Excellent Care for All

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

Thunder Bay Regional Health Sciences Centre

healthy together / En santé ensemble

The Progress Report is a tool that will help organizations make linkages between change ideas and improvement, and gain insight into how their change ideas might be refined in the future. The new Progress Report is mostly automated, so very little data entry is required, freeing up time for reflection and quality improvement activities.

Health Quality Ontario (HQO) will use the updated Progress Reports to share effective change initiatives, spread successful change ideas, and inform robust curriculum for future educational sessions.

ID	Measure/Indicator from 2016/17	Org Id	Current Performance as stated on QIP2016/17	Target as stated on QIP 2016/17	Current Perfor-mance 2017	Comments
1	"Overall, how would you rate the care and services you received at the ED?", 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). (%; ED patients; October 2014 - September 2015; NRC Picker)	935	86.50	87.00	62.70	Lag time in survey results was a barrier to real-time process improvement. Explored alternate ways to gather real-time survey results to effect more timely improvements. The information from the surveys facilitated timely small scale tests of change focused on care issues. The changes made did not help enough to achieve our target given the challenging environment within the Emergency Department. Further improvements for this indicator described in 2017-18 work plan "methods".

Realizing that the QIP is a living document and the change ideas may fluctuate as you test and implement throughout the year, we want you to reflect on which change ideas had an impact and which ones you were able to adopt, adapt or abandon. This learning will help build capacity across the province.

Change Ideas from Last Years QIP (QIP 2016/17)	Was this change idea implemented as intended? (Y/N button)	Lessons Learned: (Some Questions to Consider) What was your experience with this indicator? What were your key learnings? Did the change ideas make an impact? What advice would you give to others?
Enhance understanding and grow TBRHSC's Patient and Family Centred Care philosophy, embed the best practices; 2) Engage staff and physicians to understand and identify root causes and opportunities to improve lower patient satisfaction scores; 3) Engage those responsible and accountable for implementing change.	Yes	Patient & Family Advisors (PFA's) are an excellent resource to conduct real time surveys in the Emergency Department (ED). The information from the surveys facilitated timely small scale tests of change focused on care issues. PFA's involved in the ED redesign for mental health patients was an asset. Sharing patient experience results monthly with program/service, medical/administrative leadership encouraged accountability.

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2	"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 2014 – September 2015; NRC Picker)	935	93.40	93.90	60.20	Considerable differences in results between quarters makes it difficult to trend/determine the root causes of current performance. The change ideas encouraged the understanding of results and improved accountability to help us achieve our target. The change to measure "top box" scores only provides an opportunity for further improvement that is described in 2017-18 work plan "methods".

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Enhance understanding and TBRHSC's Patient and Family Centred Care philosophy, embed the best practices; 2) Engage staff and physicians to understand and identify root causes and opportunities to improve lower patient satisfaction scores. Consider all corporate activities and workload. Engage those responsible and accountable for implementing change.	Yes	Aligning Patient and Family Centred Care (PFCC) best practices with the leadership development "Studer" tactic "rounding for outcomes" was effective. Department coaching by the PFCC Coordinator and Decision Support was effective in identifying an organizational trend which then became a corporate improvement initiative. Restructuring the PFCC Leadership Council and providing support for the PFCC scorecard was effective in engaging those responsible and improving accountability.
Spread the Patient and Family Centred Care (PFCC) philosophy to the region's community hospitals.	Yes	

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3	Average Length of Stay (excluding ALC days). (Days; All acute patients; Dad and CIHI data; CIHI portal)	935	5.60	5.50	5.33	Successful physician engagement with average length of stay (ALOS) data helped us to surpass our target. This suggests that physician awareness of individual, section, and organization ALOS data contributes to improvements in practice. The adoption of new software allowed ancillary services to determine delays and front line staff to make timely clinical decisions. Further improvements for this indicator described in 2017-18 work plan "methods".

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Leverage patient flow software to understand root causes for longer patient stays. 2) Ensure physicians understand length of stay results and where improvements are required. 3) Implement QBPs and clinical pathways. 5) Update bed management and admission patient flow policies in standardized admission working group. 6) Develop targeted patient flow improvement strategies with standardized admission working group. 7) Develop targeted patient flow improvement strategies for patient repatriation.	Yes	The adoption of patient flow software reports by Diagnostic and Allied Health Services helped to determine delays to care plans. Unit Managers and Utilization Coordinators applying information provided through the patient flow software augmented discussions at morning rounds. Chief of Staff leadership coupled with Decision Support and Health Records supported effective corporate messaging and educating physicians on Length of Stay (LOS) using data report customization at each medical section meeting. Heightening awareness and improving overall knowledge proved to successfully engage physicians.

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4	Completion of strategic plan activities identified to impact equitable care at TBRHSC. (%; All patients; will be monitored quarterly; strategic plan completion)	935	CB	CB	NA	The current state assessment revealed many informal and formal relationships within the NW LHIN and organization, and that a coordinated and formalized approach is necessary to focus on priority relationships based on highest need. The completion of the assessment assisted the organization in pursuing priority partnerships that align with its strategic priorities. The organization continues to work towards improving its outreach services through its strategic plan.

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Assess the organization's current status of outreach services. Explore using the Health Equity Impact Assessment template.	Yes	The Health Equity Impact Assessment is one tool among others to assess the organization's current status.

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5	ED Wait times: 90th percentile ED length of stay for Admitted patients. (Hours; ED patients; January 2015 - December 2015; CCO iPort Access)	935	30.40	29.70	34.80	Infection control practice delays were identified as a root cause contributing to current performance. The change ideas led to strategies for early isolation clearance. Additionally, strategies to heighten physician awareness related to consultation response times improved physician accountability. A process mapping exercise informed that there are improvement opportunities to gain from internal work flow processes and changes are expected in Q1 2017-18. The bed management policy is a dynamic document that is responsive to internal and external environment pressures, and improvement efforts within our control are not enough to achieve our target. We continue to work with our system partners related to the reduction of alternate level of care (ALC) beds that we expect will help us to achieve our target in 2017-18. Further improvements for this indicator described in 2017-18 work plan "methods".

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Optimize Pay for Performance strategies in the Emergency department and throughout the organization; 2) Update bed management and admission patient flow policies in standardized admission working group; 3) Develop targeted patient flow improvement strategies with standardized admission working group.	Yes	Data analysis revealed infection control practices as a source of delay and therefore identified the need for an Infection Control Process Improvement position to create strategies to facilitate early isolation clearance. Having Section Chiefs share response time data increased the awareness of delays. Emergency Department (ED) consultant response times were analyzed and service specific quarterly dashboards were created for the Chief of Staff to monitor performance.

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6	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)	935	CB	CB	CB	The evaluation of the admission medication reconciliation process motivated a model redesign. Further improvements for this indicator described in 2017-18 work plan "methods".

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Report and monitor compliance monthly and quarterly, using reports for units and balanced scorecards for senior leadership and program/service management.	Yes	
Pharmacists to complete medication reconciliation quality audits on admission.	Yes	New questions will be added to admission medication reconciliation audits.
Evaluate the medication reconciliation at admission process.	Yes	Evaluation of current model and performance results motivated the model redesign to improve results.
Pilot designed for a dedicated Admission Nurse to complete Best Possible Medication History (BPMH) on admission in addition to other required best practice assessments (i.e. dementia, wound). The pilot proposes that a specialty core group of nurses trained to take comprehensive BPMH will improve quality, which in turn encourages physician confidence to complete medication reconciliation.	Yes	

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7	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 ; Most recent quarter available; Hospital collected data)	935	CB	CB	CB	A physician-led model is supported and implementation will be pursued as described in 2017-18 work plan "methods".

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Review approaches to medication reconciliation on discharge used by Ontario peers. Assess approaches to determine best fit for TBRHSC. Determine cost impacts and seek required approvals.	Yes	A comprehensive review of literature and environmental scan informed a change from the current pharmacy-led model to a physician-led model. Engaging physicians in discharge medication reconciliation process and form redesign was essential to success. Business case not feasible at this time.

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8	Risk-adjusted 30-day all-cause readmission rate for patients with CHF (QBP cohort) (Rate; CHF QBP Cohort; January 2014 – December 2014; CIHI DAD)	935	22.09	22.09	20.76	TBRHSC treated this indicator as a custom process indicator for 2016-17. Efforts were made to improve results but were unsuccessful, the root cause being that we were unable to influence adoption of QBP's/pathways at point of admission in the Emergency Department (ED). Increased accountability is required and data produced by the Health Records department informed 2017-18 target development using a non risk-adjusted indicator. Further improvements for this indicator described in 2017-18 work plan "methods".

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Corporate participation in COACH Multicentre Research Trial. 2) Improved corporate adoption/implementation of QBP pathways within first 24 hours (ED and in-patient units). 3) Support MRPs and ID team to manage this patient population to enhance continuity of care. 4) Review risk adjusted 30 day all cause readmission information when it is available. 5) Explore advanced partnership with tele-homecare post discharge.	Yes	COACH implementation date is an independent variable outside of the control/ influence of the Quality Improvement Plan (QIP). Ongoing delays diminish the value of this strategy. Work has been done on Quality Based Procedure (QBP) uptake, but have been unable to influence utilization of pathways as expected at point of admission in the Emergency Department (ED). Accountability and tools for implementing QBP pathways to be redeveloped.
Develop non risk-adjusted readmission rate reports for "TBRHSC only" patients with CHF (QBP cohort) as proxy to provide more timely data.	Yes	Having the Health Records department develop proxy data reports facilitated the development of 2017-18 performance targets.

ID	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
9	Risk-adjusted 30-day all-cause readmission rate for patients with COPD (QBP cohort) (Rate; COPD QBP Cohort; January 2014 – December 2014; CIHI DAD)	935	20.01	20.01	20.19	TBRHSC treated this indicator as a custom process indicator for 2016-17. Efforts were made to improve results but were unsuccessful, the root cause being that we were unable to influence adoption of QBP's/pathways despite development and education. Increased accountability is required and data produced by the Health Records department informed 2017-18 target development using a non risk-adjusted indicator. Further improvements for this indicator described in 2017-18 work plan "methods".

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Corporate improvement in implementation of QBP pathways for COPD within first 24 hours. 2) Explore opportunity for enhanced linkages between in-patient care and COPD clinics/community care. 3) Support MRPs and ID team to manage this patient population to enhance continuity of care. 4) Review risk adjusted 30 day all cause readmission information when it is available.	Yes	While the COPD clinical pathway was developed in 2016-17, with education completed and the pathway implemented, there is no evidence that the clinical pathway has been used to date. Future efforts focusing on physician engagement must be made to increase pathway utilization. Enhancing referrals to telehomecare, the Hospital's COPD programs, and the North West Community Care Access Centre (NW CCAC) increased linkages. Having a Clinical Nurse Specialist (CNS) educate the nursing population on COPD clinical pathway was key to the education and implementation plan. Support for COPD In-Patient care requires additional resource investment to enable COPD Nurse Practitioner to initiate an In-Patient service.
Develop non risk-adjusted readmission rate reports for "TBRHSC only" patients with COPD (QBP cohort) as proxy to provide more timely data.	Yes	Having the Health Records department develop proxy data reports facilitated the development of 2017-18 performance targets.