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

Thunder Bay Regional Health Sciences Centre

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
Effective	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)	935*	55.7	56.70	New indicator recommended by HQO for 2017-18. Note that indicator is for inpatient only and includes maternal newborn. Results are for "TopBox" from NRC tool. Ontario peer data is not yet available and NRC has expressed concerns about comparability of it. Given only 2 quarters of TBRHSC results available, considerable differences between quarters, and concerns re: peer data, suggest awaiting Q3 and Q4 results (estimated available in June 2017) and setting target at 1 point improvement from 2016-17 YTD.	1)Assess and implement best practices to 1) ensure patient/care partner understanding of information provided and 2) improve safe transition to home.	1) Integrate Patient Oriented Discharge Summaries (POD's) to identify gaps in patient understanding of discharge information and improve the coordination of transitional care needs. 2) Update discharge information resources to meet the needs of senior populations. 3) Ensure that all patient information is reviewed by a Patient/Family Advisor (PFA).	1) Percentage of Patient Oriented Discharge Summaries (POD's) completed. 2) Percentage of discharge information resources updated. 3) Percentage of patient information reviewed by a Patient/Family Advisor (PFA).	1) 80% of Patient Oriented Discharge Summaries (POD's) completed. 2) 80% of discharge information resources updated. 3) 100% of patient information reviewed by a Patient/Family Advisor (PFA).
		Percentage of patients discharged from hospital for which discharge summaries are delivered to primary care provider within 48 hours of patient's discharge from hospital.	% / Discharged patients	Hospital collected data / Most recent 3 month period	935*	CB	CB	Process indicator for 2017-18.	1)Engage the Medical Advisory Committee (MAC) and the Professional Staff Association (PSA) on the objective.	1) Identify Physician Leader and champions. 2) Develop WIIFM message and conduct a series of presentations at the Medical Advisory Committee (MAC), section meetings and Professional Staff	Percentage of physicians engaged (through presentations at meetings).	80% of physicians engaged.
									2)Assess current state and identify barriers.	1) Map process. 2) Conduct a root cause analysis.	Process map and root cause analysis completed.	100% of process map and root cause analysis completed.
									3)Engage a target group physicians to conduct a Plan, Do, Study, Act (PDSA) cycle.	1) Identify target group i.e. Hospitalists, Family Practice. 2) Define the improvement activity. 3) Implement a small scale change activity.	Percentage of small scale change activity implemented.	100% of small scale change activity implemented.
									4)Collaborate with Health Records to support the PDSA.	Identify methodologies to collect, collate and report compliance.	Data collection method identified and tested.	Preferred data collection method identified.
									5)Investigate voice recognition software upgrade.	Develop a business plan for dictation system upgrade.	Business plan developed.	Business plan completed.
		30-Day Readmission Rate for Patient with CHF (non-risk adjusted).	Rate / CHF QBP Cohort	CIHI DAD / April 2017 - March 2018	935*	22.8	21.80	HQO priority is risk-adjusted 30-day all-cause readmission rate for patients with CHF (QBP cohort). Suggested indicator is limited to "TBRHSC only" readmissions and is not risk-adjusted but as a proxy, provides more timely data. Target is 1 point improvement on 2016-17 YTD.	1)Adopt clinical pathway for CHF at point of decision to admission within the Emergency Department (ED) and monitor QBP performance.	1) Ensure all CHF patients are placed on CHF pathway for index admissions and all readmissions. This requires linkage with ongoing Quality Based Procedure (QBP) initiatives and clinicians in the Emergency Department (ED) and beyond. 2) Assign Cardiology Nurse Practitioner as the lead for CHF inpatient care coordination (associated with implementation of COACH study). 3) Assess gaps/ failures that lead to readmissions on an individualized patient basis (follow-up missed, socio-economic challenges, etc.). Collaborate with ED team to develop a small core team to handle this work. 4) Implement QBP digital order sets per Ministry of Long Term Care Provincial Project. 5) Develop reports to monitor initial admissions and readmissions.	Percentage of total CHF patients (index admission and readmission) supported by the implementation of digital CHF QBP order set.	60% of CHF patients on QBP pathway in Q3 & Q4 2017-18.
		30-Day Readmission Rate for Patient with COPD (non-risk adjusted).	Rate / COPD QBP Cohort	CIHI DAD / April 2017 - March 2018	935*	19.8	18.80	HQO priority is risk-adjusted 30-day all-cause readmission rate for patients with COPD (QBP cohort). Suggested indicator is limited to "TBRHSC only" readmissions and is not risk-adjusted but as a proxy, provides more timely data. Target is 1 point improvement on 2016-17 YTD.	1)Adopt clinical pathway for COPD within first 24 hours.	1) Ensure all COPD patients are placed on clinical pathway for index admissions and all readmissions. This requires linkage with ongoing Quality Based Procedure (QBP) initiatives and clinicians in the Emergency Department (ED) and beyond. 2) Leverage admission and re-admission data for COPD patients to ensure coordination of follow up care. 3) Connect appropriate patients with: a) TBRHSC telehomecare program. b) Northwest Community Care Access Centre (CCAC)/Local Health Integrated Network (LHIN) program. c) Primary care provider. 4) Implement QBP digital order sets per Ministry of Long Term Care Provincial Project 5) Develop reports to monitor initial admissions and readmissions.	Percentage of COPD patients supported by the implementation of an digital COPD order sets in 2017-18.	60% of COPD patients in on QBP pathway in Q3 & Q4 2017-18.
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)	935*	18.67	12.70	Assumes transfer of 30 ALC patients to Hogarth Riverview Manor effective July 1, 2017.	1)Advocate and demonstrate the need for additional health systems capacity.	Regular and ongoing conversations at the Board, CEO, Executive Vice-President, Director and Manager level. Hogarth Riverview Manor Phase 2 scheduled to open April 2017. Bethammi Nursing Home will remain open in 2017-18 under a temporary long stay license.	Number of ALC patients transferred to LTC (HRM) or Post-Acute (SJH) effective July 1, 2017.	30 ALC patients transferred.
									2)Meet regularly with local health system partners to develop and implement Alternate Level of Care (ALC) mitigation strategies.	1) Weekly Crisis Designation meetings. 2) Weekly Joint Discharge Operational Team (JDOT) meetings. 3) Quarterly Home First Operational Committee meetings. 4) Seasonal Northwest Local Health Integrated Network (NW LHIN) System-Wide Surge Planning meetings.	Percentage of meetings with system partners established.	100% of meetings established.
									3)Ensure Long-Term Care Home residents have access to timely, high quality health care within their homes and to minimize avoidable resident transfers to TBRHSC.	Restructure the role of the nurse practitioners in the Nurse-Led Outreach Team in order to provide better care in the Long-Term Care Home sector.	Restructured nurse practitioner role in Nurse-Led Outreach Team implemented.	100% of restructured role implemented.
									4)Integrate ALC strategy into Patient Flow Steering commitee and work groups terms of reference as a priority.	Update respective working groups' terms of references and ensure that ALC reduction initiatives are addressed.	Percentage of working groups' terms of references reviewed and updated.	100% of terms of references updated.
		Average length of stay (excluding ALC days).	Days / All acute patients	CIHI portal and CIHI DAD / April 2017 - March 2018	935*	5.33	5.30	Target adjusted to reflect .2 day reduction from 2016-17 target.	1)Leverage patient flow software to identify Length of Stay (LOS) improvement opportunities.	1) Produce and disseminate reports from patient flow software system that identify and quantify care barrier delays. 2) Develop process improvement plans to address the top three (3) care barrier delays.	Number of care plan delay days related to the top three (3) care plan barriers.	10% reduction (2017-18 vs. 2016-17) in care plan delay days for top three (3) care plan barriers.
									2)Engage physician leadership re: length of stay by physician service.	1) Continue to produce and disseminate physician service length of stay reports to Department Chiefs. 2) Develop and disseminate reports from patient flow software system that identify care barrier delays.	Number of ALOS improvement action plans prepared by physician departments.	One (1) ALOS improvement action plan each for five (5) largest physician services.
									3)Support the implementation of Quality Based Procedures (QBP's).	1) Engage Emergency physician leadership. 2) Advance the implementation of the digital order sets project.	Percentage of Emergency physicians leadership engaged.	100% of Emergency leaders engaged.
									4)Improve timeliness of patient discharge to regional community hospitals.	1) Produce and disseminate repatriation reports by regional community hospital that identify and quantify repatriation delays. 2) Engage physician leadership and regional community hospital administrators to develop and implement solutions to address repatriation delays.	Percentage of patients repatriated from TBRHSC to regional community hospitals in 2 or less days.	50% of patients repatriated to regional community hospitals in 2 or less days.
Patient-centred	Person experience	Patient Satisfaction: All Dimensions - ED	% / ED patients	NRC Picker / April 2017 - March 2018	935*	62.7	63.70	Replaces HQO's priority indicator "Patient experience: Would you recommend in-patient care?" and provides a more fulsome perspective on overall patient satisfaction results. Note that indicator is for ED only. Results are for "TopBox" from NRC tool. Ontario peer data is not yet available as NRC has expressed concerns about the comparability of it. Given only two quarters of TBRHSC results available, considerable differences between quarters, and concerns re: peer data, suggest awaiting Q3 and Q4 results (estimated available in June 2017) and setting target at 1 point improvement from 2016-17 YTD.	1)The Emergency Department (ED) will: a) Understand their results. b) Develop patient experience improvement action plans to address lowest categories results.	1) Review results. 2) Seek consultation from Patient & Family Centred Care (PFCC), engage ED physicians and staff to develop action plan.	Percentage of ED Action Plans developed (1-department plan, 1-corporate plan).	100% of ED action plans developed.
									2)Engage physicians and staff to increase awareness and understanding of patient experience results.	Share results and progress with ED physicians, staff and PFCC leadership.	Percentage of ED physicians and staff engaged in PFCC action planning based on total number working in ED.	50% of physicians and staff engaged during action plan development by May 19, 2017.
									3)Implement change initiatives based on results.	1) Engage key stakeholders and identify lead for each initiative. 2) Create implementation strategies, timelines and measures.	Percentage of key stakeholders engaged during action plan implementation and evaluation.	100% of key stakeholders engaged during action plan implementation and evaluation by March 31, 2018.
		Patient Satisfaction: All Dimensions - In-patient	% / All inpatients	NRC Picker / April 2017 - March 2018	935*	60.2	61.20	Replaces HQO's priority indicator "Patient experience: Would you recommend in-patient care?" and provides a more fulsome perspective on overall patient satisfaction results. Note that indicator is for in-patient only and includes maternal newborn. Results are for "TopBox" from NRC tool. Ontario peer data is not yet available as NRC has expressed concerns about the comparability of it. Given only two quarters of TBRHSC results available, considerable differences between quarters, and concerns re: peer data, suggest awaiting Q3 and Q4 results (estimated available in June 2017) and setting target at 1 point improvement from 2016-17 YTD.	1)All Programs/services/departments to: 1) understand their results, and 2) develop patient experience improvement action plans to address lowest domain results.	1) Coach leaders on performance results. 2) Coach non-clinical departments on action plan development.	Percentage of service/program/department patient experience improvement action plans developed as a proportion of the total number of services/programs/departments.	100% of service/program/ department action plans developed.
									2)Engage physician sections to increase awareness and understanding of patient experience results.	Corporate sponsorship supports coordination of corporate initiatives.	Percent of physician engagement/coaching sessions that promote understanding of patient experience as a proportion of the total number of physician sections.	100% of physician engagement sessions completed.
									3)Programs/services/departments implement change initiative based on results.	Refresh annual clinical action plans based on patient experience results.	Percentage of service/program/department patient experience improvement action plans implemented as a proportion of the total number of services/programs/ departments.	80% of service/program/ department action plans implemented.

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Efficient Patient-centred	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	935*	CB	CB	Sustained improvement dependent on new model for completion of medication reconciliation and incremental resources for same. Briefing note submitted to Senior Leadership Council (SLC) in December 2016. For 2017-18, will treat as developmental indicator due to model re-design.	1)Commit resource (Admission Nurse in Emergency) to ensure completion and quality of Best Possible Medication History (BPMH) assessments.	Train Admission Nurse on BPMH assessments and work flow process.	Percentage of training completed for Admission Nurse.	100% of training completed.
									2)Engage physicians and staff in pilot medication reconciliation process.	Targeted communication and education on pilot unit.	Percentage of physicians engaged.	90% of physicians engaged in pilot.
									3)Improve participation and completion of medication reconciliation by physicians at admission.	Admission Nurse to facilitate med rec process on 2B Medical unit.	Percentage of the total number of patients with medications reconciled as a proportion of the total number of patients admitted to the Hospital in pilot.	80% compliance of med rec in pilot.
									4)Report and monitor compliance to Chief of Staff and Medical Advisory Committee.	Monitor daily reports and follow up with care team and physicians.	Quarterly reporting of compliance to Chief of Staff and Medical Advisory Committee.	100% of quarterly reporting completed.
									5)Allocate resource and develop work flow process for BPMH audits.	Pharmacy to complete Med Rec BPMH audits on admission.	Percentage of audits of Best Possible Medication History (BPMH) in pilot.	90% BPMH completed in pilot.
		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	935*	CB	CB	For 2017-18, will treat as developmental indicator due to model re-design.	1)Engage physicians in medication reconciliation process improvements.	Physicians participate in redesign the Med Rec discharge form.	Percentage of physician engaged in the medication reconciliation process.	90% of physicians engaged.
									2)Implement physician-led med rec discharge process.	Physicians to adopt user-friendly med rec discharge form.	Percentage of med rec completion on discharge.	60% of med rec completion on discharge in Q3 & Q4.
									3)Pharmacy to complete Med Rec Audits on Discharge.	Share audits with physician individually and in aggregate at sections.	Percentage of compliance audits.	60% of compliance audits completed.
									4)Monitor and report on compliance audits.	Report on compliance audits to Med Rec working group/Sections Chiefs and quarterly to Medical Advisory Committee (MAC)/Senior Leadership.	Percentage of compliance audits reported monthly.	100% of compliance audits reported.
	Safe care	Percentage of patients with new pressure injuries.	% / All acute patients	CIHI CCRS / April 2017 - March 2018	935*	CB	6.00	Proposed target represents a reasonable stretch based on past and current performance.	1)Identify admitted adult patients earlier who are at risk for the development of pressure injury.	Increase the frequency for completion of the Braden risk assessment from once a week to daily.	Compliance with the completion of the Braden risk assessment on a daily basis.	90% compliance with the completion of the Braden risk assessment on a daily basis.
									2)Implement off-loading devices to reduce the risk of pressure injury development for patient identified as at risk.	1) Develop a pre-printed direct order for patient identified as at risk of the development of pressure injury. 2) Trial the use of off-loading devices on at risk patients.	1) Pre-printed medical directive endorsed by the Medical Advisory Committee (MAC). 2) Percentage of pressure injuries developed by patients who were cared for using off-loading devices during trial.	Off loading pilot incidence less than hospital incidence.
									3)Develop additional methodology to track pressure injury incidence.	Complete incident reports for patients that develop a stage II or greater pressure injury during hospitalization.	Percentage of patients identified as developing a stage II or greater pressure injury while in hospital compared to the number of patients identified in the P&I study.	90% of patients developing a stage II or greater pressure injury identified by incident report compared to the incidence study.
Timely	Timely access to care/ services	90th percentile ED length of stay (hours) for admitted patients.	Hours / ED patients	CIHI NACRS / April 2017 - March 2018	935*	34.8	31.00	HQO priority is 90th percentile ED length of stay for complex patients, which includes admitted and non-admitted complex patients. TBRHSC waits for high acuity non-admitted patients are within target, so TBRHSC will continue to focus on admitted patients.	1)Improve disposition decision time.	Optimize Physician extender role in Hospitalist Program.	Monitor and report Hospitalist Consult times.	2-hour Consult times.
									2)Avoid unnecessary admissions.	1) Analyze admission data to define cause of unnecessary admission. 2) Participate in Senior Friendly Pathway Project.	Percentage of "seniors" on Senior Friendly pathway in pilot.	90% of eligible "seniors" pathway criteria in pilot.
									3)Support the implementation of Quality Based Procedures (QBP's).	1) Engage Emergency physician leadership. 2) Advance the implementation of the digital order sets project.	Percentage of Emergency physicians leadership engaged.	100% of Emergency leaders engaged.