2016/17 Quality Improvement Plan
"Improvement Targets and Initiatives"

Ottawa Hospital (The) 501 Smyth Road

AIM		Measure							Change				
Quality dimension	Objective	Measure/Indicator	Unit / Population	Source / Period	Organization Id	Current performance	Target	Target justification	Planned improvement initiatives (Change Ideas)	Methods	Process measures	Goal for change ideas	Comments
Effective	**Reduce 30 day readmission rates for select HIGs**	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.	% / All acute patients	DAD, CIHI / July 2014 – June 2015	958*	16.96	16.96	To align with corporate performance scorecard and maintain current high performance.	1)Optimize the use of the Rapid Referal Clinic to ensure patients discharged from General Internal Medicine receive effective follow-up care	1)Define criteria for referral and measurement process 2)Implement opportunities for improvement identified by the audit of demand and capcity 2) Monitor and evaulate the wait-times for the identified categories	1) Develop standard metrics template for wait-times 2) Weekly wait-times for follow-ups and triage levels	New referral process for the Rapid Referral Clinic that includes systematic patient assessment and better captures appropriate patients in place by Q3.	
	Reduce readmission rates for patients with CHF	Risk-Adjusted 30-Day All-Cause Readmission Rate for Patients with CHF (QBP cohort)	% / CHF QBP Cohort	DAD, CIHI / January 2014 – December 2014	958*	23.36	22.20	Set to improve by 5%	1)Extension of post discharge phone call program	1) Prioritize post discharge phone calls based on program review and thematic analysis to capture 85% of all CHF patients discharged at the hospital 2) Realign processes to maximize the calling rate, workload and to increase patient response	1) Call prioritization process in place 2) Number of eligible CHF patients discharged who receive post discharge phone calls	85% of eligible CHF patients receive a post-discharge phone call (baseline 46% completion)	'Eligble patient' = discharged home from medicine or surgery inpatient unit with or without services; not part of other follow-up program
	Reduce readmission rates for patients with COPD	Risk-Adjusted 30-Day All-Cause Readmission Rate for Patients with COPD (QBP cohort)	% / COPD QBP Cohort	DAD, CIHI / January 2014 – December 2014	958*	20.01	19.01	Set to improve by 5%	1)Extension of post discharge phone call program	1) Prioritize post discharge phone calls based on program review and thematic analysis to capture 85% of all COPD patients discharged at the hospital 2) Realign processes to maximize the calling rate, workload and to increase patient response	1) Call prioritization process in place 2) Number of eligible COPD patients discharged who receive post discharge phone calls	85% of eligible COPD patients receive a post-discharge phone call (baseline 54% completion)	Eligble patient' = discharged home from inpatient medicine or surgery unit with or without services, not part of COPD Outreach Program
Efficient	**Reduce unnecessary time spent in acute care**	Total number of ALC inpatient days contributed by ALC patients within the specific reporting period (open, discharged and discontinued cases), divided by the total number of patient days for open, discharged and discontinued cases (Bed Census Summary) in the same period.	% / All acute patients	WTIS, CCO, BCS, MOHLTC / July 2015 – September 2015	958*	13.9	12.50	Set to improve by 10%, with an absolute target in line with TOH's Hospital Service Accountability Agreement.	1)Active use of repatriation policy	1) Determination of who is eligible for repatriation 2) Adopt an e-trigger tool / report to identify eligible patients to physicians, managers and patient flow managers 3) Update repatriation practice to include eligible patients not sent from community hospital in the repatriation protocol	1) Number of patients repatriated per month for eligible patients 2) Number of patients that could not be repatriated per month due to unavailability of required services in their community hospital 3) Number of patients repatriated that did not originate from a community hospital	Increase repatriation of eligible patients by 10% for 2016/2017 as compared to previous year	An 'eligible patient' is someone that: Does not require tertiary care; Lives outside of the Ottawa's FSA (East, Central, West); Care needs can be met in a community hospital
									2)Alternative Level of Care Toolkit	1) Develop and review ALC toolkit; gather feedback among key stakeholders 2) PPM for Psychosocial Services will report to ALC Working Group on progress 3) Impact on ALC metrics will be tracked by ALC Work group	1) Use of ALC form by MDs; PPM for Psychosocial Services will request an audit through Performance Measurement 2) Availability of finalized toolkit on MyHospital Discharge Page 3) Audit Social work use of toolkit during Discharge Planning Rounds (%of SW actually using toolkit)	ALC Toolkit will be complete and available to users by March 2016. 90 % of escalated discharge situations will have a completed appropriate toolkit documentation completed by Q3	
Patient-centred	**Improve patient satisfaction**	"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	NRCC survey, CPES IC survey. / October 2014 - September 2015	958*	48.8	52.00	The change to report on "% Excellent" only aligns with our corporate performance scorecard. Baseline results use the National Research Corporation Canada (NRCC) survey. The Canadian Institute of Health Information (CIHI) Canadian Patient Experiences Survey—Inpatient Care (CPES-IC) will replace the NRCC survey in April 2016.	1)Develop, implement and evaluate Phase 1 of the Patient and Family Communication Program using a train-the trainer model	1) Develop the Patient and Family Communication Program, including support and supplementary materials, based on the World Cafe and expert panel consultation by August 2016 2) Develop train-the-trainer curriculum by Q3 3) Deliver training as per targets 4) Evaluate training program by Q4	1) % trainers trained 2) % staff and physicians who have completed Patient and Family Communication Education Program 3) % trainers participating in the program evaluation 4) % positive response on program evaluation	The Patient and Family Communication Program will be integrated into the new TOH employee orientation / onboarding by Q4. 30% of all TOH trainers will complete training by Q4; while, 80% of staff on acceleration units and 50% of transportation workers will have completed the Patient and Family Communication Program by Q4	
									2)Identify Framework to Optimize Patient Engagement	1) Establish framework for Patient Engagement Program aimed at optimizing patient engagement (includes maintaining patient advisor registry, supporting patient advisors, and supporting HPCs to include patient voice in QI activities). 2) Create toolkit and resources that guide HCPs in use of this program 3) Quarterly reports to Patient Experience Steering Committee	Number of items accomplished compared to devised timeline	Perform internal review of current patient engagement processes by Q1, review external practices from leaders in this field and identify key opportunities at TOH by Q2, establish basic framework by Q4	This will be a multi-year initiative

Safe	**Increase proportion of patients receiving medication reconciliation upon admission**	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 Best Possible Medication History completed within 24 hours	% / All patients	Hospital collected data / most recent quarter available	958*	77.0	81.0	Current performance and target reflect the tighter performance sought for AMR completion within 48 hours of admission.	1)Improve physician compliance with medication reconciliation at admission through targeted interventions, increasing corporate awareness, and training to Medical Divisions not meeting goals.	1) Monthly data reports of medication reconciliation at admission (AMR) compliance and AMR compliance in target (within 48 hours of admission) will be sent to targeted groups. 2) Performance data on Medical Departments/Divisions will be reviewed by Med Rec Steering committee on a quarterly basis to identify areas for improvement 3) Set roles and accountability for physicians to achieve targets and set follow-up meetings with committee chairs. 4) Committee will also plan and implement 'Transition Medication Reconciliation' in one service	1) Number of Medical Divisions each quarter performing below the AMR in target goal of 89%. 2) Number of Medical Divisions selected and targeted each month, and each quarter. 3) Number of corporate targeted interventions/communication and training sessions provided each quarter.	By Q4, increase AMR in target completion (within 48 hr of admission) from 84.8% to 89%.	
	Increase proportion of patients receiving medication reconciliation upon discharge	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	Hospital collected data / most recent quarter available	958*	75.3	79.00	Set to improve by 5%. Target to reflect the tighter performance sought for DMR completion at time of discharge.	1)Improve physician compliance with medication reconciliation at discharge through targeted interventions, increasing corporate awareness, and training to Medical Divisions not meeting goals.	1) Monthly data reports of discharge medication reconciliation (DMR) compliance will be sent to targeted groups. 2) Performance data on Medical Departments/Divisions will be reviewed by Med Rec Steering committee on a quarterly basis to identify areas for improvement. 3) Map current state processes in low performing surgical areas and identify and resolve barriers that prevent timely discharge medication reconciliation (DMR). 4) Set roles and accountability for physicians to achieve targets and set follow-up meetings with committee chairs.	1) Number of Medical Divisions each quarter performing below the DMR at discharge goal of 79%. 2) Number of Medical Divisions selected and targeted each month, and each quarter. 3) Number of corporate targeted interventions/communication and training sessions provided each quarter.	By Q4, increase DMR in target completion (at time of discharge) from 75.3% to 79%.	
	Reduce hospital acquired infection rates	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	Publicly Reported, MOH / January 2015 – December 2015	958*	0.45	0.43	Set to improve by 5%	1)Patient-centered hand hygiene	1) IPAC to develop patient centered education program and identify expected behaviours for patients and staff 2) IPAC and nursing units to develop robust auditing tool to collect compliance data, evaluate findings and perform additional PDSA 3) Connect with nursing practice to spread successes to other in-patient units	1) Number of alcohol based hand rub (ABHR) available for each patient 2) Percentage of staff that demonstrate prompting of hand hygiene to patients 3) Number of patients performing the expected behavior of hand hygiene	In implemented units, 100% of all admitted patients will receive hand hygiene best-practice education and 50% will demonstrate active hand-hygiene.	
Timely	**Reduce wait times in the ED**	Proportion of ED visits admitted with ED length of stay less than or equal 24 hours.	% / ED patients	Hospital collected data / January 2015 - December 2015	958*	82	86.00	Set to match TOH's new corporate performance scorecard measure.	1)Orange dot trigger and anticipatory transfer of ED patients	1) Gather, review and act on pilot data 2) ED to collaborate with nursing unit and housekeeping managers to establish an optimal workflow 3) Perform additional PDSAs on pilot unit, acquire senior level buy-in, implement in other units and provide quarterly updates to ED Wait Times Committee	1) Number of patients admitted and transferred to units per day, per month 2) Monthly analysis of saved stretcher time for all patients sent to pilot units 3) Impact to P4R indicator "Dispo decision to in-patient bed" times for GIM patients 4) Number of patient quality/safety concerns raised during trial compared to baseline	Reduce the current 90%ile stretcher time by 30 minutes from 128 to 98 minutes for all patients sent to the pilot unit at the end of Q1; and by 30 minutes for patients sent to all medicine units at the end of Q2. •By March 1st 2017, there will be a 10% reduction in the baseline "Dispo decision to in-patient bed time" of 21.65 hours to (Target) 19.45 hours.	
									2)Patient Driven Checkout	1) Engage clinical directors and patient flow committee for support 2) Engage clinical manager/ CCLs for each unit to determine the best mechanisms for collecting data 3) Patient Flow to set up excel database and send to clinical manager/CCL/ delegate to input data 4) Patient Flow in conjunction with working group will review and analyze data and send back to unit leaders for further implementation	1) Number of green cards disseminated to patients vs. actual discharges (% patients receiving card) 2) Percentage of green cards returned to the ACC 3) Median time from discharge to entered into SMS	- Greater than 80% of patients return green card on discharge - Reduce the time discharge reported in SMS from an average baseline of 13 minutes to 5 minutes	
									3)Continue focus on improving the safe, timely and effective discharge of patients with speread of discharge board and rounds process to inpatient oncology units.	1) Engage clinical and physician leaders in implementation of discharge rounds and board 2) Perform ongoing evaluation and tracking of discharge by 11am	1) Monthy proportion of patients discharged from inpatient oncology by 11am 2) Team attendance at rounds	1) 30% of patients on target units discharged by 11am by Q4 2) Representation by all team members at discharge rounds 90% of the time on target units	This is the continuation of multi-year corporate project