SHN
SCARBOROUGH
HEALTH NETWORK

SHN's 2022/23 Quality Improvement Plan (QIP) Progress Report and 2023/24 QIP Indicators

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2022-23 YTD Q3 QIP Progress Report

Progress of 2022-23 QIP Indicators and Change Ideas

Quality Dimension	Quality Indicator 2022/23	Current Performance YTD	Target	Change Idea	Status of Work
Efficient	Conservable Beds - **Custom Indicator**	80 (January YTD)	74	Optimize early discharge planning in EPIC	Implemented
				Build on ALC Diversion Strategies	Implemented
Timely	Percentage of discharge summaries sent within 48 hours - **Priority Indicator**	89.7% (February YTD)	90%	Improve the EPIC workflow for discharge summary distribution	Implemented
				Increase the use and adoption of Health Report Manager (HRM) for our community providers	*Partially Implemented
Patient centered	% MyChart Activations - **Priority Indicator**	11% (February YTD)	35%	Improve rate of MyChart activations	Implemented
				Improve rate of After Visit Summaries (AVS) given to patients	Not Implemented
Safe	Rate of patient harm per 1000 days (moderate or higher) **- Custom Indicator**	0.7 (February YTD)	0.6 (per 1000 pds)	Enhance a comprehensive strategy for top Patient Safety areas (i.e. Falls, Sepsis, Nursing Sensitive Adverse Events, Patients, Medication events).	Implemented
				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	*Partially Implemented
	Number of workplace violence incidents – **Priority Indicator**	189 (February YTD)	155	Optimize EPIC to improve Flagging and Violence Assessment Tool	Implemented
				Utilize the cross encounters visibility of violence risk across the region	Implemented

* To be implemented through Epic optimization

Status of work | Implemented | Partially Implemented | Not Implemented

Progress of 2022-23 QIP Indicators and Change Ideas

Quality Dimension	Quality Indicator 2022/23	Current Performance (YTD)	Target	Change Idea	Status of Work
Effective	Medication Reconciliation on Discharge – **Priority Indicator**	83.8% (February YTD)	90%	Improve Pharmacy Transition of Care Metrics within EPIC	Implemented
				Education with physicians to improve medication reconciliation workflow	Implemented
	Repeat ED Visits for Mental Health – **Custom Indicator**	15.8% (December YTD)	13.3%	Improve suboxone use and take home naloxone kit distribution for patients presenting with substance use disorder in the Emergency department	Implemented
Health Equity	# of staff attending education and training sessions on diversity, health equity, and inclusion – **Custom Indicator**	1776 (February YTD)	1000	Reduce barriers to optimizing the patient experience for marginalized, racialized and vulnerable populations	Implemented

Status of work | Implemented | Partially Implemented | Not Implemented

2023-24 QIP Indicators

Keep – Aligns with fiscal strategy and Scarborough OHT c-QIP ALC indicator

Executive Lead – G. Boatswain, Dr. E. Yeung

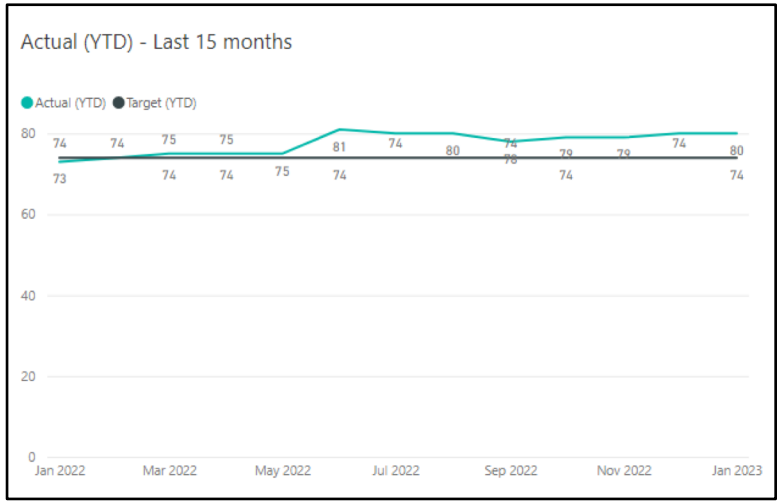
Efficient Care

Goal: To utilize bed resources efficiently and safely for patient care

Indicator: Conservable Beds

Definition: The number of beds that might be conserved, if the hospital decreased the average ALOS from existing levels to benchmark

22/23 YTD	23/24 Target
80 (January)	74



Change Idea	Methods	Process Measures	Lead
Implement **Alternate Level of Care (ALC) Strategies** as outlined in the Scarborough Ontario Health Team (SOHT) Collaborative Quality Improvement Plan (cQIP)	• Methods will be developed by the SOHT ALC working group	• 100% of the cQIP ALC change idea are implemented by the SOHT	**Nancy Veloso** Director of Medicine and Transitional Care **Dr. Bhinder** Medical Director of Medicine and Transitional Care
Optimize discharge planning by utilizing the **Estimated Discharge Date (EDD)** to set a target date for discharge	• Grounding discussions and care planning during bullet rounds around the EDD • Optimize EPIC dashboards to improve visibility of EDD performance • Improve discussion and planning with LTC/RH partners re: resident's EDD	• Percentage of patients with an established EDD	**Fred Go** Associate Vice-President of Clinical Program-Division Augment Surgery **Dr. Bhinder** Medical Director of Medicine and Transitional Care

Data Source: DAD/HBAM Inpatient Grouper (HIG) Expected Length of Stay (ELOS) for Typical Cases

External Collaborator: Scarborough Ontario Health Team

Patient-Centred

Goal: To improve information shared with patients after hospital encounters

Indicator: Did patients feel like they received adequate information about their health and their care at discharge?

Definition: Percent of respondents who responded positively (top 2 box) to "Did you receive enough information from hospital staff about what to do if you were worried about your condition or treatment after you have left the hospital" for inpatient units.

22/23 YTD	23/24 Target
N/A	75%

Change Idea	Methods	Process Measures	Lead
Improve the rate of **MyChart activations**	• Improve process for sign-up and activations using Welcome Kiosks • Improve marketing of MyChart to patients and families • Improve real time activations during inpatient and outpatient encounters	• Rate of activations during inpatient and outpatient encounters with a quarter over quarter increase in performance	**Stephanie Robinson**, Director of Quality, Patient Safety and Patient Experience
Implement **new patient experience platform** (Qualtrics) disseminate results to program as a driver for improvement	• Develop process for monitoring, analyzing and disseminating of results • Established process to ensure completion and sustainability of action plans	• Rate of programs that have received results and developed action plans to improve performance	

Data Source: Qualtrics Patient Experience Surveys

External Collaborator: Central East Region EPIC Hospitals

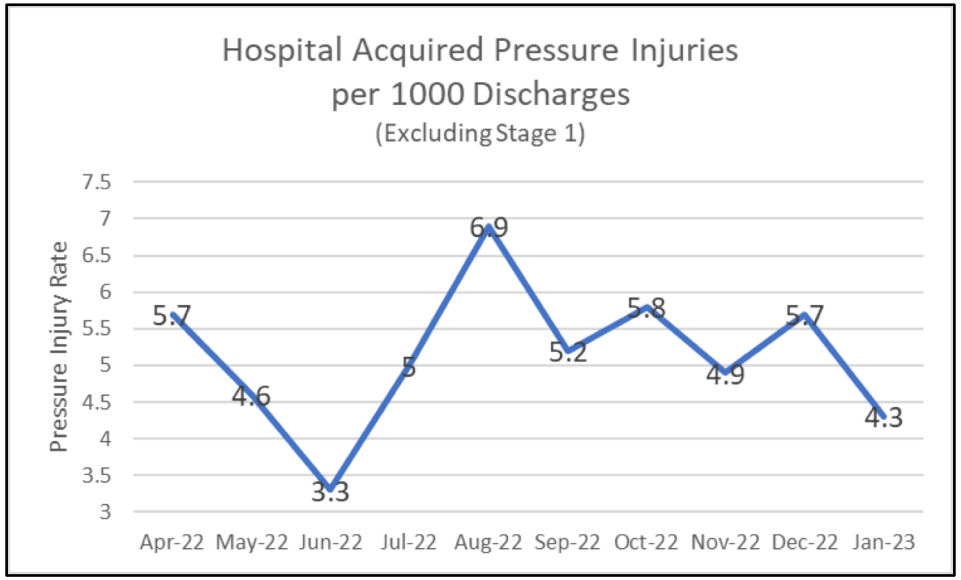
Safe Care

Goal: To reduce harm caused to patients

Indicator: Rate of Hospital Acquired Pressure Ulcers per 1000 discharges

Definition: Numerator: number of pressure injuries (excluding Stage 1) documented in EPIC, not present on admission
Denominator: discharges per month

22/23 Q3 YTD	23/24 Target
5.1 (January)	4.6 per 1000 discharges



Change Idea	Methods	Process Measures	Lead
Implement specific **unit-based action plans** to increase accountability and spread best practices.	• Spread of Pressure Injury Prevention Champions • Implement an skin care bundle including turning initiatives, briefless care, equipment usage and limiting layers.	• Number of champions • % of turning initiatives completed • Quality Check performance rates	**Stephanie Robinson** Director of Quality, Patient Safety and Patient Experience **Minette MacNeil** Interprofessional Practice and Allied Health **Dr. Praby Singh** Medical Director of Quality
Improve the quality of the Hospital Acquired Pressure Injury data though **validation of the EPIC documentation**	• Through chart reviews, validate the data by ensuring that EPIC documentation accurately reflects Hospital Acquired Pressure Injuries Stage 2 and above • Improve care plan implementation after high risk identification	• Improved accuracy of documentation each quarter • % care plans implemented	

Data Source: Hospital Collected Data through EPIC

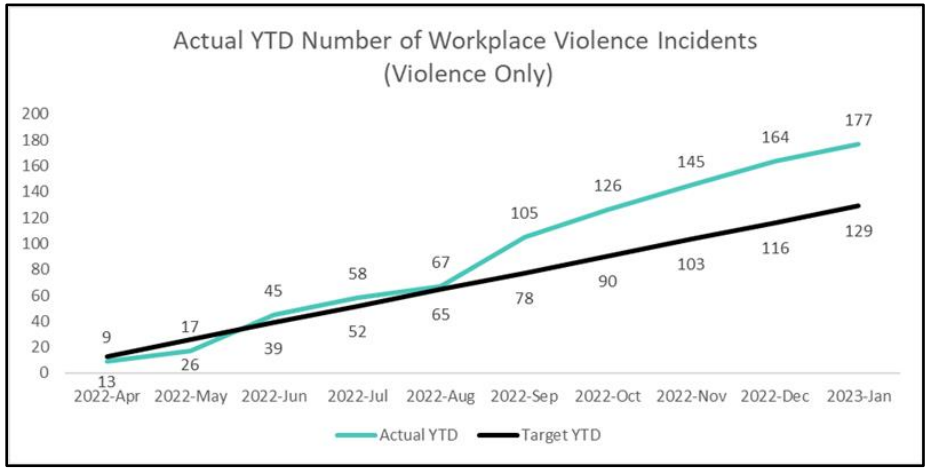
Safe Care

Goal: To reduce harm caused to staff and physicians

Indicator: Workplace Violence Incidents

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

22/23 YTD	23/24 Target
189 (February)	155



Change Idea	Methods	Process Measures	Lead
Number of staff attending **Workplace Violence education sessions**	• Education on WPV and de-escalating strategies through CPI and GPA training • Annual Mandatory education on WPV through iLearn Modules • Engaging the local team through SHN ICARE huddles	• The number of staff attending session and completing the mandatory training increases each quarter	**Ann Sideris,** Director Workplace Health and Safety **Minette MacNeil,** Interprofessional Practice and Allied Health
Completion **Workplace Violence Unit Level Risk Assessments** with action and sustainability plans implemented to mitigate risk	• Determine the nature and type of occurrence of violence anticipated through audits of WPV Risk Assessments • Established process to ensure completion and sustainability of action plans	• 100% of units/departments have completed a WPV risk assessment • 100% of action plans have been implemented	
Conduct a comprehensive analysis of incident trends through a **Quarterly review process**	• Workplace Health and Safety to develop standardized structure for quarterly review process	• Analysis process developed and review is completed on a quarterly basis • Follow-up with programs to develop strategies as required	

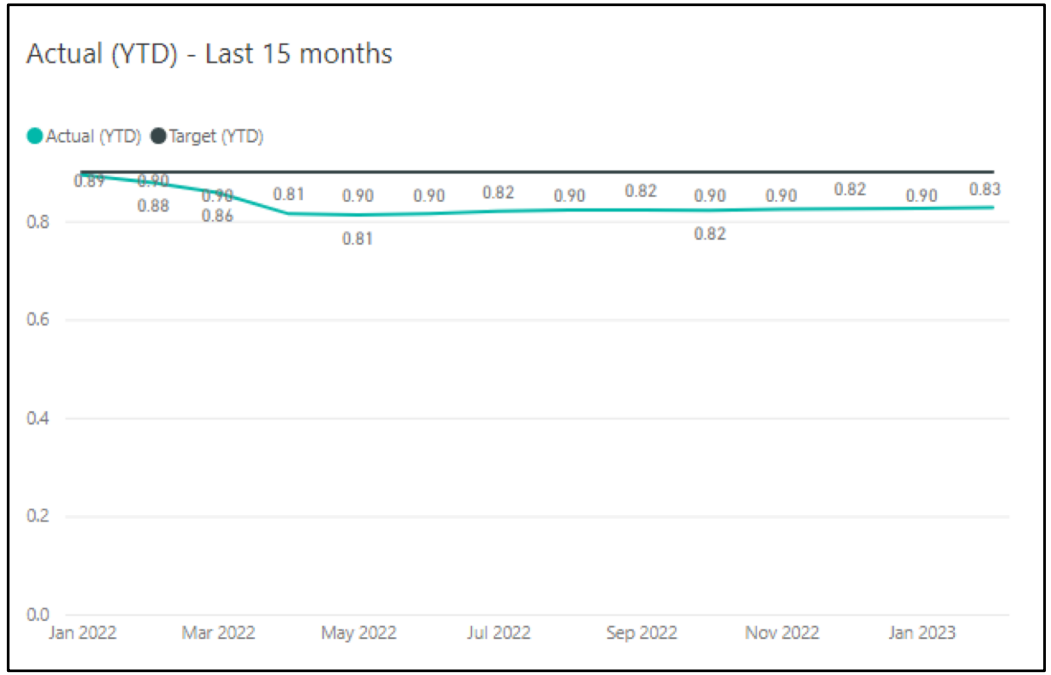
Data Source: Hospital Collected Data

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)



22/23 YTD	2023/24 Target
82.7% (February)	90%

Change Idea	Methods	Process Measures	Lead
Improve **Discharge Medication Reconciliation** data quality within EPIC (Regional Working Group and SHN Monthly Task Force)	• Establish a consensus-across all hospitals • Optimizing the dashboards by data cleaning of the programs that do not typically discharge patients	• EPIC Dashboard review and data cleaning completed • Data more accurately reflects the performance for Discharge Medication Reconciliation	**Swasti Bhajan** Director of Pharmacy Services **Dr. Susan John** Medical Director of Pharmacy
Education of physicians to improve medication reconciliation workflow with a focus on targeted program	• Targeted education on lower performing departments and leverage learnings from higher performers	• The percentage of physicians educated	

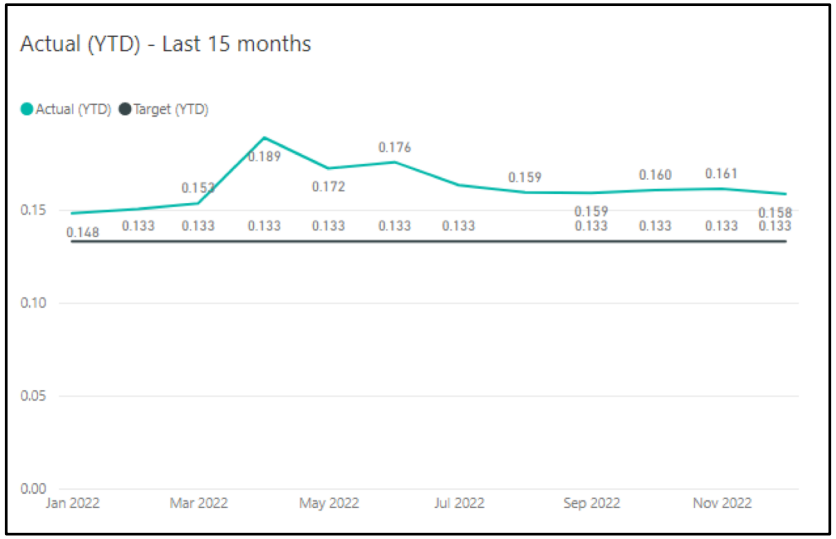
Data Source: Hospital Collected Data through EPIC

Effective Care

Indicator: Repeat ED Visits for Mental Health patients related to substance use

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

22/23 YTD	2023/24 Target
15.8% (December)	13.3%



Change Idea	Methods	Process Measures	Lead
Build real-time EPIC reports for patients returning to the ED within 30-days to mobilize Mental Health and Addictions (MHA) resources during a visit.	• Real time report built in EPIC • Communicate and socialize report with ED physicians and MHA staff. • Standard work to provide resources to patients during visit.	• Reports developed • Utilization report	**Sari Greenwood,** Director Mental Health, Oncology and Palliative Care **Dr. Ilan Fischler,** Chief of Psychiatry and Medical Director Mental Health and Addictions
Individualized Care Plans for patients that have a high number of Emergency Visits for MHA related reasons.	• Retrospective chart reviews every quarter to identify gaps with complex patients and develop care plans to support patients in the community • Education with ED staff on identification of complex patients to support Individualized Care Plans.	% of complex patients with Care plans	
Optimize schedules and align resources for MHA in the ED to meet patient demand.	• Collaborate with University of Toronto 4th year Engineering students to conduct discrete event simulation on ED patients presenting with MHA related diagnoses. • Apply scenarios from “what-if” model to test change ideas and scheduling changes.	• Left without being seen rates	

Data Source: NACRS Emergency Department visit data

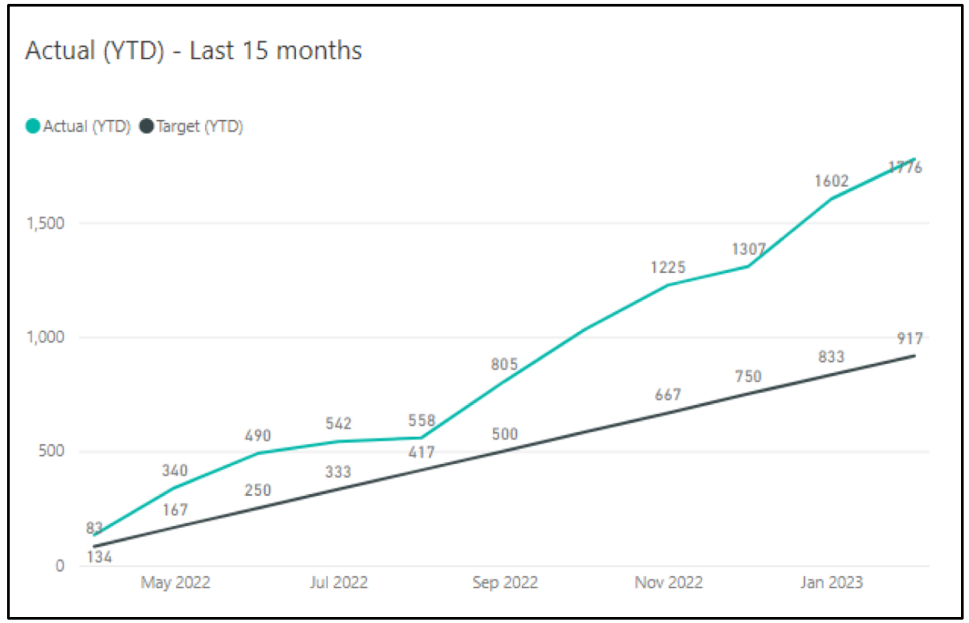
Health Equity

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

22/23 YTD	2023/24 Target
1776 (February)	2500 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	The number of staff that attend: • Stand up for Health - Simulation Exercise (three year commitment) • Net New Health Equity Certificate Program • Lunch and Learns	**Christa Hruska** Director of Health Equity and Health Systems Integration

Data Source: Internal Data

Contact Information

If you would like to learn more about the activities described in the Scarborough Health Network 2023-2024 QIP, please contact Stephanie Robinson, Director of Quality, Patient Safety and Experience at srobinson@shn.ca