# 2016/17 Quality Improvement Plan

"Improvement Targets and Initiatives"

<table>
<thead>
<tr>
<th>Quality dimension</th>
<th>Objective</th>
<th>Measure</th>
<th>Unit / Population</th>
<th>Source / Period</th>
<th>Organization ID</th>
<th>Current performance</th>
<th>Target</th>
<th>Target justification</th>
<th>Planned improvement initiatives (Change ideas)</th>
<th>Methods</th>
<th>Process measures</th>
<th>Goal for change ideas</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Effective</td>
<td>Reduce 30 day readmission rates for select HIGs</td>
<td>Percentage of acute hospital inpatients discharged with selected INRAM Inpatient Grouper (HIG) that are readmitted to any acute inpatient hospital for non-acute patient care within 30 days of the discharge for index admission.</td>
<td>All acute patients</td>
<td>ONC, CRIH / July 2014 – June 2015</td>
<td>ONC*</td>
<td>27.02</td>
<td>4.00</td>
<td>To reflect RVH use only, PY performance based on all sites. Does not align with INRAG 3D day readmit indicator. Although existing/PHR has not defined technical specifications for INRAG indicator, RVH does use CHF 28 day readmit for some select HIGs and therefore choosing to report target for this indicator in this QIP.</td>
<td>(1) Review provision of integrated and coordinated care, so inpatient can receive the right care from the right provider at the right time. Expand upon the inpatient and outpatient CHF program to also include dedicated heart function nurses and nurse practitioners and access to nine cardiologist/Review and revise pre-printed orders and the clinical pathway for COPD, CHF and stroke in collaboration with the department of internal medicine. Conduct the six minute walk test with all appropriate heart failure patients per best practices. Review and revise electronic documentation fields to align with evidence-based Practice Based Procedure (PBPs). Audit compliance with CHF PBPs standards, share resultant data sets and conduct iterative improvement cycles as indicated. Explore opportunities to introduce an electronic alert for heart failure patients presenting in the Emergency Department (ED) to alert staff and avoid unnecessary readmissions. Retrospective chart reviews will also be conducted on this patient to enhance discharge transitions. Regional approach to CHF has been employed with team of multi-disciplinary stakeholders to develop standardized protocols and policies that will prevent hospitalization and enhance the ability to keep patients safely supported in the community. Actively participate in partnership for NITOGRATE project for smooth transitions for palliative care patients along the continuum of care. Lead and intensively collaborate in the Integrated Funding Model wave II for stroke patients in the North Simcoe Muskoka Local Health Integration Network (LSN).</td>
<td>Number of FTE health care providers quarterly in the CHF programs (including physicians) meets service level standards. Percentage of PPO reviews and revisions. Percentage of compliance with six minute walk test for all heart failure patient. Percentage of electronic documentation field revisions for CHF PBPs. Audit compliance by April 1 2016 and then review and share data. Electronic alert embedded by July 1 2016.</td>
<td>Reduce readmission to RVH Enhance partnerships for smoother transitions in patient care Meet QBP targets for CHF, stroke and COPD</td>
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<td></td>
<td>(2) Collaborate with our health system partners to smooth transitions in care for patients receiving care.</td>
<td>Review and revise pre-printed orders and the clinical pathway for stroke, CHF and COPD diagnoses in collaboration with the department of internal medicine. Explore opportunities to work with the Barrie Family Health Team to develop and trial an electronic transition of care referral tool. Enhance our post care education and adherence rate and implement iterative change plans for improving upon-identified opportunities to smooth transitions in care. Open an intravenous laser clinic with our community partner. Leverage partnership with NMC Community Care Access Centre (CCAC) for ensuring safe and quality transitions for patients out of the hospital with consistent, appropriate referrals to the CHF and COPD Telehomecare program (support for moderately to severely affected patients initiated in October 2015). Lead the Integrated Funding Model wave II participation for stroke patients in our region. Consistently assess risk of readmission as an element of our individualized discharge planning processes. Facilitate arrangement of a primary care appointment before patients at high risk of readmission are discharged from RVH. Promote self-management and effective education to patients and their families with demonstrated teach backs. Introduce medication reconciliation upon discharge for patients admitted with their primary diagnosis of stroke.</td>
<td>Percentage of PPO reviews and revisions by the July 1 2016. Percentage of post care call completion rate. Percentage of referrals to the CHF and COPD Telehomecare program. Percentage of risk of readmission completed for patients. Percentage of interdisciplinary staff participating in health back educational sessions. Percentage of primary care provider appointments are scheduled prior to discharge for patients deemed high risk of readmission. Percentage of stroke patients with a completed medication reconciliation.</td>
<td>Reduce readmission to RVH Enhance partnerships for smoother transitions in patient care Meet QBP targets for CHF, stroke and COPD</td>
<td></td>
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</tbody>
</table>
### Effluent

**Reduce unnecessary time spent in acute care**

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Baseline</th>
<th>Target</th>
<th>Target exceeded</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total number of ALC patients within the specific reporting period</td>
<td>19.40</td>
<td>4.00</td>
<td>4.00</td>
<td></td>
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<tr>
<td>including non-discharged and deceased cases</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>divided by the total number of patients awaiting long term care placement</td>
<td>82.00</td>
<td>60.60</td>
<td>60.60</td>
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</tbody>
</table>

**Effluent**

- **To achieve:**
  - Leverage technology to enhance access to service, support patients with the right providers and inform and educate patients.
  - Explore opportunities to work with the Barrie Family Health Team to develop and trial an electronic transition of care referral tool.
  - Leverage partnerships with NFM Community Care Access Centre (CCAC) for ensuring safe and quality transitions for patients out of the hospital with consistent, appropriate referrals to the CHF and CPDP Telemedicine program (support for moderately to severely affected patients initiated in October 2014).

- **To achieve: (Cont.):**
  - Engage in Plan-Do-Study-Act cycles for continuous quality improvement focused on reducing unnecessary hospital readmission.
  - Implement standardized process for morbidity and mortality reviews in all medical departments including a trigger for reviews with readmissions within 30 days to our own hospital. Enhance our post care telephone call completion rate and implement iterative change plans for improving upon identified opportunities to smooth transitions in care. Lead the Integrated Funding Model wave 1 participation for stroke patients in our region. Promote self-management and effective education to patients and their families with demonstrated teach backs. Audit compliance with CHF QBP standards, share resultant data sets to conduct iterative improvement cycles as indicated.

### Inluent

**Reduce unnecessary time spent in acute care**

<table>
<thead>
<tr>
<th>Indicator</th>
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<th>Target</th>
<th>Target exceeded</th>
<th>Comments</th>
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</thead>
<tbody>
<tr>
<td>Total number of ALC patients contributed by ALC patients within the specific reporting period (open, discharged and deceased cases), divided by the total number of patient days for open, discharged and deceased cases within the same period.</td>
<td>6 / AR acute patients</td>
<td>5 / AR acute patients</td>
<td>5 / AR acute patients</td>
<td></td>
</tr>
<tr>
<td>WTIS, CCOD, BCJK, MHCSTC / July 2015 – September 2015</td>
<td>58.4%</td>
<td>69.4%</td>
<td>69.4%</td>
<td></td>
</tr>
<tr>
<td>Enhance provision of Integrated and coordinated care, on a patient can receive the right care from the right provider at the right time.</td>
<td>59 / 60</td>
<td>61 / 60</td>
<td>61 / 60</td>
<td></td>
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<tr>
<td>IL The discharge planning model to identify patients who have complex discharge planning needs and facilitate safe transition from hospital to the community. Proactively prepare discharge options and alternatives for patients with complex discharge needs. Implement visual management tools and engage in an educational campaign for care providers, patients and families to promote ‘There’s No Place Like Home’ philosophy rather than awaiting long term care bed placement while in an acute care bed. Expand a biometric, an ethics quality improvement plan to enhance consistency and appropriateness of discharge planning discussions. Build on our successes and maintain our heightened attention on patient flow throughout the hospital. Consider opportunities to engage a physician champion in discharge planning.</td>
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<tr>
<td>Collaborate with our health system partners to smooth transitions in care for patients receiving care.</td>
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<tr>
<td>With NFM CCAC to identify and address barriers to discharge early for inpatients. Proactively prepare discharge options and alternatives for patients with complex discharge needs. Implement visual management tools and engage in an educational campaign for care providers, patients and families to promote ‘There’s No Place Like Home’ philosophy rather than awaiting long term care bed placement while in an acute care bed. Enhance our post care telephone call completion rate and implement iterative change plans for improving upon identified opportunities to smooth transitions in care. Lead the Integrated Funding Model wave 1 participation for stroke patients in our region. Promote self-management and effective education to patients and their families with demonstrated teach backs. Audit compliance with CHF QBP standards, share resultant data sets to conduct iterative improvement cycles as indicated.</td>
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<tr>
<td>Leverage technology to enhance access to service, support patients with the right providers and inform and educate patients.</td>
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<tr>
<td>Introduce a real-time application for hospital leadership to access ALC and census data. Implement visual management tools and engage in an educational campaign for care providers, patients and families to promote ‘There’s No Place Like Home’ philosophy rather than awaiting long term care bed placement while in an acute care bed.</td>
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<tr>
<td>Patient-centred</td>
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</table>

**Patient-centred**

- **To achieve:**
  - Leverage technology to enhance access to service, support patients with the right providers and inform and educate patients.
  - Promote self-management and effective education to patients and their families with demonstrated teach backs. Ongoing participation in bed utilization evaluation and monitor changes based on recent revisions of bed type complements in Mental Health. Enhance our post care telephone call completion rate and implement iterative change plans for improving upon identified opportunities to smooth transitions in care. Lead the Integrated Funding Model wave 1 participation for stroke patients in our region. Promote self-management and effective education to patients and their families with demonstrated teach backs. Audit compliance with CHF QBP standards, share resultant data sets to conduct iterative improvement cycles as indicated.

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**Patient-centred**

- **To achieve:**
  - Promote self-management and effective education to patients and their families with demonstrated teach backs. Ongoing participation in bed utilization evaluation and monitor changes based on recent revisions of bed type complements in Mental Health. Enhance our post care telephone call completion rate and implement iterative change plans for improving upon identified opportunities to smooth transitions in care. Lead the Integrated Funding Model wave 1 participation for stroke patients in our region. Promote self-management and effective education to patients and their families with demonstrated teach backs. Audit compliance with CHF QBP standards, share resultant data sets to conduct iterative improvement cycles as indicated.
**Hospital**

**Slightly lower**

Continue with

"Would you

NRC Picker /

Patient-centred

admission

medication

of patients receiving

Increase proportion

satisfaction

Improve patient

patients admitted to

proportion of the

reconciled as a

number of patients

Medication

include non-

question (do not

registered any

respondents who

by number of

Canada) or

responded “Yes,

and family?” add the

space and capital

expenditures.

stretch target of

multi-year QIP

admission as it is rolled out

reconciliation upon

completed and enhance the

medication reconciliations

sustaining the quantity of

1) Build upon our success in

Human Touch).

education: (Caring, The

right providers and inform

and educate patients.

specialties or services

primary care to your

friends) to your

network of

professional staff

participating in education

sessions, for new

resuscitation

policy and procedure.

Number of bedside and over bed

tables replaced. Monthly monitoring of outpatient wait

times for version. Number of complaints/concerns logged

year over year regarding the patient experience.

2) Implement services to

meet community needs

while exceeding their

expectations and use

patient feedback to

influence optimization of

space and capital

expenditures.

Number of patient helpers boarded. Number of PPIAC

members/representatives on internal committees.

Percentage of internal quality committees with PPIAC

members on the membership. % of patients with 100% hourly rounding completed and signed off per inpatient

unit measured monthly on departmental scorecards.

Number of leaders meeting established targets for

tracking with patients within the leadership evaluation

framework. % of interdisciplinary staff participating in

teach back educational sessions. Number of teach back

education opportunities offered. % of professional staff

participating in education sessions for new resuscitation

policy and procedure. Number of beds/bed and over bed

tables replaced. Monthly monitoring of outpatient wait

times for version. Number of complaints/concerns logged

year over year regarding the patient experience.

3) Leverage technology to

enhance access to service,

enhance patients with the

right providers and inform

and educate patients.

Volumes of patient, staff and visitor questions and

concerns addressed at the technology pod.

Enhance the patient

experience.

4) Collaborate with our

health system partners to

smooth transitions in care

or patients receiving care.

Further our partnership with CCAC with use of alerts for

patients with unplanned visits to our hospital, team-

based care coordination for high users of services and

participation as a member of Health Links by 2018.

Sustain the information technology pod for

troubleshooting patient and visitor technology

questions and concerns.

Percentage of patients CTAS 4 and 5 presenting ED:

wait times in ED for admitted patients, non admitted

complex patients and non admitted non complex

patients.

Reduce ED wait times. Enhance employee

experience concerning patient care.

5) Enhance the employee

experience at RVH to

segment the core components

of the patient experience

Indicators.

Implement departmental employee engagement action

plans and measure impact on patient experience

indicators. Implement enhanced five times initiatives for

non-unionized staff members. Enhance transparency for

staff members with respect to attendance management

process and job descriptions. Introduce a new

employee emotional wellness initiative throughout the

corporation.

Percentage of employees rating RVH positively for

overall engagement scores. Percentage of employees

rating RVH job satisfaction. Percentage of employees

rating RVH as a place to work favourably.

Enhance employee experience correlating to the patient experience.

6) Introduce communication

education (Caring, The

Human Touch).

Initiate communication initiative across all in-patient

units in 2016.

Initiate baseline patient experience scores pre-

education sessions with quarterly monitoring of patient

experience results.

Enhance patient experience correlating to patient experience.

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**Safe**

increase proportion of patients receiving medication reconciliation upon admission

<table>
<thead>
<tr>
<th>% of patients with medications reconciled as a proportion of the total number of patients admitted to the hospital</th>
<th>% of patients with medications reconciled as a proportion of the total number of patients admitted to the hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>%</td>
<td>90%</td>
</tr>
<tr>
<td>% of patients with medications reconciled as a proportion of the total number of patients admitted to the hospital</td>
<td>60%*</td>
</tr>
</tbody>
</table>

* Slightly lower target that PV A focus this year on quality and processes of an electronic medication reconciliation throughout the entire organization, and not just in the Surgery Department.

**Build upon our success in**

the last couple of years by

sustaining the quantity of

medication reconciliations

completed and enhance the

quality of the medication

reconciliation upon

admission as it is rolled out

throughout the entire

organization.

Sustain medication reconciliation performance with

strong leadership support, physician champions,

substance information technology support and a

comprehensive staff education plan. Leverage the

resources and tools available from Safes Healthcare

Now, ISMP Canada, Accreditation Canada, Canadian

Patient Safety Institute etc. to ensure best practices

and evidence-based tools and processes are adopted.

Consistently monitor and improve the quality of

medication reconciliation processes using established

qualitative indicators and plan-do-study-act cycles.

Alone number of unintentional discrepancies per patient.

Percentage of patients with at least one additional discrepancy outstanding.

Ensure quality of medication reconciliation completion.
<table>
<thead>
<tr>
<th>Objective</th>
<th>Description</th>
<th>Measure</th>
<th>Baseline</th>
<th>Target</th>
<th>Improvement</th>
<th>KPI</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reduce readmissions.</td>
<td>Slightly lower than PY as focus this year on quality and processes of an electronic solution throughout the entire organization, and not just in the Surgery department.</td>
<td>Sustain medication reconciliation performance with strong leadership support, physician champions, substantive information technology support and a comprehensive staff education plan. Leverage the resources and tools available from Safer Healthcare Now, JCIW Canada, Accreditation Canada, Canadian Patient Safety Institute etc. to ensure best practices and evidence based tools and processes are adopted. Consistently monitor and improve the quality of medication reconciliation processes using established qualitative indicators and plan-do-study-act cycles.</td>
<td>Percentage of units using electronic process.</td>
<td>Percentage of patients with at least one additional discrepancy outstanding.</td>
<td>Reduce readmissions. Smooth transitions in care. Enhance communications.</td>
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<tr>
<td>Reduce hospital acquired infection rates</td>
<td>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.</td>
<td>Sustain current practices that have facilitated success in last two years.</td>
<td>Leverage the bundle of strategies for identified c. diff cases and when c. diff number is high including, but not limited to: sporidical cleaning twice daily in patient rooms and bathrooms, consistent signage for visual management of risk, double cleaning on transfer or discharge from patient environment, supplies dedicated to a single patient or disinfected before re-use; and consistent, cautious waste management strategies.</td>
<td>Percentage of signage accurately posted for patients with suspected or confirmed c. diff.</td>
<td>Sustain current practices.</td>
<td>Maintain current practices.</td>
<td></td>
</tr>
<tr>
<td>Timely</td>
<td>Reduce wait times in the ED</td>
<td>ED Wait times: 90th percentile ED length of stay for Admitted patients.</td>
<td>Months / ED patients</td>
<td>CCO iPort Access / January 2015 - December 2015</td>
<td>27 9 45 11</td>
<td>20% reduction in this indicator this year is targeted, but there will be increased focus on this target in the following years’ QIP.</td>
<td>Improve provision of integrated and coordinated care, so a patient can receive the right care from the right provider at the right time.</td>
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</table>