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Change Happen.



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



2/15/2019

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.

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## Overview

Nearing three years of unprecedented redevelopment, in 2018-19 JBH staff physicians, volunteers and learners pivoted to “ramp-up” application of the rigorous self-assessment and improvement processes of Accreditation Canada’s *Qmentum* Program to its program and services – many of which had recently transitioned into newly built or renovated physical spaces. JBH was successful in achieving an award of *Accreditation with Exemplary Standing* for an additional four years. We were intentional in aligning QIP and Accreditation priorities and efforts, and in focusing our capacity for improvement in order to achieve success. The annual objectives of our Joseph Brant Hospital Strategic Plan 2017-2022 (*Together Building Our Future – One Step at a Time*), also reflected this deliberate alignment and focus.

The 2019-20 QIP has, again, been developed to align and focus our efforts to achieve important steps toward a growth-oriented vision, while continuously improving the care and services that we provide to our patients, families and community on a day-to-day basis. In addition to the two mandatory QIP indicators, JBH has adopted seven priority QIP indicators recommended by Health Quality Ontario (HQO). These indicators are aligned to system-level quality issues that are evident in our community, and throughout the province. They are also relevant to JBH’s strategic direction, and to sustaining our Accreditation-driven achievements. We have again this year undertaken engagement activities to validate that they are also seen as priorities by the patients, families, and community that we serve. The table below displays the relationships between HQO’s system-level Quality Dimensions, and the indicators that we selected as the foci of our 2019-20 QIP:

Quality Dimension	Indicator
Timely	Discharge summary sent from hospital to community care provider within 48 hours of discharge
	Time interval between the time of disposition and time patient left emergency department
Efficient	Average number of inpatients receiving care in unconventional spaces or ER stretchers
	Total number of alternate level of care (ALC) days
Patient-Centred	Percentage of positive scores to survey question: Did you receive enough information upon discharge from hospital?
Safe	Number of workplace violence incidents reported by hospital workers
Effective	Medication reconciliation at discharge
	Proportion of patients that have their palliative care needs identified early through an assessment
	Rate of mental health or addiction readmissions within 30 days

Our QIP indicators for 2019-20 reflect our intention to largely “stay the course” established in the previous QIP as we have adopted a multi-year, continuous improvement approach to issues that remain as priorities here in our community, and across the province. This year’s improvement efforts will be informed by the knowledge acquired through previous continuous improvement cycles.

# JBH's greatest quality improvement achievement from the past year

Medication Reconciliation is an important safety practice aimed at reducing the risk of medication errors at key points in a patient's care journey. Although it has been identified by Accreditation Canada as a Required Organizational Practice (ROP) for over ten years, many organizations have been challenged to consistently adopt this evidenced-based practice at an organization-wide level. For this reason, JBH is particularly proud of its achievement in meeting this ROP across all programs and services in November 2018. Our approach was featured in the HQO *Quorum* blog in October 2018:

Joseph Brant Hospital (JBH) is using technology to significantly increase the number of medication reconciliations (MedRecs) being completed at their hospital.

Health Quality Ontario had a chance to catch up with Jessy Samuel, Director of Clinical Support Services (Pharmacy, Laboratory Medicine and Diagnostic Imaging), Dr. Frank Fornasier, Lead Hospitalist and Co-Chair of Health Records, and Hala Basheer, Manager of Pharmacy to learn how they implemented this initiative.

## ***When did you first decide to use a technology solution to improve MedRec at your hospital?***

In 2014 a decision was made to focus on improving MedRec throughout the organization since it was a quality issue that we felt required improvement. A MedRec Advisory Committee was struck, and after thorough research, a new medication reconciliation software program called MedsTracker® (by First Data Bank) was purchased.

Technology is often an enabler to quality improvement work, and the implementation of MedsTracker® was seen as an opportunity to make significant strides in MedRec at our hospital.

## ***How did you go about implementing the MedsTracker® software?***

With carefully thought out planning, a MedsTracker® pilot went live on a medical ward in June 2017. Since then, the MedsTracker® tool has been implemented in all inpatient programs and units with plans to expand to outpatient programs and clinics.

Key players in this project included our vendor, who customizes the software to meet our unique needs, our IT department who helped iron out kinks and set up the training environment, and our MedRec champions who provided support, coaching and continuously advocated for change.

We had a team that was very dedicated to the success of this project and we applaud everyone for working through the challenges, frustration and times of uncertainty.

## ***What were the biggest challenges of this initiative?***

Reflecting back, I don't think we fully understood the scope of the project that we were undertaking! We found that the biggest challenges we faced included:

- Getting buy-in from frontline staff and shifting attention to MedRec as an organizational priority
- Managing competing program/department priorities
- Understanding differing unit processes, including the roles and responsibilities of team members
- Troubleshooting process issues that the software did not compensate for
- Working on this project during organizational re-development (i.e. moving physical sites)

### ***How did you manage some of these challenges?***

Having a strategic focus on MedRec was essential to allow us to navigate through competing priorities.

Staff buy-in was also important to us, and we encouraged this buy-in by sharing the positive results obtained from the pilot project. This motivated staff to continue the effort.

Being conscious of unit space and computer availability made a big difference in staff being able to complete the MedRecs. Finally, selecting a strong team with a passion for MedRec, including a physician champion, was key to success. Our champions worked tirelessly with different hospital areas to ensure successful rollout, policy compliance and clear processes.

As with any QI process, we continuously evaluated the implementation of this project and customized changes to fit our unique environments and provider needs.

### ***What results have you seen so far?***

In the first six months of implementing MedsTracker®, we realized a 70% MedRec completion rate!

Feedback from nurses, physicians, patients and community pharmacies has been very positive. Patients now receive a printed list of medications, with clear instructions about which medications to continue, stop or change. When patients present back to hospital, providers are now able to see the last best possible medication history (BPMH), which is very helpful.

### ***What's next?***

We continue to show programs and units weekly results on compliance and disseminate success stories from providers and patients. Weekly senior leadership quality reports, which include a MedRec parameter, keep senior leadership engaged and identify areas that need increased support or resources.

We will be implementing “quality boards” on every unit with a focus on MedRec, which will display data for frontline staff to see.

Going forward, we are getting ready to roll out MedsTracker® to our outpatient programs and will continue to work on improving our current compliance and processes.

## **Patient Partnering and Relations**

Development of our 2019-20 QIP was largely based upon the successful approach taken in previous years. In addition to focus groups conducted with our well-established Mental Health Consumer Advisory Council we were again this year also able to leverage our discharge follow-up phone call pilot project, and real time patient experience interviews being conducted in a number of areas across JBH.

The input of the Mental Health Consumer Advisory Council (MHCAC) was collected through a focus group with its members conducted on January 16<sup>th</sup>, 2019. This input is particularly important as it has provided JBH with access to the viewpoints and concerns of a growing population patients and families that are at risk for marginalization in our community, and healthcare system.

A number of the multi-year initiatives included in the 2018-19 QIP, were again endorsed. The importance of preparing patients and families for discharge with information that will alleviate anxiety and identify relevant community resources and supports was again emphasized. This input was echoed in many of the 50 ED and 50 inpatient follow-up phone call interviews that were conducted as part of our 2018-19 QIP work plan. QIP-

aligned initiatives such as the expanded CoHealth (formerly *DashMD*) smart phone application and the Early Engagement collaboration with our LHIN Home and Community partners will continue to align to these important issues.

The discussion at the January 16<sup>th</sup> MHCAC also reinforced the patient and family feedback that has been formally collected through application of the *Ontario Perception of Care Tool* (OPOC). The implementation of the innovative Prioritizing Health through Acute Stabilization and Transition (PHAST) program, highlighted as a means to reducing psychiatric readmissions in our 2018-19 QIP, will continue, and will be informed by both patient and family feedback and evaluation of outcomes for PHAST participants.

Real time surveying of patients and family members in the ED by volunteers continued throughout 2018-19. Many of the opportunities for improvement arising from these surveys were related to time spent waiting. This was also typical of the feedback collected following ED visits through follow-up calls when subjects were asked how the experience of their ED visit might be improved. This source of patient input, coupled with that collected through our corporate patient relations process, mail-out surveys, and feedback directly provided to our patient-facing staff and physicians, reinforces our continued attention providing patients with the right care in the right place at the right time to achieve both optimal clinical outcomes and an outstanding patient experience. The work aligned to transitioning patients to appropriate beds in “conventional” spaces as soon as possible after there has been a decision to admit is therefore seen as a high priority in 2019-20.

Community Members of the JBH Board of Directors will also have had an opportunity to provide feedback on the 2019-20 QIP during the March 7<sup>th</sup>, 2019 meeting of the Quality Committee of the Board.

## Workplace Violence Prevention

Workplace violence is more common in health care settings than in many other workplaces, with one-quarter of all incidents of workplace violence occurring at health services organizations. It is an issue that affects staff and health providers across the health care continuum.

Accreditation Canada has adopted the modified International Labor Organization definition of workplace violence, as follows: “Incidents in which a person is threatened, abused or assaulted in circumstances related to their work, including all forms of harassment, bullying, intimidation, physical threats, or assaults, robbery or other intrusive behaviours. These behaviours could originate from customers or coworkers at any level in the organization.”

In November 2018, Accreditation Canada on-site surveyors confirmed that JBH met all tests of compliance for the Workplace Violence Required Organizational Practice (ROP). The ROP tests of compliance are as follows:

- There is a written workplace violence policy
- The policy is developed in consultation with team members and volunteers as appropriate.
- The policy names the individual(s) or position responsible for implementing and monitoring adherence to the policy.
- Risk assessments are conducted to ascertain the risk of workplace violence.
- There are procedures for team members to confidentially report incidents of workplace violence.
- There are procedures to investigate and respond to incidents of workplace violence.

- The organization's leaders review quarterly reports of incidents of workplace violence and use this information to improve safety, reduce incidents of violence, and improve the workplace violence prevention policy.
- Information and training is provided to team members on the prevention of workplace violence.

Our commitment within this year's QIP Work Plan is to further improve our capture of workplace violence incidents through our electronic occurrence system, and continue to monitor and improve uptake of the key processes and procedures that are prescribed in the ROP, and within our corporate policy.

## Performance-Based Compensation

The Excellent Care for All Act (ECFAA, 2010) requires that executive compensation be linked to the QIP. The selection of QIP indicators and work plan initiatives to be tied to Executive Pay-at-Risk remains at the discretion of each Hospital. The QIP Pay-at-Risk allocation for each fiscal year is based on the achievement of selected QIP work plan objectives. These indicators are reviewed and recommended by the JBH Senior Leadership Team and the Human Resources Policy and Compensation Committee (HRPCC) for Board approval. Payment of the Pay-at-Risk is evaluated at year end and paid out subject to Board approval. For 2019-20 the carve-out for QIP Pay-at-Risk is 5%.

The 2019-20 QIP has been developed through extensive consultation with key internal stakeholders and patient and family members, and is aligned with mandatory and priority indicators selected by the Ministry of Health.

It is recommended that executive Pay-at-Risk for 2019-20 be aligned to the indicators as summarized in the table below.

Quality Dimension	Measure/Indicator	Planned improvement initiatives (Change Ideas)	Process Measures	Target for Process Measure	Pay at Risk
Timely	The (90th percentile) 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.	Refinement and spread of Care Summary Tool and improvements to Unit Rounds.	Percentage of Medicine and Surgical units utilizing refined Care Summary Tool. Average duration of audited Unit Rounds.	By September 2019: Spread and refinements completed such that 100% of Medicine and Surgical units are utilizing Care Summary Tool. Average duration of audited Unit Rounds is less than 20 minutes during Q3 2019-20.	1.0%
Efficient	Average number of inpatients receiving care in unconventional spaces or ER stretchers per day within a given time period.	JBH Medical Model of Care for Newly-Admitted Patients	Kaizen event held that produces immediate tests of change and further refinements. Progress/evaluation report-outs held at 30, 60 and 90 days post Kaizen event.	By September 2019: Key process measures/steps identified through the Kaizen event have been tested and/or implemented by September 2019.	1.0%

Quality Dimension	Measure/Indicator	Planned improvement initiatives (Change Ideas)	Process Measures	Target for Process Measure	Pay at Risk
Patient-centred	Percentage of respondents who responded with "top box" positive score to the following question: 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?	Implementation of CoHealth (formerly Dash MD) smart phone application to provide relevant information upon discharge.	Number of clinical programs utilizing the application.	By June 2019: Application will be in use in Surgical program and Emergency program. By June 2019: Application will be in use in Maternal Child and Ambulatory Care Programs	1.0%
Safe	Number of workplace violence incidents reported by hospital workers (as by defined by OHSA) within a 12 month period.	Improvements to JBH stakeholder awareness, and the consistency of WPV incident reporting.	Education activities and WPV incident data will be reported to HRPCC, JHSC and Workplace Violence Prevention Committee.	By June 2019, education activities and WPV incident data will be reported to HRPCC, JHSC and Workplace Violence Prevention Committee.	1.0%
Effective	Rate of mental health or addiction episodes of care that are followed within 30 days by another mental health and addiction admission.	Continued implementation, evaluation and improvement of Prioritizing Health through Acute Stabilization and Transition (PHAST) program and further collaboration with community providers.	Completion of PHAST program participant readmission rate review. Completion of stakeholder mapping of concurrent disorder services.	By September 2019: Completion of PHAST program participant readmission rate review. Completion of stakeholder mapping of concurrent disorder services.	1.0%
				<b>Total Pay-at-Risk Allocation</b>	<b>5.0%</b>

### 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, Dominic Mercuri



Quality Committee Chair, Mae Radford



President & Chief Executive Officer, Eric Vandewall

