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

Joseph Brant Hospital 1230 North Shore Boulevard

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	In a collaboration with external partner? If Yes, indicate the organizations	Is this indicator included in your executive compensation? Y/N
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	**Timely**	Discharge summary sent from hospital to community care provider within 48 hours of discharge	P	Percentage	Local data collection / Most recent 3-month period.	718*	94.0%	Maintain at, or above, 90%	People-based process. Undergoing changes to physician coverage model and growth in services. Maintain performance while minimizing the impact of exceptions on safe, successful transition from hospital.	N/A		Implement a system of daily monitoring and reminders for discharge summaries	Manual review of all discharges by Health Records Clerk to capture and understand exceptions. Clerk will issue a physician reminder when Discharge Summary is not present. Quarterly summaries of exceptions will be provided to physician chiefs.	Monitoring process in place. Reminder process in place. Quarterly exception summaries provided to physician chiefs.	By June 2019: Monitoring and reminder processes in place. By September 2019: Quarterly exceptions summaries provided to physician chiefs.	Leads: Director of Health Information Services & CPO; Physician Chair of Health Records Committee		
		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.	MANDATORY	Hours / All patients	CIHI NACRS / October 2018 – December 2018	718*	44.8	42.5	5% improvement. Performance will continue to impacted by both, limited system-level capacity, and growth in patient volumes.	N/A		Refinement and spread of Care Summary Tool and improvements to Unit Rounds.	PDSA cycles to refine and spread application of Care Summary Tool and improve the efficiency and effectiveness of 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.	Leads: EVP PCS & CNE; Chief of Staff, Director of ED, Medicine, and Integration; Chief of Medicine; Director of Surgery, Oncology and Ambulatory Care; Chief of Surgery		Y
	Efficient	Average number of inpatients receiving care in unconventional spaces or ER stretchers per day within a given time period.	P	Count / All patients	Daily BCS / October - December 2018	718*	19.6	18.6	5% improvement. Performance will continue to impacted by both, limited system-level capacity, and growth in patient volumes.	N/A		JBH Medical Model of Care for Newly-Admitted Patients	Kaizen event-driven design and implementation of processes that will optimize use of space, equipment/technology and human resources.	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.	Leads: EVP PCS & CNE; Chief of Staff		Y
		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 2018	718*	14.3	13.6	5% improvement. Performance will continue to impacted by both, limited system-level capacity, and growth in patient volumes.	HNHB LHIN Home and Community		1. Continued refinement of Early Engagement Strategy for complex discharges. 2. Remote Monitoring Technology Pilot	1. PDSA cycles to refine Early Engagement Strategy for complex discharges and adapt to changes in community supports and resources. 2. Development and implementation of processes to apply technology to support remote monitoring of patients who do require acute inpatient hospital care.	1. % of med/surg patients and families engaged in discharge planning discussion by LHIN and/or hospital within 48 hours of admission. 2. Process and technology in place to meet planned capacity.	1. During Q3 2019-20, 70% of the audited charts of patients with complex discharge planning needs will include evidence of a discharge planning conversation within 48 hours of admission. 2. By end of July 2019, the process and technology will be in place to support up to ten patients for 30 to 90 days duration.	Leads: Director of ED, Medicine & Integration; (Director of LHIN Home and Community to be confirmed)	HNHB LHIN Home and Community	
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	718*	100.0%	100.0%	Current performance is meeting target. No improvements are required to maintain performance at target	N/A		Current performance is meeting target. No improvements are required to maintain performance at target				Current performance is meeting target. No improvements are required to maintain performance at target.		
		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?	P	% / Survey respondents	CIHI CPES / Most recent consecutive 12-month period	718*	52.9%	55.6%	5% improvement in those responding with "top box" positive score: **Completely** - Quite a bit - Partly - Not at all	N/A		Implementation of CoHealth (formerly Dash MD) smart phone application to provide relevant information upon discharge.	CoHealth application will provide information relevant to patient condition and follow-up post discharge from hospital. The application includes a brief patient experience survey to inform improvement.	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	Leads: Chief of Staff; Director of ED. Medicine & Integration; Director of Surgery, Oncology &Ambulatory Care; Director of Maternal Child, Critical Care & Professional Practice/Deputy CNE; Director of Quality & Strategy		Y
Theme III: Safe and Effective care	**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	718*	42.0	Year 2 baseline	42 incidents reported between Jan 1 2018 and Dec 31 2018. JBH to continue to establish a baseline and work plan for the Workplace Violence QIP indicator in 2019-20. Improvements to JBH stakeholder awareness, and the consistency of WPV incident reporting, are expected to result in increased awareness and confidence in reporting.	N/A		Improvements to JBH stakeholder awareness, and the consistency of WPV incident reporting.	Education and communication of the JBH Corporate WPV Prevention Policy, and the use of the incident reporting system will continue in 2019-20.	Education activities and WPV incident data will be reported to HRPCC, JHSC and Workplace Violence Prevention Committee.	By September 2019, education activities and WPV incident data will be reported to HRPCC, JHSC and Workplace Violence Prevention Committee.	Lead: Chief Human Resources Officer		Y
	Effective	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 2018	718*	65.1%	70.0%	As per Year 2 (2019-20) of JBH Strategic Plan	N/A		Continue to monitor and improve compliance.	Monitor and reinforce completion of medication reconciliation through education, data collection and feedback.	Medication reconciliation compliance reported to leadership and posted on units.	By April 2019: Report-outs to JBH leadership assembled for Quality Wall huddle. Weekly reports posted on unit Quality Boards	Lead: Director of Clinical Support Services		
		Proportion of hospitalizations where patients with a progressive, life-threatening illness have their palliative care needs identified early through a comprehensive and holistic assessment.	P	Proportion / at-risk cohort	Local data collection / Most recent 6 month period	718*	N/A	N/A	Baseline data to be collected	N/A		Collect baseline data to guide and evaluate improvement.	Key stakeholder group will develop and implement a process to collect data on the completion of palliative care assessments.	Data collection process implemented to collect baseline data.	By December 2019: Data collection process in place to establish baseline to guide and evaluate improvement.	Lead: Director of ED, Medicine & Integration		
		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 OMHRS,MOHTLC RPDB / January - December 2017	718*	14.5	13.8	5% improvement. Performance will continue to impacted by both, limited system-level capacity, and growth in patient volumes.	N/A		Continued implementation, evaluation and improvement of Prioritizing Health through Acute Stabilization and Transition (PHAST) program and further collaboration with community providers.	Review rate of readmissions for PHAST program participants. Participate in stakeholder mapping of concurrent disorder services.	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.	Lead: Director of Mental Health and Rehabilitation; Chief of Psychiatry and Medical Director of Mental Health & Addictions		Y