2015/16 Quality Improvement Plan for Ontario Hospitals
"Improvement Targets and Initiatives"

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
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 / Jan 1, 2014 - Dec 31, 2014	936*	31.9	25	- Meet Ministry/LHIN target (20% of 32hrs)	1)LHSC Transformational Project: a) EDST - introducing a new model of care in the ED that delivers a multi-disciplinary team approach to manage care and waiting. b) MHSD - reduce the LOS for admitted patients in the ED, facilitate patient flow and care pathways on the mental health unit, and improve utilization of the urgent clinic. c) ADSD - streamlining the flow of patients into and out of the hospital, reducing the volume of admitted patients and expediting/transitioning to discharge sooner.	a) Use TPS framework, modeling, and simulations in collaboration with other transformational project. b) Build utilization dashboards that contain in LOS data, visit numbers, etc. c) Baseline data being collected using the TPS framework, 9 kaizens have been selected for execution.	a) Review and daily monitoring of physician initial assessment time. b) Monthly review and year to date analysis of mental health dashboards. c) Monitor KPI's on all kaizens.	a) Physician initial assessment time to 2.5 hours. b) 90th%ile ED LOS to 25 hours. c) 30% of identified kaizens will be in the implementation phase by July 2015.
									2)Reducing Occupancy to 95%	a) Reduce volume of admitted patients, length of stay, and readmissions. b) Early initiation of care streams in the emergency department for chronic diseases.	Monitor occupancy rates on a daily basis and make adjustments as necessary.	Occupancy to 95%.
Effectiveness	**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 FY 2014/15 (cumulative from April 1, 2014 to December 31, 2014)	936*	-0.38	0	- Meet Ministry mandated target of 0%.	1)Submitting a Balanced Budget	a) Set and agree upon inflation assumptions. b) Completion of individual budgets by departments. c) All budget information compiled and presented before the finance and audit committee with approval from the Board of Directors.	Completion of budget approved by the Board of Directors.	Approved by April 1, 2015.
									2)Tracking Portfolio's Performance	Track monthly actuals against the established budget.	a) Review and present monthly variance reports. b) Present performance results to the finance and audit committee on a quarterly basis. - Work with portfolios on recovery plans, in order to get them back in-line with budget expectations.	100% tracking and reporting for all portfolios.
Integrated	**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. *100	% / All acute patients	Ministry of Health Portal / Oct 1, 2013 - Sept 30, 2014	936*	8.15	7.7	- Meet Ministry/LHIN target.	1)South West LHIN Discharge Planning - LHSC is reviewing current discharge policies and practices and updating accordingly to align with the South West LHIN access to care initiative framework that was developed to standardize discharge policies and practices across hospitals.	Review LHSC discharge policy and practices to ensure that they include all elements outlined in the South West LHIN access to care initiative.	Audit the discharge policy and practices for alignment.	100% direct alignment with South West LHIN access to care initiative.
									2)ALC Designation (timeliness and accuracy) - revise current processes for timely and appropriate ALC designation to ensure that LHSC aligns with the MOHLTC provincial policy.	Conduct monthly ALC meetings to monitor all patients designated ALC, as well as those that are not designated, but have a prolonged length of stay.	Audit ALC designated patient records and >30 day length of stay reports.	100% audit compliance.
	Reduce unnecessary hospital readmission	Readmission within 30 days for Selected Case Mix Groups	% / All acute patients	DAD, CIHI / July 1, 2013 - Jun 30, 2014	936*	19.15	18	- Meet Ministry target of 1% over expected.	1)Heart Failure Clinic - establish a heart failure clinic to avoid admissions and provide follow-up care with an identified portion of patients post discharge.	Monitor congestive heart failure readmission rates and ensure follow-up with an identified portion of patients post discharge.	Heart failure physician advisory council to review clinic activity and patient compliance with appointments/recommendations.	Reduce readmissions.
									2)Chronic Obstructive Pulmonary Disease (COPD) Clinical Pathway and Case Management - development of COPD pathway, standardized patient education materials, and patient navigator support for the Victoria Hospital Respirology unit.	a) Hire COPD navigator. b) Creation of iLearn module for COPD interdisciplinary staff. c) Clinical pathway to include patient early mobility and discharge plan. d) Revise the COPD order set.	a) COPD navigator working to full scope. b) Number of identified staff that complete mandatory iLearn module. c) Number of patients that receive an early mobility plan and completed discharge checklist. d) Establishment of a new order set with an education roll-out.	a) Navigator working to full scope by September 30, 2015. b) 100% of identified staff compliant. c) 100% of identified patients. d) Order set implemented on 100% of COPD patients.

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Patient-centred	**Improve patient satisfaction**	From NRC Canada: "Overall, how would you rate the care and services you received at the hospital (inpatient care)?" (add together % of those who responded "Excellent, Very Good and Good").	% / All patients	NRC Picker / October 2013 - September 2014	936*	95.2	96	- Increase patient satisfaction scores gradually.	1)Increase Patient and Family Engagement in Councils, Committee and Improvement Projects	Patient and Family Advisors are tracked through the patient experience office onboarding system. All patient advisors are interviewed and orientated through the system. Specific details such as program involvement and names are submitted to risk management for insurance purposes annually.	Review NRCC overall scores on a monthly basis. Provided dashboards at the unit level to raise awareness about patient experience and influence change ideas at the frontline. Pull specific questions related to improvements (from the larger survey) to monitor and inform projects and teams. Develop pre and post surveys to measure changes from the patient perspective.	a) Establish two new councils for 2015. b) Ensure that 100% of major projects have effective patient engagement strategies. c) Increase the number of advisor roles to 130.
									2)Embed Patient and Family Centred Care Principles and Behaviours in Staff Orientation, Education Curriculum, and Performance Development.	a) Offer interactive orientation sessions to all new hires that include patient and family presenters. b) Evaluate the sessions from a participant perspective for impact and learning. c) Deliver interactive workshops designed and delivered in partnership with patients to help the providers self-identify the vital behaviours of patient and family centred care.	Number of people to receive patient and family centred care orientation and participate in workshops.	a) 100% of new hires involved in patient experience/patient and family centred care orientation sessions. b) Percent positive scores for the session evaluations at 98%. c) Add 2 new sessions: 1. two clinical units with low patient experience scores; 2. focus on new audiences with physicians, staff and leaders for patient experience curriculum.
Safety	**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	936*	79.6	85	- Important area of focus with HUGO roll-out. HUGO is the new provider order entry portion of the electronic health record (EHR). It has been implemented at LHSC and 10 participating hospitals within the South West LHIN.	1)Provider Audit and Feedback - a multidisciplinary working group has been established to monitor and review progress and implement change ideas.	a) Meet with Physicians in leadership roles to review metrics and strategies for improvement. b) Make tools available for physicians to provide real time feedback. c) Work with the communications department to establish communication strategies for areas that are demonstrating progress.	Number of departmental/divisional meetings that include the "Medication Reconciliation at Admission" indicator on their agenda by December 2015.	100% of departmental/divisional meetings attended by December 2015.
									2)Education - a multidisciplinary working group has been established to create educational materials to support Medication Reconciliation at Admission.	a) Build an iLearn Medication Reconciliation at Admission module for residents. b) Provide "unit specific" Medication Reconciliation at Admission education.	Track the number of new residents that complete the iLearn module (post July 1st).	85% iLearn module completion rate.
									3)Workflow/Functionality Enhancement/Improvement - Medication Reconciliation at Admission is one of the HUGO optimization projects. The Medication Reconciliation workflow/functionality will be enhanced/improved and available in September 2015.	Medication Reconciliation workflow/functionality enhanced/improved and available in September 2015.	Workflow/Functionality items to be delivered to the organization by October 2015.	100% of items delivered.
	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. 2014, consistent with HQO's Patient Safety public reporting website.	Rate per 1,000 patient days / All patients	Publicly Reported, MOH / Jan 1, 2014 - Dec 31, 2014	936*	0.55	0.4	- Work towards achieving target that was missed in 2014-15 fiscal year.	1)Antimicrobial Stewardship - enhancement of the program in acute medicine.	a) Risk assessment for acute medicine patients. b) Appropriate identification and management of Urinary Tract Infections (UTI). c) De-escalation plan for broad spectrum antibiotics.	a) Auditing for completion of the risk assessment. b) Education for staff and physicians around UTI. c) Audit of broad spectrum antibiotic process.	a) 100% of risk assessments completed for acute medicine admissions. b) 100% of staff and physicians in acute medicine educated. c) Reduce patients from broad spectrum to organism specific antibiotics.
									2)Enhance Cleaning Protocols - targeted cleaning products and processes for specific patient populations.	a) Implementation of a quality assurance program thru the environmental services department. b) Staff educated on the new protocols.	Random audits of cleaning practices.	100% compliance to the standard.