Excellent Care for All

Quality Improvement Plans (QIP): Progress Report for the 2015/16 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 2015/16	Org Id	Current Performance as stated on QIP2015/16	Target as stated on QIP 2015/16	Current Performance 2016	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", "Very good" and "Good" and divide by number of respondents who registered any response to this question (do not include non-respondents). (%; All patients; October 2013 - September 2014; NRC Picker)	958	95.60	96.00	95.50	We did not achieve target. Measurement against target may be impacted by evaluation timeframe as implementation of change ideas occured Q3-Q4 (impact of these efforts would be seen after Sept 2015). We will continue to work toward target in 2016/2017.

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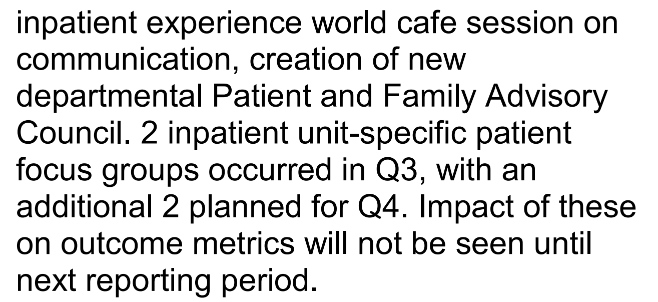
Change Ideas from Last Years QIP (QIP 2015/16)	Was this change idea implemented as intended? (Y/N button)	Lessons Learned: (Some Questions to Consider) What was your experience with this indicator? What were your key learnings? Did the change ideas make an impact? What advice would you give to others?
Develop and implement an education program to promote communication where staff and physicians consistently seek to understand, act on, and document the perspectives, wishes, and goals of patients, families, and caregivers	No	Change initiatve was led by the Patient and Family Centred Communication Workgroup, with oversight from the Patient Experience Steering Committee. Developed workplan to include developing and implemented education, defining related metrics and establishing accountability. To inform the key content of communications standards and the related education, an expert panel consultation was held followed by broader World Café style consultation of staff, physicians, volunteers, and patients and

		families. Trajectory of change initiative is on track, but delay implementation against goal timeliness due to efforts to ensure broad stakeholder consultation in design and content development phase. Focused on engaging ann developing champions to promote the required organizational culture change related to patient centred communication. . The implementation plan will be developed in Q4 with an initial roll out beginning. Key indicators and an accountability framework will be finalized in Q4. Key learnings include importance and benefit of proactively engaging patient and family voice early, and in all phases of change idea development. Also active engagement of staff and physician throughout all phases has been extremely beneficial. As per Dec 2015, fiscal YTD data shows 3.6% improvement in % positive nursing communication and 3.9% improvement in % positive physician communication as per NRC Picker. Nurse leader rounding data shows 1.9% improvement in perception of nursing communication (to 97.2% positive)and 2.3% improvement in perception of physician communication (to 93.2% positive) over previous fiscal year.
Embed the patient voice in quality improvement activities	Yes	Change initiative was led by the Patient Experience Integration Committee with oversight from the Patient Experience Steering Committee. Expectations were established in Q1. Complete corporate inventory of initiatives that include embedded patient voice was established. Patient Focus Group Toolkit was finalized and promoted in Q2 with broad communication and workshops targetting clinical leaders. Target units for implementation of patient focus group were identified and supported with education and coaching throughout implementation. Report of patient focus group learnings was received. Achived goal of minimum 10 quality improvement projects with patient focus group or patient advisor included within this fiscal year. this included completion of patient focus groups, inclusion of patient advisors as members inpatient experience committees and workgroups,



inpatient experience world cafe session on communication, creation of new departmental Patient and Family Advisory Council. 2 inpatient unit-specific patient focus groups occurred in Q3, with an additional 2 planned for Q4. Impact of these on outcome metrics will not be seen until next reporting period.

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2	Total Margin (consolidated): % by which total corporate (consolidated) revenues exceed or fall short of total corporate (consolidated) expense, excluding the impact of facility amortization, in a given year. (%; N/a; Q3 FY 2014/15 (cumulative from April 1, 2014 to December 31, 2014); OHRS, MOH)	958	-0.31	0.00	-0.41	Total margin was not zero as of December 31. Management is forecasting a balanced budget at year end given the budget recovery plan initiated in November 2015.

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Define and seek to improve ratio of outcomes over cost for Quality Based Procedures (QBP)	No	As per the identified change idea, a QBP toolkit was developed using one QBP as a pilot, then evaluated for application to other QBPs. The Colorectal QBP was selected for the pilot. A balanced scorecard/dashboard was developed in consultation with key stakeholders to provide an overview of the service line and to reflect patient needs. The factors influencing the cost of the above QBP were identified and are currently being investigated/addressed. In addition to the above, an excel tool was created which breaks down the costs of all QBPs. Key learnings during analysis were the limitations of the toolkit model. It was not sufficient to accomplish the desired goals for two reasons: first, it is not flexible enough to be applied to all QBPs, and secondly does not promote prioritization based on key problem areas and greatest opportunities for gain. Further work on developing a more flexible, suitable model is underway to address these limitations.
QBP framework development	No	This change idea is not yet implemented but still in development. Its goal is to promote a holistic approach to process improvement surrounding the QBPs, focused on the patient journey and the ratio of outcomes over cost. The framework will allow management to allocate resources appropriately and prioritize activities based on organizational needs and supporting objective evidence.

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3	Readmission within 30 days for Selected Case Mix Groups (%; All acute patients; July 1, 2013 - Jun 30, 2014; DAD, CIHI)	958	18.24	18.00	18.90	See individual change ideas.

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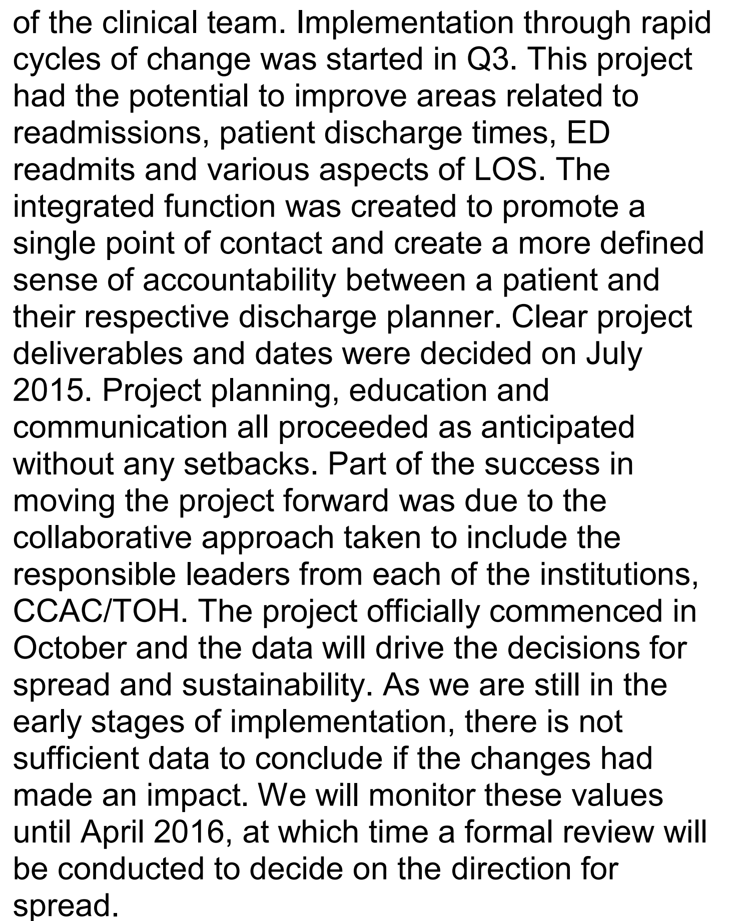
Conduct a review of the post discharge phone call program	Yes	A comprehensive review of the post discharge phone call pilot program was completed along with an options analysis for planning toward sustained operationalization. This analysis will be brought to the Quality and Performance Council in Q4 for decision on the program model go-forward. Preliminary data identified benefit of the post-discharge phone call with respect to readmissions. Data analysis also revealed those patient groups at higher risk for readmission, which will inform allocation of resource calls going forward. The centralized RN callers address numerous patient concerns and breakdowns in coordination of care on a daily basis. Issues related to understanding discharge instructions, knowing signs and symptoms to watch for, medication management and coordination of follow-up care are all managed by the centralized callers. Approximately 2% of calls are also escalated to physicians or clinical leaders from discharging units to address care issues. A total of six 911 calls have been made by the post-discharge callers since the centralization of the program in May 2014. In each of these instances, patient symptoms suggested a life-threatening situation. In addition to shaping the future of the program, this data will also be used to inform 2016/2017 initiatives within other projects targeting discharge project, coordination with ambulatory care and patient experience.

Complete transition navigator pilot project	Yes	The transition navigator demonstration project was completed in June 2015. There was no significant impact in the readmission rates for the targeted group of medically complex patients. Detailed findings were disseminated to the collaborating parties including the Ottawa Hospital, Community Care Access Centre, and Bruyere Family Health Team. Funding for the project had elapsed and although there was potential for further funding, the steering committee decided that given the results and HR challenges, it would not be feasible to continue the project. Each party was to take away key learning and apply them to their own institutions. A formal report of the TN project findings and results is expected to be available soon. At the Ottawa Hospital, opportunities were identified to transition some of the successes into the integrated discharge planning model proof of concept. The new proof of concept began in September 2015.
Collaborate with Champlain CCAC to better understand the drivers for Readmission and Return to the Emergency Department for patients discharged home with CCAC services	No	The data analysis of elective general surgery and internal general medicine patients was completed as described with a focus on identifying key drivers to readmission and return to ED. The findings were compiled and reviewed together with CCAC. However, the final step of implementation against these key drivers was not completed for two reasons: 1) it proved difficult to distinguish causal effects for those more complex patients who are by nature of their conditions at higher risk for readmission to begin with, and 2) there were challenges aligning organizational priorities against identified gaps in a collaborative manner due to work already underway in each organization. However, learning from this data have been and will continue to inform other quality improvement initiatives.
Implement integrated discharge planning model (IDPM) proof of concept.	Yes	Implementation of the Integrated Discharge Planning Model (IDPM) was conducted at one nursing/medicine unit at the Ottawa Hospital. The goal was to improve the coordination of care for all patients discharged from this unit. This process involved redefining and reassigning the roles and responsibilities currently offered by CCAC care coordinators and TOH social workers. The IDPM proof of concept project involved a thorough analysis of the current state including value stream mapping within a contained nursing unit; and the findings were then used to help realign the roles and processes



of the clinical team. Implementation through rapid cycles of change was started in Q3. This project had the potential to improve areas related to readmissions, patient discharge times, ED readmits and various aspects of LOS. The integrated function was created to promote a single point of contact and create a more defined sense of accountability between a patient and their respective discharge planner. Clear project deliverables and dates were decided on July 2015. Project planning, education and communication all proceeded as anticipated without any setbacks. Part of the success in moving the project forward was due to the collaborative approach taken to include the responsible leaders from each of the institutions, CCAC/TOH. The project officially commenced in October and the data will drive the decisions for spread and sustainability. As we are still in the early stages of implementation, there is not sufficient data to conclude if the changes had made an impact. We will monitor these values until April 2016, at which time a formal review will be conducted to decide on the direction for spread.

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4	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; Jan 1, 2014 - Dec 31, 2014; Publicly Reported, MOH)	958	0.33	0.30	0.45	We did not achieve our target. The change idea was fully implemented and perceived as successful in improving access to key information. We will continue to work toward target in 2016/2017.

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Monitor environmental hygiene Eco-lab unit-level data	Yes	Focus for this year's initiatives was to make Eco-lab unit level data easily accessible to all staff to inform, educate and stimulate quality improvement of cleaning practices. The "Environmental Audit Touch Point" was moved to a dashboard, allowing broader access to this critical information across the organization. This was coupled with a extensive corporate communication strategy targeting all leaders, care providers and support staff who play a role in infection control. Easier access via the dashboard makes it easier for leaders to track compliance with cleaning best practice, and identify and address opportunities for improvement based on trends seen. The dashboard also relays critical information in real time which benefits SWAT response to outbreak as it informs root cause analysis. CDiff is a multi-factorial issue. This year's change initiative had significant impact on the organizational ability to understand and direct efforts toward potential root causes of outbreak. All goals in this area were achieved. Key learnings were that the dashboard approach was beneficial, however to have an impact on overall CDiff rates, there is a need to provide more detailed information at unit level and promote accountability by local leaders to affect change.

		Ensuring use of data is an ongoing challenge. To promote this, a push approach to the data access was implemented when CDiff rates worsened.
Unit level CDiff information available on dashboard and pushed out when rates increase	Yes	Creation of CDiff dashboard that is directed toward clinical managers which allows them to drill down to unit level data vs. organizational performance. This allows for more targeted improvement efforts and a better understanding of current state issues. Work is underway to consolidate all information related to CDiff and environmental audits into one bundle that adds clarity to key issues and is available for clinical leaders.

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5	ED Wait times: 90th percentile ED length of stay for Admitted patients. (Hours; ED patients; Jan 1, 2014 - Dec 31, 2014; CCO iPort Access)	958	29.30	26.70	28.38	We did not achieve target, although change initiatives around discharge were implemented successfully on medicine and surgery and as a result, as of Q3 Fiscal YTD rates of % discharge by 11am have shown a 44% improvement in medicine and a 15.5% improvement in surgery over 2014/15 FY. 90th %ile ED Wait times are multi-factorial however 2015/16 performance is largely attributed to ALC patient days.

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Maintain the focus on improving the safe, timely and consistent discharge of patients on the following units: A5, B5, D5 and B2	Yes	Work to improve the safety, effectiveness and timeliness of discharge continued on these four target units in 2014/15 as well as across the organization through a number of corporate discharge initiatives. On the four target units, the focus was on refining the discharge rounds process, improving communication to patients about discharge, improving rates of discharge by 11am and addressing barriers to discharge. This discharge rounds model, which has shown positive impact on discharge by 11am on these units, staff satisfaction with team communication, and improvements in identification of estimated discharge dates, was spread to an additional 5 inpatient medicine and surgery units in Q2-3, with another 5 implementations planned in Q4. Outcome and process measures were captured for each unit, and local clinical leaders were engaged in review of these on a weekly basis. On B2, a surgical unit, patient awareness of discharge time was targeted through implementation of pre-admission

		education in the PAU. On the medicine units of A5, B5 and D5, efforts were focused on ensuring the bedside care boards in the patient rooms were kept up to date with an accurate estimated discharge date or care plan, and that patients received timely, clear information about discharge. Awareness of signs and symptoms to watch for, medication management, and effective coordination of follow-up appointments are all critical elements in safe discharge and were identified as opportunities for improvement through the post discharge phone call program. As such, emphasis was also placed on improving written discharge instructions for patients. New surgery and medicine discharge instruction tools were created through extensive interprofessional and patient consultations, and these were implemented across the 14 inpatient medicine and surgery units as well as in nephrology and Neuro Assessment Unit. Baseline measures related to booking follow-up appointments on A5, B5, and D5 were also captured, with root cause analysis to determine further opportunities for improvement in FY 2016/17.
Continue the work to improve the inpatient bed turnaround time for admitted patients in the ED	No	In 2014, an extensive value-stream mapping was completed and multiple initiatives related to bed turn-around time were identified. These initiatives were grouped into 4 processes and a large bed TAT committee was formed to work through improvement ideas related to each of the steps. The four processes flowed from patient discharge to a new patient admission from the ED. They are divided as such: 1)Patient leaves the bed to clerk enters bed empty time in system; 2) Clerk enters bed empty time in system to Housekeeping begins bed cleaning; 3) Housekeeping begins bed cleaning to Housekeeping completes bed cleaning; 4) Housekeeping completes bed cleaning to New patient arrives to the clean & ready bed. The objective was to reduce bed TAT and this would subsequently reduce ED wait times. To achieve the goals, the bed-TAT committee separated into three smaller subcommittees consisting of Patient Flow, Housekeeping and Bed Admitting Management. Members from each of these areas were responsible for enacting change ideas related one area of the bed TAT process and were responsible for reporting on their progress. However shifts in accountable parties and committees precluded significant implementation gains in Q1 and Q2. Key learnings from Q1-2 informed redesign of the project structure and a new model was implemented in Q3. A smaller team with a more direct line of accountability is helping the project stay on track. A single project manager for project

		oversight should prevent loss of project momentum caused by transitions from manager to manager. The goal is to ensure larger committee meetings are succinct and used to provide a progress update, while individual project teams only include members needed to help affect change locally. This will help all team members share the same accountability, responsibility and urgency to trial and test ideas. Progress will be tracked in Q4. Because of the complexity of bedTAT, evaluation of the progress in Q4 will be necessary to help us narrow our focus in 2016/2017.
Additional corporate discharge project work toward safe, timely and effective discharge.	Yes	Work was also done on improving discharge at a corporate level with a number of initiatives launched in 2014/15. A corporate discharge policy was created through collaborative interprofessional consultation and input. To support standard practice and consistent execution of all discharge tasks in operationalization of discharge planning and as a first step toward improved consistency of practice across the organization, a roles and responsibilities for discharge document was created for all possible discharge destinations. This document was reviewed for consensus during a world cafe session attended by physicians, residents, clinical leaders, senior management, other health professional, nursing and inpatient unit clerks. Current state surveying against this was completed with education development to follow to address practice and knowledge gaps. During the analysis phase of the large project in early 2014, staff and physicians had identified access to accurate, up to date information, tools and resources about discharge as a barrier to discharge. To address this, a working group was established to develop a web page dedicated to discharge and accessible to all staff and physicians through the internal myHospital page and via an icon on all iPads and desktops was created. This page launched in Q4.

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6	Medication reconciliation at admission: The total number of patients with medications reconciled as a proportion of the total number of patients admitted to the hospital (%; All patients; most recent quarter available; Hospital collected data)	958	80.90	85.00	85.70	We exceeded our target of 85% completion of medication reconciliation at admission, achieving a rate of 85.7% complete.

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Improve physician compliance with medication reconciliation at admission through targeted interventions and training to Medical Divisions not meeting target goal	Yes	We were successful in implementing the change ideas set out in this indicator and the changes have resulted in an 10.3% increase in overall AMR% complete rate from 77.6% to 85.6% for our targeted areas. Medical divisions performing below 85% in AMR% complete were identified from previous year's data and a corporate Med Rec committee was consulted to further narrow the focus on 5 targeted departments. Instead of targeting all departments performing under 85%, it was decided that the best use of resources leading to effective change would be apply interventions on the lowest performing groups with high number of cases. Interventions started in Q1 FY and substantial progress was observed by Q2 and Q3 We believe that the selected interventions, which included 1) providing medical department/divisions with monthly AMR compliance control charts and; 2) setting clear roles of accountability for physicians, both contributed to the increase in the rate. Overall results for the hospital and targeted departments were reviewed on a quarterly basis by the Med Rec committee. The reviews often resulted in follow up actions such as facilitating conversations between the responsible and Department/Division leads and a co-chair from the Med Rec committee. These conversations greatly helped to reinforce the targeted goals and were

generally well received. Congratulatory emails were sent as improvements were achieved. Improvement in this area hinged on the fact that data and information was easily accessible and provided in an effective manner; and also that the expectations and physician accountability were established early and followed consistently.

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7	Total number of inpatient days where a physician (or designated other) has indicated that a patient occupying an acute care hospital bed has finished the acute care phase of his or her treatment, divided by the total number of inpatient days in a given period x 100. (%; All acute patients; October 2014 – September 2015; DAD, CIHI)	958	12.94	12.48	13.97	We did not achieve our target. Performance can be attributed to downstream bottleneck for community based services.

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Develop a proposal in collaboration with LHIN partners for a transitional behavioral unit for long stay patients	Yes	Yes the change idea has been implemented as intended. The proposal will be developed as of Dec 31, 2015 and ready for submission. The solution for housing will be a partnership with MCSS who currently operate housing for the DD patients through DSOER. Healthcare will play a supporting role with a proposed Transition to team (DDFACT from The Royal) to provide mental health advice and management.