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

Joseph Brant Hospital 1245 Lakeshore Road

JOSEPH BRANT HOSPITAL

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 BRIEF DESCRIPTION OF WHAT YOU ARE GOING TO DO	Process measures EVIDENCE THAT YOU ARE DOING WHAT YOU SAID YOU WOULD DO	Target for process measure WHAT, OR HOW MUCH, BY WHEN?	Comments	In a collaboration with external partner? If Yes, indicate the organizations	Is this indicator included in your executive compensation? Y/N
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	**Timely**	Discharge summary sent from hospital to community care provider within 48 hours of discharge.	P	Percentage	Local data collection / Most recent 3-month period.	718*	91.5%	91.5%	Maintain baseline period performance.	N/A	Maintain daily system of monitoring and reminders for discharge summaries.	Manual review of discharges by Health Records to capture and understand exceptions. Physician reminders issued by email when Discharge Summary is not present. Monthly summary of compliance and exceptions provided to physician chiefs of service.	Monitoring process in place. Reminder process in place. Exception summaries provided to physician chiefs. Reporting on JBH Strategic Scorecard as a True North Metric.	By Q4 2020-21: Exception reports reviewed regularly, and acted upon as necessary, at Health Records Committee, physician department meetings. Compliance monitored as part of regular JBH Strategic Scorecard reviews.	Leads: Director of Health Information Services; Physician Chair of Health Records Committee		
		The (90th percentile) 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.	MANDATORY	Hours / All patients	CIHI NACRS Q3 FY 2019/20	718*	24.1 hours	24.1 hours	Maintain baseline period performance.	N/A	Sustain impact of JBH Medicine Model of Care and Medicine Acute Patient Care Optimization Initiatives.	Reinforce and sustain uptake of changes initiated as per JBH Medicine Model of Care and Medicine Acute Patient Care Optimization Kaizen to realize additional gains in ED LOS and its drivers (inpatient LOS): Interim ED Order Sets; estimated discharge date, documented treatment plan, and conversation with Patient/Family within 24 hours admission.	Process audit report-outs as regular agenda items at Emergency and Medicine Program Quality meetings, and Emergency and Medicine Department meetings. - Timely completion and execution of admission order sets in ED; - Documented admission note with estimated discharge date, treatment plan, and conversation with Patient/Family within 24 hours admission.	By Q4 2020-21: Process audit report-outs as regular agenda items at Emergency and Medicine Program Quality meetings, and Emergency and Medicine Department meetings.	Leads: EVP PCS & CNE; Chief of Staff; Director of Emergency; Chief of Emergency; Director of Medicine; Chief of Medicine		Y
	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 2019	718*	N/A	Baseline Data Collection	Maintain baseline period performance.	N/A	Sustain impact of Transfer to Post Acute Initiative	Reinforce and sustain uptake of process designed to efficiently transfer patient from acute care beds to post-acute beds when clinically indicated.	Process audit report-outs as regular agenda items at Medicine, Surgery and post-acute program Quality and physician department meetings.	By Q4 2020-21: Process audit report-outs as regular agenda items at Medicine, Surgery and post-acute programs Quality and physician department meetings.	Leads: Director of Medicine; Director of Surgery; Director(s) of Post Acute.		Y
		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 Q2 FY 2019/20	718*	17.23%	17.23%	Maintain baseline period performance.	HNHB LHIN Home and Community	1. Continue JBH-LHIN H&C Early Engagement Partnership for complex discharges. 2. Continued Implementation of Remote Monitoring Technology Initiative.	1. Reinforce consistent Early Engagement discharge planning conversations by JBH and LHIN H&C partners with Patients/Families flagged as complex discharges. 2. Screening for appropriate identification of, and engagement of, appropriate patients for Remote Monitoring.	1. Process audit report-outs to reinforce consistent Early Engagement discharge planning conversations by JBH and LHIN H&C partners with Patients/Families flagged as complex discharges. 2. Process audit report-outs on identification of appropriate candidates and uptake of Remote Monitoring.	By Q4 2020-21: 1. Process audit report-outs as regular agenda items at JBH program Quality meetings to reinforce consistent Early Engagement discharge planning conversations by JBH and LHIN H&C partners with Patients/Families flagged as complex discharges. 2. Process audit report-outs on identification of appropriate candidates and uptake of Remote Monitoring as regular agenda items at JBH program Quality meetings.	Leads: EVP PCS & CNE; Director of ED; Director of Medicine; Director of Surgery.	Home and Community Care Support Services	

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Theme II: Service Excellence	**Patient-centred**	Percentage of complaints	P	% / All patients	Local data collection / Most recent 12	718*	100.0%	100%	Maintain baseline period performance.	N/A	Monitor and maintain timeliness	Monitor and maintain timeliness	Implementation of upgraded	By Q4 2020-21: Upgraded	EVP PCS & CNE; Chief of Staff;		**Y**
		Percentage of respondents who responded with "**top box**" positive score to the following question: Did you	P	% / Survey respondents	CIHI CPES Most recent consecutive 12-month period (Dec 2018 to Nov 2019)	718*	57.3%	57.3%	Maintain baseline period performance.	N/A	Replace CoHealth smart phone app with a process that provides discharge and care follow-up information to	Identify and test a replacement process for CoHealth.	Identification and testing of process that provides discharge and care follow-up information to	By Q4 2020-21: A replacement process for CoHealth will be identified and tested.	Leads: Chief of Staff; EVP PCS & CNE; Director of Patient Experience		**Y**
Theme III: Safe and Effective care	**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 2019	718*	Year 2 baseline	Year 3 baseline	67 incidents reported between Jan 1 2019 and Dec 31 2019. JBH to continue to establish a baseline and work plan for the Workplace Violence QIP indicator in 2020-21. Improvements to JBH stakeholder awareness, and the consistency of WPV incident reporting, are expected to result in increased awareness and confidence in reporting.	N/A	Continued focus on the importance of reporting all incidents of violence through improvements made when awareness of incidents is brought to the attention of management.	Continued education and increased emphasis on corrective actions and updates to WPV policies. Frontline managers are invited to WVP Committee meetings to share their experiences and learnings.	Education activities and WPV incident data will be reported to HRPCC, JHSC and Workplace Violence Prevention Committee.	WVP Incident Data is reported to the HRPCC, JHSC and WVP Committee. Union members participate in the committees and assist with risk assessments. An appeals process for patient flagging has been established and tested through patient and WVP team interactions. Improvement efforts and reporting will continue throughout 2020 - 2021.	Lead: Chief Human Resources Officer		
	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	October 2019– December 2019 (Q3 2019/20)	718*	77.2%	77.2%	Sustain improvement while investigating alternatives to current software (to be sun-setted by vendor in December 2020).	N/A	Continue to monitor compliance and provide feedback to sustain improvement while investigating new software options.	Monitor and reinforce completion of medication reconciliation through education, data collection and feedback.	Medication reconciliation compliance regularly reported to leadership and shared at individual program quality committees.	By Q4 2020-21, Medication reconciliation compliance regularly reported to leadership and shared at physician department meetings. Compliance monitored as part of regular JBH Strategic Scorecard reviews.	Lead: Director of Pharmacy; Physician Chair of Medication Safety Committee		
		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	718*	N/A	Baseline Data Collection	Baseline data collection and analysis to further establish a baseline and to develop improvement approach.	N/A	Baseline data collection and analysis to further establish a baseline and to develop improvement approach.	Continue chart audits to further establish a baseline and to inform development of improvement approach.	Sustainable data collection approach implemented. Improvement to early identification identified and tested. Regular report-out to program quality committee on results of improvements.	By Q4 2020-21: - sustainable data collection approach implemented. - improvement to early identification identified and tested. - regular report-out to program Quality committee on results of improvements.	Leads: Director of Palliative Care; Chief of Family Medicine		
		Percent of unscheduled repeat emergency visits following an emergency visit for a mental health condition.	P	Percentage	Q1 FY 2019/20 (Mar-Apr-May Indexes)	718*	21.05%	21.1%	Maintain baseline period performance.	N/A	Data collection and analysis to better understand current performance and inform improvement initiatives.	Audit clinical record of individuals with three or more unscheduled repeat emergency visits per month for a mental health &/or addiction condition. Identify care partners and facilitate coordinated care planning. Other improvement initiatives as per results of analysis.	Completion of initial data collection and analysis, and audits of charts meeting 'number of visits' threshold. Initiation of coordinated care planning sessions. Review and discussion of results at program quality committee.	By Q4 2020-21: Complete initial data collection and analysis, and audits of charts meeting 'number of visits' threshold. Results reviewed and discussed at program quality committee. Coordinated care planning sessions and have been initiated. Results reviewed and discussed at program quality committee.	Leads: Director of Mental Health & Addictions; Chief of Psychiatry and Medical Director of Mental Health & Addictions		