Excellent Care for All

Quality Improvement Plans (QIP): Progress Report for 2017/18 QIP

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 2017/18	Org Id	Current Performance as stated on QIP2017/18	Target as stated on QIP 2017/18	Current Performance 2018	Comments
1	"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; April 2016 - March 2017; Hospital collected data)	858	52.70	60.00	81.80	First added in 2016/17, this indicator met and surpassed its performance over 2017/18 and saw an approximate 36% improvement during the year. Building on the steady improvement from 2016/17, the “Ask” rate of patients related to smoking was augmented by improved education and training of frontline staff and physician assistants and the support of a physician and nurse practitioner champion. For the 2018/19, we will continue to build on our learnings and better understand how our care teams are assisting and connecting patients to smoking cessation treatments, such as nicotine replacement.

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Change Ideas from Last Years QIP (QIP 2017/18)	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?
Provide education and	Yes	Aligning with RNAO Best Practice guidelines,

training to frontline providers to increase frequency of Ask and offer of Assistance		physician assistants, medical residents and nursing staff received education and training on engaging and asking patients about their smoking histories and offering smoking cessation assistance to those who smoked. Some of the key learnings related to successful implementation include: having a core group dedicated to this initiative; support from senior leadership and administration; and fostering partnerships with pharmacy, the Southeast Family Health Team and community partners such as Toronto Public Health, helped to ensure greater patient follow-up in the community and sustained efforts. Similarly, integration of this initiative within the Electronic Health Record (EHR) helped to identify trends and track progress of this initiative from a quality improvement perspective. While the change idea was implemented as intended, the working group realized that with dedicated funds and resources for a Smoking Cessation Counselor, the project could be spread further.
Establish a process for providing consultation when assistance is requested by patient	Yes	Though this change idea was implemented as intended, the gains were much slower than anticipated. This can be attributed to resource limitations –namely time and financial. There is opportunity for further growth and development particularly in the increased dissemination of a video and Nicotine Information sheet. We also realized the limitations and impracticality of creating an auto-referral alert via electronic chart, especially given the patient population. For this process of smoking cessation, patient engagement and buy-in is critical. Therefore, an electronic referral process would be ineffective. While we have begun a collaboration with Pharmacy to explore opportunities for alternative primary care involvement, we know there is more work that can be done in this area, particularly with external pharmacists.

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2	90th Percentile Emergency Department (ED) Length of Stay for Complex (CTAS 1- 3) non-admitted patients (Hours; All ED Visits; January 2016 - December 2016; In House Data; CCO)	858	7.83	7.70	7.50	Over the last year, this indicator met and surpassed its target by 4.4%. For 2017, we focused on improving services and processes that contributed to a longer length of stay in our Emergency Department (ED). As a result of this focus, we introduced a new workflow plan to reflect patient volumes and staffing levels. This allowed us to adjust accordingly to the needs of the ED to avoid bottlenecks. Over the last year we realized the opportunity and need to provide better access to mental health services overnight. We began to lay the foundation for a partnership and collaboration with MGH's Mental Health Service to help bridge the gap. We realized that successful implementation of the change ideas was a result of increased planning, engaging and helping staff to adopt the initiatives and potentially change their process flow. In fact, we believe that rigorous planning at the front end has enabled greater sustainability and allowed staff to better overcome barriers and challenges to implementation. With this indicator, we found the greatest challenges were related to cultural and behaviour changes and we helped mitigate this aspect

through recognition of the time required to bring about change.

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Formalize partnerships with community agencies and internal resources catered towards the mental health population.	Yes	While this change idea was implemented as intended, it is still undergoing some refinement. To properly implement this change idea, we had to work closely with MGH's Mental Health Service. Working with the understanding that it is very hard to remove services once introduced, we have been consulting with various stakeholders to ensure the solution will satisfy the needs of patients. In 2018/19, we will continue to build on this partnership and create accessible mental health services for patients that will enable them to better transition back into the community. Over the last year, we learned that close partnership and ongoing communication with a different department is key to successful implementation.
Streamline process for patients after triage in our ambulatory zone	Yes	To implement this change idea, we needed to look at providing the necessary diagnostic testing to help the physician reach a disposition quicker, thus reducing the overall length of stay.
Improve access to Diagnostic Services for patients	No	The purpose of this change idea was to optimize patient flow and improve access to diagnostic services for patients. During 2017/18 this change idea was put on hold and was not implemented as intended. The main reasons include competing priorities and a conflict in work within the Diagnostic Imaging department. This issue involves the procurement of new devices but we are confident that resolving this issue will drastically change and improve patient flow. Therefore, we have decided to revisit this idea once the new devices have been procured.
Introduce a role of Physician Navigators to improve patient flow and coordination between different health care providers.	Yes	As an innovative staffing model within the ED, we added this change idea mid-way through 2017/18 to better facilitate flow and patient transitions to discharge. We learned that this tactic, when paired with flexible workflow, has proven to be beneficial to staff, patients and the department. Though reducing length of stay is a complex issue, this tactic has

helped to improve patient satisfaction, as well as increase patient flow through the ED.

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3	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; January 2016 - December 2016; Publicly Reported, MOH)	858	0.07	0.25	0.09	MGH continues to be a system-leader in this area. In 2017/18, our performance was well under the target of 0.25. While we continue to see success in this area, this indicator was included within the 2017/18 QIP to align with our member hospitals from the Joint Centres for Transformative Health Innovation (Joint Centres). We believe our low CDI rate is a result of the commitment, engagement and continued vigilance of our leadership in the area of infection control and patient safety. We have recognized the importance and impact of proper hand hygiene. For 2018/19, this indicator will move off the QIP. However, we will continue to monitor its performance internally and on our hospital's Quality Dashboard, a monthly scorecard for our quality performance.

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Revise cleaning instructions for	Yes	This change idea met its target because of a

rooms when isolation is discontinued/pt. transfer/death/pt discharged home and allow for electronic tracking and direction of clean		number of success factors. First, we invested considerable time during the planning phase and engaged all key stakeholders and decisions-makers early in the process. While hospital resources remain challenged, we made sure the related supplies and staff were available to ensure successful implementation of this tactic. Secondly, from a quality improvement perspective, we engaged a continual PDSA (Plan-Do-Study-Act) cycle and attacked problems at their root cause. Thirdly, cleaning instructions were clear and specific. We considered specific audiences for related signage. We partnered with University of Toronto Human Factors Engineering Specialists to help redesign current signs for multiple audiences: patients, family, visitors and staff. Time, staffing and financial resources challenged this engagement process. For the next iteration of this process, we will increase our partnership with patients and staff.
Revise hand hygiene auditing program and initiate Electronic-monitoring on 5 inpatient units as part of a multi-facility research project	Yes	Partnership with other health care organizations raised the profile of the importance of this change idea. Benefits to partnership include sharing lessons learned, barriers and successes on weekly basis. Successful implementation of this tactic is a direct result of leadership support and buy-in and staff engagement, particularly the use of champions to assist in spreading key messages of this measure. In 2017/18, we will continue to explore ways to involve patients, families and caregivers in this aspect of quality improvement.

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4	C-section Rate: Total number of caesarian section deliveries divided by the total number of all deliveries x100 (%; Maternity Patients; Most recent quarter available; BORN)	858	28.00	28.00	30.60	Over the last two years, a considerable amount of focus has been on the development of high quality and accurate data reporting. In 2017/18, we continued to face challenges receiving timely data. Combined with the complexity of the issue and the required change management related to the physician engagement altering physician culture and behaviours, MGH continues to be challenged overall with this indicator. However, there is strong medical, clinical and leadership support and momentum for change with the involvement of physician champions and clinical leadership all mobilized to improve the performance of this performance indicator. Given these factors, MGH has elected to move this indicator off of the QIP. Its performance will be monitored and regularly reported internally and shared on the hospital's Quality Dashboard.

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Manage induction rates	Yes	While there are some areas within this change idea that still need to be completed, overall, this change idea was

		implemented as intended. In 2017/18, the working group made considerable gains with respect to managing induction rates through a review of standards for induction and (I think this may be oxytocin) use and practice policy. In 2018/19, MGH will continue to fine tune the process and formalize data collection. The greatest challenges that slowed implementation of this change tactic involved leadership changes mid-year and limited staffing resources.
Improve supportive care in labour	Yes	In 2017/18, the Family Birthing Centre sent registered nursing staff to supportive care workshops. The work to improve supportive care in labour continues and the working group is currently partnering with the Unit-Based Council to create educational videos. We are tracking the success of this initiative through engaging patients in post-discharge phone calls. Through the hospital's partnership with the Joint Centres hospitals, we are working on a survey tool related to improving supportive care in labour. In 2017/18 the Joint Centres began this project and shared education and evaluation. Similarly, to the change tactic related to managing induction rates, this initiative was also challenged by staffing resources.
Increase VBAC rate	No	While patient experience and testimony videos were made and classes conducted, this change idea was not implemented as intended. The biggest challenges involved a lack of resources to develop, design and disseminate information online. Also reaching patient populations that may not have easy access to online sources or may be challenged by language barriers also provided a stumbling block. Over 2018/19, the group will continue to increase the VBAC rate and is looking to strengthening a partnership with the hospital's corporate communications department for assistance.

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5	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)	858	62.50	65.00	54.88	In 2017/18, MGH continued to be challenged in this area. Engagement from the physician team in various areas was essential in achieving compliance for completed medication reconciliation on discharge. This year, the working group focused on three areas: surgery, mental health and cardiology. Given high patient volumes, lower performance and the impact, the group channeled much of its energy on the surgical service. Overall, compared to the hospital's medicine service, mental health and emergency department, the surgical service area continues to be an area for improvement in the area of medication reconciliation on discharge. For the 2018/19, MGH recognizes that to improve the overall performance of this indicator, a focus on changing behaviour in the surgical service is necessary.

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	as intended? (Y/N button)	What were your key learnings? Did the change ideas make an impact? What advice would you give to others?
Provide focused medication reconciliation training, and ongoing support to psychiatrist team in Mental Health	Yes	The greatest success factor was related to the provision of training in real time and the understanding and realization of the importance of multi-disciplinary, psychiatry and physician cooperation.
Increase accountability of medication and med rec errors for Surgery residents	No	Implementation of this change idea proved to be a challenge. Within the surgery service, there is high turnover and short rotation of surgical residents. As a result, this change idea was not implemented because it was hard to establish consistency of practice and accountability within this professional group. Similarly, there were conflicting priorities. One of the lessons learned is the need for an accountability framework and presence of a physician champion to influence compliance of medication reconciliation at discharge among surgeons. Performance report cards related to compliance within the surgical practice helped to provide timely feedback and raise awareness. Finally, in 2018/19, greater emphasis on change management and engagement will be necessary as feedback from surgeons revealed that the current process is not conducive to their current work flow.
Identify barriers and introduce improvements to facilitate med rec on Cardiology (CIU)	Yes	The performance report cards have been the initiating factor and have helped to raise the request for training. The Cardiology (CIU) department is performing well and so the focus has shifted to the surgery practice. A key learning is that the report cards were effective in identifying barriers and raising awareness of medication reconciliation at discharge within Cardiology.

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6	Positive Patient Experience: Percentage of positive response (“Definitely yes”) to the question “Would you recommend this hospital to your friends and family”? (%; Survey respondents; April 2016 - March 2017; CIHI CPES)	858	54.20	54.20	44.50	In 2017/18, we were challenged by the performance of this indicator. One of the main challenges we faced was related to the low number of survey respondents. We have attempted to overcome this barrier by starting to collect patient emails at registration. At this time, we are still working through some administrative challenges and plan to fully engage this tactic by Q1 of 2018/19. Secondly, we acknowledge that improving the patient experience is a complex process that includes many factors including staff satisfaction. In fact, the literature indicates that higher staff satisfaction can contribute to positive patient experiences. In 2017, our staff satisfaction scores were lower by almost 10 per cent over the previous two years. While we understand that this factor is not solely responsible for the patient experience, we do believe that our organization’s decreased staff satisfaction could have been a factor in the performance of this indicator.

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Create a valuable and useful data bank/repository for information and metrics related to patient experience.	Yes	While we did create a data repository related to patient experience, we realized the complexity of this process and were met with challenges related to staffing and resources for data collection. We had an established methodology for collecting the data at the start of 2017/18, however the data “buckets” changed mid-year. As a result, the data collected did not provide a value-add and did not enable easy comparison among comparator hospitals.
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.	No	We piloted a successful test of change related to active listening and communications within the Medical Short Stay Unit (MSSU), however we were challenged in the spread of this tactic by resource, time and staffing limitations. A group of nurses on one unit provided positive feedback related to improved patient connections and communication, but we realized with the challenges identified, the practice would be hard to sustain and hard wire among the rest of the medicine service area.
Continue to embrace patients as partners and increase their presence in structured system level processes.	Yes	In 2017/18 we further developed this change idea and fostered new patient partners within our community, particularly within the South East Toronto Family Health Team where we helped to create a patient experience committee. We are proud of the gains we have made within this change idea and continue to communicate and engage with patients. During the year, patient partners attended and contributed to our hospital’s redevelopment consultations and their participation helped to grow “Voices,” our award-winning Patient Video Program. Success was enabled through leadership support within the community and a willingness to partner and share.

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7	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; January 2016-December 2016; CIHI DAD)	858	13.10	12.00	13.90	This measure is highly variable, particularly susceptible to seasonal variations. The regular monitoring and reporting of this indicator increased awareness among leadership. In 2018/19, this QIP has been modified to focus on three specific Quality-Based Procedures (QPBs) including CHF, COPD and Stroke. MGH will continue its efforts to reduce readmissions, particularly for the COPD and CHF patient populations. For the 2018/19 QIP, this indicator has recognized interdependencies with the indicators related to Patient Experience and Medication Reconciliation at Discharge. As we move through 2018/19 and beyond, there will be increased interdependence among the work related to Patient Oriented Discharge Summaries as identified in the QI work related to patient experience.

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Order Sets: Identify and implement improvements to	No	Mid-year, we changed our approach to updating order sets to align with MGH's Readmission

order sets to align care pathways with best practice		Working Group's internal focus, however, this change idea is still a priority for this hospital, particularly heading into 2018/19. Initially it was thought that the order sets could be updated through the digital order set work sponsored by Ontario, but this was not the case. The project was primarily focused on sites that were new to electric order entry. This group was not able to share their electronic content. As a result, we did not implement this change idea as initially intended. We are now evaluating HIGs-specific order sets as part of the readmission order set group.
Readmission Flags: Leverage flag within electronic patient record to identify changes in clinical practice that will prevent readmissions	Yes	While this change idea was implemented as intended, our biggest learning pertained to training related to the process. Though we were clear about the use. We experienced some challenges related to awareness of the tool. We realized that a investment in an awareness and communication strategy was needed. We will revisit this in the future and continue to round with groups to ensure tool is being used as intended. We understand this will be helpful for spread.
Discharge Planning Process: Review current practices and identify improvements with discharge planning processes that may prevent readmissions	No	While this change idea was not implemented as intended, we are still committed to this work. Lessons learned: there is tremendous amount of development work that needs to be completed to fully understand readmission challenges related to HIG. We have actually done other things that were not part of the deliverables such as: best practices including a readmission report to identify patients for the working group/chart review; and setting up the working groups that are focused on implementing best practices identified by the Toronto Central LHIN. We know that the work done related to COPD has helped to lay the groundwork for a scalable and consistent approach to discharge planning. Unfortunately, we underestimated the complexity of the work involved, as well as realized resource challenges, particularly related to staffing.

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8	Reduction in incidents of workplace violence (Number; All MGH employees (on payroll, part and full time); April 2016 - March 2017; Hospital collected data)	858	3.00	3.00	4.00	Though we did not meet the target as stated in the 2017/18 QIP, MGH continues to lead in the area of workplace violence prevention (WVP). In fact, for almost 12 years, the hospital has made this area an organizational priority with zero tolerance of all forms of violence throughout the organization. The 2017/18 year was successful in further defining the objectives and scope of the workplace violence prevention program. In particular, a strong working relationship with the Joint Centres for Transformative Healthcare Innovation (Joint Centres) partners helped to achieve major streams of work, including: • The completion and dissemination of the new Workplace Violence Prevention Playbook by all Joint Centres hospitals; • Research development of a common approach to flagging risk of violence (including recommended processes for screening and assessment, communicating information on risk and care planning); • Participation in a research project on workplace violence reporting in partnership with the Institute for Work and Health. For 2018/19, the province and Health Quality Ontario have designated WVP as a “mandatory” indicator for all hospitals.

MGH has a robust incident reporting process and has reported on the number of incidents of workplace violence resulting in lost time since the 2016/17 QIP.

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Increase spread of Workplace Violence Prevention Training	Yes	While there have some delays to implementing this change idea, there has been an increase of dialogue and consultation among leadership and union involvement. We have taken a comprehensive, methodical approach, particularly to planning the spread of this tactic. As a result, the working group has gained a better understanding of the resources required to enable success. We continue to strengthen and refresh the content of our WVP training program.
Align and standardize the flagging and care planning processes among the Joint Centres	Yes	While this change tactic continues, MGH and the Joint Centre partners have realized that working and collaborating with seven centres is far more complicated than thought. one of the biggest learnings was the effort and time it takes for a group of hospitals to agree on a common process. Therefore, there have been delays within this change idea.
Improve and strengthen provincial partnerships and sustain MGH's position as a system leader	Yes	In 2017/18, members of the hospital's leadership were consulted and contributed to the province's 2017 Workplace Violence in Health Care Progress Report, a joint commitment from Ontario's Ministries of Labour and Health and Long-Term Care to make hospitals safer. Similarly, MGH is called upon regularly to share its insight about the topic of WVP at conferences, presentations and throughout a number of organizations across Ontario. While this change idea was implemented as intended, a key learning to achieving success has been related to having dedicated resources in place for knowledge transfer and material dissemination (WVP Playbook).

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9	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; April 2016 - March 2017; Hospital collected data)	858	1.10	1.60	1.00	In 2017/18, the Rescue Index measure reflected improvement in MGH’s capacity to identify and appropriately respond to patients at risk of deteriorating. The highlight was the three-month stretch (April to June 2017) with no “unexpected deaths.” Overall, year to date results indicate that MGH has been successful in meeting this performance target. One of the greatest success factors of this indicator has been related to on-going communication and increased awareness of the need to support consistent practices related to the identification of at-risk patients. Of particular success in 2017/18 has been the implementation of the Daily Safety Check (see Change Ideas below). The indicator also received further awareness with it’s alignment to the new Quality & Patient Safety Plan, particularly as it relates to the priority Early Warning Systems.

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Daily Safety Check: Design and implement a communication mechanism to identify patients needing extra attention	Yes	This change idea was flagged as one of the greatest QI achievements of 2017/18 as identified in the QIP Narrative. The Daily Safety Check is a 10-minute teleconference and in-person meeting with the hospital's leadership. With a purpose to proactively share and mitigate potential safety risks and increase organizational "situational awareness," the Daily Safety Check has helped over 63% of surveyed MGH leaders to gain an understanding of issues they might not have been aware of. Similarly, 74% of leaders surveyed feel that the organization's response to safety concerns are "much more" or "more" proactive than in the past. Some key drivers of the successful implementation of this change idea include: • Leveraging champions; • Engaging and gaining the buy-in of leadership and physicians; • IT support with setting up a database collection tool; • Analyst support to gain a better understanding of the data collected. Some of the challenges to implementation include the time and resources necessary to implement a system-wide process. For 2018/19, MGH sees opportunities to better leverage the Daily Safety Check at the point of care.
Morbidity & Mortality (M&M) Rounds: Design and implement a system to capture inter-professional best practice recommendations	No	This change idea was not implemented as intended and faced delays. The working group has identified related best practices and engaged physician leaders through the Medical Advisory Committee. the MAC has provided the consensus to move ahead with the initiative, however, resource challenges, irregular meetings related to M&M rounds and a need for cultural and behavioural change continue.
Key Performance Metrics (Phase 2): Continue development of an automated key performance measures	No	Though we have built the components to enable the successful implementation of this change idea, there have been ongoing challenges related to competing demands, lack of available resources, particularly related to the need for business-intelligent software and technology platform challenges (interface is not user-friendly).