2017/18 Quality Improvement Plan (QIP)

AIM			Measure						Change			
Quality dimension	**Issue**	**Objective**	**Measure/Indicator**	**Unit / Population**	**Source / Period**	**Current performance**	**Target**	**Target justification**	**Planned improvement initiatives (Change Ideas)**	**Methods**	**Process measures**	**Target for process measure**
Effective	**Effective transitions**	**Decrease Readmissions to MGH (selected conditions)**	Readmissions within 30 days for selected conditions (HIGs) to own facility • Acute myocardial infarction; • Cardiac conditions (excluding heart attack); • Congestive heart failure (CHF); • Chronic obstructive pulmonary disease (COPD); • Pneumonia; • Diabetes; • Stroke; and, • Gastrointestinal disease	Risk-adjusted readmission ratio / Discharged patients with selected HIG conditions	CIHI DAD / January 2016-December 2016	13.1	12.00	This QIP is aligned with MGH H-SAA target performance corridor and the TC-LHIN Readmission Rate Initiative	1)Order Sets: Identify and implement improvements to order sets to align care pathways with best practice	1) Assess existing TEHN/MGH order sets. 2) Review literature (eg: Ministry QBP Clinical Handbooks), and peer hospital best practices 3) Engage with TEHN/MGH clinical leaders to identify opportunities to improve care pathway and supporting order sets 4) Present findings, conclusions, and recommendations for order set improvements. 5) Develop and deliver Implementation plan. (The 8 HIGs will be grouped and assessed/implemented in a phased sequence COPD and Pneumonia will be the first group.)	Percentage completion (COPD + Pneumonia)	Q1 – 50% Q2 – 100%
									2)Readmission Flags: Leverage flag within electronic patient record to identify changes in clinical practice that will prevent readmissions	1) Gather learnings and ideas from care providers since the flag was implemented 2) Literature review 3) Develop proposal for new processes or practices (stakeholder interviews, workshops) 4) Present findings, conclusions, and recommendations (Implementation plan to be developed as separate initiative following the design phase.)	Percentage completion	Q1 – 25% Q2 – 50% Q3 – 75% Q4 – 100%
									3)Discharge Planning Process: Review current practices and identify improvements with discharge planning processes that may prevent readmissions	1) Assess existing TEHN discharge processes and supporting Powerchart technology, with particular focus on the 7 HIGs selected above. 2) Review literature , and peer hospital best practices 3) Develop proposal for new processes or practices (stakeholder interviews, workshops) 4) Present findings, conclusions, and recommendations (Implementation plan to be developed as separate initiative following the design phase.)	Percentage completion	Q2 – 25% Q3 – 50% Q4 – 100%
Efficient	**Access to right level of care**	**Reduce overall cesarean section rate**	C-section Rate: Total number of caesarian section deliveries divided by the total number of all deliveries x100	% / Maternity Patients	BORN / Most recent quarter available	28	28.00	•March 2016 – February 2017, 12 month average of 28.1%, consistent with target and current provincial average of approximately 28% (BORN). •During March 2016- February 2017 period, only 6 of 12 monthly rates were below 28.0%. •Overall birth volumes (denominator) have experienced annual decreases at a significantly faster pace than c-section volumes (numerator), resulting in higher c-section rate but not necessarily c-section volume over time. •Peer and international benchmarks vary significantly, dependent on many factors including societal, cultural and clinical practices of patients and practitioners; •Due to long term nature of pregnancy, any initiatives implemented will take several months before any change reflected in the rate	1)Manage induction rates	1) Review standards for induction and oxytocin use; 2) Review patient flow and induction scheduling/ booking practices; 3) Review current standards regarding active labour; Practitioner performance feedback; 4) Review misoprostol utilization; 5) Increase use of fetal lactate assessment	Number of induced births resulting in c-section (Robson 2 and 4)	Achieve a decrease in Robson 2 and 4 caesarean births by 5% each category by year end
									2)Improve supportive care in labour	Advance nurse training, education, and champion development to enable staff to: 1) Increase ambulation and positioning changes during labour; 2) Decrease early epidurals; 3) Enhance use of water therapy; 4) Increase practitioner performance feedback; 5)Increase use of fetal lactate assessment	Rate of complications in labour: number of deliveries with complication divided by the total number of all deliveries x100	•Decrease number of women with intrapartum complications by 4% by year end
									3)Increase VBAC rate	1) Create patient experience/testimony videos; 2) Make information pamphlets more available; 3) Discussions at MD meetings and MD or staff rounds; 4) Increase use of fetal lactate assessment	Rate of VBAC attempted: number of vaginal births after one previous c-section attempted divided by the total number of all deliveries x100	Increase VBAC attempts 5% by year end
Equitable	**Health Equity**	**Increase rate of "Ask"**	"Ask" rate: Number of patients asked if they smoke divided by the number of patients admitted to an inpatient medicine unit for greater than 48 hours x100	% / Patient admitted to inpatient medicine units greater than 48 hrs	Hospital collected data / April 2016 - March 2017	52.7	60.00	Following the introduction of the QIP in 2016/17, an improvement of approximately 10% over baseline was achieved. The target for 2017/18 aims for an improvement of 13%, with the expectation that the teams will continue to build upon the successes from year 1 while balancing the challenges experienced when implementing culture change.	1)Provide education and training to frontline providers to increase frequency of Ask and offer of Assistance	1) Provide shadowing rotation opportunities to clinic to introduce language and provide insight into impact of smoking cessation care 2) Identify barriers from frontline perspective to completing Ask 3) Develop a training and education plan 4) Provide education through external and in house opportunities 5) Develop champions through Clinical Resource Leader involvement	Number of staff that rotate through clinic	Minimum one staff per month
									2)Establish a process for providing consultation when assistance is requested by patient	1) Map current state 2) Develop new process for brief bedside consultation 3) Explore opportunities for auto-referral alerts via electronic chart 4) Collaborate with Pharmacy to explore opportunities for alternative primary care involvement	Percentage of patients who are offered support when assistance is requested	TBD following collection of baseline
Patient-centred	**Person experience**	**Improve the Patient Experience**	Positive Patient Experience: Percentage of positive response ("Definitely yes") to the question "Would you recommend this hospital to your friends and family"?	% / Survey respondents	CIHI CPES / April 2016 - March 2017	54.2	54.20	Since the new survey tool was launched last fiscal (April 2016) we have used the collecting period of April 2016 to March 29th to gather robust baseline that better reflects the progress of this QIP. Moving forward to fiscal 2017/18 we aim to further consider and reflect upon our performance and our target.	1)Create a valuable and useful data bank/repository for information and metrics related to patient experience.	1)Continue to collect, standardize and analyze data from different patient feedback channels including: -Patient Experience Survey -Patient Relations -Patient Stories 2)Roll out a standardized reporting framework. 3)Strike a working group that will seek to analyze and understand the data.	Percentage of data from the patient feedback channels that is included in the standardized reporting framework	100% of the feedback channels reporting into the standardized reporting framework by start of Q4
									2)Implement an identified best practice at the point of care that will help to improve the patient experience through active listening and communication with patients and their families.	Working with Nursing Assembly, the Clinical Resource Lead forum, Managers, Inter-professional staff and the Working Group to identify and implement one change idea from: 1.Empathy Interviews 2.Personalized Patient Posters (apple tree) 3.Empathy Building Simulation Scenarios The Working Group will also help to implement and sustain the identified practice.	Percentage of in-patient units integrated into the chosen practice	75% of in-patient units by end of Q4
									3)Continue to embrace patients as partners and increase their presence in structured system level processes.	1)Raise awareness of the impact of patient partners with leadership. 2)Develop a factsheet to support managers and directors in facilitating patient engagement.	Number of instances that involve patient experience partners (meetings, committees and processes such as hiring, policy/process creation) throughout the organization.	An increase of patient partner presence by two committees by Q4

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Safe	**Medication safety**	**Increase Best Possible Medication Discharge Plans**	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	62.5	65.00	This is a stretch target for MGH, given our current state; we have set an achievable goal of 65%, which we hope to exceed by end of the 2017/18 QIP year. By focusing efforts on specific programs of the hospital that consistently show compliance below the organizational average, we intend to drive up the proportion of inpatients for the whole hospital receiving medication reconciliation on discharge.	1)Provide focused medication reconciliation training, and ongoing support to psychiatrist team in Mental Health	1) Provide e-chart training to Mental Health physicians	Percentage of in-patient psychiatrists trained on medication reconciliation process in Cerner	100% of in-patient psychiatrists trained by September 2017
									2)Increase accountability of medication and med rec errors for Surgery residents	1)Split surgical medication reconciliation data by service. 2)Give timely feedback to the medical chief of each service. 3)Address barriers in place which prevent medication reconciliation from occurring, specifically workflow around discontinuing the pain powerplan.	Percentage completion of medication reconciliation upon discharge	65% med rec on discharge compliance for each surgical service by March 2018
									3)Identify barriers and introduce improvements to facilitate med rec on Cardiology (CIU)	1)Identify barriers 2)Obtain feedback from physicians 3)Provide e-chart training where needed	TBD	TBD
	Safe care	**Reduce Hospital Acquired C.difficile infections**	Clostridium Difficile Infection (CDI) rate per 1,000 patient days: Number of patients newly diagnosed with hospital-acquired CDI during the reporting period, divided by the number of patient days in the reporting period, multiplied by 1,000	Rate per 1,000 patient days / All patients	Publicly Reported, MOH / January 2016 - December 2016	0.07	0.25	MGH-Toronto East Health Network has set our target for 2017 at 0.25. We achieved a mean rate of 0.315 for years 2014 and 2015. Although we achieved a rate of .07 in 2016 this rate was far below our historical performance. We are considering the impact that the 2016/17 Influenza season might have on our ability to replicate last year's results. We are encouraged by our recent rates and would like to exceed the performance rates for large community hospitals in our LHIN. Key internal stakeholders involved in the decision making process agree this target can be achieved.	1)Revise cleaning instructions for rooms when isolation is discontinued/pt. transfer/death/pt discharged home and allow for electronic tracking and direction of clean	1)Policies to be updated to reflect current literature and PPE for Health Care Worker & visitors to be revised 2)Revision and approval of signage posted on doors for isolated patients and definition of associated clean expected mid –April 2017. 3)Technical change in tele-tracking & power chart to be completed approx. 6 months after signage launch. 4)Use PDSA cycle for roll out	Percentage of double terminal cleans completed on c-diff rooms when discharge/pt transfer/death or discontinue isolation	100 % double terminal cleans completed
									2)Revise hand hygiene auditing program and initiate Electronic-monitoring on 5 inpatient units as part of a multi-facility research project	Electronic Monitoring system will be installed in 5 units. Data will be collected on compliance for a period of 3 months but not shared with the units. This is done so that a baseline can be established with which to compare future rates. 1)Following a step wedge design (sequential but random rollout of an intervention over multiple time periods,)at the 3 month mark targeted unit based improvement strategies (interventions) will be initiated on one unit and real-time feedback will be provided. Thereafter, 2 wards will be initiated at month 6 and the last 2 wards will be initiated at month 9. 2)A total of 5 units will be targeted.	Percentage change in hand hygiene compliance in control and intervention periods on wards that implement eMonitoring	10% increase over baseline by year end
		Reduce incidents of workplace violence	Reduction in incidents of workplace violence	Number / All MGH employees (on payroll, part and full time)	Hospital collected data / April 2016 - March 2017	3	3.00	The organization continues to strive towards reducing all incidents of workplace violence in our journey to staff safety excellence. The target was determined upon review of data from the previous 6 years for which a range of 0 to 5 incidents was reported, with an average of 2.6 incidents per year.	1)Increase spread of Workplace Violence Prevention Training	1)Revise Training Policy & Plan 2)Review sustainability of training offered 3)Refresher Training program development and roll out	Percentage of employees working in high risk areas that complete an in-class workplace violence training session	100% of staff in high risk areas that complete in-class workplace violence training by April 1, 2018
									2)Align and standardize the flagging and care planning processes among the Joint Centres	1)Work with Joint Centres Hospitals to create a standardized flagging and care planning process 2)Educate frontline staff and frontline leadership (dyad- Clinical Resource Leader/ manager) on the standardized flagging and care planning processes 3)Explore changes to electronic medical record to increase spread of information	Percentage of patients identified as at risk for violence with a behaviour care plan completed	80% of flagged patients have a behaviour care plan completed
									3)Improve and strengthen provincial partnerships and sustain MGH's position as a system leader	1) Participate in Institute for Work and Health and Health Quality Ontario scholarly research projects 2) Expand Workplace Violence knowledge transfer to partner organizations in the Toronto East Health Network	Number of presentations to external partners	10% increase number of presentations offered to external partners
		Improve identification and response for deteriorating patients	Rescue Index: Number of "unexpected" adult inpatient decedents per thousand discharges. (Numerator excludes 1) patients under age of 18, 2) patients with DNR (Do Not Resuscitate) status, 3) decedents discharged from special care unit (eg: ICU); Denominator includes all adult discharges)	Rate per 1,000 / All discharged adult patients	Hospital collected data / April 2016 - March 2017	1.1	1.60	•This indicator is measuring an infrequent event, and thus can be highly variable •Since this is a custom indicator, no external comparators are available •First year actual performance was 1.6	1)Daily Safety Check: Design and implement a communication mechanism to identify patients needing extra attention	1) Develop ideas (brainstorming) 2) Develop proposal for new process (stakeholder interviews, workshops) 3) Test new process 4) Present findings, conclusions, and recommendations (With a successful Test of Change outcome, we hope to develop an implementation plan to be launched in Q3 as a separate Change Initiative.)	Percentage Completion	Q1 – 50% Q2 – 100%
									2)Morbidity & Mortality (M&M) Rounds: Design and implement a system to capture inter-professional best practice recommendations	1) Assess current practices 2) Review literature and peer hospitals to develop best practices 3) Develop proposals for information capture and reporting systems 4) Present findings, conclusions, and recommendations. (Implementation plan to be developed as separate initiative following the design phase.)	Percentage completion	Q1 – 100%
									3)Key Performance Metrics (Phase 2): Continue development of an automated key performance measures	1) Confirm user requirements specification 2) Design database architecture and interfaces 3) Design and develop reporting system 4) Test reporting system 5) Implement (includes Training)	Percentage completion	Q1 - 20% Q2 – 75 % Q3 – 100%
Timely	**Timely access to care/services**	**Reduce length of stay in ED**	90th Percentile Emergency Department (ED) Length of Stay for Complex (CTAS 1- 3) non-admitted patients	Hours / All ED Visits	In House Data; CCO / January 2016 - December 2016	7.83	7.70	This target is based on last year's lowest monthly achieved performance. The goal will be to reach or exceed this target by the cumulative year end.	1)Formalize partnerships with community agencies and internal resources catered towards the mental health population.	1)Collect data and identify trends in the mental health population with an elongated length of stay 2)Identify gaps in mental health coverage/needs 3)Identify/align community and internal mental resources to match patient needs 4)Educate staff and community around external resources 5)Monitor strategy compliance and uptake	Number of mental health resources developed and in use by the end of the year	-1 new pathway for Mental Health Patients by the end of the year
									2)Streamline process for patients after triage in our ambulatory zone	1)Identify process opportunities for improvement in green zone through staff engagement 2)Prioritize mini improvement projects by impact and effort 3)Identify a front line staff champion to facilitate the change aided by department resources 4)Guide the staff through QI methodology 5)Measure effectiveness of change 6)Develop sustainability of change 7)Repeat the project process with another staff member	Number of Mini Process Projects Implemented/2 months	Minimum of 1 mini project implemented every 2 months
									3)Improve access to Diagnostic Services for patients	1)Identify gaps in service and explore shifting service or increasing service 2) Educate staff on service changes 3)Monitor sustainability of change (are servicing the maximum number of patients)	Number of patients returning the next day for ultrasound due to service unavailability (after hours)	Fewer than 10 per day by end of year