WOMEN'S COLLEGE HOSPITAL
Health care for women | REVOLUTIONIZED

Quality Improvement Plan Progress Report for 2017/18

Measure/Indicator from 2017/18	Current Performance as stated on QIP2017/18	Target as stated on QIP 2017/18	Current Performance 2018	Comments
Medication Reconciliation: # patients in defined high risk category with medication reconciliation completed/total # patients defined in high risk category (%) (Patients defined by high risk criteria within day surgery program; EMR/Chart Review)	CB	60.00	63.10 (Q1-Q3 FY 2017.18)	The target for 2017.18 was achieved through the efforts of a dedicated pharmacist in Surgical Services.

Change Ideas from Last Years QIP (QIP 2017/18)	Was this change idea implemented as intended? (Y/N)	Lessons Learned: (Some Questions to Consider) What was your experience with this indicator? What were your key learnings? Did the change ideas make an impact? What advice would you give to others?
1. Establish a formal, interprofessional med rec process in surgical services as part of strategic patient safety priority.	Y	Establishing this process in our Surgical Services area allowed us to better understand the challenges associated with a paper process that relies on one member of the interprofessional team. We continue to improve work flow in Surgical Services in order to refine processes and increase reliability, particularly when there are Pharmacy staffing challenges. As we spread Medication Reconciliation to other areas of the hospital, we will work to leverage our clinical information system for patient identification, documentation and data collection.

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AACU Referrals: #of referrals per day seen in the Acute Ambulatory Care Unit (AACU) GIM service that were referred by the external partner emergency department (ED). (Patients referred from external partner ED department; Hospital collected data)	4.00	6.00	5.10	As of Q3 2017.18 we have improved by almost 28% over baseline.

Change Ideas from Last Year's QIP (QIP 2017/18)	Was this change idea implemented as intended? (Y/N)	Lessons Learned: (Some Questions to Consider) What was your experience with this indicator? What were your key learnings? Did the change ideas make an impact? What advice would you give to others?
1. Provide urgent GIM assessment and management to patients with acute internal medicine conditions in an ambulatory setting. Increase the total number of referrals from the ED to the AACU; increase efficiency by identifying patients at ED triage and re-direct to the AACU. Targets patients with pre-defined medical conditions that can be diverted from the ED to AACU, allowing appropriate and timely care and eliminating a step in the care pathway.	Y	While the AACU prevents unnecessary ED/inpatient utilization at the system level, we have learned that it also leads to a number of AACU follow-up encounters which we are taking into consideration when planning future expansion. In order to achieve optimal utilization of limited capacity, we have learned that daily monitoring and oversight is required. Efforts in the upcoming year will focus on exploring new models of care to expand AACU capacity.

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Coordinated Care Plans (CCPs): % Coordinated Care Plans (new/updated) for medically complex patients identified as per local criteria (Identified medically complex patients as per local criteria - WCH Family Practice and Elder Homebound program; EMR/Chart Review)	CB	25.00	25.40	As of Q3 2017.18 over 155 Coordinated Care Plans have been completed for 610 active patients.

Change Ideas from Last Year's QIP (QIP 2017/18)	Was this change idea implemented as intended? (Y/N)	Lessons Learned: (Some Questions to Consider) What was your experience with this indicator? What were your key learnings? Did the change ideas make an impact? What advice would you give to others?
Registry of patients (patient ID; CCP status; complexity; risk factors) initiated in 2016-17. Quarterly registry review to identify patients most appropriate for new/revised CCP.	Y	Actively connecting with patients by leveraging the relationship between providers and our vulnerable elderly population enabled us to surpass our LHIN CCP goal in WCH Family Practice. CCPs are most effective in primary care when they are iterative, allowing the patient and team to refer back to them when required and make updates as needs change, thus integrating the tool within the ongoing care planning process. An ongoing challenge we have identified is the lack of a centralized platform for CCPs that is accessible to all primary care providers.

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New Referral Wait Time: Average # of business days from new referral entry to date of appointment entry (Patients in Gynecology and Pain programs; EMR/Chart Review)	8.00	5.00	5.00 (Q1-Q3 FY 2017.18)	As of Q3 2017.18, we saw a decrease from an average 8 business days to 5 (37.5% improvement) for the first four clinics. The target of 5 business days was established by the WCH Quality Operations Committee as the organizational standard.

Change Ideas from Last Year's QIP (QIP 2017/18)	Was this change idea implemented as intended? (Y/N)	Lessons Learned: (Some Questions to Consider) What was your experience with this indicator? What were your key learnings? Did the change ideas make an impact? What advice would you give to others?
1. Establish WCH Access Centre to improve access for patients across transitions and across the care continuum through targeted improvement projects and performance monitoring.	Y	In alignment with our Ambulatory Care Centre initiative, local clinics examined intake and referral processes and identified opportunities for improvement. Processes were, and continue to be refined to achieve optimal work flow and efficiency. Focussing on select clinics and providing them with this data, allowed us to refine the process and support clinics through the changes. Lessons learned include establishing "active waiting" processes for populations with significant wait times, developing triage algorithms based best practice criteria, and clarifying role responsibilities. As we move forward this year with two additional clinics (Rheumatology and General Internal Medicine), we will also work to improve the quality of the data gathered so that it reflects the true referral processing wait, i.e. the time the referral is initially received vs. the time it is entered into the clinical system

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MyHealthRecord Activations: % myHealthRecord (patient portal) activations within 30 days of appointments (All patients signed up to personal health record at WCH; EMR/Patient Portal)	10.00	20.00	17.00	As of Q3 2017.18 we have seen a 70% improvement over baseline.

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1. Communication and education strategies to increase provider and patient interest and understanding of myHealthRecord processes and capacities. Introduce new engagement opportunities (Fast Pass; interactive communication with providers; patient experience; TC LHIN demographic survey) within the patient portal in 2017-18. Note: Fast Pass offers an opportunity to reduce inefficiencies due to no-shows and/or late cancellations. This application has been highly successful at other institutions.	Y	Our aim is to achieve and maintain the previously established target of 20% taking into account the lower margin of improvement. We will work to better understand activation rates among different populations as we have noted considerable variation. We will also learn from our high performing areas and endeavour to spread local best practices such as including activation codes as part of the welcome package for new patients.

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After Visit Summaries (AVS): % patients provided with After Visit Summaries (Level 3 & 4 Clinics; EMR)	16.00	40.00	30.7	As of Q3 2017.18 we have achieved a 92% improvement over baseline.

Change Ideas from Last Year's QIP (QIP 2017/18)	Was this change idea implemented as intended? (Y/N)	Lessons Learned: (Some Questions to Consider) What was your experience with this indicator? What were your key learnings? Did the change ideas make an impact? What advice would you give to others?
1. Provide EPIC-generated AVS at end of visit; provider training and promotion of AVS; patient education about AVS (what it is and did they receive one).	Y	We have learned that there is significant variation among clinics and providers when it comes to using the AVS and that understanding this variation is the key to designing meaningful improvements. The two most common barriers identified were lack of integration within the clinic visit workflow and a perceived lack of value by patients and/or clinicians. Learning from our high-performers we will endeavour to spread local best practices and work to re-design the AVS so that it better meets the needs of our patients.

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Utilization post Rapid Assessment Addictions Medicine (RAAM) visit: % decrease in ED visits and inpatient for RAAM patients 90 days post service. (% decrease ED and inpatient admission for patients accessing new RAAM clinics; data extracted from local site EMRs)	CB	35.00	NA	Due to ICES data lag, results for ED/inpatient utilization is not available at this time. As of Q3 2017.18, the WCH RAAM Clinic has seen 152 unique patients.

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1. Improve the quality of care for patients with addictions by implementing an integrated care pathway collaboratively across the Toronto Central LHIN. Develop new RAAM clinics (2-5) in Toronto for medication-assisted and psychosocial treatment of addiction. Educate clinicians on best practices. Work with primary care to transition care once patient is stable.	Y	Despite the data lag, we have made significant progress in advancing a new model of care for this population. Four RAAM clinics have opened to date including WCH, Toronto Western Hospital, Sunnybrook, and St. James Town Health Centre (for pregnant patients). Additional collaborations are in development. Other related activity of note includes: - Take home naloxone is now being distributed at TGH and TWH - Addiction and withdrawal management education has been provided to nurses at six Toronto EDs and to ED physicians, psychiatrists and internists at seven Toronto hospital sites - Addiction management education has been provided to five academic Family Health Teams - Buprenorphine, used for opioid withdrawal/opioid addiction, is now available at seven Toronto hospital EDs and the WCH Acute Ambulatory Care Unit (AACU) - An expanded manual for primary care providers on managing addictions in the primary care setting has once again been endorsed by the College of Family Physicians of Canada