2016/17 Quality Improvement Plan
"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	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	936*	17.62	17.00	-Shifted from CMG to HIG -QBP work continues to impact readmission rates	1)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.	a) Hire HF navigator. b) Review and update clinical pathway to include assessment in ED and discharge plan. c) Review/update HF order set.	a)HF navigator working to full scope. b) Number of identified patients with HF protocols in place. c) Number of patients that receive a completed discharge checklist. d) Establishment of an updated order set with an education roll-out.	a) Navigator working to full scope by August 31, 2016. b) ED physician compliance with order set. c) 100% of identified patients seen by navigator. d) Order set implemented on 100% of HF patients.	
									2)Enhance Care for Patients with COPD	a) COPD pathway, education tools & COPD order set used for all COPD pts. b)COPD Navigator contact for all COPD patients admitted to VH. c)Incorporate the INSPIRED COPD Outreach Program tools into discharge to community. d)Connecting Care to Home (CC2H) or CCAC Shift RN programs for moderate to severe COPD patients.	a) Number of patients where the COPD pathway, education tools & order set are used. b) COPD navigator working to full scope & receiving referrals for all admitted COPD patients at VH. c) Components of the INSPIRED COPD Outreach Program are performed by either the COPD Navigator or CCAC nurse/provider. d) Moderate to severe COPD patients are discharged to home with CCAC support.	a) 100% compliance with use of the COPD pathway, education tools & order set. b) Navigator referral received for 100% of identified COPD pts admitted to VH ED or IP units. c) 100% of identified patients have post discharge follow-up in their home and/or with their primary care provider. d) 100% of moderate to severe COPD patients are discharged on CCAC services through either CC2H or the Shift RN 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	936*	20.75	19.00	-New target -Better than provincial average -More than 5% improvement	1)Enhance Care for Patients with COPD	a) COPD pathway, education tools & COPD order set used for all COPD patients. b)COPD Navigator contact for all COPD patients admitted to VH. c)Incorporate the INSPIRED COPD Outreach Program tools into discharge to community. d)Connecting Care to Home (CC2H) or CCAC Shift RN programs for moderate to severe COPD patients.	a) Number of patients where the COPD pathway, education tools & order set are used. b) COPD navigator working to full scope & receiving referrals for all admitted COPD pts at VH. c) Components of the INSPIRED COPD Outreach Program are performed by either the COPD Navigator or CCAC nurse/provider. d) Moderate to severe COPD patients are discharged to home with CCAC support.	a) 100% compliance with use of the COPD pathway, education tools & order set. b) Navigator referral received for 100% of identified COPD pts admitted to VH ED or IP units. c) 100% of identified patients have post discharge follow-up in their home and/or with their primary care provider. d) 100% of moderate to severe COPD patients are discharged on CCAC services through either CC2H or the Shift RN Program.	Given the reporting periods, the target for this QIP is 19%, but the organization is aiming to further improve to 18% in the Calendar Year of 2016.
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	936*	9.1	8.50	-Adjust target to reflect new reporting period and historical performance -Performance largely driven by partner sites -Maintain aggressive target to place pressure on MOH/LHIN to support -Current initiative will drive ALC up	1)Enforce new LHSC Discharge and ALC policies	Ensure all members of the health care team are aware of the discharge and ALC policies, including expectations for enforcement	Audit the discharge and ALC policies and practices for alignment.	100% compliance with the discharge and ALC policies.	
									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.	a) Initiate the ALC Designation Project with the creation of the ideal future state process and education strategy. 2) Continue to 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.	a) Implement the recommendations of the ALC Designation Project, including the roll out of an education strategy. b) Audit ALC designated patient records and >30 day length of stay reports.	100% audit compliance.	
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", "Very good" and "Good" and divide by number of respondents who registered any response to this question (do not include non-respondents).	% / All patients	NRC Picker / October 2015 to March 2016	936*	96.06	96.00	-Maintain target -Sustaining of this target indicates success -Percent positive is in line with peers -Internally focusing on % excellent as well	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) Continue to support two clinical units with low patient experience scores. eg. Implementation of Bedside Verbal Report with inclusion of Patient Advisors. b)Establish a minimum of one new council for 2016. Continue to implement and sustain the current Advisory Councils. c) Ensure that as many projects as possible have effective quality patient engagement strategies. d) Increase the number of advisor roles to 140.	Due to change in NRC Picker Survey, LHSC will measure October 2015-March 2016 with the previous version of the survey, then will begin collecting baseline for the new version of the NRC Picker Survey from April-September 2016. This will help determine appropriate targets going forward with the new version of the NRC Picker Survey.
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	936*	81.09	85.00	-Maintain, target not achieved -Stretch target proposed last year given importance of metric and level of control	1)"HUGO" Med Rec Optimization Project	There is an optimization team that is being organized by ITS/CI and pharmacy leadership. This will start when the funding is in place for the resources required to take on this work. This team will lead various strategies to improve the compliance and quality of med rec at LHSC.	The process measures to detemine if the change idea is successful will be developed as the optimization team is formed. The compliance to med rec at admission will be measured during the optimizaton period to see if the enhancements, education and communication (as part of the project) will improve compliance.	To increase compliance and quality of the med rec process at LHSC.	
									2)Increase pharmacy technician resources in the ED	A proposal has been put forward for more funding for pharmacy technician resources at each ED. The technicians focus solely on documentation of the Best Possible Medication History, which supports compliance and quality of admission med rec. The technicians are gathering data (manually) and the FirstNet system also allows for data capture. The data will be analyzed to determine optimal scheduling of pharmacy technicians.	A process measure for this is to track would the percentage of patients that are seen by a pharmacy tech in the ED/shortly after admitted to have their BPMH completed.	Increase pharmacy resources to 24 hours/day, 7 days a week such that med rec on admission is supported by having all admitted patients have their BPMH completed by a pharmacy technician.	
									3)Med Rec Report Improvement	The current report which measures compliance to med rec is under improvements/enhancements by ITS/CI. This improved report will be shared with directors and providers to assess lack of compliance (less than target) in their clinical area.	The process measure would be the change in compliance to med rec on admission in a given clinical area after dissemination of the information from the new report.	The report would be shared with directors and providers by start of reporting period (Q3 in F2017).	
	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	936*	0.33	0.36	-2015 performance had significant improvements, but may be an anomaly -Peer performance is at 0.43 -Target achieved -Reduction to 0.36 contingent on cleaning agent funding -Process audits and antimicrobial stewardship activities expected to support maintenance of 2015/16 rates	1)Evaluate alternate technology/products for CDI reduction	Use data from Xenex pilot to inform targeted areas for use. New cleaning product,	Random audits of cleaning processes	Roll out use of new cleaning product all clinical areas April 1, 2016	
									2)Antimicrobial Stewardship	a) Antimicrobial stewardship led by physician and pharmacist focused on medicine and surgery b) Education sessions on best practices	a) Antibiotic Use (DDD/1,000 Patient Days) b) High Risk Antibiotics for development of C. Diff (Levofloxacin/Ciprofloxacin trends)	Continuation of education efforts	
									3)Foundational Practice Audits	Scorecard is issued by unit which displays unit based audit results and identifies corporate gaps.	Per the scorecard categories.	More units will participate in audit process for Fiscal 17	
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	936*	27.6	25.00	-Maintain, target not achieved -In 2015/16 target set based on HSAA of 20% improvement -Not expecting 2016/17 HSAA target update until July	1)Medicine ADSD: Discharge Project to improve and expedite the process from admission to discharge	Using LEAN QI methodology and project management tools, streamline the patient admission & discharge process (adopt IHI Project Red)	a) Discharge planning & expected date of discharge (EDOD) identified on admission. b) BPMH completed on all admitted pts. c) Education and discharge med rec for all discharged pts. d) Pts have follow-up appointment with MRP or primary care provider 2 weeks post discharge.	a) 100% for discharge planning and EDOD on admission. b)100% completion of BPMH on admission. c) 100% compliance for discharge education & med rec for pts at discharge. d)100% pts with follow-up with MRP or primary care within 2 weeks of discharge.	
									2)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.	Using LEAN QI methodology and project management tools 1. Integration of the Centralized Emergency Psychiatry Service (CEPS) into ED. 2. Create physician scorecard with average LOS for inpatient population in comparison to peers 3. Create a "Physican Champion" for the MH electronic Bed Board Initiative to develop procedures and protocols to maximize the effectiveness of the Regional Bed Board both within LHSC mental health as well as peer regional Schedule 1 hospitals in our LHIN.	1. Time to determine the disposition of incoming mental health patient will decrease by a minimum of 50% from baseline. 2. Physcians will increase awareness of impact of practice patterns on ALOS. Physicians seek opportunities within inpatient model of care and community resources to appropriately reduce their ALOS per patient population. 3. Clear standardized processes and protocols with defined team member. Role clarity will be developed to maximize the effectiveness of the electronic Bed Board within LHSC. This information will be used as groundwork for future development across the LHIN.	1. With this 50% reduction in determining patient disposition, the length of patient stay in the ED will be reduced thereby facilitating the flow of patients through the system. 2. Two day reduction in the average length of stay. 3. Clearly defined role responsibilities for managing the electronic Bed Board will be evident with clearly written processes and protocols for patient transfer into vacant regional mental health beds.	