St. Michael's
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Quality Improvement Plans (QIP): Progress Report for the 2015/16 QIP

Total Margin

ID	Measure/Indicator from 2015/16	Current Performance as stated on QIP2015/16	Target as stated on QIP 2015/16	Current Performance 2016	Comments
1	**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 Fiscal Year to Date Q3 2014/15 OHRS, MOH)	0.30%	0.00%	-0.40%	15/16 has been a challenging year for St. Michael's financially with continued pressure to manage our resources in the Health system funding reform environment, combined with inflationary pressures and no increase in MOHLTC base funding. Our cost per weighted case continues to improve. In 15/16 our efficiencies were reflected in our QBP work where funding exceeded our carve out.

Change Ideas from Last Year's QIP (QIP 2015/16)	Was this change idea implemented as intended?	Lessons Learned:
Stroke: Continue Implementation, measurement and feedback	Yes	This group was able to spread improvements related to weekend discharges and early referral processes to other rehab centres, including Providence Healthcare. This resulted in increased communication and collaboration across centres enabling more informed and timely transitions in care. We have improved our median LOS for both Ischemic and Haemorrhagic patient populations from 6 days to 5 days (15/16 YTD).
Congestive Heart Failure (CHF) QBP: Continue Implementation, Measurement and Feedback	Yes	Continuing the work from last year, this year focused on monitoring and continuous improvement. Challenges with complex clinical metrics caused some delays in data reporting. Lessons learned include utilizing proxy metrics where appropriate and ensuring appropriate data stakeholders are part of metric selection to weigh in on feasibility and timeliness.
Cardiac: Begin Review Process focused improvement	No	Initial data analysis of St. Michael's patients was completed. Further work to continue next year to understand both data quality and improvement opportunities.

Operational Review – Perioperative Services, Heart and Vascular, Supply Chain	Yes	There have been significant achievements to date across targeted areas including Perioperative Services, Heart & Vascular, Supply Chain with Trauma Neuro and Inner City Health joining later in the process. Lessons learned include a better understanding of the workload and resources required to undergo such a large change initiative with a high level of staff/physician engagement. The creation of an integrated project management office that brings together cross functional expertise (Decision Support, Finance, HR, Quality, Communications etc.) was a critical success factor. In the future, a mix between program/department specific and cross cutting initiatives will enable continued success.

Readmission Rate for Select CMGs

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2	**Readmission Rate for Select CMGs:** % All acute patients July 1, 2013 - Jun 30, 2014 DAD, CIHI	19.45%	18.80%	16.70%	Current performance is stated for SMH only readmissions, readmissions for select CMGs to all facilities is no longer produced by CIHI. Performance for SMH only readmissions (particularly in focus areas of CHF and COPD) highlights the need for continued work in this area moving forward.

Change Ideas from Last Year's QIP (QIP 2015/16)	Was this change idea implemented as intended?	Lessons Learned:
Retroactively predict patients with COPD, Pneumonia, or CHF being admitted into General Internal Medicine	Yes	Previous admission data was used to develop a SMH readmission score which is based on previous tools (such as LACE) but includes additional factors (does patient have family MD, are they homeless, number of ER visits in the last 6 months) and is specifically modeled from SMH patient population. Model proved quite accurate at predicting SMH readmission. The model was implemented electronically on General Internal Medicine via an access database. Case managers enter patient information into database to identify the patient's risk of readmission. The tool includes identification of supports the patient requires such as Family MD referral, CCAC referral, Smoking Cessation and Puffer Support. Further work needs to be done to leverage the model effectively and enable supports for at-risk patients. The model needs to be a part of an interdisciplinary, multi-sectoral change strategy integrating the SMH family health team and community supports for a more comprehensive approach to readmission work.

Discharge Patient Satisfaction

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3	**Discharge Patient Satisfaction:** Patient satisfaction related to Continuity & Transition. Aggregate of 5 NRC questions (Inpatient only). % Inpatient only Q3 2013/14-Q2 2014/15 NRC Picker	68.20%	70.00%	66.50%	While the hospital did not see an increase in the patient Discharge Satisfaction indicator, measurement of the specific interventions are yet to be measured on a full scale due to data lags. Initial data from manual patient surveys indicate positive impacts. This will continue to be a focus in the coming year (fiscal year 16/17) and development of sustainable methods for more timely feedback from patients being a key component.

Change Ideas from Last Year's QIP (QIP 2015/16)	Was this change idea implemented as intended?	Lessons Learned:
Process Intervention: Patient-centered components of the discharge planning toolkit	Yes	Patients participated in the co-design of the patient whiteboards as well as a checklist to support patients in actively participating in their discharge education throughout their stay in hospital. These were implemented as part of the discharge planning toolkit which has been rolled out to 8 of 11 units. There is opportunity to further revise the check-list to ensure alignment with the new Patient Oriented Discharge Summary(PODS) that is being implemented and reduce any redundancy across the tools.
Measurement/Feedback Intervention: Real-Time Patient Feedback	Yes	As part of the toolkit rollout, feedback from patients is being gathered to ensure 1) the implementation of the tool is supporting the patient experience 2) the tool itself meets the needs of patients to communicate discharge information. As part of 16/17 work there is opportunity to further incorporate patients into our improvement work and identify sustainable methods to gather timely feedback from patients on an ongoing basis.

Process Intervention: Pilot implementation of Patient Oriented Discharge Summaries	Yes	PODS template was implemented on Urology service in late June 2015.Early indication from NRC data specific to Urology service shows positive feedback in 2 of 5 NRC questions that map to the template. A pre-template containing information for PODS by Urology service allowed for consistency of information and ensuring ease of use for providers. Evaluation of implementation on Urology revealed how to better integrate PODS into overall discharge planning framework. Lessons learned are being enacted with future implementations to other services including Neurosurgery which went live in January 2015.

ED Wait Times

ID	Measure/Indicator from 2015/16	Current Performance as stated on QIP2015/16	Target as stated on QIP 2015/16	Current Performance 2016	Comments
4	**ED Wait times:** 90th percentile ED length of stay for Admitted patients. Hours ED patients Jan 1, 2014 - Dec 31, 2014 CCO iPort Access	22.23 hours	21.00 hours	23.10 hours	While both the discharge planning toolkit and expected date of discharge tools were implemented to 8 of 11 units by the end of fiscal 15/16 the hospital did not see a reduction in the Emergency Department wait times for 90th Percentile. This will continue to be a priority for fiscal year 16/17 and efforts for improvement will be targeted towards areas of highest impact based on data analysis.

Change Ideas from Last Year's QIP (QIP 2015/16)	Was this change idea implemented as intended?	Lessons Learned:
Process Intervention: Corporate Discharge Planning Toolkit	Yes	The pilot of the components of corporate discharge planning toolkit were implemented and evaluated on Trauma Neurosurgery. This included a patient whiteboard, updates to the staff rounds whiteboard and process changes to support the entry and communication of an Expected Date of Discharge (EDD) for each patient. Roll out of the components will be completed in 8 of 11 units by the end of March 2016. Further evaluation of impacts will be completed in 2016/17 to allow time for process stabilization.
Process Intervention: Standardize process for discharging off-service patients	No	Initial data analysis identified two services with the largest number of off service patients- acute care surgery and general internal medicine. Meetings were held with key stakeholders to discuss opportunities to improve discharge communication. In-depth analysis and implementation of solutions was put on hold as the organization explores large scale solutions to assist in reducing the number of off service patients.
Process Intervention: Improve bed empty time	No	Integration of electronic systems in the fall allowed for detailed information to be collected around Bed Empty Time. Initial analysis and validation of this data was completed to understand opportunity. Further work to improve this time will be completed as part of next year's plan.

Measurement/Feedback Intervention: Improve corporate, unit and service level before 11 a.m. discharge time target (B.E.D)	Yes	Both unit and service level B.E.D. data was provided back to unit leadership who set targets for their areas. Regular reporting and meetings were held to support improvement. The target for 40% B.E.D. was not met with a Q3 value of 34.3%, the organization did see over 13% improvements over baseline value of 21%. Lessons learned include opportunity to focus efforts on key units/services with the most impact on corporate level indicators.
Skills Development Interventions: Identification of Estimated Discharge Time Upon Admission (EDD)	Yes	Expected Date of Discharge (EDD) was rolled out as part of the corporate discharge planning tool kit. An analysis of historical data was completed to provide information to support identifying length of stay for patient populations. This EDD information was incorporated into electronic order sets as decision support for identification of EDD upon admission. Initial data (of units live to date) shows compliance with EDD entry at 80.2% (Jan 2015). Further evaluation of impact will be undertaken in future to measure the degree in which this supported discharge planning and length of stay.

Falls

ID	Measure/Indicator from 2015/16	Current Performance as stated on QIP2015/16	Target as stated on QIP 2015/16	Current Performance 2016	Comments
5	**Falls** Rate per 1,000 patient days % All acute patients 2014 Hospital collected data	4.17%	4.09%	4.66%	While St. Michael's did not achieve our target of 4.09 falls/1000 patient days, there was a substantial 23% improvement in the corporate rate from Q1 to Q3 of 2015/16. In addition, the work on our General Internal Medicine unit has resulted in a significant 17% reduction in their falls rate from Q1 to Q3 of 2015/16. We will continue this work to reduce falls rate through 2016/17 by focusing on new interventions for two units that have higher than expected falls rates and therefore represent an opportunity for improvement.

Change Ideas from Last Year's QIP (QIP 2015/16)	Was this change idea implemented as intended?	Lessons Learned:
Process Intervention: Update Falls Risk Assessment Screening Tool in Soarian Clinicals	Yes	Changes were made to the Falls Risk Screening tool to make the tool more intuitive to use while continuing to properly identify patients who are at a higher risk of falls. A recent evaluation of the data 6 months after the initial change indicated that patients who are highlighted as a falls risk do experience falls at a much higher rate; indicating that the tool is capturing the correct population. It is advisable for others to be diligent with setting timelines and data extraction schedules early and engage those who will pull the data well in advance. It is recommended to keep clear data collection records/histories to ensure same data is being pulled each time.
Process Intervention: Standardized Review Process	Yes	There is now a standard tool for reviewing falls with harm which also allows for falls to be reviewed on a regular basis by a steering committee. This makes it much easier to identify patterns or trends that may help inform future change ideas related to preventing falls with harm. The feedback obtained from end users indicated that the Standard Review Process did add value in diagnosing the adverse event and capturing the lessons learned in a formal, standardized way. Although feedback was obtained, a comprehensive evaluation of all aspects of the process was not performed. Developing a rigorous evaluation plan that clearly

		outlines which questions to answer, by whom, and on what schedule would be beneficial in future. It is advisable to ensure that the roles and responsibilities of each project member are clearly defined with one key person or project lead identified for each work stream.
Process Intervention: Pilot Improvement Initiative on Clinical Unit	Yes	There was a positive impact on the overall falls rate as well as on the rate of overnight falls. This can be attributed to the interventions applied, particularly around focused night-time rounding. It would be beneficial to involve front line staff more in the review of data, particularly as it relates to the interventions they are testing. It is important to formalize a process from the beginning of the project on how to analyze, disseminate and review the data relating to the specific measures of success. Development of a clear project charter with data checks and role clarification/responsibility for all team members would be very beneficial for complex projects similar to this. Having a dedicated Quality Improvement Specialist is extremely useful in guiding the process and ensuring a proper improvement methodology is followed.

Medication Reconciliation

ID	Measure/Indicator from 2015/16	Current Performance as stated on QIP2015/16	Target as stated on QIP 2015/16	Current Performance 2016	Comments
6	**Medication reconciliation at admission for the Mental Health Program**: The total number of patients with medications reconciled in the Mental Health Program as a proportion of the total number of patients admitted to the Mental Health Program (inpatient only). % Mental Health Addiction patients most recent quarter available Hospital collected data	66.70	80.00	84.10	St. Michael's met our performance goal for completion of medication reconciliation for patients admitted to the Mental Health program. The key success factors were defining the roles and responsibilities of the medication reconciliation process for each clinician, education on how to do a quality BPMH and improving accessibility of the patient's BPMH information. A current challenge is that the process is a hybrid where BPMH documentation is electronic but documentation of medication reconciliation occurs on paper once the BPMH is printed. We will continue to monitor the progress we have made and look for other opportunities to improve current workflows.

Change Ideas from Last Year's QIP (QIP 2015/16)	Was this change idea implemented as intended?	Lessons Learned:
Foundational Improvement Work: Workflow analysis and pilot improvement of medication reconciliation process within the Mental Health program	Yes	The areas of focus identified were: 1)Accessibility and accuracy of medication history and reconciliation information 2)Defining the roles and responsibilities for medication reconciliation. **Lessons Learned:** 1)The medication reconciliation process and responsibilities of each clinician need to be clearly defined 2)When there is ambiguity in who is responsible for what, it can lead to a lack of accountability in certain steps of the process 3)Regular measurement and feedback is important to sustain the changes implemented

Measurement/Feedback: Re-evaluate Corporate Medication Reconciliation measure	Yes	The activities for this section included: 1)Review and validation of corporate medication reconciliation data and reporting methodology 2)internal and external scan and literature review for medication reconciliation reporting. Lessons Leaned: 1)Metrics should be clinically meaningful (i.e. quality of medication reconciliation vs completion of medication reconciliation) and this should be balanced with what it is possible to measure 2)Periodic evaluation of any metric is recommended to ensure that the metric still accurately reflects the institutions workflows and processes that may impact the measurement (i.e. changing from a paper to electronic process for BPMH documentation)
Process Intervention: Evaluate and improve piloted electronic medication reconciliation tool	Yes	Continuing the work from last year, the eBPMH tool was improved to include more standardized fields for documentation of the name of the pharmacy as a source of the medication history.

Hand Hygiene

ID	Measure/Indicator from 2015/16	Current Performance as stated on QIP2015/16	Target as stated on QIP 2015/16	Current Performance 2016	Comments
7	Number of times that hand hygiene was performed before initial patient contact during the reporting period, divided by the number of observed hand hygiene opportunities before initial patient contact per reporting period, multiplied by 100. % Health providers in the entire facility; Jan 1, 2014 - Dec, 31, 2014 Publicly Reported, MOH	57.60%	65.00%	63.60%	Although St. Michael's did not meet our target of 65.0%, we achieved an improvement of 6% in our Moment 1 compliance rate. 17 of 19 units saw an improvement in their Moment 1 compliance and by January 2016 the organization had met its target. We are proud of this improvement and will continue to build off lessons learned as we continue our work on Hand Hygiene in 2016/17.

Change Ideas from Last Year's QIP (QIP 2015/16)	Was this change idea implemented as intended?	Lessons Learned:
Process Intervention: Workflow Analysis and Improvement Initiative on pilot intensive care unit	No	Structured observations and data analysis were completed but did not validate the hypothesis that workflow optimization could significantly reduce the number of instances Hand Hygiene was required. The working group were able to identify several additional opportunities to improve including: staff education regarding when glove use was required (over utilization was identified as a barrier), as well as ingrained historical practice impacting the hand hygiene culture on the unit. The unit was able to improve 7% points over the course of the year, though they did not meet their goal of a 10% improvement.
Measurement/ Feedback Intervention: Goal Setting	Yes	Every unit (100%) met with both Infection Prevention and Control team and Quality and Performance members to review their historical data, their common misses and barriers, which fed into the development of a target and action plan to improve. Analysis of both corporate and unit specific data was completed to ensure that unit specific targets aligned with the achievement of the corporate target (65%).This effort assisted in 5 of 19 units meeting their targets by end of December.

Skill Development/ Education: Education (Corporate Road Show and Trial of 'On the Spot' feedback)	No	A trial of On-the-Spot feedback was successfully completed as a cluster randomized controlled trial including 16 inpatient units, over a 20 week period. The initial objective of the hand hygiene road show was to demonstrate why hand hygiene is essential to patient safety. Based on the results of the On-the-Spot feedback project, as well as needs identified by front line staff and managers, the decision to modify the road show to utilize as a method for training and certifying peer auditors, who can support the need for immediate feedback and thus real-time education in the clinical setting. The content and structure for this training has been developed and will be trialed prior to roll out to the wider organization.
Measurement/ Feedback: Audit and Feedback	Yes	Audit and feedback continued to be provided to 100% of inpatient units. A new monthly report format was developed, providing units with cumulative year to date and monthly compliance percentages, thus allowing units to identify and address successes and challenges in real time. All intensive care units received data on common misses/barriers.

Timely Discharge Summaries

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8	**Timely Discharge Summaries:** The number of times a discharge summary was distributed within 48 hours from the day of discharge for patients discharged from the inpatient units, divided by the number of patient discharges multiplied by 100. % All acute patients Q3 2014/15 eDischarge and SoftMed	79.70	85.00	87.60	Implementation of the new notification feature and continued education resulted in marked improvement. We are now consistently performing above our target of 85% and these changes have been sustained for greater than 6 months.

Change Ideas from Last Year's QIP (QIP 2015/16)	Was this change idea implemented as intended?	Lessons Learned:
Education and Awareness: 85% of discharge summaries ready for distribution within 48 hours of patient discharge	Yes	Education continued through resident orientation and focused education sessions at team rounds. Changes to eDischarge notification system were made to ensure notification to attending physician within 24 hours if patient is discharged without a completed summary. The eDischarge system was updated to ensure a patient summary could not be completed until patient was discharged. These combined technical changes to eDischarge were effective interventions leading to the organization meeting our target.
Process Intervention: Improve quality of SMH discharge summaries	Yes	Learnings were taken from the TC LHIN review of discharge summaries that concluded in April of 2015 and were applied to our eDischarge system. Development of templates began with patient friendly information that is included in our eDischarge system to assist in producing a patient oriented discharge summary. While changes from TC LHIN review were enacted, evaluation this fiscal year focused on improving timeliness (which was achieved) rather than analysis of the content or quality of summaries.