2018/19 Quality Improvement Plan
"Improvement Targets and Initiatives"

Manitoulin Health Centre 11 Meredith Street

AIM		Measure								Change				
Quality dimension	Issue	Measure/Indicator	Type	Unit / Population	Source / Period	Organization Id	Current performance	Target	Target justification	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) A= Additional (do not select from drop down menu if you are not working on this indicator) C = custom (add any other indicators you are working on)														
Effective	**Effective transitions**	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?	P	% / Survey respondents	CIHI CPES / April - June 2017(Q1 FY 2017/18)	784*	84	90.00	Initial target of 80% has been achieved. Provincial performance 62.6% in 2017/18, NELHIN performance 89.5% in NELHIN. MHC is committed to improving the information provided on discharge and attaining 90th percentile amongst peers.	1)Standardized electronic processes for the provision of information on discharge.	Utilizing evidence-informed Best Practices (PODS toolkit), an electronic discharge information package will be generated for each patient on discharge.	Patients will respond Yes when asked the three specific discharge questions related to the receipt of information on discharge to improve effective transitions	90% of patients surveyed post-discharge will respond yes to all three questions measuring the effective transition to home.	
										2)Development of a regional process to identify Indigenous patients and offer Indigenous navigation services.	The incorporation of regional indigenous identification and referral process in the Meditech EMR.	Patients will be asked if they identify as Aboriginal, Metis or Inuit during outpatient visits. Notifications of inpatient admission will be sent to the local Aboriginal Health Access Centre Aging at Home Liaison/Navigator when patients identify as Aboriginal, Metis or Inuit.	100% of patient who self identify as Aboriginal Metis or Inuit will be referred to the local Aboriginal Health Access Centre Aging at Home Liaison/Navigator.	
		Rate of psychiatric (mental health and addiction) discharges 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 2016	784*	X	10.00	Target is yet to be determined as data collection continues. There are no provincial or NELHIN benchmarks or comparators available.	1)Monitor the number of patients with a primary Mental Health &/or Addictions diagnosis referred to a community mental health provider on discharge from both inpatient and outpatient locations to a home destination.	Development of an electronic referral system for community mental health referrals.	The electronic referral system will measure the number of mental health and addictions patients being discharged home who consent to a referral, refuse a referral and those who are currently receiving mental health services by a community provider. The number of MH&A patients discharged home from the emergency department and inpatient unit will be tracked and compared to the number of referrals consented to and the number of referrals refused by the patient.	75% of patients with a mental health and/or addictions primary diagnosis will be offered a referral to a community mental health & addictions provider.	

	Risk-adjusted 30-day all-cause readmission rate for patients with CHF (QBP cohort)	P	Rate / CHF QBP Cohort	CIHI DAD / January - December 2016	784*	27.19		This measurement is monitored however, not risk adjusted as defined for QBP's. Therefore, results are not comparable to Provincial and NELHIN benchmarks.	1)Identify, assess and document all admitted patients at risk of readmission utilizing a standardized tool.	The LACE standardized screening tool which predicts the risk of a patient's readmission and is completed on all patient discharged home.	Manitoulin Region primary care providers are notified 100% of the time when a patient with a CHF diagnosis and has a high risk of readmission is discharged.	100% percent of patients admitted with CHF will have a LACE tool completed on discharge.	
									2)Standardized processes are in place to notify primary care providers when their patient is discharged home from hospital to enable timely follow up in community	Manitoulin Region Family health teams and medical office receive an electronic notification from the hospital notifying them of their patient's discharge date and LACE score.	The number of patients discharge notifications with LACE scores electronically transmitted to their primary care provider.	100% of local family health teams and medical clinic have an electronic notification of patient discharges including LACE scores.	
									3)All patients admitted with a primary diagnosis of CHF will have a standardized QBP order set completed on admission.	The electronic completion of a standardized MHC QBP CHF order set on all patients admitted with a primary diagnosis of CHF. This data is available through Think Research Patient Order Sets portal and reports. The 'spotlight' report provides information on the compliance with QBP orders and required modifications to improve compliance.	The number of electronically completed QBP CHF order sets on patients admitted with a primary diagnosis of CHF.	85% of patients admitted with a primary diagnosis of CHF will have a QBP CHF order set on admission.	
	Risk-adjusted 30-day all-cause readmission rate for patients with COPD (QBP cohort)	P	Rate / COPD QBP Cohort	CIHI DAD / January - December 2016	784*	32.81	14.40		1)Identify, assess and document all admitted patients at risk of readmission utilizing a standardized tool.	The LACE standardized screening tool which predicts the risk of a patients readmission and is completed on all patient discharged home.	Primary care is notified 100% of the time when a patient with CHF who has a high risk of readmission is being discharged.	100% percent of patient admitted with CHF will have a LACE tool completed on discharge.	
									2)Standardized processes are in place to notify primary care providers when their patient is discharged home from hospital to enable timely follow up in community.	Manitoulin Region Family health teams and medical office receive an electronic notification from the hospital notifying them of their patients discharge and LACE score.	Number of patients with discharge notification and LACE scores electronically transmitted to their primary care provider.	100% of local family health teams and medical clinic have an electronic notification of discharge including LACE scores.	
									3)All patient admitted with a primary diagnosis of COPD will have a standardized QBP order set completed on admission.	The electronic completion of a standardized MHC QBP COPD order set on all patients admitted with a primary diagnosis of COPD. This data is available through Think Research Patient Order Sets portal and reports. The 'spotlight' report provides information on the compliance with QBP orders and required modifications to improve compliance.	The number of electronically completed QBP COPD order sets on patients admitted with a primary diagnosis of COPD.	85% of patients admitted with a primary diagnosis of COPD will have a QBP CHF order set on admission.	

	Effective transitions	The number of discharge summaries sent to primary care providers within 48 hours of discharge/total number of patient discharges.	C	% / Discharged patients	internal data measures / March 1st, 2018-January 31st, 2019	784*	54	70.00	Results are dependent on internal processes and timeliness of physician dictation.	1)Development of a physician quality improvement dashboard.	Quality indicators that are dependent on physician practices and those that physicians are interested in measuring will be compiled into a physician quality dashboard and presented to the physicians quarterly by the Chief of Staff.	The physician dashboard will be presented to the physicians quarterly.	Physicians will be provided with a quarterly physician quality improvement dashboard.	
										2)MHC Physicians will receive individualized reports of quality indicator results.	MHC physician individualized results of compliance with dictation within 48 hours of discharge will be provided quarterly to physicians, including the patient's name, diagnosis, discharge destination and time from discharge to discharge summary dictation.	The physicians will receive quarterly individualized reports of their compliance with dictating discharge summaries within 48 hours.	100% of MHC physicians will receive individualized reports of compliance with dictating discharge summaries within 48 hours of discharge.	
Effective	**Improve Organizational Financial Health**		A	N/A	OHRS, MOH / Q3 FY 2017/18 (cumulative from April 1, 2017 to December 32, 2018	784	4.8	0.50%	Closing total margin varies according to Q4 strategic investments	1) Monitor and respond to funding and investment earnings	Per defined formulas within Hospital Sector Accountability Agreement (HSAA)	Reported monthly to the MHC Board of Directors.	To exceed HSAA obligations in order to facilitate strategic investments within the Manitoulin Region.	
Efficient	**Access to right level of care**	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	P	Rate per 100 inpatient days / All inpatients	WTIS, CCO, BCS, MOHLTC / July - September 2017	784*	30	12.70	Northeast LHIN ALC target.	1)48/5 Model of Care continuing to include the assessment of functional mobility status and risks of functional decline in patients 65 years age and older with a standardized tool.	The physiotherapy department completes TUG screens on eligible patients within 48 hours of admission for patients over the age of 65. Individualized care plans are developed and documented in the EMR for viewing by the multidisciplinary team.	The number of TUG assessments completed within 48 hours of admission on eligible patients.	95% of eligible patients will be screened with the TUG within 48 hours of admission.	
										2)48/5 Model of Care continuing to include nutrition and hydration assessment with a standardized tool.	A standardized nutrition tool is utilized to screen patients within 48 hours of admission. The dietician receives the nutritional screening results electronically and provides individualized nutritional plans for patients who screen as high risk.	The number of nutritional screens completed on eligible patients within 48 hours of admission.	80% of eligible patients will have a nutritional screen completed within 48 hours of admission.	
										3)48/5 Model of Care to be initiated to include bowel and bladder assessment and training with standardized tools.	The nursing team will assess a patients bowel and bladder function on admission. Eligible patients will have best practice clinical protocols and/or order sets established during their admission.	The number of patients with bowel and/or bladder clinical protocols and/or order sets in place during their admission.	70% eligible patients will have bowel and/or bladder clinical protocols and/or order sets in place during their admission	
										4)48/5 Model of Care to be continued to include Medication Reconciliation on transitions of care.	Medication reconciliation is performed on all patients on admission.	Medication reconciliation rates	95% of all admitted patients will have medication reconciliation completed on admission.	

										5)Estimated length of stay physician order field to be included on all electronic patient order sets.	MHC is currently standardizing all electronic order sets to ensure that they include evidenced based practices such as estimated lengths of stay for all admissions.	The number of electronic patient order sets with estimated lengths of stay fields.	100% of electronic standardized order sets will have a mechanism to input the estimated length of stay for admitted patients	
										6)Optimize hospital capacity and patient flow through daily assessments to remove barriers to discharge.	In partnership with the NELHIN Home & Community Care discharge planner, the Aboriginal Health Access Centre Aging at Home Liaison and the multidisciplinary team meet regularly to develop plans to transition patients from the hospital back to the community.	Number of multi-disciplinary rounds at each site.	The multi-disciplinary team will round at least weekly to address patient flow and barriers to discharge.	
										7)Include the Manitoulin Island Health Care Collaborative (MIHCC) Partners inclusive of Primary Care, Home Care, Public Health, District Social Services, Long Term Care in the development of process measures that contribute to the decrease in ALC days.	The Manitoulin Island Network of Care Providers (MINCP) will engage in the development of a collaborative Quality Improvement Plan that provides sector process measures that contribute to the reduction of ALC days.	The MIHCC and MINCP will develop a QIP that includes organizational process measure that contribute to the reduction of ALC days.	The collaborative QIP will include evidence-based cross-sector process measures that contribute to the reduction of ALC days.	The MINCP is currently establishing a QIP for 2018-2020 that will include evidenced-based process measures to reduce the risk of patients becoming ALC.
Patient-centred	**Person experience**	"Would you recommend this emergency department to your friends and family?"	P	% / Survey respondents	EDPEC / April - June 2017 (Q1 FY 2017/18)	784*	96.4	92	Provincial benchmark is 70.6%.	1)Partnering with patients and families in health care redesign and quality improvement projects.	Inclusion of a Patient Advisor on the Emergency Department Committee	A Patient Advisor will attend at least two emergency department committee meetings annually	Maintain and improve opportunities for families and patients to provide feedback.	
										2)Maintain the accessible compliments and concerns comment cards at specific locations in the organization to provide patients and families with the opportunity to provide feedback.	Locked drop boxes are strategically located within the organization for patients and families to comment either anonymously or leave contact information to receive a call back from the appropriate person.	Compilation of results with positive qualitative comments and or opportunities for improvement addressed in real time with the department(s) involved.	Maintain or improve opportunities for patients and families to provide feedback.	

										3)The provision of space at both sites that support spiritual and cultural needs of patients and families.	The spiritual room at the Little Current site will be renovated to provide a quiet, space that supports their physical comfort and provides opportunities for spiritual and cultural rituals.	The completion of the renovations of the Little Current Spiritual Room.	Patients will be provided with access to an environment that supports their physical, spiritual and cultural needs.	MHC provides health care services to a high proportion of Indigenous patients. The spiritual rooms at both sites will provide the opportunity to practice cultural traditions such as smudging and cedar baths.
Patient-centred	**Person experience**	"Would you recommend this hospital to your friends and family?" (inpatient care)	P	% / Survey respondents	CIHI CPES / April - June 2017(Q1 FY 2017/18)	784*	98.4	92	Provincial benchmark is 70.6%.	1)Partnering with patients and families in health care redesign and quality improvement projects.	Inclusion of a Patient Advisor on the Inpatient Committee	A Patient Advisor will attend at least two inpatient committee meetings annually	Maintain and improve opportunities for families and patients to provide feedback.	
										2)Maintain the accessible compliments and concerns comment cards at specific locations in the organization to provide patients and families with the opportunity to provide feedback.	Locked drop boxes are strategically located within the organization for patients and families to comment either anonymously or leave contact information to receive a call back from the appropriate person.	Compilation of results with positive qualitative comments and or opportunities for improvement addressed in real time with the department(s) involved.	Maintain or improve opportunities for patients and families to provide feedback.	
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Safe	**Safe care/Medication safety**	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.	P	Rate per total number of discharged patients / Discharged patients	Hospital collected data / October – December (Q3) 2017	784*	97	95.00	Bench mark data from NELHIN and Province is not available. With current data collection methods, when a patient is discharged without medications the printing of the medication reconciliation form on discharge is required or it is captured as a 'miss'.	1)Maintain and monitor current processes of standardized computerized utilization of medication reconciliation tools on all discharged patients.	Quarterly monitoring of medication reconciliation on discharge utilizing an auditing process. Evaluate the effectiveness of medication reconciliation processes with community partners including pharmacies, long term care and primary care. Ongoing reporting to physicians, staff and the Board Quality Assurance Committee.	Medication Reconciliation on discharge rates.	95% of eligible patients will have medication reconciliation completed on discharge.	
		Medication Reconciliation on Admission: The total number of patients who receive medication reconciliation on admission to hospital.	C	% / All acute patients	Hospital Collected Data / March 1 2018 to January 31st 2019	784*	97	95.00	Bench mark data from NELHIN and Province is not available. With current data collection methods, when a patient is admitted it is dependent on the nursing team to manually indicated that medication reconciliation on admission has occurred. This limits the ability to exclude patients who are admitted without medications.	1)Maintain and monitor current processes of standardized utilization of medication reconciliation tools on all admitted patients.	Quarterly monitoring of medication reconciliation on admission using an electronic reporting system. Ongoing Reporting to physicians, employees and the Board QA Committee.	Number of patients who have medication reconciliation completed on admission.	95% compliance rate for completion of medication reconciliation on admission.	

	Workplace Violence	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 2017	784*			Number of incidents/ number of FTE's	1)Train internal Non-Violence Crisis Intervention (NVCIT)instructors to provide non-violence crisis intervention training to medium/high risk employees. Employees are classified as per the Crisis Prevention Institute.	Mandatory Non-Violence Crisis Intervention Training for medium/high risk employees.	The number of employees trained in Non-Violence Crisis Intervention Training/ The number of employees classified as medium/high risk.	An initial cohort of employees classified as medium/high risk will receive Non-Violence Crisis Intervention Training in the next 12 months.	
										2)Review and revision of the MHC Workplace Violence and Harassment program as per Accreditation Canada, the Occupational Health & Safety Act, Preventing Workplace Violence in the Health Care Sector Report & the Ministry of Labour Workplace Violence and Harassment Key Terms and Concepts.	In collaboration with the Occupational Health & Safety Committee, the Director of Human Resources will review and update the current Workplace Violence and Harassment program.	The Workplace Violence and Harassment program review will be completed. Employees will be educated on the program through a mandatory educational program annually.	90% of employees will be provided with the opportunity to review the Workplace Violence and Harassment Program annually.	
										3)The review and update of the MHC Code White Emergency Preparedness response by the Emergency Preparedness committee.	The updated Code White response will be reviewed by the Occupational Health and Safety Committee and mandatory education will be provided to all employees.	The number of employees who are educated on the revised code white response.	90% of employees will be provided with the opportunity to complete education on the revised code white response.	
Timely	**Timely access to care/services**	Total ED length of stay (defined as the time from triage or registration, whichever comes first, to the time the patient leaves the ED.	C	Hours / Patients with complex conditions	CIHI NACRS / January 2017-December 2018	784*	7.8	8.00	Provincial target of 8 hours.	1)Continue to monitor internal clinical practices and maintain performance compliance with the total ED length of stay, congruent with the provincial and NELHIN targets.	Current methods include the quarterly monitoring of all CTAS 1-3 visits for completion of visits from triage and/or registration to disposition, being transferred, discharge, death or admission. The registration/triage data is captured from our electronic record and discharge times are recorded manually on the ER outpatient record.	100% of all ER visits of complex CTAS 1-3 patients are included in the data capture.	The total ED length of stay for complex CTAS 1-3 patients will be = 8 hours.	