2016/17 Quality Improvement Plan
Improvement Targets and Initiatives

Haliburton Highlands Health Services Corporation 7199 Gelert Road Box 115

AIM			Measure								Change				
Quality dimension	**Objective**	**Department / Division**	**Measure/Indicator**	**Unit / Population**	**Source / Period**	**Organization Id**	**Current performance**	**Target**	**Target justification**	**Priority level**	**Planned improvement initiatives (Change Ideas)**	Methods	Process measures	Goal for change ideas	Comments
Effective	**Reduce 30 day readmission rates**	**Acute/ED**	Number of acute hospital inpatients discharged that are readmitted for non-elective patient care within 30 days of discharge	Number of readmissions (within 30 days of discharge) per year / patients discharged from HHHS acute care unit	DAD, CIHI / July 2014 – June 2015	938*	2015/ 2016 = **2.18** patients/ year (based on a projection of 11 month actual) 2014/2015 = **9** patients 2013/2014= **15** patients	8 patients/ year	Target set is slightly less than the average of the actual performance over the past 3 years (average 8.7)	1	Develop improvement strategies to prevent readmissions.	1) Investigate reasons for readmissions. 2) Develop improvement strategies, communicate and perform PDSA (Plan-Do-Act- Study) cycles on initiatives.	1) Collate reasons for readmissions and target improvement initiatives on common reasons.	1) Prevent acute inpatient readmissions.	1) Investigating the reasons for readmissions most likely will be limited to patients readmitted to HHHS.
	Reduce worsening bladder control	**LTC**	Percentage of residents with worsening bladder control during a 90-day period	% / Residents	CCRS, CIHI (eReports) / Q2 FY 2014/15	51154*	Hyland Crest 15% Highland Wood 17%	12%	Benchmark 12%, Provincial average 19.5%.	1	Identify residents who have a continence assessment completed on admission.	Track Electronically via Point Click Care software.	# of continence assessments completed on admission	To improve bladder control for residents.	Continence program is in process of being developed.
	Reduce the inappropriate use of anti-psychotics in LTC	**LTC**	Percentage of residents on antipsychotics without a diagnosis of psychosis	% / Residents	CCRS, CIHI (eReports) / Q2 FY 2014/15	51154*	Hyland Crest 8% Highland Wood 23 %	15%	Improve current combined performance (31%) by 50%	1	Continuing education for staff on the benefits of reducing the use of anti psychotics.	Provide education sessions for staff through Psychogeriatric consultant on the benefits of reducing the use of antipsychotics	Number of staff participating in education sessions	Increase Pharmacist and Physician communications with alternate strategies.	P&T reviewing quarterly with Physicians.

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	Reduce repeat rates for Mental Health and Substance Use Calls to OPP through the use of the Mental Health Response Unit	**MH&A**	Risk-Adjusted 30-Day Mental Health and Substance Use Repeat Call for individuals accessing OPP	% / Mental Health and Substance Use clients accessing OPP	OPP Database / April 2016 - March 2017	938*	32%	20%	New program and new indicator. Target set based on first six months of operation	3	Implement ED CATT Tool .	Establish working group with cross program multi disciplinary representation in order to implement training program.	1) Working group established with cross representation 2) ED CATT completed by 100% of patients.	Improved assessments of MH clients seen by Mental Health Response Unit result in decrease repeat calls	
											Implement safety plan.	Develop and implement safety plan to encompass all community resource referrals such as Four County Crisis.	80% of all patients seen by Mental Health Response Unit will have a safety plan completed.	Increased number of safety plans in place resulting in decrease in Mental Health Response Unit calls	
											Implement follow up appointment from Mental Health Response Unit.	Confirm that follow-up appointment is booked for patient to be seen within one week of Mental Health Response Unit visit.	80% of all patients seen by Mental Health Response Unit will have their follow up appointment booked by clinician	Increased number of follow up calls resulting in fewer repeat calls for Mental Health Response Unit	

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	Reduce ED 30 day return visits for substance use	**MH&A**	Risk-Adjusted 30-Day Substance Use Readmission (repeat visit) Rate for Patients presenting in ED	% / All Substance Use Clients accessing ED	ADT / April 2016 - March 2017	938*	34.78%	23.5%	New indicator. Target set by Mental Health and Addictions Core Action Group	2	Implement discharge safe plan.	Develop and implement discharge safety plan to encompass all community resource referrals such as Four County Crisis.	80% of all patients presented to ED will have a safety plan completed on discharge.	Increased number of safety plans in place resulting in decrease repeat visits to ED	
											Implement follow up appointment from ED.	Confirm that follow-up appointments booked by MH clinic enable patients to be seen within one week of discharge and include patient and family as requested by patient.	80% of all patients discharged from the ED will have their follow up appointment booked prior to discharge.	Increased customer satisfaction resulting in fewer repeat visits to ED	
											Implement Discharge follow up phone calls.	Follow up calls to be completed within one week following discharge from ED.	80% of all patients discharged from the ED will receive a follow-up phone call.	Increased number of follow up calls resulting in fewer repeat visits to ED	
	Reduce 30 day return visit post discharge from mental health	**MH&A**	Risk-Adjusted 30-Day Mental health Readmission (repeat visit) Rate for Patients presenting in ED	% / All Mental Health Clients accessing ED	ADT / April 2016 - March 2017	938*	10.43%	16.7%	New indicator. Target set by Mental Health and Addictions Core Action Group	2	Implement discharge safety plan.	Develop and implement discharge safety plan to encompass all community resource referrals such as Four County Crisis.	80% of all patients presented to ED will have a safety plan completed on discharge.	Increased number of safety plans in place resulting in decrease repeat visits to ED	
											Implement follow up appointment from ED.	Confirm that follow-up appointments booked ensure patients are seen within one week of discharge and include both patient and family as requested by patient.	80% of all patients discharged from the ED will have their follow up appointment booked prior to discharge.	Increased customer satisfaction resulting in fewer repeat visits to ED	

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Efficient / Integrated	**Reduce unnecessary time spent in acute care**	**Acute/ED**	Percentage of ALC inpatient days	% / All acute patients	Ministry of Health Portal / Oct 1, 2013 - Sept 30, 2014	938*	24.66 in 2015/ 2016	20%	Improve last years actual	1	Maintain or reduce ALC days.	Continue daily bullet rounds to address barriers to discharge 2. Early identification and referral to the GAIN team and other Community Support Services as appropriate 3. Promotion of the Home First program with patients, families, and staff 4. Improve discharge communication to families and patients 5. Initiate discharge planning process within first 48 hours of admission.	Occurrence of daily bullet rounds.	Reduce ALC days .	Reducing the number of ALC days will be dependent on available beds in LTC and access to the necessary community services. **Note - target may change, as formula from MOHLTC is changing.
											Improve Access to Care.	Work with CCAC to embrace the home first philosophy 2. Develop process for daily bullet rounds to address barriers to discharge 3. Educate families on supports available in the community.	Number of patients in Home First initiative.	Reduce ALC days .	
	Reduce potentially avoidable emergency department visits	**LTC**	Number of emergency department (ED) visits for modified list of ambulatory care sensitive conditions* (ACSC) per 100 long-term care residents	% / Residents	Ministry of Health Portal / Q3 FY 2013/14 - Q2 FY 2014/15	51154*	14%	8%	reduce current performance by 6%	1	Explore opportunities for ED physician to assess resident in LTC home, as opposed to transporting resident to ED.	Discuss options with ED physicians and LTC Medical Directors.	Increased percentage of residents assessed in LTC .	Increase communication with physicians and registered staff for the guidelines for need to transport to ER.	

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	Improve access to in-home palliative care services	**CSSD**	Percentage of clients who die at home who choose home as preferred location	% / All palliative clients who choose to die at home	Chart Review of Palliative Care Patients on PCCT roster.	938*	new indicator, therefore no baseline	75%	establishing baseline	3	Patient Centred Coordinated Care Planning.	Case conferencing and care plan update for patients with a Palliative Performance Score of less than 40%.	Increased percentage of patients with shared coordinated care plan (multiple HSP's receiving a copy of CCP and participating in creation of plan).	Increase level of care coordination.	The Palliative trajectory is unpredictable but the assumption is that enhanced coordination of services and HSP communication will enable more people to die at home who choose to.
	Improve access to palliative services	**CSSD**	Number of referrals to Palliative Care Community Team	# / Persons eligible for palliative care services	PCCT Data	938*	61 (Q3 YTD)	155	MSAA-established target	1	Early identification and referral to PCCT once palliative or life-limiting illness has been diagnosed.	Process map created with multiple service providers across the continuum.	Number of patients referred with a PPS of greater than 60%.	Increased referrals to PCCT earlier in the palliative trajectory.	
											Integrate Palliative Care Liaison Coordinator (PCCT) in LTC service provision.	Implement a trigger mechanism for LTC patients with a PPS of less than 40%.	Number of patients with a PPS of less than 40% who have been referred to PCCT.	Increased referrals from LTC	
											Increase awareness of PCCT.	Outreach to PCP's serving patients in Haliburton County.	Number of referrals from PCP's.	Increased referrals from Primary Care.	

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	Reduce emergency department visits for persons in the community who are eligible for GAIN program	**CSSD**	Number of referrals to GAIN program	# / persons eligible for GAIN services	GAIN Data	938*	new indicator, therefore no baseline	150	Program newly operational. Regional standards regarding caseload being established.	2	Explore partnership with EMS community paramedicine program for home wellness checks on at-risk frail elderly.	PDSA on 5 clients.	Pre-post 6 month ED visits in patient cohort.	Decrease unnecessary ED visits.	New partnership
											Increase awareness of GAIN.	Increase collaboration with PCP through involvement in collaborative case reviews and outreach at MAC.	Number of referrals from PCP's.	Increased referrals from primary care.	
Equitable	**Improve access to health system for persons in rural community**	**Acute/ED**	Number of Telemedicine consultations/ visits	# / Persons requiring out-of-town medical visits/consultations	Telemedicine database / April 2016-March 2017	938*	Actual for 2015/2016= **2268** (456 medical and 1812 mental health consults)	2,381	5 % increase from 2015/2016 actual consult volume	3	Develop marketing strategies to promote this service and increase patient consultations.	Network with other hospitals to determine marketing strategies and other uses for telemedicine consultations.	Track marketing strategies and investigate feasibility of new consultation services.	Increased consultations/ visits.	
	Improve access to routine health monitoring for persons with CHF/ COPD in rural community	**Acute/ED**	Number of enrolled referrals to Telehomecare program	# / Persons enrolled in Telehomecare program	Telehomecare database / April 2016-March 2017	938*	Program began in Nov./ 2015 with 47 patients enrolled in 4 months.	96	CCAC has oversight of this program. Their goal is for each clinician to accept 8 patients per month.	3	Provide education/ program promotion to MAC.	CCAC Telehomecare Health Lead will attend HHHS MAC in April 2016	Seek feedback from physicians attending MAC in regard to how to increase patient enrolment.	Increased number of patients enrolled in this service	Program continuation is dependent on external funding being continued.
Patient/Resident/Client-centred	**Improve patient/client satisfaction**	**Acute/ED**	Percentage of persons responding positively to: “Overall, how would you rate the care and services you received at the ED?”	% positive responses/ all responses from all emergency department patients	In-house survey / Apr 2016 - Mar 2017	938*	new indicator, therefore no baseline	85%	New indicator; aligning with inpatient satisfaction and benchmark to establish target	3	Improve patient satisfaction.	1) Call patients that have LWBS to address in real time issues that can increase patient satisfaction 2) Review need for outsourced satisfaction survey 3) Ensure all patients are provided with opportunity to provide feedback on their experience.	Evaluate process for DC follow and LWBS calls by March 30, 2016.	80% patient satisfaction, 90% of LWBS called.	

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		Acute/ED	Percentage of persons responding positively to: "Overall, how would you rate the care and services you received at the hospital?" (inpatient)	% / All patients discharged from acute care	In-house survey / Apr 2016 - Mar 2017	938*	98%	98%	Continue with current performance	3	Improved patient satisfaction with care/ experience	1) Provide information on admission to HHHS that discusses the admission and discharge process 2) Call patients that have LWBS to address in real time issues that can increase patient satisfaction 3) Review need for outsourced satisfaction survey 4) Ensure all patients are provided with opportunity to provide feedback on their experience.	Number of calls made to patients post discharge, to ask about satisfaction with care/ experience	Improved patient satisfaction	
		CSSD	Percentage of persons responding positively to: "Overall, how would you rate the care and services you received through the Community Support Services program?"	% / All CSSD Clients	In-house survey / Apr 2016 - Mar 2017	938*	new indicator, therefore no baseline	85%	Aligned with other organization departments; new indicator for this year.	1	1) Improved client satisfaction 2) Would you recommend community support services to others?	Involve technology and paper-based surveys to be conducted on a yearly basis.	Number of surveys completed (via telephone and in person).	Increase in community referrals.	

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	Receiving and utilizing feedback regarding resident experience and quality of life. "Having a voice".	**LTC**	Percentage of residents responding positively to: "What number would you use to rate how well the staff listen to you?" (NHCAHPS)	% / Residents	In-house survey / Apr 2016 - Mar 2017	51154*	new indicator, therefore no baseline	85%	New indicator; aligning with inpatient satisfaction to establish target	1	Add the following questions to the in-house survey "Would you recommend this home to others?" and "I can express my opinion without fear of consequences".	Involve technology and paper-based surveys to be conducted at post-admission and annual care conferences for a quicker response time to resident care related issues. Involve volunteers in survey completion process.	Number of surveys returned.	Involving residents with changes in LTC.	Utilizing volunteers to conduct surveys.
Safe	**Avoid patient/resident falls**	**Acute/ED**	Acute/Emergency: Number of falls per month	number of falls per month	DAD April 1, 2016 - March 31, 2017	938*	2015/2016 Annual projection based on first 3 quarters actual experience = **2.44 falls per month** (29.33 falls/ 12 months) Q1= 8 falls Q2= 11 falls Q3= 3 falls	1.22	50% reduction in falls based on last years actual experience	1	1) Conduct regular hourly rounds. 2) Educate and train staff on fall prevention and strategy initiatives. 3) Designate a "Falls Prevention Champion" to encourage and support staff compliance with fall's prevention program requirements. 4) Develop improvement initiatives in response to reasons for falls.	1) Audit hourly rounds. 2) Develop a competency quiz. 3) Successful appointment of a "Falls Prevention Champion" and offer external education to this person. 4) Develop a falls risk/ prevention ad hoc committee.	1)Percentage of patients with completed fall risk assessment on admission. 2) Regular monitoring of the number of falls. 3) Communicate number of falls to staff and leadership monthly.	1) 100% of patients have risk assessment completed. 2) continued reduction of number of falls.	

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		LTC	LTC: Percentage of resident falls within past 30 days	% / Residents	CCRS, CIHI (eReports) / Q2 FY 2015/16	51154*	31%	14%	Benchmark 9% Provincial average 14.2%	1	1) Conduct regular hourly rounds. 2) Educate and train staff on fall prevention and strategy initiatives. 3) Designate a "Falls Prevention Champion" to encourage and support staff compliance with fall's prevention program requirements. 4)Develop improvement initiatives in response to reasons for falls.	1) Track electronically via Point Click Care Software. 2) Develop a competency quiz. 3) Successful appointment of a "Falls Prevention Champion" and offer external education to this person. 4) Develop a falls risk/ prevention ad hoc committee.	1) # completed falls risk assessments on new admissions . 2) Regular monitoring of the number of falls. 3) Communicate number of falls to staff and leadership monthly.	Post fall physio assessment. Quarterly falls risk assessments or with any change in condition.	
	Reduce incidence of new pressure ulcers	Acute/ED	Number of patients per month with a hospital acquired pressure ulcer	% / All admitted patients	DAD April 1, 2016 - March 31, 2017	938*	new indicator, therefore no baseline	0	New indicator; based on historical trend; best practice; zero tolerance	1	1) Provide inservice/ update to all FT/ RPT staff on completion of the Braden scale on admission and weekly thereafter. 2) Begin developing policies and procedures that follow the Best Practice Guidelines for wound management from RNAO.	1) FT and RPT staff to complete a competency quiz.	Percentage of patients with completed Braden scale on admission.	100% of patients have risk assessment completed.	
	Reduce worsening of pressure ulcers	LTC	Percentage of residents who had a pressure ulcer that recently got worse	% / Residents	CCRS, CIHI (eReports) / Q2 FY 2014/15	51154*	Hyland Crest 16% & Highland wood 6% (using Q3 data)	3%	Benchmark 1%, Provincial average 3%	1	Evaluate the percentage of Braden scale completed on admission.	Track electronically via Point Click Care Software .	# of Braden scales completed within 24 hours of admission divided by the number of admissions in a month.	Increasing staff and physio awareness of equipment we have available to aid; i.e. air beds.	

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	Increase proportion of patients receiving medication reconciliation upon admission	**Acute/ED**	Percentage of patients with medications reconciled on admission	% / All patients	Hospital collected data / most recent quarter available	938*	86.80%	86.80%	Continue with current performance.	1	1) BPMH on all admitted patients. 2) Identify current state of medication reconciliation on admission. 3) Articulate the expected practice and formalize the same in policy and procedure format.	1) Improve accuracy and process related to collection of the best possible medication history 2) All patients admitted to acute care will have a BPMH completed 3) Implement Computerized Medication Administration Records (CMARs) 4) Revise process for tracking medication reconciliation for every admitted patient.	Health Records department to track med rec completion at time of coding.	85% med rec at admission.	
	Increase proportion of patients receiving medication reconciliation upon discharge	**Acute/ED**	Percentage of discharged patients for whom a Best Possible Medication Discharge Plan was created prior to discharge from hospital	% / All patients	Hospital collected data / Most recent quarter available	938*	46.10%	75%	Improve current performance by 30%	1	1) Identify current state of medication reconciliation on discharge. 2) Articulate the expected practice and formalize the same in policy and procedure format.	1) Improve accuracy related to collection of the best possible medication history 2) Establish a process to assess quality and accuracy of reconciliation at discharge 3) Develop discharge med rec prescription (will be done as part of upgrade to MedSelect system and CMAR implementation).	Health Records department to track med rec completion at time of coding.	75% of patients to have med rec at discharge.	

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	Reduce hospital acquired infection rates	**Acute/ED**	Hospital-acquired C-Difficile infection (CDI) rate per 1,000 patient days	Rate per 1,000 patient days / All patients	Publicly Reported, MOH / Jan 1, 2014 - Dec 31, 2014	938*	0	0	Best practice; zero tolerance	1	Maintain target of zero cases of CDI.	1) Continue to monitor patients and follow IPAC standards 2) Continue with sporicidal cleaning and best practice for environmental cleaning 3) Continue linkages with RMH for antimicrobial stewardship.	Audit quarterly via IPAC data.	Zero tolerance.	
		All departments/divisions	Incidence of hand hygiene performance prior to initial patient/resident contact	% / Health providers in the entire facility	Publicly Reported, MOH / Jan 1, 2014 - Dec, 31, 2014	938*	80%	85%	Improve past compliance rate by 5%	1	Increase percentage of hand hygiene.	1) Review with staff and physicians the 4 moments of hand hygiene 2) Increase availability of hand hygiene stations across the organization 3) increase audits of hand hygiene compliance to monthly.	Audit for compliance.	80% compliance of the 1st moment of hand hygiene.	
	To Reduce the Use of Restraints	**LTC**	Percentage of residents who were physically restrained (daily)	% / Residents	CCRS, CIHI (eReports) / Q2 FY 2014/15	51154*	Hyland Crest 14% & Highland wood 7% (using Q3 data)	10%	decrease current combined performance by 5%	1	Restraint or PASD assessments completed for EVERY resident utilizing restraints.	Restraint or PASD assessment completed.	Monthly audit of restraint/PASD assessment/ documentation.	Increasing awareness to have restraints reassessed and reviewed with changes in condition, as well as education to families. i.e. restraints will not prevent a fall.	
	Foster healthy work environment	**All departments/divisions**	Percentage of staff and volunteers at HHHS who receive the Flu Shot (excludes medically exempt staff and volunteers)	% / All HHHS staff and volunteers	Hospital collected data / Sept 2015 to Jan 2016	938*	70%	75%	Improve current performance by 5%	1	Increase compliance of staff obtaining flu vaccine.	1) Offer in house flu clinics 2) Implement and provide education on revised policy for staff declining flu shot 3) Develop policy for Tamiflu.	Compliance report for percentage of staff who have received vaccine.	70% by Dec 31, 2016.	

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		All departments/divisions	Percentage of staff who provide positive responses to Pulse survey by rating excellent, very good, good to the question: "Overall, how would you rate the organization as a place to work?"	% / All HHHS staff	Pulse survey / 2016-17	938*	79.90%	85%	Improve employee satisfaction by 5%	2	Improve employee satisfaction.	Engage staff in working groups and in decision making.	Percentage of positive responses to the Pulse Survey.	Improve employee engagement to increase satisfaction.	
			Sick time rate	%/ full time HHHS employees	Payroll/HR reports / April 2016-March 2017	938*	2014/2015 12.9 2013/2014 22.28 2012/2013 18.12	10.5	CE LHIN Average for 2014/15 is 10.5 sick days/ full-time employee each year.	2	1) Continue with implementation of ASP. 2) Implement a Healthy Workplace Strategy.	1) Track and follow ASP program on a quarterly basis. 2) Establish a Healthy Workplace working group.	# of Sick days/ full-time employee.	Decrease sick time of employees.	
Timely	**Reduce wait times in the ED**	**Acute/ED**	ED Wait times: 90th percentile ED length of stay for Admitted patients	Hours / ED patients	CCO iPort Access / Jan 1, 2014 - Dec 31, 2014	938*	27 in 2015/ 2016	24	Improve last years actual	1	Improved flow for admission.	1) Track trends 2) Problem-solve daily based on trends 3) Refine process for repatriations 4) Complete a review of the admission process using a value stream map to address non value added items .	Track DART.	Reduce ER LOS.	
											Improve patient flow.	1) Develop policy for surge 2) Develop visual management board for ED 3) Refresh daily bullet rounds to address barriers for discharge 4) Revisit Home First program 5) Identify opportunities for collaboration with Community Support Services to help expedite discharges.	Track DART, compliance of daily bullet rounds, use of surge policy.	100% compliance of bullet rounds Use of surge policy.	