St. Michael's
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Quality Improvement Plans (QIP): Progress Report for the 2016/17 QIP

Medication Reconciliation

ID	Measure/Indicator from 2016/17	Current Performance as stated on QIP2016/17	Target as stated on QIP 2016/17	Current Performance 2017	Comments
1	**Best possible medication history(BPMH) completion:** The total number of patients with a best possible medication history completed as a proportion of patients admitted (excluding Labour & Delivery and NICU) % All inpatients (excluding L&D and NICU) October - December 2016 Salumatics	73.0%	73.0%	78.1%	BPMH completion is a process measure for Medication Reconciliation on Admission and although slightly decreased from the previous quarter, remains above the target value.

Change Ideas from Last Year's QIP (QIP 2016/17)	Was this change idea implemented as intended?	Lessons Learned:
1) Build an electronic Medication Reconciliation (eMedRec) solution	NO	A request for proposal (RFP) process was initiated to procure a medication reconciliation solution that would be able to integrate with our current Soarian Clinicals and Pharmacy systems. However, the RFP process was unsuccessful in identifying a solution that met our requirements as determined by input from our clinicians. Discussions are underway to determine next steps in our journey towards a fully electronic medication reconciliation solution.
2) Support ongoing completion of BPMH on admission (Inpatient Units)	YES	Modified performance reports have now been in place for Q1 and Q2. For Q3, data from each unit will be broken down by service as well as by unit and program to better identify the patient populations where further improvement opportunities exist. The recommendation is to complete the baseline quality assessment of both BPMH and Medication Reconciliation in 2017/18.

Change Ideas from Last Year's QIP (QIP 2016/17)	Was this change idea implemented as intended?	Lessons Learned:
3) Support Medication Reconciliation process on Mental Health Unit	YES	The completion rate for mental health continues to be monitored. A decrease in rates for Q3 was noted. Next steps will be to reconnect with the Mental Health team and identify where in the process further improvement work may be needed.

Discharge Patient Satisfaction

ID	Measure/Indicator from 2016/17	Current Performance as stated on QIP2016/17	Target as stated on QIP 2016/17	Current Performance 2017	Comments
2	**Discharge Patient Satisfaction:** Patient satisfaction related to continuity & transition % Inpatient only April-December 2016 NRC Picker	Collecting baseline	Collecting baseline	62.4%	This year we rolled out patient oriented discharge summaries (PODS) on several services, evaluated the roll out of expected date of discharge and patient whiteboards, and piloted post-discharge patient feedback phone calls to obtain additional patient discharge satisfaction data. Our current performance is based on the new survey rolled out by NRCC. In 2017/18 we will continue the roll out of PODS to additional services and will expand methods for obtaining patient feedback (e.g. phone calls, in-persons surveys, patient and family advisory councils).

Change Ideas from Last Year's QIP (QIP 2016/17)	Was this change idea implemented as intended?	Lessons Learned:
1)Optimize the use of discharge toolkit components on Orthopaedic and Trauma Neurosurgery Units	YES	Work for this year focused mainly with the orthopaedic service to develop a pathway to support communication both throughout care teams and with patients regarding their stay in hospital as well as their plan for discharge. Additional work included an evaluation of the roll out of Expected Date of Discharge and patient whiteboards to understand barriers and challenges.
2)Implementation of Patient Oriented Discharge Summary(PODS) on Orthopedic and Trauma Neurosurgery Units	YES	The rollout of Patient Oriented Discharge Summaries has occurred on all planned services. Tailoring patient discharge summary content to the service performing the discharge is essential to creating a relevant document. Providing the document earlier in the patient stay has been trialed on the Cardiology service receiving positive feedback and has potential to improve patient discharge satisfaction.

Change Ideas from Last Year's QIP (QIP 2016/17)	Was this change idea implemented as intended?	Lessons Learned:
3)Develop method to collect timely discharge satisfaction data to inform the creation of internal discharge satisfaction measures	YES	A model was developed and piloted which involved volunteers calling patients discharged from two services (Orthopedic and Neurosurgery) post discharge to gain feedback related to their discharge experience in hospital. Patients reacted positively to being asked to provide feedback on their experience, while the information was valuable to evaluate and enhance discharge processes. Training programs for volunteers was a key success factor to ensure they were comfortable and prepared for their role. Thank you to William Osler Health System and Peterborough Regional Health Centre for sharing their experiences and materials.
4)Develop a robust reporting processes across discharge continuum	YES	An evaluation of discharge processes was completed across eight units with the aim to analyze current performance, opportunities and gain feedback from patients and staff. This informed the creation of a revised performance report and dissemination process.

Emergency Department Wait Times

ID	Measure/Indicator from 2016/17	Current Performance as stated on QIP2016/17	Target as stated on QIP 2016/17	Current Performance 2017	Comments
3	**ED Wait times:** 90th percentile ED length of stay for Admitted patients Hours ED patients January 2016 - December 2016 CCO iPort Access	23.1 hr	23.0 hr	24.6 hr	Reducing the 90th percentile ED LOS for admitted patients remains a challenge. Despite efforts to match capacity to demand we have continued to experience an increase in our overall ED volumes and care for a higher proportion of complex patients. In addition we are undergoing the redevelopment of our ED along with the building of a new patient care tower which has resulted in a decrease in available beds throughout the year. This has all placed extra constraints on the ability to consistently and reliably flow patients through the organization. Efforts in 2017/18 will focus on reducing the wait times for our less acute and non-admitted patients.

Change Ideas from Last Year's QIP (QIP 2016/17)	Was this change idea implemented as intended?	Lessons Learned:
Smooth admissions from emergency department (ED) to General Internal Medicine (GIM) throughout the day	YES	Eight beds were moved from the Heart & Vascular program to the General Internal Medicine (GIM)Program. This created an eight bed ACE unit and thus more GIM capacity. Two interventions focused on improving bed cleaning times and communication between nurses and housekeeping staff have been implemented. It is anticipated that these two interventions will positively impact the overall amount of time a clean bed remains empty. Further data analysis is required. Key lessons included the importance of understanding the data and its limitations in terms of accuracy. It is crucial to have a reliable way to test the impact of proposed interventions.

Change Ideas from Last Year's QIP (QIP 2016/17)	Was this change idea implemented as intended?	Lessons Learned:
Improve surge management practices	YES	A flow escalation policy with measurable criteria has been developed and is ready to be piloted. Refinement of daily bed management practices was added to this change idea to serve as a foundation for the escalation protocol. Impact is to be determined. This is a complex initiative involving many stakeholders and limited ways to increase capacity to meet demand.
Optimize daily flow processes	NO	Through the development of the flow escalation policy the need to revise daily bed management structures was identified. Implementation of such changes will now coincide with the implementation of the overall flow escalation policy in 17/18.
Refine existing daily management practices related to Alternate Level of Care (ALC) on General Internal Medicine (GIM)	YES	Despite the successful implementation of a review process, that includes biweekly rounds with community partners and the development of patient and family education material, this indicator remains a challenge due to system-wide issues such as capacity in complex continuing and long-term care.

Falls

ID	Measure/Indicator from 2016/17	Current Performance as stated on QIP2016/17	Target as stated on QIP 2016/17	Current Performance 2017	Comments
4	**Falls rate:** Number of falls in General Internal Medicine and Trauma Neurosurgery per 1,000 patient days in General Internal Medicine and Trauma Neurosurgery Units % General Internal Medicine and Trauma Neurosurgery inpatients January - December 2016 Risk Monitor Pro	7.99	7.19	6.61	Both the Trauma Neurosurgery Unit (9CC) & General Internal Medicine Unit (14CC) have met and exceeded their improvement targets for 2016/17. The focus for 2017/18 will be on monitoring performance data and sustaining the process changes that have led to these improved results.

Change Ideas from Last Year's QIP (QIP 2016/17)	Was this change idea implemented as intended?	Lessons Learned:
Implement post fall debrief tool and process on Trauma Neurosurgery Unit (9CC)	YES	A post fall debrief tool and process was developed in collaboration with 9CC and 14CC to be used in the event of a fall with moderate to severe harm. Though no such falls occurred on 9CC during 2016, the tool was successfully trialed on 14CC. Key lessons include the importance of unit leadership in initiating and completing the post fall debrief tool. The process works best when the tool is completed by the local incident analysis team with additional support from a Patient Safety Specialist.
Improve identification of patients at risk for falling	YES	The Falls Risk Assessment tool was embedded into the Initial Shift Assessment. This resulted in an improvement from 63% of patients screened within 24 hours of admission in 2015 to 68% in 2016. Soliciting staff feedback and suggestions for incorporating improvements in electronic documentation to increase compliance is important as well as sharing data with all staff. Unit leadership is pivotal to communicating and reviewing compliance.

Change Ideas from Last Year's QIP (QIP 2016/17)	Was this change idea implemented as intended?	Lessons Learned:
Implement strategies to reduce falls for at risk patients	YES	On 9CC, intentional rounding during peak time period for falls (1-5am and 1-3pm) resulted in a 20% reduction in the average number of falls/1000 patient days for calendar year 2016. 14CC achieved a 17% reduction in average falls rate for calendar year 2016. This was achieved by sustaining intentional rounding from 1-6 AM, employing low beds, floor mats and bed alarms on patients identified as at risk for falls and enacting environmental changes that allow nurses respond to call bells more quickly. Both units implemented and received education on managing responsive behaviors (MRB) in 2015/2016 which includes tools and individualized plans of care and attention to falls risk and interventions. The key lessons learned were the importance of using iterative tests of change and of involving the entire interprofessional team in the design of different change ideas.
Provide key performance data to General Internal Medicine (14CC) and Trauma Neurosurgery (9CC) Units	YES	Quality Boards have been implemented on both 9CC and 14CC and a process has been adopted to update the board with falls data on a weekly basis. The most important learning was understanding that a Quality Board is merely a tool, and in order for successful adoption it must be integrated with the unit's.

Hand Hygiene

ID	Measure/Indicator from 2016/17	Current Performance as stated on QIP2016/17	Target as stated on QIP 2016/17	Current Performance 2017	Comments
5	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, 2016 - Dec, 31, 2016 Publicly Reported, MOH	63.6%	67.0%	63.6%	Focused effort on the ICUs resulted in relative improvement of 14% across these four units. Unfortunately this alone did not result in meeting our target for the overall corporate rate as other units struggled to maintain their previous improvements.

Change Ideas from Last Year's QIP (QIP 2016/17)	Was this change idea implemented as intended?	Lessons Learned:
Focused efforts in the intensive care units (ICUs) aimed at improving appropriate glove use	YES	Through focused improvement projects the four ICUs were able to increase their relative hand hygiene moment 1 compliance by 14%. Unit culture was identified as one of the key drivers to compliance and each unit identified unique ways to address in their specific context. Key lessons learned included involving frontline staff throughout the entire quality improvement journey, consistent inclusion of HH during clinical and other discussions such as rounds and unit meetings, tailoring approaches based on individual needs and the importance of audit and feedback to help drive change.
Implement a Peer Auditor Program	YES	The Hand Hygiene Ambassador Program was developed by the Infection Prevention and Control (IPAC) department to support units in training and developing hand hygiene champions. Key learnings included involving frontline staff to tailor the educational program to address misconceptions, support from management to ensure staff have dedicated time for audits, and manageable expectations to ensure the program was sustainable from both IPAC and frontline staff.

Change Ideas from Last Year's QIP (QIP 2016/17)	Was this change idea implemented as intended?	Lessons Learned:
Explore opportunities to trial an electronic solution for real-time feedback	YES	An electronic hand hygiene system was identified and pilot test planned to begin in March 2017. The pilot will be implemented on eight in-patient units and aims to assess the impact of more robust, frequent and objective data reports. This will support the units awareness of the impact of quality improvement initiatives and enable more timely responses.
Provide key information to units regarding their Hand Hygiene performance for moment 1	YES	Performance reports continue to be provided back to units on a monthly basis and are key to understanding impacts of improvement initiatives.

Equity

ID	Measure/Indicator from 2016/17	Current Performance as stated on QIP2016/17	Target as stated on QIP 2016/17	Current Performance 2016	Comments
6	**Participation Rate for Equity Survey:** The number of patients approached to participate in collection of equity data who completed the survey % Family Health, Ambulatory Clinic, First Day Surgery Patient and Direct Admit In-Patients April 2016 - January 2017 Hospital collected data	90.0%	90.0%	90.0%	St. Michael's maintained our performance and target of 90.0%; this does not include data collected from our ED. We have identified some workflow challenges that have impeded our ability to reliably collect health equity data. Proactive action plans are underway to address these changes and improve our ability to collect data. Changes should result in an increased collection rate and we will continue to build off lessons learned as we advance our work on Health Equity in 2017/18.

Change Ideas from Last Year's QIP (QIP 2016/17)	Was this change idea implemented as intended?	Lessons Learned:
Continued collection of equity survey data	YES	The pilot for health equity data collection in the ED has been completed and 2400 questionnaires were completed. Results were presented to the TC-LHIN to inform broader implementation. We are in the process of determining the most sustainable method of offering the equity questions going forward. Although a summary of equity opportunities was not created, we have implemented service specific equity reports in two clinics, Diabetes and Transplant, which will help to inform their programs and services. Additional reports will be produced after equity data collection rates improve across the organization. Rigorous data validation needs to be completed before making assumptions and identifying additional equity opportunities.

Readmission rate for Congestive Heart Failure Patients

ID	Measure/Indicator from 2016/17	Current Performance as stated on QIP2016/17	Target as stated on QIP 2016/17	Current Performance 2016	Comments
7	Risk-Adjusted 30-Day All-Cause Readmission Rate for Patients with CHF (QBP cohort) to St. Michael's facility % CHF QBP Cohort Four quarters Oct 2015-Sept 2016 CIHI DAD	22.1%	20.1%	19.1%	Through September 2016 SMH achieved its target of a 2% decrease in readmissions for CHF patients. This coming fiscal year will focus on sustaining and monitoring the interventions implemented over the past 12 months.

Change Ideas from Last Year's QIP (QIP 2016/17)	Was this change idea implemented as intended?	Lessons Learned:
Implement a General Internal Medicine Rapid Assessment Clinic (RAC)	YES	The Rapid Referral Clinic (RRC) pilot has been highly successful in avoiding unnecessary admissions from the ED, as well as connecting various clinics and services together for a seamless patient journey. The team is constantly working on improving this process with their stakeholders. The pilot has seen a few CHF and COPD cases; RRC facilitated efficient diagnostic tests, specialty treatment and consults and patient education for many complex disease groups. Other medical services have also begun to look into whether this ambulatory model would work for their specialties. The pilot initially consisted of three half-day morning clinics. The next phase of the expansion will include post-discharge follow up from general internal medicine, and direct referrals from family practices.
Use of risk-assessment tool to identify and support patients at high-risk for readmissions	YES	Use of the risk-assessment tool implemented on GIM has seen strong adoption by case-managers who are using it to identify all patients at higher risk of readmission. Those identified as high-risk are provided with additional supports at discharge with emphasis on providing community support through the health links program. The integration with the GIM admission note will electronically produce the score helping to streamline workflow.

Change Ideas from Last Year's QIP (QIP 2016/17)	Was this change idea implemented as intended?	Lessons Learned:
Family Health Team (FHT) transitions to home	YES	Moved the clinic booking upstream to allow GIM clericals to book directly into the FHT clinic. The FHT clerical still receives daily list of discharged patients and follows-up with patients to either book or confirm appointment. Training for clerical staff occurred in fall 2016 and group is tracking process measure indicating follow-up within 7 days to support evaluation.
Integrated communication between General Internal Medicine and FHT physicians	YES	The eAdmit tool has widespread use for GIM admissions making it a viable tool to distribute admission information to primary care providers (PCP). The note has received positive feedback from both primary care providers and hospital staff as it notifies the PCP of the reason why their patient has been admitted and enables two-way communication. This offers the possibility of the PCP providing important information to the hospital staff. Improvement in the database for secure e-mail addresses would help spur expansion of the tool.

Readmission rate for Chronic Obstructive Pulmonary Disease Patients

ID	Measure/Indicator from 2016/17	Current Performance as stated on QIP2016/17	Target as stated on QIP 2016/17	Current Performance 2016	Comments
8	Risk-Adjusted 30-Day All-Cause Readmission Rate for Patients with COPD (QBP cohort) to St. Michael's facility % CHF QBP Cohort Four quarters Oct 2015-Sept 2016 CIHI DAD	26.4%	24.4%	21.3%	Through September 2016 SMH achieved its target of a 2% decrease in readmissions for COPD patients. This coming fiscal year will focus on sustaining and monitoring the interventions implemented over the past 12 months.

Change Ideas from Last Year's QIP (QIP 2016/17)	Was this change idea implemented as intended?	Lessons Learned:
Implement a General Internal Medicine Rapid Assessment Clinic (RAC)	YES	The Rapid Referral Clinic (RRC) pilot has been highly successful in avoiding unnecessary admissions from the ED, as well as connecting various clinics and services together for a seamless patient journey. The team is constantly working on improving this process with their stakeholders. The pilot has seen a few CHF and COPD cases; RRC facilitated efficient diagnostic tests, specialty treatment and consults and patient education for many complex disease groups. Other medical services have also begun to look into whether this ambulatory model would work for their specialties. The pilot initially consisted of three half-day morning clinics. The next phase of the expansion will include post-discharge follow up from general internal medicine, and direct referrals from family practices.
Use of risk-assessment tool to identify and support patients at high-risk for readmissions	YES	Use of the risk-assessment tool implemented on GIM has seen strong adoption by case-managers who are using it to identify all patients at higher risk of readmission. Those identified as high-risk are provided with additional supports at discharge with emphasis on providing community support through the health links program. The integration with the GIM admission note will electronically produce the score helping to streamline workflow.

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