Quality Improvement Plans (QIP): Progress Report for 2016/17 QIP

London Health Sciences Centre

Positive Patient Experience

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
"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 2015 to March 2016; NRC Picker)	936	96.06	96.00	98.01	To date the target has been achieved, with plans to continue to work on patient experience in the 2017-18 QIP.

Change Ideas from Last Year's QIP (QIP 2016/17)	Was this change idea implemented as intended? (Y/N)	Lessons Learned
Increase Patient and Family Engagement in Councils, Committee and Improvement Projects	Yes	1. The change plan was successful with a current complement of **146** patient, family and community advisors volunteering at LHSC (exceeding the target of 140). These volunteers bring their perspective to various aspects of decision making, including the development of alternatives and identifying solutions for improving the patient and family experience. In addition to consultation and support from the Patient Experience Office team, this requires programs/teams to dedicate staff/leader resource to foster new relationships and help ensure a successful onboarding process, ample communication and effective inclusion of the role. The current process identifies a need to enhance an understanding of roles and responsibilities and increase interactive learning to support the staff liaison and patient and family advisors. A working group of the Patient Experience Committee called the *'The Patient and Family Advisors (PFA) Community of Practice (COP)'* sought insight from a survey to all PFAs and staff, and identified areas of practice that would build more meaningful participation and a greater sense of satisfaction for those involved with patient and family engagement. Based on the results, a recommendation is to establish more frequent and local educational and networking opportunities and provide formal mentor support.

		There is also a plan to determine the best evaluation approach available for measuring the results of patient and family engagement and introduce this tool across LHSC in 2017-2018. A sample of feedback driving the development of the COP Terms of Reference is found below: **What have you found most rewarding about your staff liaison role?** "*The group of advisors I am teamed with are kind, honest, motivated, uplifting. Being connected with PFAs is the best part of my entire role at LHSC. It is rewarding to have the ability to look at the actual implementation of PFCC principles at the program level*" **How can we best prepare staff for the advisor liaison role?** "*Provide a site-map of what information is accessible on a shared drive. Host check-in meetings with staff peers in similar positions, provide updates, open forum to ask questions and seek input from each other*" **How can we better prepare Advisors for this role?** "*Provide an opportunity for new advisors to shadow experienced advisors where possible. Assign an experienced advisor to serve as a mentor or "buddy"* **What other opportunities would you like to be made available to you?** "*I think it would be great to include area hospitals, to help them get this program in their Hospital. As a lot of people are transferred to London for care and support, myself included. I would like to be a part of this, as my journey started in Tillsonburg, to Woodstock and then to London. Maybe we can invite representatives from some locations to our meeting's and or story telling nights to see what it is all about and help to establish groups in their Hospitals?*" 2. The Inpatient Medicine Units at VH partnered with the Patient Experience office to re-introduce verbal bedside reporting with an emphasis on the value this practice has when patients and families are included. Five patient advisors participated in professional development sessions, hosted by the Continuous Quality Improvement Councils. Patient satisfaction with nursing communication increased significantly after this intervention (>10%).
Embed Patient and Family Centred Care Principles and behaviours in Staff Orientation, Education Curriculum and Performance Development	**Yes**	A reflective practice method for education has been used for new and existing staff for patient experience orientation and education of patient and family centred care. In partnership with our patients, the behaviours and actions of patient and family-centred care that are seen as fundamental to improving patient and family experiences are highlighted. Patient and family advisors co-facilitate these sessions with a Specialist. Following the definitions for Patient Experience, advisors share their lived experiences from patient care. These stories help us become more aware of the value specific interactions and processes have for the person's physical, emotional, spiritual well-being and bring insight to the vital behaviours of patient and family centred care. Evaluation results from these sessions indicate strong support for including this method of training for all staff.

Clostridium Difficile Infection

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
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)	936	0.33	0.36	0.34	The target was achieved. This is a key patient safety indicator, reported publically through the Health Quality Ontario system and will continue to be measured and monitored in F17/18. It is anticipated that performance targets based on the provincial average will be more difficult to achieve, as academic teaching hospitals carry the highest burden of patients with risk factors for this disease. Work will continue to focus on the highest risk factors for this disease - antimicrobial exposure and acquisition of the infective agent.

Change Ideas from Last Year's QIP (QIP 2016/17)	Was this change idea implemented as intended? (Y/N)	Lessons Learned
Evaluate alternate technology/products for Clostridium Difficile Infection (CDI) reduction	Yes	1. Development of a standardized protocol for the use of the equipment used to generate UVC light required evaluation of the high risk clinical areas, optimal location for use within these areas (bathrooms, multi-bed rooms as contamination is higher) and the frequency of use (daily and/or discharge). Cleaning staff require additional training which limits the flexibility to move equipment throughout the organization as needs are identified. 2. The organization upgraded the disinfectants used for cleaning of both the environmental and medical devices that are shared between patient and require disinfection between use.
Antimicrobial Stewardship (AS) 1. Antimicrobial Stewardship Rounds led by physician and pharmacist on General Medicine and Surgery services at both sites.	1. Partially implemented Staffing shortage meant we were not able to continue surgery rounds during the 2016 year. The ASP team continued Medicine and Critical Care rounds.	1. The impact of Antimicrobial Stewardship on CDI is limited to the hospital areas where the AS program engages with the team. CDI rates in at LHSC are largely influenced by outpatient antimicrobial prescribing (i.e. referring hospitals, community prescribers) which is difficult to influence. In 2016, Antimicrobial Stewardship performed antimicrobial review rounds in a prospective audit and feedback format with all 6 general medicine teams (between two sites) biweekly. Defined Daily Doses (DDD)/1000 patient days have continued to decrease for targeted antimicrobials since the implementation of our program. Tables 1 & 2 provide examples of some of targeted antimicrobials and the respective change in DDD/1000 patient days pre-implementation (2014) and post-implementation in March 2015.

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<tr>
<td>2. Education Sessions on Best Practices</td>
<td>2. Yes</td>
<td>
Table 1. Victoria Hospital: General Medicine
<table>
<tr><th>Antimicrobial</th><th colspan="3">Annual Average DDD/1000 Patient days</th></tr>
<tr><th></th><th>2014</th><th>2015</th><th>2016</th></tr>
<tr><td>Clindamycin</td><td>6.71</td><td>4.78</td><td>4.28 ↓</td></tr>
<tr><td>Ciprofloxacin</td><td>71.22</td><td>45.52</td><td>35.85 ↓</td></tr>
<tr><td>Levofloxacin</td><td>98.04</td><td>69.03</td><td>34.81 ↓</td></tr>
</table>
Table 2. University Hospital: General Medicine
<table>
<tr><th>Antimicrobial</th><th colspan="3">Annual Average DDD/1000 Patient days</th></tr>
<tr><th></th><th>2014</th><th>2015</th><th>2016</th></tr>
<tr><td>Clindamycin</td><td>10.81</td><td>5.35</td><td>6.15 ↓</td></tr>
<tr><td>Ciprofloxacin</td><td>61.86</td><td>48.30</td><td>43.27 ↓</td></tr>
<tr><td>Levofloxacin</td><td>114.14</td><td>79.27</td><td>45.64 ↓</td></tr>
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Antimicrobial stewardship rounds were effective in reducing the utilization of these high-risk antimicrobials for CDI as demonstrated by the significant reduction of DDDs. Ongoing challenges with this practice change include workload of the teams to allot time for this process as well as ASP team to review such large volumes of patients.

2. During the 2016-17 year, monthly teaching rounds were resumed in CCTC & MS-ICU to capitalize on an opportunity to instill stewardship principles to medicine and surgery residents. Grand rounds were presented to Plastic Surgery, ENT and Mental Health. Academic Half Days were presented to Urology and Medicine. CDI case reviews by staff pharmacists still demonstrate the need to intervene on the initial therapy for CDI approximately ~25% of the time.

There was success in the 2014-15 year with Grand Rounds presentations to General Surgery on intra-abdominal infections and surgical prophylaxis which lead to improved severity stratification, reduced quinolone use and reduced antimicrobial duration. Education sessions will be ongoing to disseminate best practice antimicrobial guidelines and stewardship principles.
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<td>Foundational Practice Audits</td>
<td>No</td>
<td>The pilot process audit tool was developed for an in-patient medical-surgical ward and required adjustment for use in other care locations such as the emergency departments and the critical care environment. This limits the intended use to create internal benchmarks within our organization and the focus has shifted to individual unit validation for compliance with foundational practices.</td>
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90th Percentile Emergency Department Length of Stay for Admitted Patients

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
ED Wait times: 90th percentile ED length of stay for Admitted patients. (Hours; ED patients; January 2015 - December 2015; CCO iPort Access)	936	27.60	25.00	25.7	The target is not achieved to date. For the 2017-18 QIP this indicator will be transitioned to include all complex patients.

Change Ideas from Last Year's QIP (QIP 2016/17)	Was this change idea implemented as intended? (Y/N)	Lessons Learned
Medicine ADSD: Discharge Project to improve and expedite the process from admission to discharge	Yes	The Medicine Admission and Discharge System Design (ADSD) Project was initially launched in August 2014 with a focus on reducing inpatient occupancy and decreasing wait times in the emergency departments. In 2016-17, the leadership of the Ambulatory and Inpatient Medicine Program implemented specific strategies that are aligned with recommendations from the Institute for Healthcare Improvement (IHI) Project Red, to enhance the discharge planning processes and reduce the patient acute length of stay. Success was noted in the implementation of a seven day Health Discipline Model, early morning discharge bullet rounds, early discharge planning discussions with patients and/or families (including the estimated date of discharge), as well as, discharge medication reconciliation and post discharge follow-up by phone and/or with an Internal Medicine Specialist or the Primary Care provider. The 90th percentile ED length of stay for Admitted Medicine patients has improved from 30 hours in the 1st quarter of 2016-17 to 21 hours in the 3rd quarter.
Mental Health Access and Flow System Design: Focus on the three major aspects of the decision to admit, the patient Length of Stay via physician practice metrics and the coordinated access to vacant regional schedule 1 beds.	Yes	The quality improvement initiative relating to the decision to admit was successfully implemented with the development of the Front Bubble RN Screening role wherein the percentage of appropriate patients being referred to the ED Psychiatrist improved from 61% to 93% over this fiscal year. The patient Length of Stay via physician metrics were developed and successfully implemented during F16 Q1. These physician-specific metrics in combination with the Navigator Pilot were instrumental in leveraging the reduction in the number of long stay inpatients (LOS>31 Days) by 41%. The coordination of access to vacant regional schedule 1 beds dramatically improved through the combined efforts of a physician access and flow champion role and the implementation of the provincial Mental Health Electronic Bed Board.

Medication Reconciliation at Admission

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
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 (Rate per total number of admitted patients; Hospital admitted patients; most recent quarter available; Hospital collected data)	936	81.09	85.00	82.80	The target has not been achieved to date. Work will continue on this indicator for the 2017-18 QIP.

Change Ideas from Last Year's QIP (QIP 2016/17)	Was this change idea implemented as intended? (Y/N)	Lessons Learned
"HUGO" Med Rec Optimization Project	No	The Hugo Optimization project for Medication Reconciliation was not implemented in F2017 at the time that this metric would have been tracked and reported to Health Quality Ontario. The Optimization project is on track for implementation Q4 2017 and Q1 2018. The plans for optimizing medication reconciliation in the electronic health record involve the following: • Building Form-Form Compatibility • Enabling Auto-Substitutions for Combo Meds • Enabling and utilizing "Related Results" functionality where lab orders can be associated to medication orders • Making "Compliance Comments Tab" visible to end-user in the med history view • Roll-out of education and eLearning for end users related to BPMH, Admission, Transfer and Discharge Med Rec Optimization of the Medication Reconciliation functionality in the EHR should positively influence provider compliance. In addition to compliance metrics, satisfaction will be determined through user satisfaction surveys post-optimization of the system. Part of the optimization plan is also to enhance educational materials, which should also increase compliance. A corporate team is being assembled to look at other ways to influence compliance to med rec besides optimizing the EHR in F2018. Senior and medical leadership will support the corporate team with a goal to influence enhanced compliance by providers. Ongoing engagement is needed with the vendor to continue to optimize the electronic functionality of medication reconciliation based on user experience, ideas and feedback.

Increase pharmacy technician resources in the ED	Yes	Pharmacy technicians have been deployed to the emergency departments (ED) to electronically document the best possible medication history (BPMH) since the summer of 2014. The coverage was 7 days a week, 12 hours a day at both sites during the reporting period of Q3 F2017. As of January 2017, the coverage expanded to 16 hours/day, 7 days a week at both sites as a result of increased funding from the Pay for Results Initiative. With the current model, pharmacy technicians see approximately 50% of patients that are admitted through the emergency department. From a recent chart review done at University Hospital, it was determined that when the BPMH is documented by a health care professional (non-pharmacy staff), there are 3.8 medication discrepancies per patient history, however, when documented by a pharmacy technician this is reduced to 0.5 discrepancies. Reviewing the chart results in another way showed that 70% of BPMHs done by pharmacy technicians have no medication discrepancies, or are 100% accurate. This accuracy is what is desired for patients being admitted to LHSC to reduce unintended medication errors. Another chart review is planned for the summer of 2017 to continue to assess quality of the BPMH and also to detect if there is a correlation between the pharmacy technician completing the BPMH and higher quality, more accurate medication reconciliation. This makes sense intuitively and has been shown in the literature on this subject but has not yet been directly proven with LHSC data. From provider and nursing perspective, this change initiative has been successful at encouraging admission medication reconciliation compliance. For the upcoming fiscal year, the program will be enhanced through development of risk-based assessment criteria for involving the pharmacy technician in the BPMH. Assessment criteria will be implemented in early F2018 to ensure the most efficient use of the limited technician hours in the ED.
Med Rec Report Improvement	Yes	Pharmacy leadership, Decision Support and Information Technology Services have been working together to optimize the medication reconciliation reports for over 2 years. In the fall of 2016, the programming of the reports was completed, and testing was performed in January 2017. Additional IT programming after testing was identified and changes were required. This resulted in the official launch of the final full report to be delayed until the current 2017/18 year. The enhanced reports will allow for more accurate matching of performance to provider compliance, which in turn will allow for increased accountability to providers. The medication reconciliation admission compliance metric was added to the corporate and portfolio balanced score cards in F2017 as part of the LHSC Operation Management Planning (OMP) Process. The addition of this metric was a key enabler to achieving increased provider compliance to admission medication in areas that were struggling to meet the target of 85%. Improvement initiatives and accountability conversations were facilitated at the program director level with providers in Q3 which positively impacted compliance. In December, for the first time since 2014, this metric was 85% for LHSC.

Readmission Within 30 days for Selected HBAM Inpatient Grouper

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
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)	936	17.62	17.00	17.64	The target has not been achieved to date.

Change Ideas from Last Year's QIP (QIP 2016/17)	Was this change idea implemented as intended? (Y/N)	Lessons Learned
Heart Failure (HF) - Clinical Pathway and Case Management - update of HF pathway, standardized patient education materials, and patient navigator support for University Hospital Cardiac Program.	Yes	A Clinical Pathway for Heart Failure was in place and utilized. With the completion of a current state analysis of the existing Clinical Pathway, improvements were identified in the areas of variability of process utilization and criteria evaluation. A multi-disciplinary team developed and implemented a revised Clinical Pathway focused on a standardized approach to reduce the variability in the process; primarily though enhanced criteria evaluation and a focus on its consistent utilization. This focused approach allowed for patients to get the help they need more accurately by the appropriate care provided faster. Additionally, a Heart Failure Patient Navigator started in October of 2016 with the implementation of the navigator role at the University Hospital Site. With the implementation of the patient navigator, patient education materials were reviewed and updated to reflect current best practice. The initiatives lead Cardiologist and the Cardiology team have taken an active role in creating, reviewing and approving the Education Materials, resulting in the Cardiology team actively participating by using the new education documents. Refocusing on the use of the education materials with the patient navigator and entire Cardiology team has resulted in an anticipated higher use of materials for more patients. It has been identified that patients who would have normally not been identified in the ED and inpatient areas are now being screened with the utilization of new criteria. It is too soon to tell if there are any direct correlations linked to the revised materials and new criteria. Two key learnings were identified. First, you cannot underestimate different perspectives as each care provider has their unique approach to care. Not every care provider is aware of the program and the requirements. The need for ongoing engagement and education among all care providers in every health discipline was identified as an area to focus on to ensure improvements are sustained. Secondly, there was increased variability in the diagnosis of Heart Failure patients.
Enhance Care for Patients with COPD	Yes	A clinical pathway and patient education materials have been in place since June 2015 to enhance the care of patients who are admitted with Chronic Obstructive Pulmonary Disease (COPD) at both sites. The LHSC clinical pathway was expanded in the Fall of 2015 to include the community resources for patient care, such as Primary Care providers, the Southwest Community Care Access Centre and the Chronic Obstructive Lung Disease (COLD) Rehabilitation program at St. Joseph's Health Care to improve clinical management and transitions across the continuum of care. This expanded pathway set the framework for the introduction of the Connecting Care to Home, an integrated funding model between LHSC and the SW CCAC to support earlier discharge and management of COPD patients in their homes with technology enabled home care.

Risk-Adjusted 30-Day All-Cause Readmission Rate for Patients with Chronic Obstructive Pulmonary Disease

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
Risk-adjusted 30-day all-cause readmission rate for patients with COPD (QBP cohort) (Rate; COPD QBP Cohort; January 2014 – December 2014; CIHI DAD)	936	20.75	19.00	22.23	The target has not been achieved to date.

Change Ideas from Last Year's QIP (QIP 2016/17)	Was this change idea implemented as intended? (Y/N)	Lessons Learned
Enhance Care for Patients with COPD	Yes	A clinical pathway and patient education materials have been in place since June 2015 to enhance the care of patients who are admitted with Chronic Obstructive Pulmonary Disease (COPD) at both sites. The LHSC The clinical pathway was expanded n the Fall of 2015 to include the community resources for patient care, such as Primary Care providers, the Southwest Community Care Access Centre and the Chronic Obstructive Lung Disease (COLD) Rehabilitation program at St. Joseph's Health Care to improve clinical management and transitions across the continuum of care. This expanded pathway set the framework for the introduction of the Connecting Care to Home, an integrated funding model between LHSC and the SW CCAC to support earlier discharge and management of COPD patients in their homes with technology enabled home care.

Alternate Level of Care Rate – Acute

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
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)	936	9.10	8.50	9.15	The target has not been achieved to date, however LHSC's performance exceeds the HSAA target of 9.68%.

Change Ideas from Last Year's QIP (QIP 2016/17)	Was this change idea implemented as intended? (Y/N)	Lessons Learned
Enforce new LHSC Discharge and ALC policies	Yes	LHSC Discharge Policy updated in 2015 to align with the Southwest LHIN Discharge Policy Toolkit. The initiative was led by Director of Access and Flow in consultation with the Policy Development Consultant, Social Work, Clinical Departments and the Clinical Ethicist. A new Alternate Level of Care policy was created to compliment the Discharge Policy. Both policies were approved and details communicated to clinical leadership for implementation. Further work and monitoring of the discharge policy continues to be a focus of improvement and monitoring in all clinical areas.
ALC Designation (timeliness and accuracy) - revise current processes for timely and appropriate ALC designation to ensure that LHSC aligns with the MOHLTC provincial policy.	No	An Alternate Level of Care (ALC) Designation Project was launched in December 2015. After six months of minimal progress, the project scope was reviewed and a decision was made to change the scope and definition of the project. Consultation with other healthcare centres, and in particular William Osler, regarding their approach to ALC designation, resulted in the creation of a Home First Refresh and ALC Avoidance strategy. This new strategy was launched in the Fall of 2016 and led by the Access Resource Team (ART) in collaboration with the Southwest Community Care Access Centre (CCAC) and the LHSC Clinical Ethicist. Home First Refresh educational sessions have been conducted with clinical program administrative and physician leaders, including key messages of home first being a philosophy of care, initiation of early discharge planning and clear role accountabilities related to supports for discharge for both hospital team members and CCAC. This has resulted in fewer patients designated as ALC, as well as, fewer total days waiting in hospital for those who are designated as ALC. Weekly reports continue to be generated and shared with clinical program leadership for "ALC Open Cases" and ">30 Day not ALC".