patient Engagement	Yes	• Senior management has provided full commitment and support to advance this initiative. We are currently further along than we expected to be at this time and on track to achieve goals by the end of the fiscal year. Several leaders and departments have reached out for patient advisors, supporting tools and guidance for engaging with patients. • Dedicated time and resources are required to advance and ensure success and long term viability. There is a strong interest for patient engagement by all stakeholders. • The change ideas have raised awareness of the benefits and feasibility of engaging patients and families. This aligns well with the patient engagement requirements from Accreditation Canada. We expect to see an impact once the patient engagement strategy and tools are fully implemented. The development of a centralized approach will also allow the organization to track progress and uptake of patient engagement. • Advice for others include start small with patient engagement - 1 or 2 patients engaged in a meaningful way and can build upon that. Best to have centralized approach for recruitment and onboarding of advisors to alleviate time commitment by the team/programs looking to engage. Also be consistent in tools and methods applied. Celebrate and build awareness as you engage.

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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 patient days; All patients; January 2015 – December 2015; Publicly Reported, MOH)	958	0.45	0.43	0.42	Target was achieved. See change ideas for details.

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Patient-centered hand hygiene	Yes	• Positive experience supporting a change in hand hygiene behaviour by patients, ensuring safe practices are maintained at the hospital. A unit-by-unit implementation approach allowed to identify barriers and celebrate successes along the way. Reception has been positive by all stakeholders such that we anticipate every unit to have PCHH implemented by the end of this fiscal year. • Key learnings include that delivering a patient-centred, high performing, collaborative and sustainable hand hygiene program is possible. Also, we received a strong willingness from both patients and healthcare providers to engage in this project focused as it focused around the patient. Patients greatly respect and trust healthcare providers involved in their circle of care, this initiative encouraged staff to inform and engage the patient in safe hand hygiene practices, thereby the patients responded well and were quick to comply with their instructions. The posters created served as a good reinforcement of the messaging. This project is an excellent example of patient-centred care, in which we had a patient join the committee, informing us how best patients would learn and assisted with the creation of educational material to encourage patients to practice hand hygiene. Another lesson learned was the importance of allocating a budget and required resources at the onset of the project. As no budget existed for this project, the Directors informed their managers to cover the cost of the posters and the ABHR holders and gel. We learned that this expectation must be

repeated quarterly when new units were added. A clear and organized implementation plan and checklist allowed to easily roll-out the program to other units and managers. The PCHH program overall involves shared responsibility and teamwork by the patient and staff, so multiple opportunities exist for reinforcing the message. • This project was innovative and ground-breaking and to our knowledge we are the only hospital with a formal PCHH program. Although we have not seen a direct impact between the introduction of PCHH and a change in infection rates, the change ideas adopted have made an impact on changing the focus of hand hygiene to be centred around the patient. This project has allowed staff to help increase the level of knowledge and awareness of PCHH and its importance for patient safety. We will also be conducting semi-structured interviews with nurses to collect qualitative data on their experiences. • Embarking on a hospital-wide implementation of a new initiative requires the patient voice, a multidisciplinary team, and continuous follow-up. It is important to celebrate successes, recognize areas/people doing well, and to focus on the positive. A project will succeed if you and your team are working on something you truly believe in.

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3	Medication reconciliation at admission within target: The total number of patients with medications reconciled within 48 hours of admission as a proportion of the total number of patients admitted to the hospital with a complete Best Possible Medication History (%; with completed BPMH; most recent quarter available; Hospital collected data)	958	84.80	89.00	78.20	The current performance value for med rec at admission is 78.20%. The previous baseline and target values were initially set at 84.80% and 89.00% respectively. However, a discrepancy in the attribution of the data set was noticed shortly after the submission of the QIP in March 2016 and consequently the baseline and target values were readjusted to 77% and 81%. These changes were made on all public documents from TOH as advised by HQO.

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Improve physician compliance with medication reconciliation at admission through targeted interventions, increasing corporate awareness, and training to Medical Divisions not meeting goals.	Yes	• Although 3/4 of the targeted groups have shown some improvement in the Med Rec area of focus (admission or discharge), hospital wide med rec metrics have not reached our target. AMR in target performance has remained rather stable in the last quarter while DMR in target has seen improvement since Q1 but is still at the previous year's baseline. • The systems, process, education and training components to complete med rec both at admission and discharge are well structured. The resources are available but the challenge remains integrating this into the standard workflow of

physicians and to have a formal system for greater accountability. • Yes, the change idea made and impact on selective units, however not every one of the targeted areas responded in the same way. This improvement idea was heavily focused on providing timely data to physicians and having them respond to meet the compliance. Although some areas responded positively, there was areas that did not and ultimately, the metric did not improve as a result. • Med Rec has a been a focus for our institution for many years and we have made great progress. Every year we have raised our goals either in terms of completion % or time of complete. or both. We have reached a point were the processes and education available can no longer move this metric beyond our targets. A firm and clear structure for physicians accountability around this practice is now required to drive these Med Rec metrics to a new level.

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4	Percentage of acute hospital inpatients discharged with selected HBAM Inpatient Grouper (HIG) that are readmitted to any acute inpatient hospital for non-elective patient care within 30 days of the discharge for index admission. (%; Discharged patients with selected HIG conditions; July 2014 – June 2015 ; CIHI DAD)	958	16.96	16.96	17.39	Target was not achieved. See change ideas for details.

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Optimize the use of the Rapid Referal Clinic to ensure patients discharged from General Internal Medicine receive effective follow-up care	Yes	• Standard referral process implemented across all GIM units since July 2016 • Indicator was 30 day readmission rate for GIM not specific to HIGs. The data is trending towards improving this indicator. A larger sample size would confirm this. • Getting multiple units, campuses, physicians required engagement to implement a new process. Frequent reminders were needed to ensure the process was followed. Physicians and units following the new process, and seeing benefit. • Benefits: Patients seen in a timely fashion, and trending towards reducing readmissions and physicians seeing a benefit to the appointments Process seems simple but very complex and required multiple reiterations and investment in actively resolving problems as they arose. Required significant time and resources. Needed key project leads to drive the process

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5	Proportion of ED visits admitted with ED length of stay less than or equal 24 hours. (%; ED patients; January 2015 - December 2015; SMS)	958	82.00	86.00	76.20	Target was not achieved. See change ideas for details.

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Orange dot trigger and anticipatory transfer of ED patients	Yes	• The roll out to all non-monitored units is scheduled for Feb. 1 2017. This is 1 month behind schedule, but it ensured clear communication was provided to the organisation • Data drives change. Safety concerns must be immediately addressed. It is important to involve all stakeholders. When choosing metrics as measure of success, realize there are many variables that may affect these metrics. • Initially results showed we saved 55 minutes of ED stretcher time per patients on pilot unit. • Advice would be to communicate, respond to concerns in a timely manner, dispel myths.
Patient Driven Checkout	No	• The units where this checkout trial was initiated have reported success & have noticed it has made a difference in both patient satisfaction (feel discharge is complete) & in communication (clerks get confirmation of discharge faster). Project momentum was lost many times and full change idea was not implemented as intended. • Need to stay on track & keep momentum going on current units in order to guarantee continued interest & commitment • Many pressures (occupancy at hospital) have made it more difficult to keep this project a top priority • Key learning include the need to set firm timelines, book meetings well in advance of set schedule, adhere to project charter in order to stay committed & on-track, set goal dates and have

		more accountability with frequent check-ins to see if everyone is staying on track
Continue focus on improving the safe, timely and effective discharge of patients with speread of discharge board and rounds process to inpatient oncology units.	Yes	• The data shows that the percentage of patients who are being discharged by 11am has not improved. • The communication has improved in the unit. The team seem to be working better to come up with the discharge plan. On occasion, we believe the implementation of boards have reduced the length of stay. Consult services (for example Physiotherapy) have been involved sooner because the multidisciplinary discussions are happening. • This change has made an impact on enhancing communication between providers within the team, however no impact has been observed with this specific indicator. • This indicator seems to be highly physician driven, therefore it requires strong partnership between management and physicians.

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6	Risk-adjusted 30-day all-cause readmission rate for patients with CHF (QBP cohort) (Rate; CHF QBP Cohort; January 2014 – December 2014; CIHI DAD)	958	23.36	22.20	20.98	Target was achieved. See change ideas for details.

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Extension of post discharge phone call program	Yes	• Although we encountered some barriers with implementation of IVR and the IS enhancements which forced us to reevaluate how we could meet the planned improvement we were able to prioritize post discharge phone calls and capture 85% of patients discharged from the hospital • We obtained enhanced data quality in the development of an algorithm and an operational manual. There is now a process to escalate calls and prioritize disease specific calls • We changed the call prioritization schedule and now are reaching more patients. • This indicator requires collaboration and strong partnerships between management, physicians and the patient

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7	Risk-adjusted 30-day all-cause readmission rate for patients with COPD (QBP cohort) (Rate; COPD QBP Cohort; January 2014 – December 2014; CIHI DAD)	958	20.01	19.01	20.97	Target was not achieved. See change ideas for details.

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8	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 2015 – September 2015; WTIS, CCO, BCS, MOHLTC)	958	13.90	12.50	14.34	Target was not achieved. See change ideas for details.

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Active use of repatriation policy	Yes	• We were able to execute the methods and objectives set to provide educational tools for Repatriation. • Ongoing process-launched the education material, tools and process. • Although repatriation tools and education were provided and made readily available, there needs to be a deeper dive into the reasons behind cancellations, etc. • This change idea generated a lot of discussion and awareness around the repatriation practice and areas of improvement. Still continue to receive questions regarding the "report" -inpatients units seem to have adopted it into the daily practice with rounds. • Continue to follow up on implementation, ongoing use of resources provided on the inpatient unit. Monitor metrics month over month for opportunities.
Alternative Level of Care Toolkit	Yes	• Progress has been slower than anticipated due to various organizational constraints (Form approval, meetings with physicians and residents, etc) • It was a great opportunity to review ALC designation with staff and to debunk some myths about ALC and the ALC process. It was also a good way to identify efficiency ideas • It is possible, although somewhat challenging, to enforce one effective process to designate patients ALC. Some ALC designations still need to be reversed, particularly at times of high occupancy, to ensure that the provincial definition of ALC is followed accurately. We suggest that some fine tuning of process issues is still needed. • The idea of the Toolkit and order form was well received; ongoing education about the ALC

process should be sustained to continuously debunk myths and perceptions about ALC. The education associated with the Toolkit and ALC Order Form implementation has made an impact with the designation and also brought awareness to this issue with the CMs, CCLs, MDs and SWs assigned to high volume admissions and ALC designations." • Advice is that when implementing new forms and roll-out to physician group, allow more time for development and for implementation. Form development process can be detailed and onerous. Education about ALC designation and discharge planning has to be pushed out with motivation and broad reach as this is not a topic that is always front of mind for clinicians.

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9	Total number of discharged patients for whom a Best Possible Medication Discharge Plan was created prior to discharge as a proportion the total number of patients discharged. (%; All patients; most recent quarter available; Hospital collected data)	958	75.30	79.00	75.30	Target was not achieved. See change ideas for details.

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