2017/18 Quality Improvement Plan DRAFT
"Improvement Targets and Initiatives"

Markham Stouffville Hospital 381 Church Street

AIM		Measure							Change				
Quality dimension	Issue	Measure/Indicator	Unit / Population	Source / Period	Organization Id	Current performance	Target	Target justification	Planned improvement initiatives (Change Ideas)	Methods	Process measures	Target for process measure	Comments
Effective	Coordinating care	% of patients identified as meeting Health Link criteria who are offered access to Health Links Approach	% / Patients meeting Health Link criteria	In house data collection / Collect Baseline	905*	CB	CB	This is a baseline year to build processes and collect baseline data	1)Develop a process to collect accurate data	Create a registration triage report to identify new health link patients by collaborating with IT; Add Health Links as part of the C-LHIN dashboard; Collaborate with CCAC to align reporting	# of new care plans completed/month	20 new care plans completed/month	Understanding the baseline will support timely access and coordination of care for patients in the future
	Effective transitions	Did you receive enough information from hospital staff about what to do if you were worried about your condition or treatment after you left the hospital?	% / Survey respondents	CIHI CPES / April - June 2016 (Q1 FY 2016/17)	905*	57.60	60.00	Patient Experience is a strategic priority, however, 4% improvement is a feasible target because 2016/17 was a baseline year (new survey tool and methodology introduced) and patient experience is a difficult measure to move	1)Roll out the Collaborative Care Model	Execute the Collaborative Care Model Project Plan to roll out unit huddles, patient and family guidebooks, communication boards, and guidelines for handover; Introduce Daily Purposeful Rounding between Clinical Managers and Directors	Compliance of the use of the Patient Guidebook, Huddles and the Purposeful Rounding	80%	The roll out of this project aligns with the Patient Experience Strategy
									2)Introduce Patient Oriented Discharge Summary (PODs) in Surgery	Formalize Roles and develop project plan to execute	% PODs Utilization	Collect Baseline	
		Risk-adjusted 30-day all-cause readmission rate for patients with COPD (QBP cohort)	Rate / COPD QBP Cohort	CIHI DAD / January 2015 – December 2015	905*	18.46	17.50	Based on the complexity of the disease management and the progress of the 2016/17 QIP projects for COPD, 5% reduction is an achievable target	1)Identify gaps within the QBP process and ensure COPD patients are linked to appropriate support upon discharge	1) Staff Education of the digital order sets 2) Follow up on QBP to ensure all admitted COPD patients have pathway in chart 3) Manual audits of the COPD Readmit patients to identify challenges (work with decision support to pull a monthly list for review) 4) Continue the Breathe Better Program 5) Identify COPD patients at high risk for readmission and refer to the Health Links Program 6) Review process to improve the discharge to follow up in clinic time	1) % of patients on the COPD QBP pathway referred to be followed up in clinic 2) Time of discharge to follow up in clinic 3) Improve waitlist for the "Breathe Better" Program 4) Improvement in Quality of Life Outcome Scores after participating in the "Breathe Better" Program (Pre and Post Survey)	Aligned with Process Measures: 1) 100% by Q3 and Q4 2)From 3 weeks to 2.5 weeks 3) From 6 weeks to 5.5 weeks 4) 20% (sustainability)	
		Rate of psychiatric (mental health and addiction) discharges that are followed within 30 days by another mental health and addiction admission	Rate per 100 / Mental health patients	CIHI DAD,CIHI OHMRS,MOHTLC RPDB / 2016	905*	14.30	12.70	Goal of meeting the C-LHIN average, as initiatives will not have full impact in year 1	1)Data Evaluation to improve quality	Understand the data; audit and review readmit cases to identify gaps and root causes; Evaluate the documentation process	% of patients readmitted to MSH % of patients readmitted to MSH with same MH condition	Collect Baseline	Accurate data is important to drive improvement
									2)Collaboration with Community Partners	Educate patients/family regarding community supports; engage staff to refer to appropriate programs in the community	% of patients referred to Community partners	Collect Baseline	Establish relationships and process with the Community Partners to ensure smooth transition
	Effective transitions	% of acute hospital inpatients discharged with selected HBAM Inpatient Grouper (HIG) who are readmitted to any acute inpatient hospital for non-elective patient care within 30 days of the discharge for index admission	% / Acute Hospital Inpatients	CIHI DAD / 2017/18	905*	CB	CB	Monitor data and review trends to identify HIGs that require improvement	1)Monitor data	Review the data Quarterly to see trends and select HIGs requiring improvement	# of HIGs requiring improvement	Collect Data	Monitoring Year

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Efficient	**Access to right level of care**	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	WTIS, CCO, BCS, MOHLTC / July – September 2016 (Q2 FY 2016/17 report)	905*	13.02	12.5	As the current performance is better than the C-LHIN average (2016/17) and the C-LHIN ALC rate for 2017/18 is projected to increase, MSH will action multiple initiatives to reduce the rate by 5%	1)Improve Clinical Documentation and data quality for patients designated ALC	Work with physicians, clinical team and the Coders to align Clinical Documentation with the Clinical Documentation Improvement Toolkit	Audit of Quality Documentation	Collect Baseline	Accurate data is important to drive quality improvement
									2)Continue to enhance the ALC management Program	1.Implement interdisciplinary rounds in the ALC Transitional Care Unit 2.ALC Dashboard to track progress and compare with peer hospitals in the C-LHIN 3.Develop and implement an escalation process to ensure the discharge criteria are followed 4.Develop a project plan to scale the ALC Avoidance Strategy 5.Implement family education sessions regarding their roles in the unit and as a potential SDM	1.# of SDM Family Education Sessions 2.% Compliance on deciding on the SDM 3.% of family members requiring follow ups to comply to the discharge process 4.# of referrals to Health Links	Collect Baseline for all indicators to set targets for the following year	These strategies align with C-LHIN ALC avoidance best practices
Patient-centred	**Palliative care**	Percent of palliative care patients discharged from hospital with the discharge status "Home with Support".	% / Palliative patients	CIHI DAD / April 2015 – March 2016	905*	82.08	82.08	This is a new priority indicator, and 2017/18 will focus on understanding the data and evaluating the process	1)Data Evaluation	Understand the data; Review the current process of identifying discharged palliative patients with home support; Evaluate the documentation process; Establish Reports	Chart Audit to collect baseline for data quality	Collect Baseline	Accurate data is important to drive improvement
									2)Initiate collaborative (patient/family and staff) discharge planning and improve staff education	Establish Patient Advisory Council to involve them and their family in discharge planning process; Establish Palliative Care education (De Souza training) for staff	Patient Experience feedback in discharge planning; % of Palliative Care staff receiving training	Collect baseline for patient experience feedback and staff receiving feedback	This is a baseline year, as these are new methods being implemented
	Person experience	"Would you recommend this hospital to your friends and family?" (Inpatient care)	% / Survey respondents	CIHI CPES / April - June 2016 (Q1 FY 2016/17)	905*	68.60	71.50	Patient experience is a Strategic Priority, however, 4% improvement is a feasible target because 2016/17 was a baseline year (new survey and methodology introduced) and patient experience is a difficult measure to move	1)Roll out of the Collaborative Care Model	Execute the Collaborative Care Model Project Plan to roll out unit huddles, patient and family guidebooks, communication boards, and guidelines for handover; Introduce Daily Purposeful Rounding between Clinical Managers and Directors	Compliance of the use of the Patient Guidebook, Huddles and the Purposeful Rounding	80%	The roll out of this plan aligns with the Patient Experience Strategy
									2) Organizational assessment for the renewal project	Develop a project plan (goal, objectives, scope and measures) to assess the current state for organizational renewal and establish actionable improvement opportunities for the following year (2018/19)	Completion of the organizational assessment by March 31, 2018	100%	This is a Very Important Priority, as part of the Strategic Plan
Safe	**Medication safety**	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	Hospital collected data / Most recent 3 month period	905*	92.00	92.00	Sustainability of multiple initiatives in the past 2 years	1)Sustain the quality of the medication reconciliation process on admission	Continue to ensure appropriate resources are allocated to complete the Med Rec process; Perform ongoing Quarterly audits to provide feedback to front line staff; Raise awareness of the quality of BPMHs; Maintain quality by ensuring the process is followed accurately	Quality of the Med Rec Process on admission (% Accuracy)	Maintain at 80%	
		Medication reconciliation at 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.	Rate per total number of discharged patients / Discharged patients	Hospital collected data / Most recent quarter available	905*	20.00	50.00	The current performance and target is based on Surgery program only. The Surgery Program has a very low rate and improvements in this program will drive significant improvement in the overall rate	1)Improve the Med Rec process on discharge in Surgery	Allocate a dedicated resource in Surgery; Evaluate the process and quality of the discharge Med Rec completed; Launch a Surgery task force to champion education and provide expertise	Quality of the Med Rec process on discharge (%accuracy)	Collect Baseline in Q1; 5-10% improvement depending on the baseline accuracy rate	This year the focus will be on the Surgery department ONLY. Collaboration with the Surgery team will drive overall improvement
	Safe care	# of Workplace Violence Incidents resulting in Lost Days	Number / All Staff	In house data collection / 2016/17	905*	0.00	0.00	This initiative is part of the Joint Centers	1) Roll out WVP Playbook	Current state assessment of Workplace Violence Prevention practices; Develop an implementation plan to address the gaps	Completion of the implementation plan	100% completion of the implementation plan	Will also monitor the # of WPV incidents that resulted in health care
									2) Flag patients at risk for violence	Establish a flagging process; Educate staff on how to develop care plans; Monitor flagged patients and their involvement in violence incidents to identify improvement opportunities	% of flagged patients at risk for violence; % of flagged patients with a developed care plan	Collect Baseline for both process measures	

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		Clostridium Difficile Infection (CDI) rate per 1000 patient days: Rate of patients newly diagnosed with Hospital Acquired CDI during the reporting period	Rate per 1,000 patient days / All patients	In house data collection / 2016	905*	0.25	0.22	It is not possible to achieve a rate of 0 for Hospital Acquired Clostridium Difficile Infection (CDI), as there are multiple factors that can cause an infection. However, York Region Public Health has set the threshold for MSH Site at 0.29 based on a retrospective analysis of the past 8 years and the trends of peer community hospitals (similar bed capacity) in the region. MSH site has committed to achieve a rate 25% better than the set threshold.	1)Implement Hand Hygiene Strategy	Training for new and existing auditors; Audit the auditors; Monitor monthly and request variance reports if Hand Hygiene goals are not met	Hand Hygiene (HH) Compliance (%); % of units/clinical areas meeting 80% of the minimum observed opportunities per month; # of total observed opportunities met	Hand Hygiene Compliance = 90% % of units/clinical areas meeting 80% of the minimum observed opportunities per month = 100% # of total observed opportunities met = 640/month	
									2)Improve Infection Prevention & Control processes	Education in huddles and rounds to reduce delays in isolating patients; Establish a program that incorporates an interdisciplinary approach to addressing cases of Clostridium Difficile Infection (CDI) (launch a trigger tool, additional Hand Hygiene audit and Personal Protective Equipment audits); Partnership with Environmental Services to maintain effective cleaning and disinfection practices; Product review to ensure the most appropriate products are being used for cleaning	% of appropriate terminal cleaning completed upon identification of the isolation status; Time from symptom onset to when patients are isolated	% of appropriate terminal cleaning completed upon identification of the isolation status = 100%; Time from symptom onset to when patients are isolated = Collect Baseline in Q1 and Q2 and improve by 10% in Q3 and Q4	
		The proportion of inpatients (medical and surgical) with a hospital acquired stage 2 or greater pressure ulcer in a given period of time X 1000 (ages 55 and over)	Rate per 1,000 patient days / All inpatients	In house data collection / 2016/17	905*	6.90	6.90	There has been significant improvements over the past 2 years and this year will focus on sustainability	1)Implement an inter professional approach to prevent pressure injuries	Use of Braden Scale to help identify high risk patients; Use of specialty surfaces; involvement in wound care trials; select wound champions for education and communication	Quality of the use of the Braden Scale (% accuracy)	Collect Baseline in Q1 and Q2; 5-10% improvement depending on the baseline rate	The champion model will ensure the selected champions are trained to educate and audit staff on the use of the Braden Scale
Timely	**Timely access to care/services**	Total ED length of stay (defined as the time from triage or registration, whichever comes first, to the time the patient leaves the ED) where 9 out of 10 complex patients completed their visits	Hours / Patients with complex conditions	CIHI NACRS / January 2016 – December 2016	905*	7.70	7.31	The current performance is better than the C-LHIN average and the Provincial target. This year will focus on monitoring and sustainability	1)Maintain improvements in ED LOS for Non-admitted Complex patients	Maintain the process flow improvements from triage until discharge	Door in to Door out Time (Time spent in ED)	Improve by 5%	Improve and sustainability
									2)Align projects to maintain the ED LOS for complex admitted patients	Improve the Bed Management process; Physicians to begin assess and note the discharge time (digital order sets); Sustain the management of the admit to discharge ratio	Bed Turn Around Time	Collect Baseline in Q1 and Q2; Improve by 10% in Q3 and Q4	There has been improvements for this indicator in the past 3 years, therefore, this year will be focused on sustainability