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

AIM		Measure						Change			
Quality dimension	Objective	Measure/Indicator	Unit / Popltn	Source / Period	Current perfmnce	Target	Target justification	Planned improvement initiatives (Change Ideas)	Methods	Process measures	Goal for change ideas
Effective	**Improve Home Support for Palliative Patients**	Number of palliative patients (inpatient acute care) discharged home from hospital with support, divided by the number of home discharges in the reporting period with a hospital admission that indicates that the patient is receiving palliative care.	% / Palliative patients	DAD, CIHI / April 2014 – March 2015	73.02	75.00	Continue to Improve	1)Community awareness/understanding of Advance Care Planning	Work with local health partners to provide Community Education Session re: Advance Care Planning	# of Community Advance Care Planning Sessions provided	One Community Education conference completed
								2)CCAC Palliative Referral	Refer appropriate palliative patients to CCAC for homecare planning prior D/C	# of palliative patients referred to CCAC from hospital will increase	Increase # of discharged palliative patients referred by 10%
								3)HealthLink Referral	Refer appropriate palliative complex patients to HealthLink planning prior D/C	# of palliative patients enrolled to local Health Link following hospital discharge will increase	Increase # of discharged palliative patients enrolled by 10%
	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	16.09	15.00	Continue to improve	1)Transition to Home (T2H) Discharge Plan - Patient Take-Away	Design/implement a 'T2H Patient Discharge Plan' document for patient reference and clear communication	# of T2H D/C Plans provided to patient cohort	Transition to Home (T2H) Discharge Plans provided to 80% of identified patients
								2)Transition to Home (T2H) Discharge Calls	T2H team will engage 'complex discharge' patients in a follow-up call within 48-72h of D/C from hospital	# of T2H D/C calls placed to patient cohort	Transition to Home (T2H) Discharge Calls place to 80% of identified patients
								3)HealthLink screening and referral	T2H team will screen/refer HealthLink appropriate patients prior discharge	Decrease 30d readmission rates for Health Link enrolled patients	Decrease 30d readmission for HealthLink patients by 5% of 15/16
								4)Implementation of NS-QIP ON - iERAS (project to Enhance Recovery after Surgery)	Review data sets through NS-QIP ON participation to identify opportunities for care quality improvements	Participation in all requirements of NS-QIP ON program	Identification and implementation of initiatives as identified
	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	19.49	19.49	Monitor	1)Monitor - Will focus on this metric in the next period	Monitor - Will focus on this metric in the next period	Monitor - Will focus on this metric in the next period	Monitor - Will focus on this metric in the next period
	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	18.13	17.10	Continue to Improve	1)COPD Task Force Initiatives	Review current processes and implement evidence based 'best practices'	# Initiatives implemented	80% of identified initiatives implemented
								2)COPD QBP Initiatives	Implement COPD QBP initiatives	30d Readmit rate for patients with COPD as admit diagnosis	Reduce 30d readmit rate for patients with COPD as main diagnosis to <15%
								3)Integrated COPD PR Community Rehab Program	Implement an integrated community based COPD Rehabilitation Program	# patients referred to community based integrated COPD Program	Increase referrals by 25% to community based integrated COPD Program
	Reduce readmission rates for Stroke patients	Risk-Adjusted 30-Day All-Cause Readmission Rate for Patients with Stroke (QBP cohort)	% / Stroke QBP Cohort	DAD, CIHI / January 2014 – December 2014	8.79	8.79	monitor	1)Monitor - Current Regional Program in early development. Will focus on this metric in the next period	Monitor - Will focus on this metric in the next period	Monitor - Will focus on this metric in the next period	Monitor - Will focus on this metric in the next period

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	21.7	20.00 Link to Pay @ Risk	Continue to Improve	1)Transition Management ALC Initiatives	Partnership strategies to better manage patient transitions, improve patient flow to discharge destination	Decrease ALC LOS , Decrease MNR admissions rates	Decrease by ALC LOS 5% of 15/16
								2)LHIN/Regional ALC Recommendations Initiatives	Work with LHIN partners to prioritize and implement local/regional strategies to decrease ALC hospital days	Decrease ALC LOS , Decrease MNR admissions rates	Decrease by ALC LOS 5% of 15/16
								3)Activation Program Redesign and Decentralization	Redesign/decentralize Activation Program to all inpatient units to decrease number of internal transfers and improve patient flow from the ED.	Decrease 90%ile Time to Inpatient Bed (from Decision to admit)	Decrease by 10% of current performance.
								4)HealthLink partnership project to provide a coordinated community care plan for complex patients to support their healthcare needs in the	Transition 2 Home team will screen and refer HealthLink appropriate patients engaging in early planning prior discharge	# of complex patients enrolled to local Health Link following hospital will increase	Increase # of discharged complex patients enrolled will increase by 30%
Patient-centred	**Improve patient satisfaction**	"Overall, how would you rate the care and services you received at the ED?", 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).	% / ED patients	NRC Picker / October 2014 - September 2015	92.61	93.00	Continue to Improve	1)"Patient Family Advisory Council" (PFAC) Patient Satisfaction Action Plan development	Share ED patient satisfaction survey, complaints/commendations trending to PFAC for feedback in process redesign	PFAC input into ED process design changes	Council input on implementation of 3-4 ED redesign initiatives
								2)Patient Visiting Redesign	Redesign Patient/Family Visiting Policy and related processes	Engage 'patient voice' input into process design changes	Updated Patient Visiting Policy implemented
								3)ED Wait-time initiatives	Improve satisfaction through decreasing ED wait through P4R initiatives	# of identified improvements implemented	Completion of >75% of initiative identified
								4)Implement Customer Service Initiatives	Implementation of initiatives such as Studer 'AIDET' and Age Awareness Education	Improve satisfaction through customer service improvements	2 Customer Service initiatives implemented
								5)ED Redesign	Implementation of redesigned space to enhance patient flow/patient experience	Improve patient satisfaction via redesigned space and flow	Completion of 60% of ED targeted renovations
								6)ED Crisis Team scope expansion	Improve patient satisfaction through care improvements for patients requiring mental health support	Decrease ALOS for patients requiring mental health support/care	Decrease ALOS (Form 1) by 10% of current performance
		"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).	% / Admitted Patients	In-house survey / Oct 2014 - Sept 2015	94.5	95.00 Link to Pay @ Risk	Continue to Improve	1)"Patient Family Advisory Council" (PFAC) Patient Satisfaction Action Plan development	Share patient satisfaction survey, complaints/commendations trending to PFAC for feedback in process redesign	PFAC input into Inpatient process design changes	Council input on implementation of 3-4 redesign initiatives
								2)Implement Customer Service Initiatives	Implementation of initiatives such as Studer 'AIDET', Gentle Persuasive Technique and Age Awareness Education	Improve satisfaction through customer service improvements	2 Customer Service initiatives implemented
								3)Patient Visiting Redesign	Redesign Patient/Family Visiting Policy and related processes	Engage 'patient 'voice' input into process design changes	Updated Patient Visiting Policy implemented

Safe	**Increase proportion of patients receiving medication reconciliation upon admission**	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	Hospital collected data / most recent quarter available	97.7	97.70	monitor	1)Perform well - Continue to hold gains	Monitor - Continue to hold gains	Monitor - Continue to hold gains	Monitor - Continue to hold gains
	Increase proportion of patients receiving medication reconciliation upon discharge	Total number of discharged patients for whom a Best Possible Medication Discharge Plan was created as a proportion the total number of patients discharged.	% / All patients	Hospital collected data / Most recent quarter available	8.33	20.00 Link to Pay @ Risk	Incremental improvement toward goal	1)Discharge Med Rec Working Group	Engage Stakeholder Task group to include internal and community Physicians and Pharmacy staff	Task group founded and meeting regularly to achieve goals for change	Achievement of D/C Med Rec deliverables as identified
								2)Develop of ordering and documentation of D/C Med Rec in EMR	Design D/C Med Rec components into Meditech	D/C Med Rec order entry and documentation processes in place in Meditech	D/C Med Rec order entry and documentation available in Meditech
								3)Hospitalist Patients Pilot	Develop and implement processes to support D/C Med Reconciliation is completed for Hospitalist enrolled patients on D/C from hospital	# of Hospitalist patients with poly-pharmacy with D/C Med Rec performed on D/C from Hospital	Increase # of Hospitalist' D/C Med Rec performed at D/C for this patient cohort by 50%
	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	0.4	0.40	monitor	1)Monitor - Low denominator makes system comparison difficult - no outbreak x4 years	Monitor - Low denominator makes system comparison difficult - no outbreak x4 years	Monitor - Low denominator makes system comparison difficult - no outbreak x4 years	Monitor - Low denominator makes system comparison difficult - no outbreak x4 years
		Number of times that hand hygiene was performed before initial patient contact during the reporting period, divided by the number of observed hand hygiene opportunities before initial patient contact per reporting period, multiplied by 100.	% / Health providers in the entire facility	Publicly Reported, MOH / Jan 2015 - Dec 2015	77.1	80.00 Link to Pay @ Risk	Incremental improvement toward ideal	1)Hand Hygiene Awareness Program Initiatives	IP&C and Leadership support high level of Hand Hygiene awareness and compliance through joint development/implementation	Leadership and IP&C Committee will review implementation of Hand Hygiene Awareness Program on a quarterly basis through IP&C reporting	>75% of Hand Hygiene Awareness strategies implemented by Q3 15/16
								2)Engage Patient Family Advisory Council to increase Hand Hygiene Awareness	Further implementation of initiatives to engage Patient/Family/Visitor in Hand Hygiene awareness	Implement 2 strategies to engage patient/family in Hand Hygiene Awareness and practice	2 strategies implemented
								3)Increase staff/public awareness of Hand Hygiene performance	Increase local communication of Hand Hygiene Rates and Programs	Increase communication of Rates/Programs performance info in public areas	1-2 Hand Hygiene focus communication per month
		Rate of central line blood stream infections per 1,000 central line days	Rate per 1,000 central line days / ICU patients	Publicly Reported, MOH / Jan 2015 – Dec 2015	0	0.00	Monitor	1)Monitor - Continue to hold gains	Monitor - Continue to hold gains	Monitor - Continue to hold gains	Monitor - Continue to hold gains
	Reduce rates of deaths and complications associated with surgical care	Number of times all three phases of the surgical safety checklist were performed ('briefing', 'timeout' and 'debriefing') during the reporting period, divided by the total number of surgeries performed in the reporting period, multiplied by 100.	% / All surgical procedures	Publicly Reported, MOH / Jan 2015 - Dec - 2015	99.85	99.85	Monitor	1)Monitor - Continue to hold gains	Monitor - Continue to hold gains	Monitor - Continue to hold gains	Monitor - Continue to hold gains

Timely	**Reduce wait times in the ED**	ED Wait times: 90th percentile ED length of stay for Admitted patients.	Hours / ED patients	CCO iPort Access / January 2015 - December 2015	21.7	19.50 Link to Pay @ Risk	Continue to improve	1)CCAC e-Refferal Initiative	Work jointly CCAC and Meditech partners to design/implement e-solution for referrals to increase community care service access	90%ile Time to Inpatient Bed (from decision to admit) Decrease in MNR Admission rates	Decrease rate of patients who require ALC within 48h of admission & Waits for RM&R destinations
								2)Activation Program Redesign and Decentralization	Redesign/decentralize Activation Program to all inpatient units to decrease number of internal transfers and improve patient flow from the ED.	Decrease 90%ile Time to Inpatient Bed (from Decision to admit)	Decrease by 10% of current performance.
								3)Bed Board/EVS Trial	Improve 'bed-turnover' times to improve patient flow from ED to Inpatient Units	90%ile Time to Inpatient Bed (from decision to admit)	Decrease by 10% of current performance
								4)Transition to Home Team Process design	Transition 2 Home Planner initiatives to improve patient transition planning support and improve patient flow. P4R Taskforce/Change Steering Committee will monitor progress.	90%ile Time to Inpatient Bed (from decision to admit) Decrease in MNR Admission rates	Decrease by 10% of current performance