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	"Would you recommend this emergency department to your friends and family?" (%; Survey respondents; April - June 2016 (Q1 FY 2016/17); EDPEC)	968	65.10	67.00	64.40	MAHC performance exceeds the NRCC community average of 53.9% and the 75th percentile was 68.4%

Realizing that the QIP is a living document and the change ideas may fluctuate as you test and implement throughout the year, we want you to reflect on which change ideas had an impact and which ones you were able to adopt, adapt or abandon. This learning will help build capacity across the province.

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?
Elevate patient and family engagement at MAHC.	Yes	Leader rounding of managers, senior executives and front-line clinical leaders is well underway. Implementation of MAHC's Patient and Family Advisory Committee was initiated in January 2017 and they have been lending their voice to initiatives that impact the patient experience. The remainder of the strategies are just starting to be rolled out.
Improve return rate of surveys.	No	No change. Considered a manual survey and other strategies to increase the uptake of the NRC surveys. No viable options.

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2	"Would you recommend this hospital to your friends and family?" (Inpatient care) (%; Survey respondents; April - June 2016 (Q1 FY 2016/17); CIHI CPES)	968	63.20	65.00	68.30	MAHC performance exceeds the NRCC community average of 64.4%. The total NRCC average was 70.5% for the same time period and a 75th percentile rate of 79.2%

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Elevate patient and family engagement at MAHC.	Yes	• Leader rounding of Senior Executives, Managers and front-line clinical leaders is well underway. • Implementation of MAHC's Patient and Family Advisory Committee was initiative in January 2017 and they have been lending their voice to initiatives that impact the patient experience. • Inpatient Clinical leaders are engaged with nursing staff to identify to the patient and family the expected date of discharge well in advance. • Inter-professional team engaging with patient/family about discharge needs well in advance of discharge date. • White boards installed
Improve return rate of surveys.	No	

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3	Did you receive enough information from hospital staff about what to do if you were worried about your condition or treatment after you left the hospital? (%; Survey respondents; April - June 2016 (Q1 FY 2016/17); CIHI CPES)	968	0.00	0.00	NA	This was not part of the 2017/18 QIP for MAHC

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4	ED Wait times: 90th percentile ED length of stay for admitted patients. (Hours; ED patients; January 1 to December 31, 2017; CCO iPort Access)	968	12.00	12.00	13.10	MAHC is doing very well in achieving patient flow and bed availability in spite of a high volume of ALC patients on the inpatient units. Since June, the hospital has been in over census and in January opened 26 unfunded beds to accommodate the increased demand similar to the province.

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Improve flow through the Emergency Department.	Yes	MAHC is working on the following initiatives: • Ongoing collaboration with community services to discharge "at risk for ALC" patients prior to ALC designation. • Collaborating with physicians and community services to safely decrease length of stay and improve occupancy management. • Twice daily bed meetings with clinical managers, leads and bed allocation occur to discuss patient flow and available beds and resources. Increasing to a third meeting. • Inpatient team pulling patients up from the ED.

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5	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 (Rate per total number of admitted patients; Hospital admitted patients; Most recent 3 month period; Hospital collected data)	968	78.70	80.00	84.10	For the first 6 months of 2017/18, the target has been met or surpassed 5 out of 6 months.

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Identify interdisciplinary medication reconciliation process and documentation to improve efficiency and accuracy of BPMH (Best Possible Medication History), Medication Reconciliation upon admission.	Yes	In addition to monthly monitoring, we are monitoring Med Rec number daily and weekly to ensure we maintain our successes to date and re-deploy staff if needed. Now that we have started to reach our targets, we are continuously looking to improve our performance by seeking to shorten the time from admission to Med Rec so that patient safety is further improved. This is being accomplished by re-deploying pharmacy technicians to the Emergency Department at the time of admission to have the medication history accurate before the orders for admission are written whenever possible, as this reduces re-work and risk of errors.

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6	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)	968	0.00	80.00	1.00	Currently finalizing the pilot project for the PharmNet module in CERNER (Electronic Health Record) to enable medication reconciliation on discharge. Target Feb 28, 2018 for go-live. First software solution was not viable.

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Identify interdisciplinary medication reconciliation process and documentation to improve efficiency and accuracy of BPMH (Best Possible Medication History), Medication Reconciliation upon discharge.	Yes	Process mapping completed and provided insight to inform the med rec policy and procedure. A key success factor.

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7	Percent of palliative care patients discharged from hospital with the discharge status "Home with Support". (%; Discharged patients ; April 2015 – March 2016; CIHI DAD)	968	72.09	0.00	85.42	Not part of our QIP for 2017/18

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8	Risk-adjusted 30-day all-cause readmission rate for patients with CHF (QBP cohort) (Rate; CHF QBP Cohort; January 2015 - December 2015; CIHI DAD)	968	17.68	11.00	16.51	Our readmit rates are higher than expected and exceed our target. Relatively small volumes. Current performance at February 15, 2018 is 19.2%.

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QBP implementation for CHF	Yes	We are monitoring pathway compliance and the following actions are occurring: • Ensuring in-patient unit managers and clinical leads are aware of the importance of using the Clinical pathway for affected admitted patients to ensure that this important tool is incorporated into each admission • In-patient unit managers and clinical leads to provide education to all staff to ensure that the Clinical Pathway is included in the patient chart and is part of daily documentation. • Ongoing chart audits reported monthly to Quality Council an in-patient managers. • Weekly audits by in-patient unit managers and clinical leads to ensure the appropriate Clinical Pathway is included in the chart. • Small group organized to better understand shift in readmit rate at the HDMH Site.
2) Work collaboratively with CCAC to increase the number of patients enrolled in the CCAC Tele homecare.	Yes	
3) Implement medication reconciliation upon discharge.	No	Currently finalizing the pilot project for the PharmNet module in CERNER (Electronic Health Record) to enable medication reconciliation on discharge.

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9	Risk-adjusted 30-day all-cause readmission rate for patients with COPD (QBP cohort) (Rate; COPD QBP Cohort; January 2015 – December 2015; CIHI DAD)	968	25.00	10.00	15.09	Our readmit rates are higher than expected and exceed our target.

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QBP implementation for COPD.	Yes	We are monitoring pathway compliance and the following actions are occurring: • Ensuring in-patient unit managers and clinical leads are aware of the importance of using the Clinical pathway for affected admitted patients to ensure that this important tool is incorporated into each admission • In-patient unit managers and clinical leads to provide education to all staff to ensure that the Clinical Pathway is included in the patient chart and is part of daily documentation. • Ongoing chart audits reported monthly to Quality Council an in-patient managers. • Weekly audits by in-patient unit managers and clinical leads to ensure the appropriate Clinical Pathway is included in the chart. • Small group organized to better understand shift in readmit rate at the HDMH Site.
Work collaboratively with FHTs to increase the number of COPD patients enrolled in their pulmonary rehab programs.	Yes	
Work collaboratively with CCAC to increase the number of patients enrolled in the CCAC Tele homecare.	Yes	
Implement medication reconciliation upon discharg.	No	Currently finalizing the pilot project for the PharmNet module in CERNER (Electronic Health Record) to enable medication reconciliation on discharge.

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10	Risk-adjusted 30-day all-cause readmission rate for patients with stroke (QBP cohort) (Rate; Stroke QBP Cohort; January 2015 - December 2015; CIHI DAD)	968	8.83	10.00	10.07	Our readmit rates are higher than expected and exceed our target.

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QBP implementation for Stroke	Yes	Door to Needle Time was reduced from 75.3 min. to 57.3 min.
Enhance access to TPA.	Yes	Education is provided: • to all MAHC patients with TIA/Stroke, using a patient and family centered care approach • Transient Ischemic Attack (TIA) packages available in the ED's for patient's who are not admitted • Partnership with March of Dimes initiated June 2015 and ongoing (Monthly Stroke Survivor and Caregiver Support Group) • Community Education Sessions on Stroke Recognition and Prevention • ongoing, focused staff education • stroke information events carried out during June (Stroke Month) annually • information bulletin board at both sites.
Stroke Special Project 640: Dysphasia Screening for all patients with stroke symptoms, including TIA.	Yes	Education provided to all inpatient and emergency staff. Our compliance rates for dysphasia screening have improved; however, MAHC will continue to strive for improvements in the Emergency Department for patients with minor strokes or TIAs who are discharged from the emergency department.
Implement medication reconciliation upon discharge.	No	Currently finalizing the pilot project for the PharmNet module in CERNER (Electronic Health Record) to enable medication reconciliation on discharge.

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11	Total ED length of stay (defined as the time from triage or registration, whichever comes first, to the time the patient leaves the ED) where 9 out of 10 complex patients completed their visits (Hours; Patients with complex conditions; January 2016 – December 2016; CIHI NACRS)	968	0.00	0.00	NA	Not part of our QIP for 2017/18

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12	Total number of alternate level of care (ALC) days contributed by ALC patients within the specific reporting month/quarter using near-real time acute and post-acute ALC information and monthly bed census data (Rate per 100 inpatient days; All inpatients; July – September 2016 (Q2 FY 2016/17 report); WTIS, CCO, BCS, MOHLTC)	968	10.84	12.00	13.96	PSW support for Muskoka has not been readily available since May 2017. This lack of resource availability has results in longer ALC days. The NSM LHIN leadership is aware of the resulting challenges at MAHC. Twelve (12) supportive housing units were launched in 2018 specifically designated for ALC patients – however to date 6 remain vacant as the current ALC's are not appropriate for these spaces. Long waits for LTC spaces.

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Continue to collaborate with CCAC on Home First initiative.	Yes	
Update MAHC ALC policy to reflect alignment with LHIN-wide ALC standardization work.	Yes	MAHC has undertaken a number of best practice initiatives, including: • Weekly ALC rounds with HCC (Home and Community Care) and other community partners that focus on challenging discharges. • Family meetings between the clinical team and the patient/family occur within 48 hours of admission on those patients who are deemed "at risk of becoming ALC". • Chief Nursing Executive & Clinical Services received a daily ALC report from the clinical teams and intervenes to remove barriers. • The senior team is aware of the ALC data weekly. •

		Concerns related to transitions of ALC patients escalated to LHIN Leadership
Continue to participate/partner in LHIN system-wide service developments, including ALC Planning Steering Committee.	Yes	
Continue to utilize the Health Links system and process already established to facilitate discharges from hospital to home for ALC and complex medical patients.	Yes	