2014/15 Quality Improvement Plan for Ontario Hospitals
"Improvement Targets and Initiatives"

London Health Sciences Centre

Aim		Measure							Change			
Quality Dimension	Objective	Measure/Indicator	Unit / Population	Source / Period	Current Performance	Target	Target Justification	Priority Level	Planned Improvement Initiatives (Change Ideas)	Methods	Process Measures	Goal for Change Ideas
Integrated	**Increase the 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 acute patients	EMR/Chart Review / Q3 2013/14	79	80	Presently Medication Reconciliation at Admission is captured manually. A current performance of 79% is based on that process. Once HUGO rolls out, the Medication Reconciliation at Admission will be captured electronically and there is a degree of uncertainty related to the uptake of this new process. Recognition that the Medication Reconciliation at Admission is not a forced field in HUGO, may pose risk to a target higher than 80%.	Improve	1 - **Provider Engagement in Medication Reconciliation** - Ensure provider engagement in medication reconciliation at admission with HUGO functionality through support from SLT, Medical Affairs, Med Rec Sustainability Team and the HUGO Team. Use techniques of auditing, evaluation with feedback and also positive deviance to increase compliance. Collaborate with other institutions (as well as IMSP, SHN!) about their successes in electronic medication reconciliation. Revise workflows to increase compliance in areas that are struggling to meet targets.	-use Cerner generated reports to detect compliance in the indicator. -provide feedback via usual corporate communication routes and explore options for providing feedback directly to providers with low compliance (i.e. dept chief/chair). -look for providers that have high compliance rates to the indicator, study their success, make them champions, spread their success (positive deviance). -revise workflows in areas that are struggling to meet the expected target.	-% of providers that are compliant with metric vs. those that are not reaching the 80% goal.	-30% compliance by end of F2015 Q1, 60% compliance by end of F2015 Q2 and reaching 80% compliance by end of F2015 Q3.
									2 - **Emergency Department Pilot for Medication Reconciliation** - Trial having pharmacy resources implemented in the emergency room (as this is a crucial entry point into the hospital) similar to the model that is currently in the Preadmission clinics at both University and Victoria Hospital. This would facilitate timely collection of the medication history into the electronic system. It would improve provider compliance to medication reconciliation at admission as the first step (documenting the home medications) would be done. It would also improve the quality of the medication information being used since this is a proactive model of medication reconciliation (and the pharmacy staff would use various sources and unique medication expertise to obtain the best possible medication history).	-trial having pharmacy resources (such as a pharmacy student, pharmacy technician and/or pharmacist) in the emergency room at various shifts to document the best possible medication history (BPMH) into Cerner. -teach skills (or attending training courses) at gathering this information efficiently and effectively from patients. -set up space for these pharmacy staff to work within ED. -develop a workflow for providers to efficiently identify patients to be admitted for whom a BPMH is necessary for pharmacy staff to complete in advance of admission medication reconciliation.	-% of patients for which a pharmacy staff person was able to enter the BPMH before medication reconciliation occurred. -audit of charts before and after this intervention to detect medication discrepancies and time involved/efficiencies gained in this approach (using ISMP Quality Med Rec Measurement/ tools).	-80% of patients admitted through the ED have their BPMH documented by a pharmacy staff person proactively before admission medication reconciliation is done by the provider. -save time by the provider. -decrease medication discrepancies by 50% (increase quality of BPMH).
									3 - **Utilization of Electronic Medication Reconciliation -** Consider adjusting functions within HUGO to increase compliance with medication reconciliation at admission. For example: create alerts (or pop-up screens/reminders) that 'med rec needs to be completed'. Consider making medication reconciliation at admission a "forced function" by in turning off partial med rec capabilities.	-ITS to create alerts to remind providers to complete medication reconciliation on admission. this alert would "Stop" the provider from continuing until all medications were reconciled. -disable partial medication reconciliation (need to consider a new workflow/process for patients on methadone at home due to prescribing privileges/authorization of temporary prescribing).	-look at % compliance with medication reconciliation before and after such an alert was created.	-increase the compliance to target for medication reconciliation at admission by creating this alert.
	Reduce unnecessary time spent in acute care	Percentage ALC days: Total number of acute inpatient days designated as ALC, divided by the total number of acute inpatient days.	% / All acute patients	Ministry of Health Portal / Q3 2012/13 – Q2 2013/14	9.9	7.7	The target is (at times) outside of the hospital's complete control as it involves working with external partners including Long Term Care facilities, Rehab facilities and the Community Care Access Centre. There have been a number of improvements made related to ALC designation and discharge of ALC patients, unfortunately this is causing our numbers to go up. Better data capture is appearing to cancel out improvements in patient placement from a data perspective. A target of 7.70% from a current performance of 9.90% has been established as a fair balance between a stretch and attainable target.	Maintain	1 - **ALC Designation** - Define our current state processes for ALC designation, identify process and documentation improvements, creation of a formal ALC policy, and new educational materials for providers.	-understand current practices and processes for provider designation of alternate level of care (ALC). -develop an LHSC ALC Policy. -develop education program for providers and frontline care staff regarding ALC definition and designations. -streamline process for entry of ALC designation into the Cerner/WTIS to improve accuracy of reporting. -develop a sustainability strategy that includes regular monitoring for compliance.	-improvement in accuracy of reporting of ALC designation. -% reduction in ALC days.	-10% improvement in % ALC days. -10% reduction in average number of ALC patients/day.
									2 - **Home First: Monthly ALC Reviews and ALC Long Term Care Sign Off** - Sustainability strategy to review each ALC case on a monthly basis and build in accountability for designating patients as eligible for long term care home placements.	-conduct monthly ALC reviews at UH and VH. -develop communication tool for CCAC and Social Work to document patient/family meetings for complex discharge planning. -develop process and sign off form to be reviewed and completed by CCAC and LHSC leadership before a patient is able to be designated ALC-LTC.	-% reduction in patients designated ALC-LTC waiting in hospital. -% reduction in average number of ALC patients. -% reduction in ALC days.	-10% improvement in % ALC days. -10% reduction in average number of ALC patients/day.
									3 - **Southwest LHIN Discharge Planning** - SW LHIN Access to Care initiative that builds a framework to standardize discharge policies and practices across the hospitals.	-review of current discharge policies from sample hospitals in the SW LHIN. -develop a framework for SW LHIN hospitals to use to revise discharge policies. -emphasize the Home First philosophy in the discharge Policy framework.	-% reduction in patients designated ALC-LTC waiting in hospital. -% reduction in average number of ALC patients. -% reduction in ALC days.	-10% improvement in % ALC days. -10% reduction in average number of ALC patients/day.
	Reduce unnecessary hospital readmission	Readmission to any facility within 30 days for selected CMGs for any cause: The rate of non-elective readmissions to any facility within 30 days of discharge following an admission for select CMG's.	% / All acute patients	DAD, CIHI / Q2 2012/13-Q1 2013/14	18.58	18.00	This is a new indicator for LHSC in its current grouping and definition. The reporting period for this target is already 65% completed. Presently 3 out of 7 Case Mix Groupings have projects or change ideas that are starting or already underway. Historically, we have seen improvements of approx. 4% per year, therefore, a decision to use the same estimate was made.	Maintain	1 - **Implement HF-GAP** "Heart Failure: Guidelines Applied in Practice" Tools in Cardiology at UH and VH, followed by implementation within Medicine at both sites.	Phase #1: -develop HF-GAP tools. -UH ED and Cardiology: Educate physicians and staff & launch the new HF-GAP tools by Feb 18, 2014. Phase #2: -VH ED, Vascular-Cardiology, Medicine: Develop order set in HUGO and then, after HUGO has been launched, educate physicians and staff & launch the new tools. -conduct chart audits on the use of the order set and other tools. Audits to be conducted (X#) months after first launch.	Phase #1: -% of HF patients on HF Pathway. Phase #2: -% of HF patients on the HF Pathway who have a signed patient contract in their chart.	Phase #1: -70% HF patients on HF Pathway, by Nov 1, 2014. Phase #2: -80% of HF patients on the HF Pathway have signed patient contracts, by Nov 1, 2014.
									2 - **COPD Clinical Pathway** - Develop a clinical pathway for COPD patients to standardize the approach to care.	-develop standardized pathway for the care of the COPD patient from decision to admit through discharge. -develop pathway guidelines. -develop a patient journey map for patient and their families. -create a patient mobility care plan. -develop patient education materials. -define the discharge planning process, including a discharge checklist.	-% COPD patient on COPD pathway. -% unplanned COPD readmissions within 30 days. -reduction in avoidable COPD visits to ED. -reduction in average length of stay for a COPD patient. -% patients seen by Respirologist within 24 hours of admission.	-10% reduction in readmission and ED repeat visit rates for COPD patients. -90% COPD patients on a COPD pathway by March 31, 2015. -100% COPD patients have a mobility care plan and are provided education materials related to COPD.
									3 - **COPD QBP Communications to Respirologists** - Earlier consultation with Respirology from ED physician and more timely access to follow-up in Respirology routine and urgent clinics.	-develop current state process map. -identify improvement opportunities and create future state process map. -develop tools to improve appointment booking process for Respirology follow-up from ED or inpatient unit. -incorporate patient feedback into the process. -complete PDSA cycles. -identify key process and outcome indicators, including goals and red flag limits.	-% unplanned COPD readmissions within 30 days. -% COPD repeat visits to ED. -% COPD admissions. -% inappropriate admission diagnosis of COPD.	-10% reduction in readmission and ED repeat visit rates for COPD patients. -90% COPD patients have follow-up appointment with Respirologist and/or primary care provider within 2 weeks of discharge before leaving the hospital.

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Safe	**Reduce hospital acquired infection rates**	CDI rate per 1,000 patient days: Number of patients newly diagnosed with hospital acquired CDI, divided by the number of patient days in that month, multiplied by 1,000 - Average for Jan-Dec. 2013, consistent with publicly reportable patient safety data.	Rate per 1,000 patient days / All patients	Publicly Reported, MOH / 2013	0.45	0.40	The target was set to match the 2014/15 target set back in Feb 2013 as part of the three year target setting process with a goal of reaching top quartile in the near future.	Improve	1 - **Outbreak Management System** - Utilization of standardized outbreak management alert system and accountability checklists.	-infection control team initiates alert level based on nosocomial transmission and baseline unit levels; all stakeholders enact their accountability checklist and notify IPAC when they have initiated their checklist. -meeting is set within 72 hours for Alert Level 1 and 48 hours for Alert Level 2, to review the evolving situations, all checklists and escalate any barriers to complete.	-% notification within 24 hours of checklists being initiated.	-100% of stakeholders attend meeting -100% of checklist items have been completed or plan for escalation is clear.
									2 - **Improvement in Medication Related Risk Factors and Treatment of C. *Difficile* Patients** - Pharmacist review of antibiotics for patients newly diagnosed with c-difficile, preprinted orders for treatment.	-IPAC team notifies infectious stewardship pharmacists of all nosocomial and newly admitted patients with a diagnosis of c-difficile disease. -the team pharmacist reviews antibiotic list and ensures that antimicrobials are being prescribed as per best practice and recommends changes to the MRP -new pre-printed order (now available) and will be part of the HUGO order set to ensure that severity of disease is considered in prescription of antimicrobials.	-% of C. *Difficile* patients who receive antimicrobial review.	-75 % of patients with confirmed C. *Difficile* have an anti-diarrheal on order.
									3 - **Cleaning Pilot Utilizing New Cleaning Agent with Sporicidal Properties** - 4 IP medicine UH is considered an endemic unit and therefore will be the focus on this pilot to determine efficacy and feasibility in broader deployment.	-a new hydrogen peroxide agent will be used as a replacement for daily disinfecting cleaning process.	-% bioburden measurement will be conducted - evaluating pre implementation and every month post intervention x 6 months, as a random sampling of rooms and overall transmission rates.	-statistically significant reduction in bioburden and rate of recontamination -50% reduction in baseline transmission levels for 4IP.
	Increase proportion of eligible stoke patients receiving tPA	tPA Administration Rates for Eligible Stroke Patients: The number of times that tPA was administered on eligible stroke patients as a proportion of the total number of eligible stroke patients.	% / Eligible Stroke Patients	Hospital collected data / Q1 2013/14 - Q3 2013/14	Collecting Baseline	80	tPA Administration Rates for Eligible Stroke Patients is a new indicator for LHSC in its current definition. The use of the stroke protocol form will provide more accurate data to measure. This is an internal indicator and not the same as the tPA indicator(s) measured on the Ontario Stroke Network report card, therefore we have more control over the variables and can more directly link improvement efforts to measured performance.	Maintain	1 - **Stroke Standardized Care Pathway** - Develop hyperacute stroke standardized care pathway.	-hyper acute pathway completed with roles and responsibilities clear and signed off by key stakeholders. Implement NASCAR approach with parallel actions of all stakeholders to minimize door to CT and door to needle time.	-time for door to CT ; time for door to needle.	-80% of eligible patients receive tPA.
									2 - **New Stroke Unit** - Opening of hyperacute stroke unit on 7IP UH with exclusive tPA bed.	-4 plus 1 tPA bed unit in A7-210 as level II beds, tPA RN role initiated with pager and no caseload. Flow strategy implemented to ensure hyperacute patients are monitored for first 24 hours in this unit.	-% placement of acute stroke patients in room A7-210.	-4 plus 1 (tPA bed) level II bed unit in operation by July 1, 2014.
									3 - **Code Stroke Process** - Defined and initiated for admitted patients at both UH and VH.	-education and training provided to all nursing staff to recognize and identify an admitted patient as having a stroke and initiate Code Stroke response for patient to enter hyperacute pathway as determined by MRP and neurologist on call.	-% time for Code Stroke 55555 call to CT/needle.	TBD
Timely Access	**Reduce wait times in the ED**	ED Wait times: 90th percentile ED length of stay for Admitted patients.	Hours / ED patients	CCO iPort Access / Q4 2012/13 – Q3 2013/14	30.3	29.2	This target is largely guided by Local Health Integration Network's Pay for Results funding, where all participating hospitals are expected to achieve a 20% improvement. The 2014/15 YTD target has been calculated assuming an incremental monthly improvement aligned with project implementation dates until the 20% goal is reached by year end (24.2hrs). This amounts to a 6 hour improvement in patient wait time. The YTD performance was therefore calculated to be 29.2hrs.	Improve	1 - **Patient Flow Management System** – Move to full functionality including report generation.	-re-Launch of PFMS underway to include a current assessment of system utilization, end user uptake and a review of current processes based on experience since go-live. -continue to work with CERNER/Areoscout to release and test codes and improve system.	-ED Wait times for Admitted Patients. -full functionality of PFMS will improve bed turnaround time and provide consistent/seamless communication across departments and functions to support patient flow.	-100% functionality of the system and full implementation with report features by March 31, 2015.
									2 – **Dedicated Bed Model** – Implement the Dedicated Bed Model and open 21 additional beds at UH.	-phase 1 of the bed map implementation at UH and VH. -planning and implementation of 21 new beds on the 10th floor at UH. -develop Level 2 critical care Bed Model.	-improve % of patients assigned to the right bed first time. -implementation of the Bed Maps reduce # of internal transfers.	-88% of patients assigned to right bed first time by December 31, 2014.
		ED Wait times: 90th percentile ED length of stay for Non-admitted patients (CTAS 4 & 5)	Hours / ED patients	CCO iPort Access / Q4 2012/13 – Q3 2013/14	5.9	5.2	Through the staff led ED System Transformation project, it is believed that the organization will achieve a wait time of 3.2 hours by December 31, 2014. This amounts to an improvement of 3.7 hours over the course of the year, which translates into a target of 5.2 hours based on YTD average. The ED System Transformation Project is expected to see initial improvements in August 2014. It is believed that low acuity patients may be the first to feel the positive impact of the changes.	Improve	1 - **Emergency Department System Transformation** - Will initially address the front end process to significantly reduce PIA time. Initial assessment and triage will be based on a First In First Out (FIFO) philosophy which will significantly reduce the LOS for this patient population.	-complete front-line staff knowledge transfer of Lean Toyota Production System methodology. -establish facility renovation needs and timelines. -develop, simulate and implement front end production model.	-% of CTAS 2-5 assessed and dispositioned from front end production cell within 60 minutes.	-75% compliance with 60-minute timeline by October 31, 2014.
									2 - **Radiology Improvement in the Emergency Department** - Designed to expedite diagnostics imaging testing and results delivery for patient in the Emergency Department.	-develop a standardized criteria and process for ordering/triaging of U/S and CT scans. -establish timelines for the completion and report of CT scans for head, c-spine and thorax.	-% compliance by ED/RAD physicians with standardized ordering/triaging criteria and process flow. -% of CT head, c-spine and thoracic scans completed within one hour of order. -% of CT head, c-spine and thoracic scan results reported within one hour of test completed.	-80 % Compliance by ED and RAD MDs with standardized ordering and triaging criteria and process flow by September 30, 2014. -75% of CT, CT c-spine and non-contrast CT Abdomens completed within 2 hours of ordering by Dec 31, 2014. -90 % of CT Head, C-spine and non-contrast abdomens preliminary reported within 2 hours of test completion by Dec 31, 2014.
Effectiveness	**Reduce unnecessary deaths in hospitals**	HSMR: Number of observed deaths/number of expected deaths x 100.	Ratio (No unit) / All patients	DAD, CIHI / 2012/13	93	88	Matching the 2014/15 target set back in Feb 2013 as part of the LHSC three year Quality Plan target setting process. HSMR internal calculations continue to improve due to a combination of clinical efforts and improved documentation procedures which is expected to continue this year. The clinical documentation project has adopted a new process of flagging markers of patient complexity. The sepsis project is active and is expecting to see results in the summer of 2014. Period is FY 2013/14 as of November 2013 YTD.	Improve	1 - **Sepsis Management in the Emergency Department**- Improve identification and treatment of sepsis in the Emergency Department.	-implementation of electronic Sepsis Order Set for Computerized Physician Order Entry - April/2014.	-use of Sepsis Order Set for patients with diagnosis of or suspected onset of Sepsis. -time from order entered to first dose antibiotics administered.	-80% use of Order Sets by October 31, 2014. -antibiotics administered within 1 hour of order entry by October 31, 2014.
									2 - **Death Review Process Improvement** - Develop education plan to support the implementation of the new death review process post HUGO. Review and audit death charts and capture data with a tool that includes the IHI Global Trigger Tool.	-implementation of web-based tool to be used by MRP and Chief of service to identify system-related issues and opportunities for improvement. A random selection and charts identified as requiring more in-depth review will be flagged for an audit by the Clinical Auditor, using a tool that incorporates the IHI Global Trigger Tool. - June 2014.	-charts reviewed by MRP and Chief of service within 14 days of death.	-80% of charts reviewed by MRP and Chief of service within 14 days by Dec. 31, 2014.
									3 - **Improvement in Clinical Documentation** - Documentation of factors that impact the HSMR and creation of education/tools to support improved documentation.	-focus on documentation to accurately report on and support the Quality Based Procedures. -implement new inpatient face sheet.	-measure results before/after related to the inpatient face sheet. -continue to modify the inpatient face sheet based on results and feedback received.	-increase in coding compliance.
	Improve organizational financial health	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	OHRS, MOH / Q3 2013/14	0.78	0	The Total Margin indicator target is aligned with the Ministry's expectations of zero.	Maintain	1 - **Submitting a Balanced Budget** - As an organization, the budget must be balanced to meet the total margin target. Portfolios are working on saving strategies to balance the budget.	-balanced HAPS budget submitted to LHIN.	-balanced budget submitted to LHIN on time.	-balanced budget submitted to LHIN on time.
									2 - **Dollars and Sense Campaign** - Through the Office of Innovation. This is an initiative collecting ideas on cost savings or revenue generation ideas that will be reviewed by organizational leadership.	-office of Innovation collecting and evaluating submissions.	-office of Innovation collecting and evaluating submissions.	-implementation of some strategies received through the Office of Innovation during F15.
									3 - **Tracking Portfolio's** - Tracking the achievement of saving strategies for each portfolio through monthly variance analysis reports submitted to Finance.	-each portfolio completing monthly variance analysis.	-budgeting department receiving variance analysis from portfolios.	-all areas submitting variance reports to the budgeting department.

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Patient-centered	**Improve patient satisfaction**	From NRC Picker: "Overall, how would you rate the care and services you received at the hospital (inpatient care)? (% of those who responded "Excellent" only)	% / All patients	NRC Picker / Q3 2012/13 – Q2 2013/14	47.4	50.0	Aiming to meet the target that was missed on the 2013/14 QIP. Timing related to the roll-out of the Patient Experience initiatives were strategically adjusted given other pressing corporate priorities. It was expected that this indicator could fall short of the target. More effort has been spent in the past few months to integrate patient experience strategies into corporate priorities and invest in establishing the required infrastructure and resources to support clinical units in improving the patient experience.	Improve	1 - **Patient and Family Advisors -** Involved in different quality and planning committees.	-recruit more patient and family advisors. -update committees' terms of reference. -orient and train advisors and staff.	-number of patient and family advisors engaged in committees.	-increase patient and family advisors by 20%.
									2 - **Patient and Family Engagement** - In projects and on committees (e.g. EBD, patient shadow mapping, membership, surveys) to advise in formulating solutions, and to be incorporated in decision making to the maximum extent.	-introduce patient engagement in Partnering in Transformation projects (Integrated Care for Chronic Disease management - Connecting Care Collaborative and Integrated Care for Complex Population), and ED System Transformation projects.	-number of key corporate projects with active patient engagement.	-active and meaningful patient engagement in 3 corporate projects.
									3 - **Key Standards & Behaviours for Recruitment** - Orientation and Education, and Performance Development - Patient and Family Centered Care (PFCC) and Service Excellence. Goal is to have patient concerns and aspirations inspire and educate about vital behaviours and system changes for PFCC.	-continue to embed patient and family perspective into learning curriculum and engage leaders, staff and physicians in understanding and applying principles. -update staff competencies by September 2014.	-number of patient storytellers involved in courses. -updates to recruitment postings and performance appraisal language.	-involve 6 patient storytellers in corporate orientation(HR) and nursing orientation (NPP). -complete recruitment and performance updates (HR) by September 2014.
									4 - **Patient Experience Office & Resource Centre** - Establish a Patient Experience Office and Resource Centre On-site at Both Hospitals to increase accessibility to the office and supportive resources.	-update 3 corporate policies (managing complaints, abusive behaviour and disclosure). -meet 1-1 with all leaders regarding feedback - complaints management and patient satisfaction results. -begin construction of patient experience office at VH.	-policy update completion. -opening of the Office and Resource Centers.	-complete policy reviews and leader engagement by September 2014. -VH office established by September 2014. -begin dialogue for UH office when facilities has the capacity.