2018/19 Quality Improvement Plan
Improvement Targets and Initiatives

AIM		Measure					Change				
Quality dimension	**Issue**	**Measure / Indicator**	**Unit / Population**	**Current performance**	**Target**	**Target justification**	**Planned improvement initiatives (Change Ideas)**	**Methods**	**Process measures**	**Target for process measure**	**Comments**
Effective	**Effective transitions:** receiving enough information for care at home	% Patients Receiving After Visit Summaries (AVS)	% / Specialized Medicine Clinics Level 3 & 4	30.7%	40%	**Establish a relative improvement goal.** Despite not achieving last year's target, a 92% improvement was achieved over the baseline of 16%. The margin for improvement will decrease as the "low hanging fruit" are addressed. Future improvement efforts will be more resource intensive. A relative improvement of 30% results in a target of 40%.	1) **Process Redesign**. A multi-disciplinary group (including a patient, physician and IT staff) will collaborate to redesign the AVS in order to ensure it meets the needs of patients and clinicians, as well as optimizes upcoming clinical system updates. Other process redesign efforts will focus on workflow and spreading the best practices of high performing providers and clinics within the hospital.	The improvement team is led by the hospital's Chief Nursing Executive and will provide regular updates to the Collaborative Practice Advisory Committee using area or provider-specific AVS utilization reports as required. In addition, regular updates will be provided to the Senior Leadership Team including tracking on the quarterly Quality Report.	# of areas that have tested new AVS processes; % patients receiving AVS specific to an area or provider; informal feedback from patients and clinicians	at least 2 areas will test new AVS processes by December 2018; clinics or providers targeted for improvement will achieve an AVS utilization of 40% by December 2018; feedback on the new format will be largely positive by December 2018	
							2) **Education & Awareness**. Efforts will also focus on promoting the benefits of the AVS to both patients and clinicians alike via multiple venues and methods.	These efforts will be tracked by the improvement team noted above. Regular updates will be provided to the Senior Leadership Team including tracking on the quarterly Quality Report.	# of promotional communications related to promoting the use of After Visit Summaries	at least 3 promotional communications (with at least 1 being directed to patients) will be launched by December 2018	
	Effective transitions: avoiding inpatient admission by receiving the right level of care	Acute Ambulatory Care Unit (AACU) Referrals	Count / average per day	5.1	6.0	**Aim for theoretical best.** The target takes into account the current capacity available in the AACU. Benchmark data is not available for this indicator.	1) **Increase Capacity**. The majority of efforts will focus on expanding capacity, exploring additional resources and new models of care that continue to divert unnecessary utilization of ED and inpatient services within the system.	The leadership team for the AACU are closely tracking the progress of these efforts and report regularly to the Senior Leadership Team. Regular updates are also provided via tracking on the quarterly Quality Report.	# of new models of care tested in the AACU	at least 1 new model of care tested by December 2018	
							2) **Process Improvement**. The team will also work to optimize workflow to ensure that patients are seen in the most efficient way. These efforts include collaborating with the IT teams of our two partner sites at UHN to provide electronic access to available AACU appointment slots in order to maximize utilization.	The AACU leadership team monitors utilization on a daily basis and is closely tracking the progress of these efforts via team meetings and their program scorecard. Regular updates on AACU utilization are provided to the Senior Leadership Team including tracking on the quarterly Quality Report.	# of patients seen in AACU per day; number of unutilized AACU slots	6 AACU patients per day by December 2018; the ultimate goal is to achieve 0 unutilized AACU slots	While the AACU diverts ED/inpatient utilization, we are learning that it also leads to a number of AACU follow-up encounters which is taken into consideration when planning further expansion.

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Efficient	**Access to right level of care:** avoiding overuse by providing access to the right level of care	Total # of Calls to the Imaging Centre	Count / # of calls received	36	72	**Establish a relative improvement goal.** Two key drivers impacting the number of overall calls were identified: the utilization rate of providers already registered with SCOPE (which is quite low at approximately 4%) and the number of new providers registered. Using various modeling scenarios that takes into account a combination of both drivers, the ambitious target of 72 calls per month was established, which represents an improvement of 100%.	1) **Process Redesign & Awareness**. A number of interviews with registered providers have been scheduled to identify utilization barriers. This information along with a collaboration with the TCLHIN Primary Care Lead will inform process redesign. It is also anticipated that this information will generate ideas for meaningful awareness activities among registered providers.	This process is tracked by the Joint Department of Medical Imaging (JDMI) leadership team via their scorecard. Regular updates are provided to the Senior Leadership team including tracking on the quarterly Quality report.	% utilization of providers registered with SCOPE	>10% by January 2019	
							2) **Outreach**. JDMI will undertake a number of outreach efforts directed at community primary care providers not registered with SCOPE via in-person visits and accredited education sessions.	This process is tracked via the Joint Department of Medical Imaging (JDMI) leadership team via their scorecard. Regular updates are provided to the Senior Leadership team via the Quality Report.	# of new providers registered with SCOPE; # of outreach activities completed	30% improvement in the # of new providers registered by January 2019; at least 6 outreach activities completed by January 2019	
Equitable	**Equity:** capture equity information from our patients	Equity Survey Response Rate	% responses / Total unique patients in Epic	27.5%	40.0%	**Establish a relative improvement goal.** Since 2016 the response rate has gone from 2.2% to 27.5% which demonstrates a significant increase as a result of making the survey available in myHealthRecord, our online patient portal. Our efforts will continue to focus on leveraging adoption of our patient portal as this mechanism of administration eliminates the need for manual data entry. A target of 40% translates to a 45% improvement over current baseline.	1) **Awareness & Process Improvement**. The primary strategy to improve survey response rates is to leverage efforts to increase the rate of myHealthRecord activations (see Patient Centred indicator). Efforts include promoting the benefits of using the patient portal via multiple venues and spreading local best practices such as providing activation codes as part of the welcome package for new patients.	As a component of the WCH Health Equity Plan, equity survey response rates are monitored closely and reported to the Board Quality, Academic and Equity Committee. Regular updates are provided to the Senior Leadership team including tracking on the quarterly Quality Report.	% myHealthRecord activations; # of activities promoting activation of myHealthRecord	25% by January 2019; at least 2 promotional activities will be implemented by December 2018	Mandanted by the Toronto Central LHIN, the purpose of the equity survey is to capture standardized demographic data from patients/clients to inform equity work at both the organization and system level. At WCH, we aim to advance our demographic data collection so that we can more robustly evaluate links to health outcomes and improve our services from an equity lens.
							2) **Process Improvement**. In collaboration with our IT colleagues we will explore improvements to the current process, such as implementing prompting messages and/or active acknowledgement that patients are declining to complete the survey. We will also undertake an analysis of the survey data in order to understand whether respondents are representative of our overall patient population and identify possible barriers for specific groups.	As a component of the WCH Health Equity Plan, equity survey response rates are monitored closely and reported to the Board Quality, Academic and Equity Committee. Regular updates are provided to the Senior Leadership team including tracking on the quarterly Quality Report.	# of process improvements implemented	at least 1 improvement to the current process will be implemented by December 2018	

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Patient-centred	**Person experience:** using patient-centred technology to engage patients in their care	MyHealthRecord Activations	% / All patients	17%	20%	**Sustain improvement or hold the gains.** While the target has not been reached as of Q3, activations did increase by 70% from last year's baseline of 10%. Our aim is to achieve and maintain the previously established activation rate target of 20%, taking into account a lower margin of improvement. We will also work to better understand activation rates among different populations.	1) **Process Improvement.** Several different options will be explored to improve activation rates including the spread of a local best practice whereby activation codes are provided as part of the welcome package for new patients.	myHealthRecord activation rate is monitored at multiple venues including within IT and individual programs. Regular updates are provided to the Senior Leadership team including tracking on the quarterly Quality Report.	# of process improvements tested	at least 2 process improvements will be tested by December 2018	
							2) **Audit & Feedback**. Improvements will be made to the reporting activation rates at the Clinic level including integration within the Epic dashboard.	myHealthRecord activation rate is monitored at multiple venues including within IT and individual programs. Regular updates are provided to the Senior Leadership team including tracking on the quarterly Quality Report.	# areas with myHealthRecord activation rate on their scorecard	at least 3 areas by December 2018	
							3) **Awareness & Promotion**. Activities to increase awareness among clinicians and patients of the benefits of using myHealthRecord via multiple venues.	myHealthRecord activation rate is monitored at multiple venues including within IT and individual programs. Regular updates are provided to the Senior Leadership team including tracking on the quarterly Quality Report.	# of activities promoting activation of myHealthRecord	at least 2 promotional activities will be implemented by December 2018	
Safe	**Safe care:** medication safety	Medication Reconciliation - Surgical Services & Acute Ambulatory Care Unit (AACU)	% / eligible patients in Surgical Services & AACU	Collecting Baseline	65%	**Surpass internal benchmark.** Currently Med Rec in Surgical Services is at 63.1% and baseline data is being collected in the AACU. A small sample from AACU in January revealed that a Best Possible Medication History (BPMHH) is completed 96% of the time, but only 2 of 28 (7%) patients received full Med Rec along with an updated medications list. The combined target was therefore set at 65% to reflect a modest increase from the current performance, while taking into account the challenges of spreading to a new clinical area.	1) **Process Redesign**. The AACU Pharmacy team & IT will collaborate to formalize Med Rec processes by leveraging our clinical system's capability, including the documentation of any changes to the complete medications list in order to provide a copy to the patient. Other changes will include automated reporting and flagging of patients who meet criteria (those who would benefit the most from Med Rec). It is anticipated that these efforts will set the stage for future spread across the organization.	Progress will monitored by both the Pharmacy leadership team and the Interdisciplinary Medication Reconciliation Working Group. Regular updates will be shared with the AACU via their scorecard. Senior Leadership will be provided with regular udpates including tracking on the quarterly Quality Report.	% AACU patients meeting criteria who receive an updated medications list	65% by December 2018	
							2) **Process Improvement**. The team will work to improve workflow in Surgical Services and refine processes to increase reliability, particularly when there are Pharmacy staffing challenges.	Progress is monitored by both the Pharmacy leadership team and the Interdisciplinary Medication Reconciliation Working Group. Regular updates are shared with Surgical Services via their quality committee and staff meetings. Senior Leadership is provided with regular Med Rec updates including tracking on the quarterly Quality Report.	% Surgical Services patients missed due to Pharmacy staffing issues	<10% by December 2018	

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Safe	**Workplace violence:** enhancing safety	Number of workplace violence incidents reported by hospital workers (as by defined by OHSA) within a 12 month period.	Count / Worker	7	14	**Establish a relative improvement goal**. Benchmarks are not available at this time. Although it is generally accepted that ambulatory settings report fewer workplace violence incidents than inpatient facilities, the consensus at WCH is that such events are currently under reported. Results from the 2016 employee engagement survey revealed that of those staff who experienced violence or threats of violence, only 61% reported those incidents. In consultation with the Joint Health & Safety Committee (JHSC), it was felt that a 100% improvement was reasonable for 2018 considering the small number. The aim is to increase reporting while reducing severity.	1) **Education & Training.** As part of our Human Resources strategy, all staff will be participating in three hour de-escalation training sessions provided by external experts.	Human Resources will track attendance at the sessions and feed this information back to area Managers and Directors to ensure that staff are encouraged and supported to attend. Updates on the number of staff trained will be reported regularly to the Senior Leadership team.	% eligible staff who complete de-escalation training	50 % by September 2018	FTE=659.8
							2) **Awareness.** The importance of reporting workplace violence incidents and near misses will be highlighted in the training noted above. Other efforts include in-services across the hospital, posters, pamphlets and discussions at key meetings (e.g. Managers Council, staff meetings, staff orientation). A TAHSN group is working to develop resources and supports for physicians related to the management of domestic violence, which should also heighten awareness in this group.	Human Resources & Occupational Health staff will attend departmental team meetings, committees, and team huddles to promote reporting of all actual and near miss events. The importance of reporting will also be emphasized in post incident follow-up and debriefing sessions.	# of meetings/ huddles attended by HR or OHSS	15 by December 2018	
							3) **Process Improvement.** A process for flagging patients who present a safety risk within the electronic health record will be implemented in the Spring of 2018. The process will include the communication of patient specific triggers and safety strategies to ensure that all members of the healthcare team are aware and take appropriate steps. At a minimum, patients who are flagged will have their status reviewed on an annual basis. We will also explore whether we can create an additional field prompting consideration for patient flagging within the workplace violence sections of the incident reporting system.	Human Resources is collaborating with Risk Management & IT to develop the process and roll it out. Each instance of patient flagging will be reviewed by a multi-disciplinary group and regular reports about the process will be provided to the JHSC.	# of patient safety risk flags put in place vs. # of requests made; # of reports on the patient flagging system provided to JHSC	no target is associated with # of patient flags - monitoring is to understand frequency & appropriateness; at least 2 reports about the patient flagging system will be provided to JHSC by January 2019	We will also be stratifying the # of workplace violence incidents in terms of type, location and category of staff reporting in order to identify opportunities for safety improvements.

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Timely	**Timely access to care and services:** reducing wait times	Referral Wait Times Gynaecology, Pain, Rheumatology & General Internal Medicine Clinics	Average # of business days / new referrals	9	5	**Match internal benchmark.** The 5 business day standard for all clinics was established by the WCH Quality Operations Committee. As of Q3 2017.18, we saw a decrease from 8 to 5 days (an improvement of 37.5%) in the first 4 clinical areas targetted. The 5 business day target represents a 44% improvement over the current baseline that now includes 6 clinical areas.	1) **Process Redesign**. In alignment with our Ambulatory Care Centre initiative, processes will be re-designed to ensure optimal work flow and efficiency.	Quality Operations Committee monitors the progress of these efforts as well as the leadership teams of the 6 clinical areas. Regular updates are provided to the Senior Leadership team including tracking on the quarterly Quality Report.	Referral wait times each of the individual clinical areas	5 business days by January 2019	
							2) **Audit & Feedback**. The integration of referral wait time performance within area scorecards for discussion and review at quality and safety huddles will serve to promote process improvement initiatives.	Quality Operations Committee monitors the progress of these efforts as well as the leadership teams of the 6 clinical areas. Regular updates are provided to the Senior Leadership team including tracking on the quarterly Quality Report.	% of 6 clinical areas with referral wait times on their local scorecard; # of discussions about referral wait times and related processes at team meetings or quality & safety huddles	100% by December 2019; at least one discussion quarterly	