2019/20 Quality Improvement Plan
"Improvement Targets and Initiatives"

AIM		Measure									Change				
Issue	Quality dimension	Measure/ Indicator	Type	Unit / Population	Source / Period	Organization Id	Current performance	Target	Target justification	External Collaborators	Planned improvement initiatives (Change Ideas)	Methods	Process measures	Target for process measure	Comments
M = Mandatory (all cells must be completed) P = Priority (complete ONLY the comments cell if you are not working on this indicator) C = custom (add any other indicators you are working on)															
Theme I: Timely and Efficient Transitions	**Efficient**	Average number of inpatients receiving care in unconventional spaces or ER stretchers per day within a given time period.	P	Count / All patients	Daily BCS / October - December 2018	941*	13.18	0.00	High reliability target		1)Maintain current performance of 0 inpatients receiving care in unconventional spaces	Leverage Command Centre Generation 2 and iPLAN to track patients	Percentage of inpatients being tracked on iPLAN	100% of inpatients being tracked on iPLAN	
		Total number of alternate level of care (ALC) days contributed by ALC patients within the specific reporting month/quarter using near-real time acute and post-acute ALC information and monthly bed census data	P	Rate per 100 inpatient days / All inpatients	WTIS, CCO, BCS, MOHLTC / July - September 2018	941*	10.2	12.70	As determined by the Central Local Health Integration Network HRH 2018/19 Target was 14.6%	North York General Hospital, Mackenzie Health, Markham Stouffville Hospital	1)Continue to build capacity by using iPlan and the CLHIN's discharge planning pathway as tools for ALC management.	Leverage iPlan and the CLHIN's discharge planning pathway.	Tracking of patients through iPlan.	100% of ALC patients to be tracked through iPlan.	To sustain system improvement
	Timely	Percentage of patients discharged from hospital for which discharge summaries are delivered to primary care provider within 48 hours of patient's discharge from hospital.	P	% / Discharged patients	Hospital collected data / Most recent 3 month period	941*	78	80.00	Health Records Committee setting target and collecting baseline, 2% improvement		1)Develop and implement hospital policy mandating discharge summaries to be delivered to primary care providers within 48 hours of discharge	Develop and implement corporate policy	Policy created and implemented	100% of physicians made aware of corporate policy	
											2)Create a dashboard to track the delivery of discharge summaries	Information Services & Telecommunications and Health Information Records to create dashboard	Percentage of patients whose discharge summaries were delivered to their primary care provider within 48 hours of discharge	80% of discharged patients had discharge summaries sent to their primary care provider within 48 hours of discharge	

		The time interval between the Disposition Date/Time (as determined by the main service provider) and the Date/Time Patient Left Emergency Department (ED) for admission to an inpatient bed or operating room.	**M A N D A T O R Y**	**Hours / All patients**	**CIHI NACRS / October 2018 – December 2018**	**941***	**12.28**	**10.00**	**As determined by the Pay for Results (P4R) Wait Time Target. HRH aims to sustain a 10-hour 90P time to inpatient bed**		**1)Develop close to real-time tracking of admitted patients in the ED waiting for an inpatient bed**	**Utilize Command Centre to identify bottlenecks and leverage Patient Flow Managers (PFMs) to facilitate flow throughout the hospital**	**Utilize Command Centre data**	**10-hour 90th percentile time to inpatient bed**	
Theme II: Service Excellence	**Patient-centred**	Percentage of complaints acknowledged to the individual who made a complaint within five business days	P	% / All patients	Local data collection / Most recent 12 month period	941*	88.97	91.00	HRH 2018/19 Target was 80%. FY2019/20 is 91% a 2% improvement.		1)Streamline HRH review process of patient complaints	Optimize patient relation resources	Automate intake process	100% of email complaints acknowledged within 24 hours	
		Percentage of respondents who responded positively to the following question: Did you receive enough information from hospital staff about what to do if you were worried about your condition or treatment after you left the hospital?	P	% / Survey respondents	CIHI CPES / Most recent consecutive 12-month period	941*	51.49	57.50	NRC Health provincial target is 57.5%		1)Monitor distribution of SMART discharge packages on inpatient units	Create electronic reporting tool to audit utilization	Percentage of inpatients receiving SMART discharge packages	100% of inpatients receiving SMART discharge packages	
Theme III: Safe and Effective Care	**Effective**	Medication reconciliation at discharge: Total number of discharged patients for whom a Best Possible Medication Discharge Plan was created as a proportion the total number of patients discharged.	P	Rate per total number of discharged patients / Discharged patients	Hospital collected data / October - December 2018	941*	77.87	81.00	Identified by MedRec Steering Committee		1)Enhance physician adoption of the medication reconciliation process	Inpatient physician training on the medication reconciliation process	Percentage of inpatient physicians that have received training on the medication reconciliation process	85% of inpatient physicians received training on the medication reconciliation process	
											2)Medication Reconciliation Steering Committee to review potential opportunities of incorporating clinical pharmacists in the workflow of medication reconciliation on discharge	Current-state workflow assessments to identify process changes for clinical pharmacists	Percentage of clinical pharmacists supporting medication reconciliation on discharge	Formative exercise to determine target	

	Proportion of hospitalizations where patients with a progressive, life-threatening illness have their palliative care needs identified early through a comprehensive and holistic assessment.	P	Proportion / at-risk cohort	Local data collection / Most recent 6 month period	941*	1	1.00	Sustain 100 percent		1)Monitor number of palliative care patients who receive an initial assessment	Create an electronic report to track total number of palliative care patients receiving a comprehensive assessment	Percentage of palliative care patients receiving a comprehensive assessment	100% of palliative care patients receive a comprehensive assessment	
	Rate of mental health or addiction episodes of care that are followed within 30 days by another mental health and addiction admission.	P	Rate per 100 discharges / Discharged patients with mental health & addiction	CIHI DAD,CIHI OHMRS,MOHTLC RPDB / January - December 2017	941*	14.23	11.00	Provincial average (Jan 1 to Dec 31, 2017). Sustain target of 11%.	Cota, Addiction Services for York Region (ASYR), York University, Griffin Centre	1)Enhance and strengthen collaboration efforts with select community partners (e.g., ARCs and RAAM)	Conduct deep dives to assess clinical effectiveness and utilization with ARCs and RAAM	Number of deep dives conducted with ARCs and RAAM	1 deep dive conducted with ARCS and RAAM	
Safe	**Number of workplace violence incidents reported by hospital workers (as by defined by OHSA) within a 12 month period.**	**MANDATORY**	**Count / Worker**	**Local data collection / January - December 2018**	**941***	**110**	**118.00**	**2% reduction from FY2018/19 Target (n=120)**		**1)Increase workplace violence prevention awareness among HRH staff**	**1) Utilize consistent signage at RCC sites in consultation with other partner hospitals 2) Flag potentially violent patients in outpatient areas 3) Provide Code White Simulation training as part of general orientation for new staff**	**1) Percentage of signage standardized across RCC 2) Percentage of identified violent patients flagged 3) Percentage of new staff who attend general orientation**	**1) 100% of displayed signage complying with standardized HRH signage 2) 100% of identified violent patient flagged 3) 100% of new staff attending general orientation**	**FTE=3155**
										2)Increase safety measures across HRH	1) Improve collaboration with the police (Police Liason Committee) 2) Implement plans to roll out Code Silver Drill for the hospital 3) Roll out "Active Attack Simulation" to a broader group of management/staff	1) Number of collaborative projects with police identified 2) Code Silver Drill action plan created 3) Active Attack Simulation roll out plan identified	1) At least 1 collaborative project with police identified 2) Code Silver Drill action plan executed 3) Active Attack Simulation plan executed	