2022/23 Quality Improvement Plan (QIP) Indicators and Workplan

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Ontario Health QIP Update

- For the past two years, Quality Improvement Plan (QIP) submissions have been **on pause** while organizations did the necessary work to manage the COVID-19 pandemic in their communities and regions.

- For 2022/23 we are not required to submit our QIP to Ontario Health, the submission of our QIP to Ontario Health will be **considered voluntary.** However, some organizations do have existing legislative and/or contractual obligations to *complete* a QIP.

- Ontario Health encourages all organizations to develop and post the 2022/23 QIP on our websites and share it with our administrative staff, clinicians, and patients/residents and their families.

- Individual organizations who choose to submit their QIPs to Ontario Health are encouraged to do so by April 1, 2022. However, in consideration of the current pressures on the health care system, there will be **flexibility with timing of submissions and QIP Navigator will be kept open until June 30, 2022.**

Launch of 2022/23 QIP Priorities

- These priorities will guide us in our quality improvement efforts over the coming year
- Organizations may also choose to integrate other local issues that are of importance to their communities

	Hospital QIP Priority Indicator	OHT c-QIP Mandatory Indicator
Theme 1: Timely and Effective Transitions	1. Percentage of **discharge summaries** sent from hospital to primary care providers within 48 hours of discharge **(New to SHN QIP)**	1. Number of people whose first point of contact for a **mental health and addictions** condition is the emergency department 2. Percentage of inpatient days with an **alternate level of care** designation
Theme 2: Service Excellence	1. Patient experience: Did patients feel they received adequate **information** about their health and their care **at discharge**?	
Theme 3: Safe and Effective Care	1. Proportion of patients **discharged** from hospital for whom **medication reconciliation** is provided 2. Number of **workplace violence incidents** overall	

Guiding Principles of the Quality Improvement Plan

Align indicators with the seven dimensions of quality, and SHN strategy.

All indicators **drive performance** and are tied to a current or planned QI initiative.

Indicators should be **relevant** to the organization, represented by high quality **attainable data** and supported by evidence and best practice.

Indicators must be **driven from experience** surveys, patient and family advisory input patient relations data and/or safety incidents.

Initiatives will drive **local improvement** and support **strategic change**.

SHN 2022/23 QIP Indicator Recommendations

Quality Dimension	Quality Indicator	Current Performance (YTD Jan/Feb 22)	Proposed Target	Recommendation for QIP 22/23
Efficient	Conservable Beds	76	74	**Custom Indicator -** Aligns with Quality and Safety to promote timely discharges and transitions of care, in collaboration with Scarborough OHT c-QIP ALC indicator. New target for 22/23
Timely	Percentage of discharge summaries sent within 48 hours	New indicator	90%	**Priority Indicator-** Ontario Health Priority indicator 22/23
Patient-centered	% MyChart Activations	8% (Mar)	35%	**Priority Indicator-** Aligns with SHN Quality Strategic Direction. Custom indicator for experience with information on discharge and EPIC priority
Safe	Rate of patient harm per 1000 days (moderate)	0.7	0.6	**Custom Indicator-** Aligns with SHN Quality Strategic Direction.
	Number of workplace violence incidents	172	155	**Priority Indicator-** Ontario Health Priority indicator 22/23. New target to decrease by 10%
Effective	Medication Reconciliation on Discharge	78.9% (March 2022)	90%	**Priority Indicator-** Ontario Health Priority indicator 22/23
	Repeat ED Visits for Mental Health	14.9%	13.3%	**Custom Indicator-** Aligns Scarborough OHT c-QIP MH ED visit indicator
Health Equity	# of staff attending education and training sessions on diversity, health equity, and inclusion	New indicator	1000	**Custom Indicator-** Aligns with SHN Culture and Population Health Strategic Directions.

Custom Indicator – Aligns with quality & safety and Scarborough OHT c-QIP ALC indicator

Executive Lead – Dr. A. Lauwers and G. Boatswain

Efficient Care

Goal: To utilize bed resources efficiently and effectively to promote safe and timely discharge and transitions of patient care

Indicator: Conservable Beds

Definition: The number of beds that might be conserved, if the hospital discharge and transition patients within their ELOS from existing levels to benchmark.

YTD (February 2022)	22/23 Proposed Target
76	74

Change Idea	Methods	Process Measures	Lead
Optimize **early discharge planning in EPIC**	• Estimated LOS targets and EDD, updated in rounds and care planning • Implement weekend bullet rounds • Advancing care daily to align with the ELOS through seven day a week modelling • Refresh patient resource guide around discharge planning and what to expect during stay (informing patients of the d/c plan early on) • Strengthening process, and initiatives such as the whiteboard, etc.	• ALC days • Average LOS • % of patients with an ELOS documented	**Nancy Veloso**, Director Medicine. and Transitional Care **Dr. Elaine Yeung**, Chief and Medical Director of Medicine
Build on **ALC Diversion Strategies**	• Early referral to rehab. • Continue to build on admission avoidance • Optimize the EPIC ALC dashboard • Quality Improvement work on admission stream ED patients	• ALC Days • Avg Acute LOS	

Timely Care

Goal: To improve the timeliness of discharge summaries sent to primary care providers

Indicator: Discharge summary sent from hospital to primary care provider within 48 hours of discharge

Definition: The percentage of patients discharged from hospital for which discharge summaries are delivered to their primary care provider within 48 hours of patient's discharge from hospital.

YTD	22/23 Proposed Target
New indicator	90%

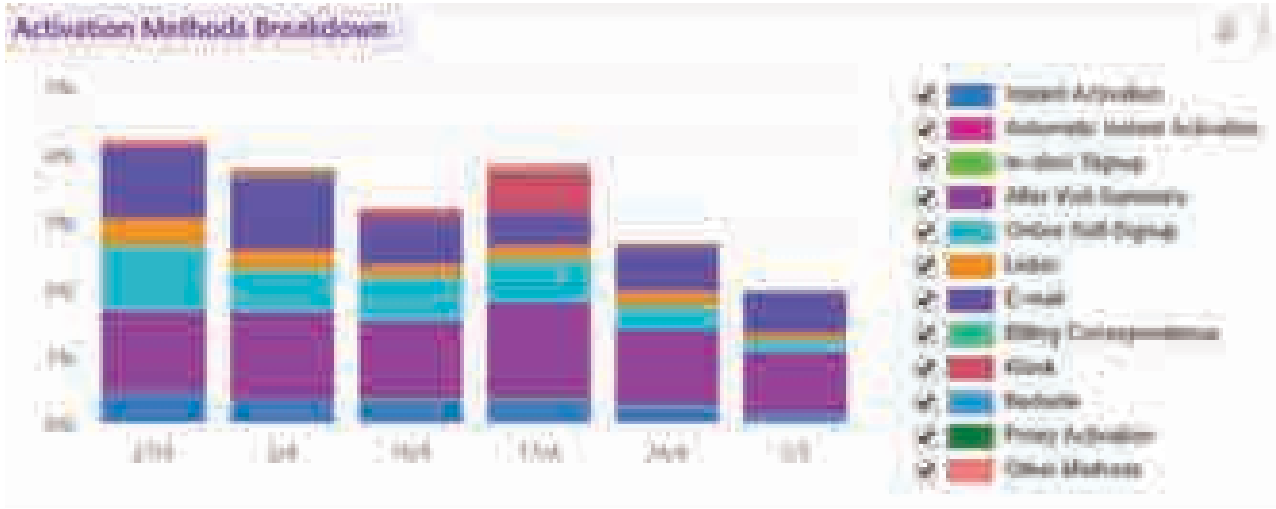
Change Idea	Methods	Process Measures	Lead
Improve the **EPIC workflow for discharge summary** distribution	• Optimize the EPIC Provider dictionary • Update fax numbers for providers in Scarborough Community	• Accurate provider dictionary for all sites	**Andrea Gates,** Director Information Management
Increase the use and adoption of **Health Report Manager (HRM)** for our community providers	• Implement strategies for community providers to adopt HRM • Optimize the reporting by reevaluating the quality of the reports being sent (type, versions). • Improve the workflow and update the distribution algorithm for the routing of reports	• % adoption within Scarborough OHT	**Lauren Rinaldo,** Manager Digital Systems and Innovation, **Dr. Naresh Mohan,** Chief Medical Information Officer

Patient-Centred

Goal: To improve patients' access to their information after hospital encounters

Indicator: % MyChart Activations

Definition: The percentage of patients seen in the 12 months prior to the end of the summary interval that were MyChart active at the end of the summary interval. Includes patients that were seen in a completed face-to-face encounter that were living at the end of the summary interval.



YTD (Mar 22)	22/23 Proposed Target
8%	35%

Change Idea	Methods	Process Measures	Lead
Improve rate of MyChart activations	• Improve process for sign-up and activations using Welcome Kiosks • Improve marketing of MyChart to patients and families • Improve activations during inpatient and outpatient encounters	• Same Day Activation Rate • Improve activations during inpatient and outpatient encounters	**Stephanie Robinson**, Director Quality, Patient Safety and Patient Experience **Andrea Gates,** Director Information Management
Improve rate of After Visit Summaries (AVS) given to patients	• Educate staff to complete After Visit Summaries and provide to patients • Educate patients on benefits of MyChart which can be activated from code on AVS	• Rate of MyChart activation through AVS	**Stephanie Robinson**, Director Quality, Patient Safety and Patient Experience **Dr. Naresh Mohan,** Chief Medical Information Officer

Safe Care

Goal: To reduce harm caused to patients

Indicator: Rate of patient incidents with moderate harm or higher (per 1000 patient days)

Definition: The number of patient incidents related to moderate and severe injuries for Inpatient and Day Surgery as a rate per 1000 patient days (excluding nurseries)

YTD (March 2022)	22/23 Proposed Target
0.68	0.6

Change Idea	Methods	Process Measures	Lead
Enhance a **comprehensive strategy for top Patient Safety areas** (i.e. Falls, Sepsis, Nursing Sensitive Adverse Events, Patients, Medication events).	• Develop a ZERO Harm Strategy • Key programs and committees to identify 2 priority areas for improvement	• # of Adverse events • Rate of patient harm per 1000 patient days	**Stephanie Robinson,** Director Quality, Patient Safety and Patient Experience **Minette MacNeil,** Interprofessional Practice and Allied Health **Dr. Praby Singh,** Medical Director of Quality
Optimize **EPIC to implement quality and safety-related workflows** (i.e. Early Warning Systems (EWS), sepsis) and implementation of order sets based on best-practice guidelines	• Implementation of EWS • Optimize workflows through clinical informatics team	• % of Care Plans utilized • Rate of patient harm per 1000 patient days	

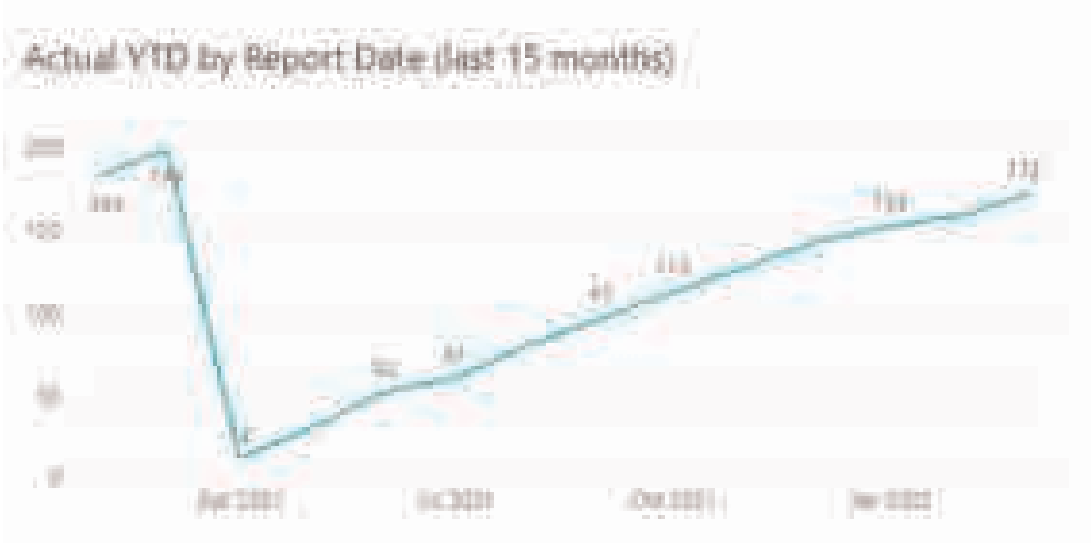
Safe Care

Goal: To reduce harm caused to nurses, staff and physicians

Indicator: Workplace Violence Incidents

Definition: The number of reported workplace violence incidents by hospital workers.

YTD (March 2022)	22/23 Proposed Target
172	155



Change Idea	Methods	Process Measures	Lead
• Optimize EPIC to improve **Flagging and Violence Assessment Tool**	• Improve the utilization of EPIC during optimization phase of implementation • Using an assessment tool, audit and review the charts to identify opportunities for improvement	• Utilization of tool for appropriate patients	**Ann Sideris,** Director Workplace Health and Safety
• Utilize the **cross encounters visibility** of violence risk across the region	• Develop a local working group to understand how workflow can improve visibility of violence risk	• Working group milestone met	**Minette MacNeil,** Interprofessional Practice and Allied Health

Effective Care

Goal: To provide appropriate care for mental health patients

Indicator: Repeat ED Visits for Mental Health patients

Definition: Percent of unscheduled repeat emergency visits following an emergency visit for a mental health condition

YTD (February 2022)	YTD Target
14.9%	13.3%

Change Idea	Methods	Process Measures	Lead
Improve suboxone use and take home naloxone kit distribution for patients presenting with substance use disorder in the Emergency department	• Comprehensive Education plan for stakeholders on SUD treatment and assessment • Standardized Care Pathways - targeted care plans for specific group of patients (inpatient, outpatient, ED), including data analysis of frequent users of ED and use of COWs • Resource re-distribution of services addiction and counselling in the ED	• Revisit rates for Substance Use Disorder • % of staff and physicians trained • % use of care pathways	**Sari Greenwood,** Director Mental Health, Oncology and Palliative Care **Dr. Ilan Fischler,** Chief of Psychiatry and Medical Director Mental Health and Addictions

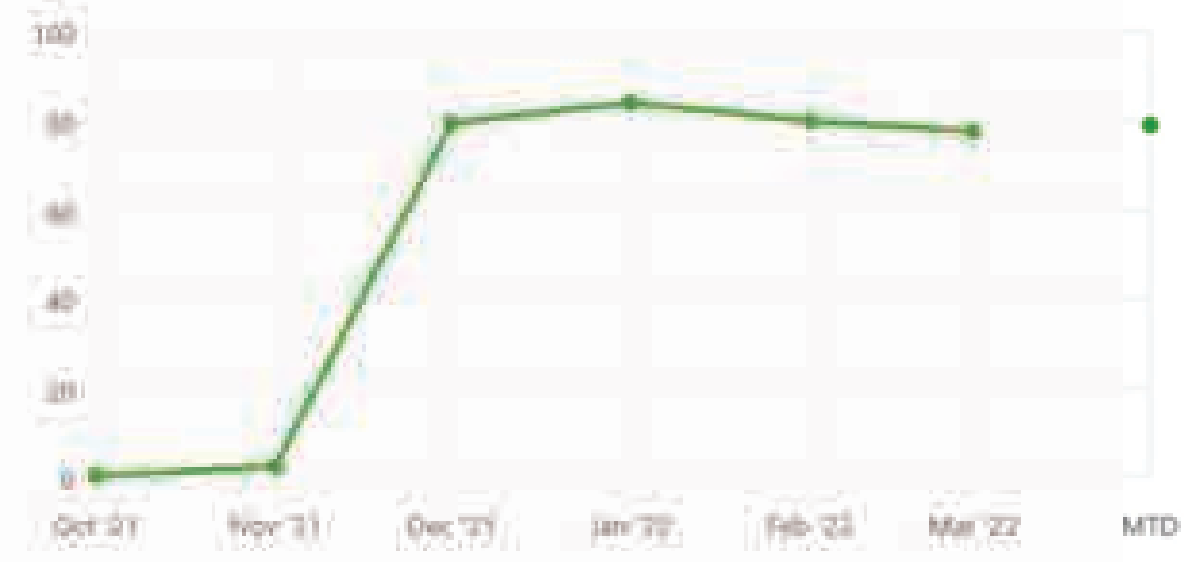
Effective Care

Goal: To enhance medication safety for patients

Indicator: Medication reconciliation at Discharge

Definition: The percentage of BPMH has reviewed, completed and signed by MD based on the total number of audit (Total BPMH reviewed). Numerator (# of completed audit) divided by denominator (total audit)

YTD (Dec - Mar)	YTD Target
78.9%	90%



Note: Data since EPIC go-live in Dec 2021

Change Idea	Methods	Process Measures	Lead
Improve **Pharmacy Transition of Care Metrics** within EPIC	• Real-time data collection • Understand and modify the current EPIC reports • Improving Med Rec on admission rates by conducting a deep dive into patient populations	• Medication reconciliation on admission, transfer and discharge	**Shelley Dorazio** Director Pharmacy Services
Education with physicians to improve medication reconciliation workflow	• Physician education on medication reconciliation workflow from admission to discharge • Targeting particular programs	• % of the physicians educated	

Custom Indicator – Aligns with SHN Strategy

Executive Lead –M. James

Health Equity

Goal: To be the sector leader in the area of Diversity, Equity and Inclusion

Indicator: # of staff attending education/training sessions on diversity, health equity, and inclusion

Definition: Number of staff attending various events, forums, meetings and sessions divided by the total number of staff

YTD	YTD Target
New indicator	250 per quarter (1000 staff)

Change Idea	Methods	Process Measures	Lead
Reduce barriers to optimizing the patient experience for marginalized, racialized and vulnerable populations.	• Education sessions for staff on diversity, health equity, and inclusion	• # of staff attending education and training sessions	**Christa Hruska** Director of Strategy & Transformation