Excellent Care for All

Quality Improvement Plans (QIP): Progress Report for 2014/15 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 2014/2015	Current Performance as stated on QIP14/15	Target as stated on QIP 14/15	Current Performance 2015	Comments
1	ED Wait times: 90th percentile ED length of stay for Admitted patients. Hours ED patients Q4 2012/13 – Q3 2013/14 CCO iPort Access	23.48	21.30	26.60	Note on Target: RVH continues to focus on ED wait time for admitted patients. 24 Hours is the target as a 90th percentile wait time for an inpatient bed and achieving this performance would place RVH within the top quartile, however, several challenges were faced throughout the year: Ebola - Although RVH did not experience any EBOLA cases, there was a new layer of complexity added to screening and pandemic planning, all of which influenced both the resources and process flow, resulting in longer ED wait time. Wide-spread Influenza Activity - RVH did experience significant impact on ED volumes through wide-spread flu activity in Simcoe County, as well as an outbreak in one of our units resulting in temporary closure of a 40 bed unit. This had a negative impact on patient flow and ED wait times. The flu also impacted the LTC sector in our LHIN with as many as 18 LTC facilities being closed to admissions at one time for several weeks, again impacting patient flow. Increase in ED Volumes - In 2010/11 RVH averaged 190 ED visits per day (with admit rate at about 10% equaling about 19 admissions per day from ED). In 2014/15 240 visits was the average. An admit rate of 10-12% remained somewhat constant, however, this translated into 24-26 patients per day requiring an inpatient bed. With the increasing regional role, the aging population

with complex chronic conditions in our LHIN, and widespread flu activity, the end of 2014/15 we saw the ED visits climb in excess of 300 visits per day. All of these factors significantly impacted our patient flow and the ED LOS for admitted patients. Increase in Acuity - As per above, RVH ED Volumes have grown significantly, to an additional 4,500 cases per year with higher acuity. Although this is part of our post construction plan (PCOP), we are seeing significant growth in higher acuity. Rapidly Expanding Regional Role - RVH's service activity continues to demonstrate our growing role as a regional healthcare facility within our LHIN. Increased capacity provided as part of the health centre's capital expansion, which opened in 2012 and doubled the size of the facility, enabled RVH to meet the needs of a rapidly growing and aging population within the Primary Service Area (PSA) and the LHIN. Currently 50% of RVH's patients are from outside of the City of Barrie, with 9% being out of LHIN residents. RVH's acute inpatient weighted case volumes continue to increase and we expect to see an additional increase in these cases in the 2015/16 fiscal year. The acuity increase is in alignment with RVH's new strategic direction as well as our Clinical Priorities for the next 5-7 years. Population Growth - Barrie is the largest city in NSM and remains one of the faster growing census metropolitan areas (CMA) in Canada. Barrie and the immediately surrounding area represents 43% of the NSM LHIN population and is home to one hospital (RVH). The recent census indicates other areas within the NSM LHIN are also amongst the fastest growing in the country and this will impact RVH as a regional provider. Recreation Effect - Portions of the Primary Catchment area are considered "all season" recreation hot spots for Ontarians, with high weekend and holiday population explosions, and the busiest highway (400) in the province on long weekends. RVH is planning for 89,000 ED visits in fiscal 2015/16, up 5% from current projected

			2014/15 volumes and aligned with the growth experienced since opening our expanded emergency department. Aging Population - The North Simcoe Muskoka LHIN contains ever changing demographics including being the third fastest growing seniors population in the province, that will challenge RVH in the coming years. As such the 65 years+ resident population is growing at the third fastest rate in Ontario and will encompass 25% of the region's population in the next 20 years. The relationship between age and patient utilization of services correlates exponentially, which will put pressure on RVH to be innovative in the allocation of resources and care for this growing age group. Another aspect of change stems from the higher than average incidence of chronic disease in our LHIN, along with risk factors such as obesity, smoking and sedentary lifestyle. This will add another level of complexity in delivery of timely, quality patient services.

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Change Ideas from Last Years QIP (QIP 2014/15)	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?
Patient Flow Initiative - Estimated Date of Discharge (EDD) Project.	Yes	RVH has successfully implemented and sustained a culture that uses an estimated date of discharge (EDD) as a cornerstone of the patient flow model. Ultimately, in it, patient flow (outgoing) creates capacity for incoming and enhances our ability to reduce the wait time for admitted patients in ED Lessons learned from this: - Physician education, engagement and participation - Frontline education and transparency in data - Senior Leadership oversight and support - Integration into overall performance evaluation framework (reporting)
Revised hospitalist model and implementation of Ward-Based Hospitalists to improve quality and access to care.	Yes	- New Hospitalist contract with accountabilities for client flow - Hospitalists now have dedicated units and are part of "team" - Does require additional resources for Hospitalist salary, as not all 100% of

		salary is recoverable through OHIP billings Lessons learned from this: - See above
RVH has partnered with North Simcoe CCAC to launch the Home First program.	Yes	RVH has successfully partnered and re-launched the “Home First” program and philosophy in partnership with the NSM CCAC. This program ensures that RVH and the CCAC optimize discharge planning and transition patients to community and alternate levels of care where appropriate. Lessons learned from this: - Active partnership - Communication (Internal and External) - Stakeholder Engagement - Physician education, engagement and participation - Frontline education and transparency in data - Resources to meet demands of additional Health Information - Senior Leadership buy-in and focus - Integration into overall performance evaluation framework (reporting)
RVH and Barrie Family Health Team collaborative launch of the Health Links program.	Yes	Royal Victoria Regional Health Centre (RVH) has always collected and analyzed specific information about high users of RVH, looking for opportunities to better care for this population. In the fall of 2014/15, RVH and the Barrie Health Link actively partnered in information management and performance evaluation and launched a joint position that reports to the HealthLink but works as an integrated member of the RVH Decision Support team. In the winter of 2014/15, RVH, Barrie Health Link and Simcoe County Emergency Medical Services (EMS) partnered in a study, focused on EMS high users. As a result, as a tri-partnership we are actively developing care plans to assist and reduce the utilization of this specific community of patients. Further, RVH will continue to support and maximize the opportunity of partnership with the HealthLink and look for increased opportunity to develop plans for high user patients, ultimately increasing the efficiency and optimizing the experience for these complex patients. Lessons learned from this: - See above
Bed Management System Implementation.	No	RVH regularly reviews the data as an integral foundation to any successful strategy. In 2014/15 RVH continued investigating the need and value of implementing a bed management system. RVH is in the final stages of preparing for an RFP. Beyond the bed management system, RVH will continue to optimize other information/data sources as the enabler of utilization of all beds. Lessons learned from this: - Optimization of existing systems as the enabler to a final solution

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2	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 Q3 2013/14 OHRS, MOH	-0.87	0.00	-0.08	The greatest financial risk currently facing RVH that would be a further reduction in planned revenue assumptions around funding through both PCOP and HSFR. Any material difference in these planning assumptions will impact our ability to achieve the targeted patient services we plan to provide for our community in 2015/16. RVH financial planning assumptions are challenged by a high degree of uncertainty, as currently HSFR remain unconfirmed for 2015/16. As a result, RVH considers the timeliness and delay in funding continues to be a financial risk to our 2015/16 operating plan. Alignment of PCOP and HSFR funding continues to be a factor as RVH and peer hospitals that recently completed an expansion project are being penalized in HBAM formulas due to the 6 year funding ramp up and impact an expansion has on cost per weighted case.

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Interventional Radiology Inventory Management Review to occur with COHPA.	Yes	Inventory levels are aligned with clinical impact, which is a good result, however, no impact on operating margin.
Implementation of Position Control.	Yes	RVH created plans of establishment (POE) for each department, ultimately improving control of positions. Enhanced position control did result in

		improvement of the operating margin. Lessons learned from this: - Continued focus - Leadership accountability
Model of Care Review.	No	Due to complexity of initiative and the timing to complete the right stakeholder engagement there was no operating impact on 2014/15 operating margin. This will be included in the 2015/16 progress report.
Benchmarking Study.	Yes	RVH continually uses benchmarking and peer performance data to asses and monitor program level operations and financial positions. Benchmarking studies were used to help inform 2015/16 operating plan, that will ultimately improve RVH operating margin. Lesson Learned - Benchmarking is only a high level indicator / process, and cannot be used as ultimate factor in determining program level performance as many complexities are inherit in the peer program design(s) and operating structures.
Replacement Protocol Implementation.	No	This initiative was included in the POE process along with control of overtime and sick time replacement.
Add Retail Tenants.	Yes	In 2012 /13 RVH implemented retail food vendors and continues to see success from this initiative. Based on the success of the retail food model, RVH continues to develop and add retail tenants beyond food that will add to the patient experience as well as contribute to improving the operating margin.
Increase Uninsured/Non-resident Revenue Rates.	No	Although this was not implemented yet in 2014/15 due to competing priorities. RVH will continue to focus on this initiative and looks forward to developing a comprehensive policy to support additional revenue.

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3	Percentage ALC days: Total number of acute inpatient days designated as ALC, divided by the total number of acute inpatient days. % All acute patients Q3 2012/13 – Q2 2013/14 Ministry of Health Portal	23.19	12.50	15.34	Wide-spread Influenza Activity - RVH did experience significant impact on ALC through wide spread flu activity in Simcoe County, as well as an outbreak in several of the local Long Term Care (LTC) homes. This again has a significant impact on the resources and process flow, having a negative impact on our ALC rates. Aging, Growing Complex Population - Based on 2011 population estimates, approximately 74,025 people in NSM are age 65+, representing 16.9% of the NSM population (Ontario average 14.6%). In the period 2010-2012, seniors accounted for 22.4% of all NSM Emergency Department visits. In 2013, dementia, mental health and behavior conditions accounted for 20% of all NSM Alternate Level of Care (ALC) length of stay days. According to the Simcoe Muskoka District Health Unit, the prevalence, rate of hospitalization and risk of death from Chronic Obstructive Pulmonary Disease (COPD), Diabetes, Ischemic Heart Disease, High Blood Pressure and Stroke increase significantly with age. Based on a review of 2009/10 data, the Ministry found seniors accounted for 55% of the top 10% of high users in the province. Many programs and services have developed for seniors in NSM over the last ten years. Within the context of this growth there are opportunities for system re-design.

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Patient Flow Initiative - Estimated Date of Discharge (EDD) Project.	Yes	All inpatient units utilize standardized bullet rounds, patient and unit whiteboards. RVH developed to a new process to improve the accuracy of EDD. All staff and physicians received education on EDD methodology and the new process. Front line staff were engaged, including selecting a champion on each unit to implement the initiative. System partners such as CCAC were involved in our process change. Home First initiative reinforced at front line along with the EDD initiative. a) Monitor discharges within EDD daily through the bed meetings and monthly through automated processes b) Monitor conservable days monthly and quarterly c) Monitor ALC days monthly and quarterly d) Integration of Conservable days into QBP reports e) Sustainability plan to be implemented with annual audits to commence. Lessons learned from this: - Comprehensive education for staff/physician brings value to the process, recognizes the need for health information to support transitions in care. - Senior Leadership endorsement and oversight - Resources to meet demands of additional health information
Revised hospitalist model and implementation of Ward Based Hospitalists to improve quality and access to care.	Yes	To improve patient flow by ensuring timely care thereby reducing percentage of ALC. - New Hospitalist contract with accountabilities for client flow - Hospitalists now have dedicated units and are part of this accountability - Hospitalists at the ward unit, drive patient discharge process which is the focus thereby reducing LOS - Additional financial resources to support Hospitalists salary is required as 100% of their salary is not recoverable through OHIP billings Lessons learned from this: - See above
ED TRST tool implementation. Apply evidenced based screening tool to all patients over 75 who present to ED.	Yes	Utilization of the TRST tool triggers identification of high risk patients for ALC status, allowing for identification and early deployment of additional support services such as CCAC support. Reduce ALC bed days by rapidly identifying patients at risk for not returning home. Lessons learned from this: - Value of collaborative partnerships and health professional engagement

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4	Percentage of acute hospital inpatients discharged with selected Case Mix Groups (CMGs) that are readmitted to any acute inpatient hospital for non-elective patient care within 30 days of the discharge for index admission. % All acute patients Q2 2012/13-Q1 2013/14 DAD, CIHI	17.21	15.50	17.38	Readmission rates are considered a marker of poor hospital performance. Reducing readmission rates mitigates costs associated with re-hospitalization. Readmission rates as reported by the MOHLTC are complex due to the integration of readmission to ANY acute facility despite discharge location. Although RVH acknowledges the robustness and requirement to track readmission at a provincial level, we focus our QIP and QBP on data that is both timely and readily available, we focus on readmissions specific to our facility. We continue to work with regional partners to ensure efficiency and high quality care. RVH continues to develop partnerships and programs as a means to address complex cases and to prevent readmission. Our most current data from the MOHLTC (Q4 2013-14) shows a significant performance improvement where RVH is below the target at 14%. Internal readmission rates continue to be monitored and remain at or below targeted levels.

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Implementation of QBPs for COPD and Stroke.	Yes	Engaged stakeholders developed gap analysis for both QBPs. Work teams implemented and revised existing order sets and clinical

		pathways to reflect evidence based care. Lessons learned from this: - Active partnership - Communication (Internal and External) - Stakeholder Engagement - Physician education, engagement and participation - Frontline Coder education - Continued monitoring - Senior Leadership oversight and support
Collaborative launch of the Home First program with CCAC.	Yes	Home First is a program which supports individuals waiting at home for a long term care bed when it is safe to do so. TRST tool administered in ED for all patients over 75 years of age to identify patients at high risk ALC designation. Lessons learned from this: - Continued focus - Home First is an essential option for ALC patients - Collaboration on data / metrics and definitions is essential between hospital and CCAC - Senior Leadership oversight
Working in collaboration with the Barrie Family Health Team to implement the Health Links Patient ED Care Plan program.	Yes	RVH and BFHT collaborated to address the multi-visit patients in the ED. This partnership resulted in the development of the MVP Clinic with an outcome of diminished ED visits. Lessons learned from this: - Address privacy concerns / data sharing at commencement of the partnership - Additional resources (shared roles) is significant enhancement - Active partnership - Communication (Internal and External) - Stakeholder Engagement - Physician education, engagement and participation - Frontline education and transparency in data
	Yes	Other opportunities / initiatives we implemented: RVH is committed to reduce repeat unscheduled ED visits and to this end have implemented: - Post discharge care calls to all inpatient mental health recipients - Further development of Multi Visit Patient (RVH MVP) to provide care plans for patients for present multiple time to the ED - Continuous reviewing of inpatient discharge protocols. - Increased involvement of community service providers during admission and discharge planning. - Enhancement of the crisis clinic hours of coverage to 16 hours per day with an added urgent clinic follow up component - Partner with community agencies to ensure seamless transition to supportive services in the community.

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5	From NRC Canada: "Would you recommend this hospital (inpatient care) to your friends and family?" (add together % of those who responded "Definitely Yes" or "Yes, definitely"). % All patients Oct 2012- Sept 2013 NRC Picker	70.80	82.00	72.00	RVH has set a stretch target, and will continue utilizing all tactics, as an enabler of experience. In this past fiscal year RVH achieved the highest results seen for the past 3 years. Of importance to note is that RVH has chosen to report only on the TOP BOX “Yes Definitely” as its measure of patient experience recognizing benchmarking to other organizations may include the top 2 boxes for their total score. Patients and their families are at the centre of Royal Victoria Regional Health Centre’s Strategic Plan. It is a plan rooted in the belief that every patient will have the best possible experience in our health centre. It is a philosophy we call “MY CARE” and it’s this focus on patients and their families that drives our entire plan. Recently RVH has been recognized by Accreditation Canada for Leadership Leading Practice on our tactics to move patient experience. The Institute of Public Administration of Canada (IPAC) recognized RVH with a silver award, as one of the top 2 health or education organizations in Canada for our submission “Driving Quality by Transforming Culture” based on our MY CARE strategy. The leadership award recognizes “organizations that have demonstrated outstanding leadership by taking bold steps to improve Canada, through advancements in public policy and management”. What is MY CARE? Royal Victoria Regional Health Centre will ensure your CARE is the best, safest and centred on you. Our MY CARE philosophy means we will THINK BIG and exceed your expectations. We will treat

you and your loved ones with courtesy, dignity and RESPECT, while being responsive to your unique circumstances and cultural needs. We want you to be a partner in your care. We will listen carefully to you and keep you informed about your condition and treatment so, together, we can make the best decisions. We will WORK TOGETHER to coordinate your care – inside and outside our facility – and we will OWN our decisions and behaviours. Our unwavering focus on you will enable us to Make each life better. Together. Ultimately, our strategic plan focuses on all aspects of the QIP, but sees the success of this indicator as a primary outcome.

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Revised hospitalist model and implementation of Ward-Based Hospitalists to improve continuity and access to care.	Yes	This revised model provided clarity for hospitalists related to accountability of their role to inpatient based care. This focus supported patient flow and timely care. Patient and family rounding feedback has supported this model as the consistency of physician providing care fostering continuity that improved both the patient and family experience.
Implementation of Patient Experience Scorecards at program level.	Yes	RVH recently launched the MY CARE Experience report specific to programs which provides patient experience drivers, key drivers for patients and overall experience based on NRC Picker results. Part of the data gathering included implementation of real time surveys at point-of-care for inpatient programs, developing data sharing process for leaders to link data to quality improvement initiatives (clinical tactics), increase front line staff knowledge of patient experience data and engaging staff in development of action plans to improve patient experience. The overall goal is to improve patient and family experience. Lessons learned from this: - Physician and staff education related to all tactics - Senior Leadership oversight, monitoring and support

Diagnostic Imaging (DI) to implement outpatient leader rounding with patients.	Yes	40 patients per month to be rounded on for 2014/15. This tactic has proven to be invaluable to gathering in the moment information allowing for immediate service recovery. Lessons learned from this: - 100% of target rounding to be completed starting April 1st, 2014 and sustained throughout the year - Data is shared with all staff in the department to reinforce the values of the tactics and the impact on the patient experience
To design and develop a corporate Patient Family Advisor Framework.	Yes	In order to support RVH's MY CARE philosophy where “patients are at the centre of all we do and are informed and engaged in planning and decision making”, RVH implemented a Patient Family Advisor Council. The Patient Family Advisory Council enables direct patient and/or family engagement to improve the patient experience throughout the continuum of care. Lessons learned from this: - Participation and involvement of patients/families is critical to improving the patient family experience
	Yes	Other Action Plans: - Manager rounding on every patient daily. - Hourly purposeful rounding by staff. Bedside Shift Report (SBARD). - In-patients also have access to an anonymous bedside survey for unit based feedback. - Discharge phone calls. - Senior leader rounding with direct reports, staff and patients.

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6	Medication reconciliation at admission: The total number of patients with medications reconciled as a proportion of the total number of patients admitted to the hospital. % All patients Most recent quarter available (e.g. Q2 2013/14, Q3 2013/14 etc) Hospital collected data	83.00	90.70	84.00	RVH continues to develop medication reconciliation (Med Rec) across the organization. RVH continues to invest in Med Rec as a means of ensuring patient safety. Medication reconciliation at admission: The total number of patients with medications reconciled as a proportion of the total number of patients admitted to the hospital. Lessons learned from this: Physician education, engagement and participation; Frontline education; Senior Leadership oversight and support

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Phase one of RVH medication reconciliation plan is to establish a Med Rec program that will meet all tests of compliance for Accreditation 2015.	Yes	Plan progress includes: a) Moving from unit based implementation to a sustainable organizational wide implementation plan to be completed by February 2015. b) Initial milestone measures will be monitored such as: development/approval of project charter and associated project management process requirements; c) Current state analysis & process mapping for future states completed. d) Time studies and analysis of patient.
The second phase of the plan includes selection and implementation of computerized medication reconciliation software to be completed.	Yes	Review and understand RVH's current ability to support electronic documentation of the BPMH & other Med Rec requirements with current version of Meditech and evaluate the available electronic Med Rec systems. Process measures at present would include: a) Milestone monitoring until the project charter and other measures have been determined; b) A matrix of requirements and available functionality to be developed.

	Yes	Other Action Plans: - Implement best possible medication history in Surgery Program. - Full Surgery Project Team working on this: daily audits to identify quality improvements. - Implement improvements to update process (Plan Do Study Act – Rapid Improvement cycles). - Working group that meet weekly to assess results and recommend changes for continued implementation.

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7	CDI rate per 1,000 patient days: Number of patients newly diagnosed with hospital-acquired CDI, divided by the number of patient days in that month, multiplied by 1,000 - Average for Jan-Dec. 2013, consistent with publicly reportable patient safety data. Rate per 1,000 patient days All patients 2013 Publicly Reported, MOH	0.26	0.31	0.12	As a result of specific program development and strategic direction, RVH has had great success with controlling its CDI rate. There are many factors that combine to continue and sustain this level of performance, but overall it is due to a high level of focus and dedication to our mission: Exceptional care is our passion. People are our inspiration. Safety is our promise. Although not a change idea listed below, RVH continues to perform in the top levels of Hand hygiene compliance, with the most recent data February 2015 for inpatient areas averaging above 97%.

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Implementation of a comprehensive RVH Antibiotic Stewardship Program (ASP).	Yes	Since the inception of the Antimicrobial Stewardship Program (ASP) in April 2013, we have seen close to 2500 patients and assessed the appropriateness of their prescribed antibiotic(s). Recommendations are accepted on average 80% of the time and over half of these recommendations are to stop or narrow the initial antibiotic therapy. We have seen a reduction in antibiotic consumption of

		125% and a 33% reduction in length of stay in patients with a diagnosis of community acquired pneumonia. In comparison to the inpatient units who do not have ASP, we have seen a 68% reduction in Clostridium difficile infections translating to 40 fewer cases per year. Lessons learned from this: - Active partnership / Stakeholder Engagement - Communication (Internal and External) - Physician education, engagement and participation - Frontline education and transparency in data - Resources to meet demands - Senior Leadership support and oversight - Promoting and demonstrated outcomes and sharing of success
Improve unit level responses to rise in C. difficile cases through a standardized communication and escalation process.	A standardized tool allows for earlier multi-factorial interdisciplinary responses to increases in C. difficile cases. Early actions have proven to reduce likelihood of additional cases. Evaluation of this process must occur to ensure overall improvement. A robust evaluation occurs through the IPAC Committee.	
Implementation of Environmental Services dedicated educator.	The hiring of a dedicated Environmental Services Educator has been recognized by Accreditation Canada to be a leading best practice. Lessons learned from this: - The importance of education at every level of the organization	
ED "ICRT" Team early identification of patient precautions through triage.	Yes	ED ICRT Committee goal to ensure early identification through patient screening and communication for patients requiring isolation. Electronic documentation enables staff to identify patients requiring isolation. A process map and action plan has been developed by the ED ICRT Committee, and is going through the process. Lessons learned from this: - RVH

		to have close oversight and monitoring of the successes of the electronic reporting.
ED ICRT Committee struck to ensure early identification through patient screening and communication for patients requiring isolation. Streamlined patient identification process through electronic documentation assists staff with easily identifying the patient requiring isolation.	Yes	A process map and action plan was developed by the ED ICRT Committee. Lessons learned from this: - Electronic documentation is the enabler to timely identification - Sustainability education for all new staff is critical