Excellent Care for All

Quality Improvement Plans (QIP): Progress Report for the 2015/16 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 2015/16	Org Id	Current Performance as stated on QIP2015/16	Target as stated on QIP 2015/16	Current Performance 2016	Comments
1	"Would you recommend this ED to your friends and family?" add the number of respondents who responded "Yes, definitely" (for NRC Canada) or "Definitely yes" (for HCAHPS) and divide by number of respondents who registered any response to this question (do not include non-respondents). (%; ED patients; October 2013 - September 2014; NRC Picker)	968	67.20	80.00	68.70	This target was not met. MAHC is strategically integrating patient and family centered care into the MAHC culture. PFCC has been part of our onboarding process for the past 12 months and will continue. The 10 and 5 Rule has been implemented, a family presence policy has been implemented, leader rounding on patients has been implemented, post care calls has been implemented, and AIDET has been implemented. P4R funding has been lost which has resulted in longer waiting times and increased complaints from patients. In addition, staffing levels have been challenging throughout the hospital again resulting in increased ED LOS and contributing to decreased patient satisfaction. Recruitment efforts successful to increase the available staffing in the ED and efforts ongoing for the inpatient units.

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 2015/16)	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?
Implement patient and family centered care philosophy.	Yes	Implementation of this philosophy has been a positive experience for those on the implementation committee. It has been very positive to have a family member representative on our committee.

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2	“Would you recommend this hospital (inpatient care) to your friends and family?” add the number of respondents who responded “Yes, definitely” (for NRC Canada) or “Definitely yes” (for HCAHPS) and divide by number of respondents who registered any response to this question (do not include non-respondents). (%; All patients; October 2013 - September 2014; NRC Picker)	968	80.80	80.00	78.50	This target was not met. MAHC is strategically integrating patient and family centered care into the MAHC culture. PFCC has been part of our onboarding process for the past 12 months and will continue. The 10 and 5 Rule has been implemented, a family presence policy has been implemented, leader rounding on patients has been implemented, post care calls has been implemented, and AIDET has been implemented.

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Change Ideas from Last Year’s QIP (QIP 2015/16)	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?
Maintain stretch target as performance target above that for large community hospitals.	No	Our change ideas did make a positive difference, but coupled with these implementations was "big bang" implementation of electronic documentation within our hospital.

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3	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 FY 2014/15 (cumulative from April 1, 2014 to December 31, 2014); OHRS, MOH)	968	0.00	0.00	-2.00	This target was not met. MAHC is focused on operational efficiencies although it is already a lean organization. The cascade of ongoing challenges and risks associated with provincial funding allocation combined with the increase in mandatory initiatives could result in declining opportunities due to financial and resource restrictions.

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Ensure balanced budget.	No	Provincial funding allocation model adjustments need to be considered for smaller organizations.

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4	Readmission within 30 days for Selected Case Mix Groups (%; All acute patients; July 1, 2013 - Jun 30, 2014; DAD, CIHI)	968	15.44	14.00	22.50	This target was not met. Extensive working group efforts are ongoing in implementing patient order sets, clinical pathways, LACE scores and safe discharge checklists.

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Reduce 30 day readmit rate for pneumonia, COPD, CHF.	Yes	Daily audits for compliance with QBP pathways did occur and successfully ensured that patients were on the pathway. Upon investigation of readmits, it was discovered that many of the patients were readmitted for a different reason than the first admission.

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5	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; Jan 1, 2014 - Dec 31, 2014; Publicly Reported, MOH)	968	X	0.26	0.19	This target was met.

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Reduce antibiotic days of therapy.	No	Comparison with historical data was interrupted this year due to migration to new electronic medical record.
Addition of probiotics to the formulary for all patients receiving antibiotic therapy.	Yes	Physicians receive regular reminders about the utilization of probiotics in patients receiving antibiotic therapy.

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6	ED Wait times: 90th percentile ED length of stay for Admitted patients. (Hours; All ED patients; January 1, 2015 to December 31, 2015; Hospital collected data)	968	17.00	15.00	20.30	This target was not met. MAHC is no longer a P4R organization. We continue to manage LOS for admitted patients by ongoing improvements to our flow process including twice daily bed meetings, bed board huddles, and monitoring the utilization of QBP pathways for COPD, CHF, and stroke. Additionally there are significant wait times for people awaiting admission to a mental health bed. Regionally the mental health beds have been over 90% occupancy which has limited the access to these beds. Further, there is no regional surge plan for mental health beds. Partnering to address patient flow especially after hours for mental health beds. Hospital average occupancy increased over previous year limiting access to beds from the ED.

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Implement leading practices related to inpatient discharge planning to create bed capacity and thus patient flow from the ED to the inpatient unit.	Yes	Very positive and dramatic improvements in patient flow occurred at the HDMH Site. SMMH experienced staffing issues this fiscal that created challenges around flow.
Implement data sharing tactics for ALC and complex medical patients to facilitate discharge from hospital to home.	Yes	Data sharing occurs daily between hospital sites and the CCAC.

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7	Increase proportion of patients receiving medication reconciliation upon discharge. (%; All Inpatients; most recent quarter available; Hospital collected data)	968	49.15	80.00	32.80	This target was not met. In the summer of 2015, we adjusted the way in which we collected our med rec data as a result of our switch to an electronic medical record. The adjustment in our data collection method skewed the data for this metric. Work is underway to implement an electronic med rec on discharge in the new system.

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Expanding medication reconciliation upon discharge to all inpatient units.	No	Change to electronic documentation halted the expansion of this project.

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8	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; Hospital collected data)	968	89.00	80.00	44.70	This target was not met. In the summer of 2015, we adjusted the way in which we collected our med rec data as a result of our switch to an electronic medical record. The adjustment in our data collection method skewed the data for this metric. For December 2015 and Jan 2016 rates were 79.6% and 80.7% respectively. In November, electronic recording of Med Rec was implemented, allowing electronic data capture for all patients (versus only a sample of patients prior to this date). The numbers for the third quarter reflect zero for October tracked in our computer system, although med rec was done, just not captured, improved processes in November for more accurate tracking.

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Expanding medication reconciliation upon admission to all inpatient units.	No	Change to electronic documentation halted the expansion of this project.

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9	Total number of falls divided by the number of patient days, multiplied by 1,000. (%; All Inpatients; most recent quarter available; Hospital collected data)	968	5.60	3.50	6.50	This target was not met and is a new area of focus for MAHC. We selected a target based upon an assumption versus hard data, and now better understand our rate. All admitted patients undergo a falls risk assessment upon admission, interprofessional post fall huddles occur on every patient who falls with a readjustment of the care plan in order to mitigate future falls, and pharmacy is involved in a review of medications.

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Reduce the number of all falls by ensuring compliance of a post fall huddle after a patient's first fall at the hospital.	Yes	Post fall huddles occur daily during bed rounds and have resulted in implementation of safety plans for high risk patients.
Improve the quality of individualized care plans for all repeat fallers by ensuring the compliance of a medication review after a fall.	Yes	Pharmacy review of charts post fall has highlighted a focus on best practices related to medications in patients who are at risk for a fall. A best practice conversation on this topic has been occurring at Quality Council, Pharmacy & Therapeutics and Medical Advisory Committee meetings.
Prevent the deterioration of patient mobility by ensuring the implementation of a mobilization strategy for patients who are at risk for falling.	Yes	All inpatients are assessed for falls risk upon admission with mobilization strategy developed and implemented for those who are identified as at risk.

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10	Total number of inpatient days where a physician (or designated other) has indicated that a patient occupying an acute care hospital bed has finished the acute care phase of his or her treatment, divided by the total number of inpatient days in a given period x 100. (%; All acute patients; October 2014 – September 2015; DAD, CIHI)	968	24.69	20.00	20.29	This target was not met. We have seen drastic improvements in this metric as a result of a reinvestment in education on home first to our physicians and nursing staff, because of a change in practice around planning for discharge upon admission, and by an increased focus on admission avoidance in our ED.

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Continue to collaborate with CCAC on Home First initiative.	Yes	Have implemented formal recognition of patients at risk for ALC upon admission. This has resulted in proactive patient/family meetings on day 2 of admission with strategies for discharge home implemented immediately. Daily meetings thereafter around the risks of meeting the estimated discharge date in order to put strategies in place to ensure success.
Monitor successful implementation of ALC Designation Policy.	Yes	ALC designation policy reviewed each time patient deemed ALC to see whether we have followed the policy, whether there are gaps in the policy or whether we veered away from the policy and why.