Let's Make Healthy Change Happen.

Quality Improvement Plan (QIP) Narrative for Health Care Organizations in Ontario

MUSKOKA ALGONQUIN HEALTHCARE

4/4/2016

This document is intended to provide health care organizations in Ontario with guidance as to how they can develop a Quality Improvement Plan. While much effort and care has gone into preparing this document, this document should not be relied on as legal advice and organizations should consult with their legal, governance and other relevant advisors as appropriate in preparing their quality improvement plans. Furthermore, organizations are free to design their own public quality improvement plans using alternative formats and contents, provided that they submit a version of their quality improvement plan to Health Quality Ontario (if required) in the format described herein.

Overview

Muskoka Algonquin Healthcare (MAHC) proudly serves the community of Muskoka providing safe, quality patient and family centered care at two sites located in Bracebridge and Huntsville. We are committed to best practices and delivering the highest quality of care that ensures optimal patient outcomes. To reflect this commitment, MAHC has identified "quality care outcomes and patient safety" as one of 5 key foundational pillars within its new Strategic Plan. Our 2016/17 Quality Improvement Plan (QIP) is designed to leverage the forward momentum of our overarching quality and safety culture by ensuring that our environment becomes even safer for our patients, by elevating best patient outcomes through cost effective strategies, by being proactive in anticipating and responding to patient needs, and by improving care transitions from our hospital to the community in collaboration with our partners.

Our ongoing quality improvement journey has been informed by our patients and their families, our staff, physicians, and health care partners. Our collaborative work and engagement with our community partners ensures that our patients receive the right care, in the right place, at the right time. To support the MAHC culture of quality through collaboration, we have chosen six (6) QIP objectives to direct and streamline our focus of improving quality and safety by:

- Reducing 30 day readmit rate
- Improving organizational financial health
- Reducing unnecessary time spent in acute care
- Improving patient satisfaction and engagement
- Improving safety through medication reconciliation upon admission
- Improving access by reducing wait times in the ED

Each selected objective, and its associated improvement indicator, is supported by several underlying initiatives to improve quality of care at MAHC. The carefully targeted initiatives will drive and achieve improvements in the domains of Patient- and Family-Centered Care, quality, safety, access, efficiency, and effectiveness. These initiatives range from unit level engagement of staff, to quality board huddles, to system wide strategies such as Health Links and Home First that have been collaboratively developed, implemented, and sustained with our community partners. The MAHC culture supports and encourages high quality care in each and every patient-family/provider interaction. We believe that together we can build healthy communities that are aligned with regional and provincial priorities.

QI Achievements From the Past Year

Challenges, Risks and Mitigation Strategies:

Fiscal constraints faced by all mid-size acute care health care organizations in Ontario is MAHC's biggest challenge. Managing a multi-site organization requires significant stakeholder engagement and creativity when executing essential changes to improve efficiency and manage within the shrinking financial envelope. Already a lean and efficient organization, the cascade of ongoing challenges and risks associated with the provincial funding allocation combined with the increase in mandatory initiatives could result in service reductions/elimination due to financial and resource restrictions. To date, and in spite of these challenges, MAHC continues to provide a range of clinical services that support the Muskoka community and in a way that is very fiscally responsible.

As an organization, we continue to focus on operational quality and efficiency In support of this focus, MAHC developed and proposed a strategic Master Program/Master Plan and submitted its pre-capital plan to the NSMH LHIN who in turn forwarded to the MOHLTC for review. This work focusses directly on ensuring that we sustain top quality and safe care to Muskoka residents over the long term. Broad stakeholder engagement and consultation has been the central theme with the Master Program/Master Plan initiative and this collaborative work will continue in 2016/17.

MAHC has invested in developing quality improvement expertise throughout tis leadership structure. This includes developing LEAN capacity at all levels of the organization. Investment in decision support resources has assisted the senior team and front-line leaders in identifying key quality improvement opportunities and has allowed us to realize quick wins that leverage stakeholder support and build momentum for change success in multiple areas like patient flow and navigation.

Our commitment to Patient-and-Family-Centered Care is without exception central to the overarching success of our Quality Improvement Plan. Involving patients and their families in decisions that will affect the care they receive and the way that they receive it, is a strategic objective of MAHC. The role and voice of the patient and family at tables within the organization is powerfully driving our quality agenda.

Information Management Systems:

Information and information technology are key enablers to the success of delivering on our new Strategic Plan. To support effective and efficient operations, it is essential to have IT systems that manage information in a consistent manner across the organization. Information sharing between providers and across the full continuum of care will optimize the patient experience and maximize the quality of care delivered at all points in the patient journey.

MAHC implemented a large scale information technology project in the early spring of 2015 that results in transitioning the organization from a paper-based system to one that is predominantly electronic. Our new electronic medical record platform is driving best practices and providing us with a tool to continue to standardize the way in which care is provided. Enhancing standardization at MAHC will ensure that our patients always receive the highest quality of care.

Integration & Continuity of Care

MAHC actively seeks strategic partnerships to fully realize the potential of integrated care. We work extensively with partners within our North Simcoe Muskoka (NSM) Local Health Integrated Network (LHIN) to successfully implement an integrated health system plan through the Second Curve forum. We have collaborated with our local Family Health Teams (FHT), Community Care Access Centre (CCAC), Nurse Practitioner Hubs, the NSM LHIN, the District of Muskoka, Canadian Mental Health Association, and Long Term Care to focus on the care of seniors and people with complex medical needs through Health Links. We have a highly integrated relationship with our CCAC focused on discharge planning and Home First. Finally, we have partnered in the development of the Health Hubs in our area. Through our strategic partnerships we are creating an interconnected system that promotes shared care models that optimize transitions through better information management and information sharing. These interconnected partnerships enhance quality and

improve safety for our patients and their families by simplifying the system and designing services that maximize efficiencies.

MAHC is committed to focusing on the experience and engagement of our patients through their health care journey. Through the creation of a Patient and Family Advisory Council, our patient partners will have a strong voice in key decisions, strategies, and changes that will drive results and align with our 2016/17 QIP. Our philosophy of Patient- and Family-Centered Care is enhancing safety and quality of care through specific service excellence tools including bedside shift report, the use of whiteboards at every patient bedside to translate information about their care, leader rounding on patients and families, and post-care telephone calls ensuring that patients have all of their necessary medications and are recovering well at home. All of these tools support the integration of the patient and their family into the health care team as a full partner in care.

Engagement of Leadership, Clinicians and Staff

Engagement of clinical staff and leadership in the development of the MAHC QIP has been broad this year. Board members, the senior leadership team, front-line managers, front-line clinicians, and physician representatives have all collaborated in the development of our QIP. MAHC has also led the development of an integrated QIP with external partners including: the North Simcoe Muskoka (NSM) CCAC, the NSM LHIN Quality Improvement Network, the Cottage Country Family Health Team, the Algonquin Family Health Team, the Canadian Mental Health Association, and Muskoka Health Links. MAHC employees in all departments are involved in quality improvement initiative methodologies such as LEAN, KAIZAN that continuously enhance the quality of care for our patients. As well, all employees are strongly encouraged to identify and implement quality improvement strategies throughout the year.

Leadership and front-line staff participate in daily huddles around quality boards to identify current safety issues and to discuss urgent and/or emerging issues. Our senior leadership team conducts rounding on both staff and patients creating not only a visible presence to patients and staff but providing an opportunity to compliment and recognize staff on excellent work and address any concerns.

Patient/Resident/Client Engagement

MAHC has been very purposeful in elevating the patient voice in our 2016/17 QIP. Patients and families that were identified through our compliments and complaints process were invited to participate in the development of our QIP. As well, MAHC offered an open community discussion in January 2016 that focused on our suggested and draft QIP goals as a starting point in a deliberate patient quality of care conversation. For each engagement conversation, a brief overview of the QIP process was provided as context before launching into a discussion around the proposed goals.

Performance Based Compensation [part of Accountability Mgmt]

Accountability Management:

The priorities and targets within our QIP support priorities identified in our Strategic Plan to improve patient engagement, experience, and outcomes. These targets and priorities are further supported by the MAHC business commitments which form the performance based compensation structure of the senior leadership team. To ensure that the QIP initiatives become part of the MAHC fabric, unit specific goals and objectives are developed by front-line leaders and staff and reviewed at huddles and staff meetings to guarantee target success. With oversight from the Board of Directors, the senior leadership team will be held accountable for the overall performance of the organization through monthly reviews of the quality indicators.

Performance Based Compensation:

The Ontario government passed the Excellent Care for All Act (ECFAA) and Bill 16 in 2010 which required Hospital Boards to establish an "at risk" component of executive compensation and achieve targets tied to the QIP. At MACH, each senior leader develops goals that create synergy with the Strategic Plan and the QIP and that align with responsibilities within their portfolio and in accordance with our Executive Compensation Policy. Executive compensation is linked to performance in three performance assessment categories: Quality, Financial, and Strategic. Performance assessment categories are rated on the following scale:

- Quality = 50%
- Financial = 30%
- Strategic = 20%.

Each year, all executives at MAHC have 3% of their compensation "at risk". This portion of the compensation is held and measured against achievement of goals and objectives.

Health System Funding Reform:

MAHC is an evidence-based organization and continues to advance evidence-based care with the adoption of best practices outlined in Quality Based Procedures including, but not limited to, chronic obstructive pulmonary disease, congestive heart failure, pneumonia, stroke, reducing readmissions within 30 days for specific case mix groups, and decreasing ED wait times for admitted patients. MAHC will continue to seek partnerships and strategies that improve our fiscal health including the health system funding reform alignment thoughtfully embedded within our QIP.

Sign-off

It is recommended that the following individuals review and sign-off on your organization's Quality Improvement Plan (where applicable):

I have reviewed and approved our organization's Quality Improvement Plan

Board Chair Charles Forrett
Quality Committee Chair Evelyn Brown
Chief Executive Officer Natalie Bubela
Other leadership as appropriate Karen Fleming

2016/17 Quality Improvement Plan
"Improvement Targets and Initiatives"

MUSKOKA ALGONQUIN HEALTHCARE

Muskoka Algonquin Healthcare 100 Frank Miller Drive

AIM		Measure							Change				
Quality dimension	Objective	Measure/Indicator	Unit / Population	Source / Period	Organization Id	Current performance	Target	Target justification	Planned improvement initiatives (Change Ideas)	Methods	Process measures	Goal for change ideas	Comments
Effective	**Improve organizational financial health**	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	OHRS, MOH / Q3 FY 2014/15 (cumulative from April 1, 2016 to December 31, 2016)	968*	0	0.00	Balanced Budget	1)Submit the HIP (Hospital Improvement Plan) and remain on target with submission.	1.1 Implement cost saving initiatives identified through the OR and ED review. 1.2 Work with the NSM LHIN to ensure sufficient HSFR funding is secured.	Monthly variance analysis to monitor progress of cost saving initiatives and revenue increases.	Achievement of all identified cost reductions and revenue improvements.	
	Reduce 30 day readmission rates for select HIGs to own facility.	Percentage of readmissions to own facility within 30 days for selected HBAM inpatient grouper conditions (HIG).	% / selected denominator	DAD, CIHI / July 2015 - June 2016	968*	13.8	13.50	Reduction in 30 day readmits.	1)QBP implementation for pneumonia, COPD and CHF.	1.1 Ongoing education of staff related to the utilization of the pathway, the rationale for the utilization and the importance of meeting the pathway timelines. 1.2 Audit compliance with pathway implementation for pneumonia, COPD and CHF every quarter through a standardized chart audit tool.	1.1 80% of all pathways are completed upon discharge. 1.2 Monitor the trends for non-compliance with the pathway and re-evaluate the pathway timelines and treatments.	80% compliance with pathways as demonstrated through quarterly chart audits. 80% compliance with pathways as demonstrated through quarterly chart audits.	
									2)Work collaboratively with CCAC to increase the number of patients (COPD and CHF) enrolled in the CCAC Tele homecare monitoring program.	Collaborate with CCAC on an implementation of sustainability plan, which includes engagement activities specific to patient enrolment.	Number of patients enrolled in the monitoring stream of Tele homecare.	Five (5) hospital patients at each site enrolled in the Tele homecare monitoring stream by March 31, 2017.	
									3)Streamline Medication Reconciliation process and documentation.	3.1 Map Medication Reconciliation process by June 2016. 3.2 Education on the Medication Reconciliation process to improve quality will be ongoing. 3.3 Identify specific responsibilities in the Medication Reconciliation Process according to role and by June 2016. 3.4 Work with partner organizations using CERNER to identify any additional efficiencies on an ongoing basis.	Measure the number of staff who complete the education module on Medication Reconciliation at discharge.	By streamlining the medication reconciliation and improving accuracy and efficiency at the time of discharge, it will mitigate a readmission related to a medication error and improve patient safety.	

Efficient	**Reduce unnecessary time spent in acute care**	Total number of ALC inpatient days contributed by ALC patients within the specific reporting period (open, discharged and discontinued cases), divided by the total number of patient days for open, discharged and discontinued cases (Bed Census Summary) in the same period.	% / All acute patients	WTIS, CCO, BCS, MOHLTC / July 2015 – September 2015	968*	20.8	20.00	This indicator is complex for MAHC and requires system improvements with multiple LHIN stakeholders. MAHC Unit/Population will be %/Total days - newborn days. MAHC will also use DAD/CIHI Source data for the period of October 1, 2015 to September 30, 2016.	1)Continue to collaborate with CCAC on Home First initiative.	1.1 Continue weekly collaborative ALC rounds with CCAC at both sites. 1.2 Meet with patients/families of at risk for ALC patients on Day 2 of admission to review options and create plan.	1.1 Clinical Lead and Patient Flow Navigator to attend weekly meetings with CCAC. 1.2 Clinical Lead to coordinate and facilitate meetings with patients/families at risk of ALC on Day 2.	1.1 100% compliance with ALC rounds with a focus on reducing ALC days. 1.2 80% of patients/families at risk of ALC will participate in Day 2 meeting and validated through daily bed summary report.	
									2)Monitor successful implementation of ALC Designation Policy	Continue daily bed meetings at both sites with front line staff, CCAC and Leadership where estimated date of discharge is assessed and plan of care is reviewed.	Clinical Lead to facilitate daily bed meetings, focusing on discharge and care plans.	100% compliance with policy.	
									3)Continue to participate/partner in LHIN system-wide service developments including ALC Planning Steering Committee, Regional Specialized Geriatric Services, Primary Care, Community/Outpatient and Regional Rehabilitation Planning to impact on patient flow.	3.1 Implement standardized processes for ALC management and service transition as per direction from the LHIN ALC Planning Steering Committee. 3.2 Collaborate with the LHIN Lead for Specialized Geriatric Services related to quality improvements in the care of patients with concerning behaviours. 3.3 Collaborate with LTC partners, FHT partners and CCAC in establishing a "Transition Protocol" that standardizes processes and practice ensuring a smooth transition from hospital to LTC home.	3.1 Evaluate standardized processes quarterly to ensure ALC reduction to 20%. 3.2 Monthly meetings with the LHIN Lead to review outcomes associated with quality improvements and to discuss process/system changes that may be identified as beneficial. 3.3 Implement a "Transition Protocol" by December 2016 and after extensive consultation and collaboration with LTC partners.	Enhanced collaboration with LTC and community partners to transition ALC patients to the right environment in a timely manner.	
									4)Continue to utilize the Health Links system and process already established to facilitate discharges from hospital to home for ALC and complex medical patients.	Patient Flow Navigators and Transitional Care Coordinators will continue to identify patients that meet the criteria for Health Links.	Monitor the number of patients who are admitted to Health Links.	Tactics implemented on 20 patients per site.	
Patient-centred	**Improve patient satisfaction**	"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	% / All patients	NRC Picker / October 2014 – September 2015	968*	78.5	80.00	Patient and family centered care is a pillar of MAHC quality and safety plan.	1)Elevate patient and family engagement at MAHC.	1.1 Implement AIDET, leader rounding on patients, a refresh on patient whiteboards and bedside shift report. 1.2 Continue to support the Family Presence Policy and post care calls. 1.3 Develop Patient and Family Advisory Council. 1.4 Through consultation with our patients and families, revise and refresh the Patient Declaration of Values and Responsibilities.	1.1 Audit compliance of clinical tactics through tracking of data from leader rounding on patients daily starting in April 2016. 1.3 Implement Patient Family Advisory Council by September 2016. 1.4 Launch refreshed Patient Declaration of Values.	By elevating patient and family engagement at MAHC, we will increase the number change ideas in real time that will improve the patient and family experience.	

		respondents who registered any response to this question (do not include non-respondents).							2)Improve return rate of surveys.	2.1 Nursing staff to provide education to patients at discharge on the importance of survey completion and return allowing MAHC to make improvements in service delivery. 2.2 Educate patients on importance of survey completion and return on MAHC website.	Implement standardized patient education around survey completion.	By elevating patient and family engagement at MAHC, we will increase the number of change ideas in real time that will improve the patient and family experience.	
Safe	**Increase proportion of patients receiving medication reconciliation upon admission**	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	Hospital collected data / most recent quarter available	968*	44.7	80.00	Key indicator to improve patient safety at MAHC. MAHC will monitor data collected from CERNER (Electronic Medical Record Program) including completion of Medication Reconciliation upon admission.	1)Streamline Medication Reconciliation process and documentation to improve efficiency and accuracy of BPMH.	1.1 Map Medication Reconciliation process by June 2016. 1.2 Identify patients who require BPMH as defined by Accreditation Canada versus those who only require a list of current medications. 1.3 Education on the Medication Reconciliation process to improve quality of BPMH by June 2016. 1.4 Identify specific responsibilities according to roles by June 2016. 1.5 Work with partner organizations using CERNER to identify any additional efficiencies on an ongoing basis.	1.1 Measure improvement in BPMH accuracy by measuring the already collected data of number of discrepancies identified by pharmacy once the BPMH and admission orders are complete. This will be measured on a monthly basis. 1.2 On a quarterly basis, measure the number of medication reconciliation completed upon admission as documented in the CERNER system. 1.3 Measure the number of staff who complete the education module on completion of a BPMH. 1.4 Implement role responsibilities. 1.5 Collaborate with partner organizations.	By streamlining the medication reconciliation process and improving accuracy and efficiency, the time to complete a medication reconciliation will be decreased allowing us more time to complete a larger proportion of medication reconciliation and improve patient safety through reduced number of medication errors.	
Timely	**Reduce wait times in the ED**	ED Wait times: 90th percentile ED time from triage/registration (whichever is first) to Physician Initial Assessment (PIA) for CTAS 2	Hours / CTAS 2	Hospital collected data / January 1, 2016 to December 31, 2016	968*	1.3	0.50	Targets set as hospitals in Canada range from 15 minutes to 0.5 hours for PIA for CTAS 2.	1)Implement leading practices related to patient flow and resource utilization in ED.	1.1 Complete chart audit of CTAS 2 patients with time to PIA greater than 0.5 hours. 1.2 Review data of CTAS 2 wait times by time of day, physician, day of week and month. 1.3 Review triage/patient flow and develop procedure for patient flow and physician second on call. Ensure clear accountability and trigger for initiating second on call. Consider seasonal variation in triage procedures. 1.4 Review medical directive to ensure timely patient care of CTAS 2. 1.5 Review physical space availability to accommodate all CTAS 2's. 1.6 Identify learnings/educational opportunities.	1.1 Monitor times. 1.2 Revised procedures and/or medical directives. 1.3 Compliance with revised procedures/directives. 1.4 Wait times data and results of chart audit presented to ED Services Committee for discussion. 1.5 Physical space review to occur with inter-professional team. 1.6 Educational opportunities identified through the implementation of leading practices.	Improve flow of patients through the ED and the process from triage to PIA.	