2019/20 Quality Improvement Plan
"Improvement Targets and Initiatives"

St. Joseph's Healthcare Hamilton

St. Joseph's Health Care System Hamilton 50 Charlton Avenue East

AIM		Measure									Change				
Issue	**Quality dimension**	**Measure/Indicator**	**Type**	**Unit / Population**	**Source / Period**	**Organization Id**	**Current performance**	**Target**	**Target justification**	**External Collaborators**	**Planned improvement initiatives (Change Ideas)**	**Methods**	**Process measures**	**Target for process measure**	**Comments**
M = Mandatory (all cells must be completed) P = Priority (complete ONLY the comments cell if you are not working on this indicator) C = custom (add any other indicators you are working on)															
Theme I: Timely and Efficient Transitions	**Efficient**	Decrease the revisit rate to the Emergency Department for Mental Health concerns witin 30 days of initial visit by March 31st, 2020.	C	Rate / Mental health patients	CIHI NACRS / 2017/2018	674*	23.65	16.30	This is the target for this indicator in the HNHB LHIN.		1)To implement a greater number of coordinated care plans for high-frequency Emergency Department patients.	The number of new care plans will be monitored monthly.	Number of new care plans.	Our target is to achieve 5-10 new care plans per month	
		Decrease the revisit rate to the Emergency Department for Substance Use concerns within 30 days of initial visit by March 31st, 2020	C	Rate / Mental health patients	CIHI NACRS / 2017/2018	674*	40.03	22.40	This is the performance target for the HNHB LHIN.		1)To increase the number of emergent MHA high-frequency ED patients who have an evaluation of their current support services and when appropriate referrals to other support services.	Emergency mental health and addiction high-frequency users are defined as those visiting ED greater than twice per month.	Evaluations will be made on the number of these users compared to those who have their services evaluated.	At this time we are collecting baseline.	
		Increase the percent of patients designated 'ALC to home' with LHIN supports discharged home within 5 calendar days of designation	C	% / ALC patients	WTIS, CCO, BCS, MOHLTC / July-Sep 2018	674*	50.6	90.00	By streamlining discharge planning processes between SJHH and HNHB LHIN, 100% should be achievable with the caveat of home supports being available.		1)All patients or SDMs are to be engaged with within two days of admission	This will be regularly reviewed with the teams.	Manual case review and count entered into HNHB and SJHH Social Work joint database for tracking and trending.	All patients or SDM's.	This will be a collaborative project between hospital and Home and Community as is all of our work with ALC patients.
	Timely	Percentage of patients discharged from hospital for which discharge summaries are delivered to primary care provider within 48 hours of patient's discharge from hospital.	P	% / Discharged patients	Hospital collected data / Most recent 3 month period	674*	82	85.00	This target was chosen in order to have all programs performing at a standard of at least 85%.		1)Increase the percent of community care providers receiving a discharge summary within 48 hours to 85%	This data will be collected using our electronic medical record. It will be reviewed frequently by the project group and every two months by the Senior team.	Process measures will include performance by program.	To increase the percent of community care providers receiving a discharge summary within 48 hours to 85% by March 31, 2020.	
		The time interval between the Disposition Date/Time (as determined by the main service provider) and the Date/Time Patient Left Emergency Department (ED) for admission to an inpatient bed or operating room.	**MANDATORY**	**Hours / All patients**	**CIHI NACRS / October 2018 – December 2018**	**674***	**23.43**				**1)Reduce Transport (portering) turnaround times by 15% from baseline of 24 minutes by December 2019.**	**Will focus on removing non-value add tasks through process mapping exercise and feedback from staff.**	**Process measures will include a reduction in non-value added tasks. PDSA cycles will be implemented based on results.**	**To reduce turnaround times by 15% by December 2019.**	
											2)Decrease length of stay for isolated patients in the nephrology program.	Data on this change idea will be measured using our electronic medical record. Progress will be reviewed at monthly program meetings as well as at the corporate patient access steering committee.	This will include specific tracking of isolated patients who do not meet the length of stay target.	To decrease the length of stay for isolated patients in the nephrology program to 25 hours.	
Theme II: Service Excellence	**Patient-centred**	Percentage of complaints acknowledged to the individual who made a complaint within five business days	P	% / All patients	Local data collection / Most recent 12 month period	674*	100	100.00	Intent is to sustain performance at 100%		1)To maintain current performance of 100%.	This data is monitored constantly to ensure all patient complaints are acknowledged as soon as possible.	The patient relations team will continue to monitor track this information.	To continue to acknowledge patient complaints within 5 business days 100% of the time.	
		Provide an After Vist Summary (similar to PODS) that is fully completed (based on 5 paramaters) to 90% of patients discharged from 5 inpatient units.	C	% / Discharged patients	Hospital collected data / 10 chart audit from each unit	674*	0	90.00	Although over 70% of patients receive an After Visit Summary, the audit showed that all 5 parameters are not being met.		1)That 90% of discharged patients from 5 identified units receive a completed After Visit Summary.	Each program will track their progress through monthly audits. Progress will also be tracked at program and quality councils.	Staff will be educated on using the patient navigator in the Electronic Health Record. Patients and families will be involved in determining content for the SMART text.	All staff to be educated on using the patient navigator.	
Theme III: Safe and Effective Care	**Effective**	Rate of mental health or addiction episodes of care that are followed within 30 days by another mental health and addiction admission.	P	Rate per 100 discharges / Discharged patients with mental health & addiction	CIHI DAD,CIHI OHMRS,MOHTLC RPDB / January - December 2017	674*	9.82				1)Maintain readmission rate for mental healh and addiction patients to below the ontario average.	This data will be tracked monthly using coded data.	This data will be reviewed at Mental Health and Addiction program and quality meetings.	To maintain the 30 day readmission rate for mental health and addiction patients to below 14.2%.	
		Increase Best Possible Medication Discharge Plan (BPMDP) completion at discharge across the hospital. This is the percent of patients with a completed BPMH who also received medication reconciliation at discharge.	C	Number / All patients	Hospital collected data / July-December 2018	674*	85.3	88.00	This will aim to have all units performing at 88%.		1)Ensure all programs are performing at 88%.	Review data to understand where the areas of focus will be. This will be reviewed at the Medication Reconciliation steering committee.	We will monitor the performance of each area.	The target is 88% for all areas.	This is a valuable step in the patient's journey and we are also partnering with patients and families as we work through this process improvement.
		Meet LHIN target readmission rate for patients with Congestive Heart Failure.	C	% / CHF QBP Cohort	CIHI DAD / 2017/2018	674*	22	15.00	This is the LHIN and province target for this readmission rate.		1)Ensure order sets are applied to all CHF patients.	Regularly review with team members.	This will be tracked using our electronic health record.	The target for this indicator is 90%.	This is an important piece of our work to ensure standardized care for our patients.
		Meet LHIN target readmission rate for patients wtih Chronic Pulmonary Disorder (COPD)	C	% / COPD QBP Cohort	CIHI DAD / 2017/18	674*	17.9	15.50	15.5% is the LHIN and provincial target for this readmission rate.		1)Ensure ordersets are applied to 90% of all COPD patients.	Use of ordersets is tracked using our electronic health record.	Percent of COPD patients with ordersets applied.	The target for this measure is 90%.	This is an important piece of work to ensure standardized care for our patients.
	Safe	**Number of workplace violence incidents reported by hospital workers (as by defined by OHSA) within a 12 month period.**	**MANDATORY**	**Count / Worker**	**Local data collection / January - December 2018**	**674***	**756**	**737.00**	**Actions taken (e.g patient alert and screening processes, focus on corrective actions, organization wide workplace violence Risk Assessments) has contributed to the stabilization of number of reports.**		**1)Implement "Support to Report" campaign 2019 - promotion of reporting all incidents.**	**Tracking of data for this indicator is done at the Joint Health and Safety committees.**	**The process measure that will be tracked is the number of workplace voilence incidents.**	**Maintain the level of reported incidents of workplace violence at 737 (the average of the past 2 years)**	**FTE=3748**
		Ensure all patients on three inpatient units identified at risk of suicide have a "fully completed" safety plan documented in the electronic medical record.	C	Rate / Mental health patients	Hospital collected data / February 2019	674*	63	80.00	Suicide is a leading cause of death in Canada and worldwide. St. Joe's is committed to providing percent centred care that empowers and promostes hope among those experiecing suicidality and seeks to make suicide a never event in our facility.		1)Education plan to staff to support increase usage of safety plans by staff.	Develop and create education module for all staff on these units.	Number of staff who complete the education session.	All staff to participate in education session.	