2017/18 Quality Improvement Plan
"Improvement Targets and Initiatives"

The Ottawa Hospital - Ottawa Hospital 501 Smyth Road

AIM		Measure							Change				
Quality dimension	Issue	Measure/Indicator	Unit / Population	Source / Period	Organization Id	Current performance	Target	Target justification	Planned improvement initiatives (Change Ideas)	Methods	Process measures	Target for process measure	Comments
Effective	Coordinating care	Percentage of patients identified with multiple conditions and complex needs	% / Patients meeting Health Link criteria	Hospital collected data / Most recent 3 month period	958*	CB	CB	Will be determined once pilot results are analyzed.	1)Population health strategy for health links	1) Project team will review the findings of the current-state pilot project and seek to optimize opportunities to expand	1) Number of Health Link patients identified 2) Proportion of patients offered access to HealthLinks by area 3) Creation of work flow process and establish baseline	Will be determined once pilot results are analyzed	Consider design linkage between Rapid Referral Clinic and Health Links seeking to
	Effective transitions	Did you receive enough information from hospital staff about what to do if you were worried	% / Survey respondents	CIHI CPES / April - June 2016 (Q1 FY 2016/17)	958*	61.9	65.00	Target set for 5% improvement. We are doing better than the provincial	1)Systematic implementation of Patient Engagement Framework	1) Systematic development and implementation plans to be developed for each aspect of TOH's Patient Engagement Framework	1) Completion and rollout of each aspect of the TOH's Patient Engagement Framework	1) Systematic development and implementation plans to be developed for each	Multi-year initiative
		Risk-adjusted 30-day all-cause readmission rate for patients with CHF (QBP cohort)	Rate / CHF QBP Cohort	CIHI DAD / January 2015 - December 2015	958*	20.98	20.00	Target set for a 4.7% reduction that builds on the success of previous year's	1)Implementation of Ottawa Smoking Cessation Model	1) Coordinator to perform baseline 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) By April 1, 2017, intervention will be	1) % 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)	1) 80% of expected inpatient smokers. TOH is to provide the Ottawa Model for Smoking	Past studies have demonstrated that inpatient smokers who were offered the
		Risk-adjusted 30-day all-cause readmission rate for patients with COPD (QBP cohort)	Rate / COPD QBP Cohort	CIHI DAD / January 2015 – December 2015	958*	20.97	19.50	Although our current baseline for this indicator is identical to the rate for the CHF	1)Implementation of Ottawa Smoking Cessation Model	"1) Coordinator to perform baseline 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) By April 1, 2017, intervention will be	1) % 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)	1) 80% of expected inpatient smokers. TOH is to provide the Ottawa Model for Smoking	Past studies have demonstrated that inpatient smokers who were offered the
		Readmissions - 30 day unplanned (%)	% / Discharged patients	SMS (In-house registration system) / Dec/15-Nov/16	958*	10	9.50	Performance has improved but we are a low performer. Targets set to for 5% improvement.	1)Planning and execution of new Health Information System platform and program delivery	1) Program plan and scope confirmed and contract obtained 2) Recruitment and training of project teams 3) Finalization of governance structure 4) Execution of program plan"	Meeting baseline scheduling estimate	1) Completion of first three items by Q2 2) Execution of program started by Q3 extending into	Multi-year initiative.
									2)Optimize use of ambulatory care clinics to avoid ED visits and readmission (Rapid Referral Clinic)	1) Expand the program to other divisions within the hospital including other medicine and surgical areas.	1) Completion of rollout and implementation for each activity	1) Q1, complete data collection to evaluate RRC 2) Q2, design linkage between RRC and	This initiative builds on the success of previous year's work related to
Efficient	Access to right level of care	Total number of alternate level of care (ALC) days contributed by ALC patients within the	Rate per 100 inpatient days / All inpatients	WTIS, CCO, BCS, MOHLTC / July – September 2016 (Q2 FY 2016/17 report)	958*	14.34	12.50	Target set at the HSAA agreement value. We are the lowest performer	1)Patient flow optimization and discharge enhancements	1) To develop the discharge planning coordination role and gather information to standardize and optimize patient flow 2) Close the gaps using a QI approach (starting with integrated discharge planning) 3) Look for opportunities to conduct natural experiments to	1) Overall flow independent of ALC	1) Metric and target to be determined as project develops	Will also look for opportuniteis to better articulate ALC challenge to our partners.
	Efficiency	Cost per weighted case - Total acute/DS ($/HIG)	Dollars / All acute IP and DS	CIHI DAD / Oct/15-Sep/16	958*	6240	5900.00	Target set to reflect MOH Expected TCPWC (acute/DS)	1)Surgical Supply Costing	1) Create a baseline of costs by service, procedure and surgeon 2) Generate consumable data to clinical staff 3) Engage clinical community and provide them with data to drive practice change to drive better cost and quality to the patient. 4) Establish an efficient Nurse workflow	1) Progress on selected activities 2) Increase surgeon awareness of cost per case"	1) Capture complete and accurate costs and quantities of surgical supplies	Exposure of detailed case costing to Clinical Staff will enable data driven
Patient-centred	Palliative care	Percent of palliative care patients discharged from hospital with the discharge status	% / Palliative patients	CIHI DAD / April 2015 – March 2016	958*	91.67	90.50	We are the best performer among our benchmarked peers by an	1)Optimize palliative support	1) Develop project management plan and establish baseline around 4 guideline metrics from the Ontario Palliative Care Network (OPCN) 2) Create checklist to ensure that the 4 guidelines are in place and work with community partners to close gaps in care"	1) Number of audited charts of patients discharged home and followed by internal palliative care	1) Identification of indicators of success to be completed by Q3 2) Development of	
	Person experience	Overall Rating of Experience Inpatient survey (% Top Box)	% / All inpatients	CIHI CPES / Apr/16 - Nov/16	958*	68.6	72.00	Aim for 5% improvement	1)Systematic implementation of Patient Engagement Framework	1) Systematic development and implementation plans to be developed for each aspect of TOH's Patient Engagement Framework	1) Completion and rollout of each aspect of the TOH's Patient Engagement Framework	1) Systematic development and implementation plans to be developed for each	Multi-year initiative

									2)Enhance audit and feedback mechanisms	1) Patient and Family Centered Communication Working Group, in collaboration with other Patient Experience Working Groups, will continue to manage and execute selected patient experience projects. 2) Implementation and communications subgroups will	1) Number of patient experience initiatives completed 2) Number of non-physician trained per month 3) Patient experience dashboard usage	1) Implementation and communications subgroups will ensure focused	
Safe	**Safe care**	CDI rate per 1,000 patient days: Number of patients newly diagnosed with hospital-acquired CDI	Rate per 1,000 / All inpatients	Publicly Reported, MOH / January 2016 - December 2016	958*	0.42	0.40	After 2 years of increasing CDI rates, this past year we have improved and	1)Standardize and implement environmental control systems (Care Environment)	"Implement recommendations from Infection Control Resource Team (ICRT) visit (September 2016) to: 1) Evaluate effectiveness of Housekeeping training and standardized processes 2) Close the gaps using a QI approach 3) Look for opportunities to decrease	1) Establish baseline of current performance 2) % of HK staff trained 3) % of staff audited for effectiveness of training and compliance to standardized work 4) Number of standard housekeeping work practices established 5) Number of standardized cleaning	1) Identify current performance metrics by Q1 2) Determine frequency of audits	
		Hospital Standardized Mortality Ratio (HSMR - 2015)	Ratio (No unit) / All inpatients	CIHI DAD / Nov/15-Oct/16	958*	83.3	80.00	Same targets as last year to maintain high performance	1)Drug stewardship	This is a new program. TOH will begin looking at best practices in the field and create a committee to oversee.	Change initiatives will focus on building a comprehensive drug stewardship program through enhancement of our antibiotic stewardship program. As such it will still focus primarily on the appropriate use of antibiotics.	1) Bolster current program in Q1 – Q2 by: - Identifying the improvement needs to the	
		Urgent surgical cases (A-E) performed within target (%)	% / All urgent surgeries	SIMS (In-house surgical system) / 2016	958*	76.7	85.00	Performance for this indicator has previously been quite strong. Bundled	1)Organizational redesign of urgent surgery	1) By end of Q1, we will formulate our revised model and recommendation for urgent vs plan surgery. In Q2, we will begin the staffing and scheduling changes. In Q3 - Q4, we will be full implementation. This process will result in enhanced system and process monitoring and	1) Surgical case hours, case volume, block hours (budgeted), surgical classifications (Elective, A-H), wait times, compliance to classification, surgical room utilization and LOS	1) 100% implementation of recommendations for Q4 2) Higher compliance in all	The initiative may morph into more of a Process Redesign requiring us to
	Staff Safety	Staff incidents - Total reportable workplace incidents per month	Counts / All staff from TOH	Parklane / Nov/15-Oct/16	958*	43.7	41.00	Performance has shown steady improvement but we are a low performer. Target set for slightly above 5% improvement.	1)Implementation of Just Culture within processes and culture	1) Q1: Roll out plan for all staff including providing Just Culture education for all staff. At the same time, by end of Q1, we will have enhanced the event investigation and have the roll out strategy for this defined. 2) Q2-Q4: Carry on with planned rollout and develop	1) % of staff trained (for general just culture) 2) % of leaders trained (event investigation)"	1&2) 100% by end of Q4	
									2)Violence in the workplace initiatives	1) Rollout comprehensive plan to prevent violence and harassment in the workplace. The core elements of our violence prevention program are implementing preventative measures through risk assessment, providing training appropriate to the level of risk for all	1) % of staff trained 2) Number of risk assessments completed 3) Number of recommendations implemented 4) Establish baseline for personal alarms available for summoning assistance.	1) Target: 98% compliance with mandatory violence and harassment	
Timely	**Timely access to care/services**	90th %ile ED LOS – Non-admitted CTAS I-III (hours)	90th percentile / Non-admitted ED patients	SMS (In-house registration system) / 2016	958*	8.25	8.00	Performance has slipped and we are a low performer. Target is set at	1)TOH-wide implementation of orange dot moves	1) Expand previous year's pilot program to other medicine units 2) Spread orange dot process to all ED patients admitted to non-monitored units corporately. Expand scope of Orange dot to internal transfers	1) Family satisfaction, Stretcher availability 2) ED stretcher time savings 3) Disposition decision to inpatient bed time	1) Goals and targets will be set as a 5-10 % improvement based on the	This indicator is linked to another indicator. See Proportion of Admitted
		Proportion of Admitted Patients whose ED LOS was less than 24 hours (%)	% / Admitted ED patients	SMS (In-house registration system) / 2016	958*	76.2	83.00	Performance has slipped and we are a low performer. More aggressive target	1)TOH-wide implementation of orange dot moves	1) Expand previous year's pilot program to other medicine units 2) Spread orange dot process to all ED patients admitted to non-monitored units corporately. Expand scope of Orange dot to internal transfers	1) Family satisfaction, Stretcher availability 2) ED stretcher time savings 3) Disposition decision to inpatient bed time	1) Goals and targets will be set as a 5-10 % improvement based on the	