Let's Make Healthy Change Happen.

Quality Improvement Plan (QIP) Narrative for Health Care Organizations in Ontario

March 15, 2017

SOUTHLAKE REGIONAL HEALTH CENTRE

Overview

This is an open communication to the Patients and Families in our community who we exist to serve in keeping with our philosophy to create the Ultimate Hospital Experience. Our intent is to share our Quality Improvement Plan (QIP) in an open and transparent declaration of our pursuit of Quality. Thank you for taking the time to find and read our QIP. Every year we create a new plan and post it publically which is a part of our commitment to you. At Southlake Regional Health Centre (Southlake), we are committed to continuously improving the quality and safety of the care we deliver to Our Patients and the work environment we provide to Our People—staff, physicians and volunteers. Our QIP is an important element in our commitment to deliver *Shockingly Excellent Experiences* and our ability to achieve quality outcomes and create value in Healthcare. The QIP provides the basis for our Corporate Quality Scorecard and every QIP indicator is included there. In addition, each of our programs has developed or is in the process of developing, program scorecards whereby QIP elements for which they have an impact are included and monitored on a regular basis. We have also developed Corporate Scorecards for Our People and Our Financial Health and relevant indicators from the QIP are included within these corporate scorecards. Together, the results of the three corporate scorecards are fully analyzed and discussed at minimum, quarterly, at all of our Leadership and Board Committees and each of us is held accountable to achieve the QIP outcomes through our personal Management Performance Plan process. In addition to regular reporting, and in order to ensure that all of Our People have access to the most up to date information in real time, we rely on our Business Intelligence System. With this system, our staff has the ability to drill down into each report card element to monitor portfolio or unit-level real time performance against our goals. At Southlake, we embrace our responsibility to ensure that each of us is aware of and actively pursuing our priorities.

Southlake will continue to work with its partners in the Joint Centres for Transformative Health Care Innovation (Joint Centres). The Joint Centres is a unique partnership between six large community hospitals comprising of Mackenzie Health, Markham Stouffville Hospital, Michael Garron Hospital, North York General Hospital, Southlake Regional Health Centre and St. Joseph's Health Centre. The inclusion of the work of the Joint Centres in our QIP is intended to reinforce our commitment to improvement through collaboration and to leveraging the knowledge, expertise and experience of our partners to maximize the benefits across all of our hospitals.

The member hospitals will continue to work together on a number of spread initiatives designed to improve quality, safety and value in healthcare including: reducing the rate of Clostridium *difficile* associated infections, reducing the percentage of Caesarean Sections performed and reducing unnecessary tests through Choosing Wisely which received *Adopting Research to Improve Care* (ARTIC) Program funding through Health Quality Ontario (HQO) and the Council of Academic Hospitals of Ontario (CAHO) to further advance the spread of leading practices across the participating hospitals and affiliated primary care practices. In addition, all six hospitals are sharing leading practices for adaptation for the prevention of workplace violence**.** This work includes creating a common approach to identification, assessment and care planning for patients at risk for violent behavior. For 2017-18, an additional area of focus for the Joint Centres will be on reduction of harm through an applied learning approach.

We are proud of the work we do, and we know that we can always do better. We would like to invite you to tell us about your experience with us, good or bad. Please share your thoughts on where we can improve and challenge us to do better because your voice is essential to our ongoing journey. As we encourage Our People to speak up, so do we encourage you to speak up, and we commit to listening up and thanking you for taking the time to help us.

For the 2017/18 QIP, Southlake will focus our time and energy to achieving the following objectives:

A. Reduce the rate of hospital acquired Clostridium Difficile Associated Infection (CDI) by 21 percent

(*Decrease from 0.28 to 0.22 per 1000 patient days*).

As a community member who uses our services, you may not know about CDI and the importance of preventing this illness. We want you to be as safe as possible and to know that Hospital acquired CDI is caused by many different variables, and is not always preventable, but there are some steps we can take to decrease CDI at your hospital. To you, the patient, this decrease that we are targeting would mean that 8 less patients acquire CDI at Southlake this year. Please click on this link to learn more about CDI and what we can do together to keep you safe. The reduction of CDI is also a Joint Centres initiative. Strategies to reduce CDI will continue by supporting our Antimicrobial Stewardship Program (AMSP) and by the use of a vapor spray technology to sanitize isolation rooms. In addition, Southlake will further role out quality assurance auditing using the Assure product to measure the effectiveness of our environmental cleaning and identify improvement opportunities.

B. Improve Hand Hygiene Compliance before Patient Contact by 8.7 percent

(Increase from 92 percent to 100 percent)

You may not know that infections, including CDI, can spread on the hands of health care providers. It is important that we protect you by practicing excellent hand hygiene. Here is some information for you to read about the importance of hand hygiene and the role you can take in this important safety practice.

Southlake's current hand hygiene compliance is 92 percent. In 2017/18, Southlake will again strive for a theoretical best practice of 100 percent organizational compliance. We will continue to report weekly on performance from both anonymous auditors and unit based auditors and target improvements based on this data. We would like you, our patients and family members to play an important role in improving our hand hygiene performance. We will develop a strategy to encourage "speaking up" by you, our patients and families, whenever you notice anything you are not sure of, including if Our People have washed their hands prior to providing care. We will monitor this by tracking the frequency with which you are provided with our Safety Pamphlet "Ask Us, Tell Us, Help Us Keep You Safe". An important element of this strategy will be to work with Our People to invite you to play this role and to say "thank you," when you do remind us or ask us about any safety issue including our hand hygiene compliance before we provide care to you.

C. Reduce the Number of Patients with Hospital Acquired Pressure Injury by 10%

(Reduce from 3.1 percent to 2.8 percent)

A pressure injury, sometimes called a bedsore, is an injury to the skin or underlying tissue caused by pressure, friction and moisture. These injuries often occur when patients have limited mobility and can't change position in bed on their own. When pressure injuries occur they must be treated quickly or they can damage the skin and underlying tissue, causing slow recovery, pain, infection and other problems. Almost all pressure injuries are preventable and, in fact, hospital acquired pressure injuries (stage 3 or higher) are considered Never Events. At Southlake, all our providers are trained in pressure injury prevention. There are many interventions used to prevent this condition such as assessing individual patient risk, providing good skin care, regularly assisting patients to change their position and using pressure reducing cushions, mattresses, and heel boots. We are proud of our success in reducing pressure injury and have improved from 20% in 2012 to 3.1% in 2016. We do believe we can do better however and this year, we target a 10% improvement in the pressure injury rate. Our plan is to continue to ensure our corporate bed plan is implemented to ensure patients are on appropriate surfaces that reduce pressure and prevent injury. We will also develop a stretcher replacement plan that includes a standardized stretcher for Southlake with a pressure relieving mattress and submit to Capital Replacement for 2018/19.

D. Improve Medication Reconciliation compliance for patients at admission by 4.7 percent

(Increase from 86 percent to 90 percent received Medication Reconciliation).

It is important that your health care providers know exactly what medications you are taking and to ensure any changes are accurately made. Accuracy in hospitals is facilitated by a process we call Medication Reconciliation. Medication Reconciliation is widely recognized as an important patient safety initiative and we know it can save lives. As such, Southlake is committed to exceeding the set target by ensuring the standardization of practice to attain Best Possible Medication History (BPMH), a precursor to effective Medication Reconciliation compliance.

BPMH is the activity by which we ensure we ask you about your current medications and document the medications you took prior to coming to the hospital. We will implement the use of a specially-designed form to ensure our practice is standardized and will audit compliance with these BPMH forms. Another important strategy is the introduction of a resource for six months within our Mental Health units to educate and focus on the Medication Reconciliation process as patients transition from the Emergency Department to the Mental Health areas and then into the community.

E. Improve Medication Reconciliation compliance for patients at discharge by 100 percent

(Improve from 18% to 36% compliance corporately)

When you are discharged from hospital often changes will have been made to your medication that you were taking prior to your admission. It is important that you know what medications you should be taking when you return home and we ensure this by performing medication reconciliation on discharge. We monitor this process by checking the number of patients who had a Best Possible Medication Discharge Plan (BPMDP) created. This is a multi-year plan to achieve 100% compliance by 2020.

F. Reduce ER Wait Times for Patients with Complex Conditions by 35 percent

(Reduce from 12.3 hours to 8 hours.)

It is important to us that you are seen in the Emergency Department in a timely manner and that your time to transition to an inpatient bed upon admission is as short as possible. We are pleased to report to you that, for the last four years in a row, we have been recognized in the Province as the best performer for how quickly patients are seen by a physician upon arrival; although less than 10 percent of our more than 100,000 visits to the Emergency Department every year require admission. However, we do recognize that if you need to be admitted, the time to get you or your loved one to an inpatient bed is too long. We know that all the things that contribute to the availability of beds in a hospital is complex and often being able to move patients out of the hospital contributes to your bed being made available. However, at Southlake, we know that even though there has been a significant amount of work to improve flow there are still things we can do to improve your wait time for a bed. We intend to understand more about these opportunities by using a research student to perform a chart review and to identify common themes that would benefit from intervention.

G. Improve Patient Satisfaction in the Emergency Department by 10 percent

(Improve from 53.2 percent to 58 percent)

We are passionate about the feedback we receive from you and make it a priority to use this feedback to improve the care we provide. We are proud that your feedback indicates we are performing well for Patient Satisfaction in our group of hospitals that see more than 75,000 patients a year – however, we recognize that you deserve better. Our plan is to continue to provide you with *Shockingly Excellent Experiences* and strive to further improve. You have told us that our volunteers at Southlake really make a difference in your stay. That is why we changed our model of care in the Emergency Department to include dedicated volunteers alongside our nursing staff to assist in meeting your needs

in real time. We ensure that you are kept informed during your stay through the use of White Boards and the introduction of bedside shift reporting. This year we will install 10 monitors in the waiting areas in the Emergency Department for all patients to see. In this way, we will provide real time information to you and therefore enhance your experience by keeping you well informed.

H. Reduce Unnecessary Hospital Readmissions for Congestive Heart Failure (CHF) by 10 percent

(Reduce from 14.7 percent to 13.2 percent)

We want to make sure that your needs are taken care of in a way that will allow you to safely remain in the community and prevent unnecessary (preventable) readmission to the hospital after you go home.

A review of all of our data shows us that if you are a patient with Congestive Heart Failure (CHF), we can make improvements to ensure your successful transition to home following your stay at the hospital. We know that sometimes, as your health changes, it is important that you are readmitted to the hospital, but we also know that sometimes we could do a better job working with you and your health team in the community to keep you safely out of the hospital. Our focus will be on reducing readmission to Southlake. Currently we strive to improve your ability to manage your condition in the community after discharge by the provision of a transitional care package to you which includes a referral to Health Link. Health Link is a special program, sponsored by the Ministry of Health and Long Term Care, with the sole focus of working with you, your family and your health team (doctors, pharmacists, etc.) to make sure we are all working together to do everything we can to keep you healthy in the community. In addition to Health Link, you also may need some care in the community to be arranged quickly after your discharge from the hospital. We currently provide a referral to the Community Care Access Committee (CCAC) rapid response team which provides you with the early assistance in the community that you may need. In addition to these measures, this year we will engage in a quality improvement project (value stream mapping) to identify gaps in your care journey and implement appropriate changes. We will also implement the “Transitions of Care Standards” that will ensure appropriate measures have been put in place for a successful journey home.

I. Reduction of Incidence of Workplace Violence that Result in Lost Time by 100 percent

(Reduce from 1 incident to 0)

Southlake has been on a three-year journey to become the safest hospital globally. As a recognized leader in providing a safe workplace Southlake will share our learnings so far with our Joint Centres partners, all the while continuing to improve on our quest to become the safest hospital. Southlake, through its work with its partners in the Joint Centres has added a new spread project related to workplace violence prevention that will be undertaken in collaboration with all six hospitals. This initiative represents a commitment to creating secure, safe and healthy work environments for all Our People by leveraging the expertise of the member hospitals within the Joint Centres. Inclusion in each hospital’s QIP signifies that the prevention of workplace violence is recognized as a key dimension of quality that directly impacts patients and families. Our strategies for improvement include the development of a new prevention and investigation tool for incidents of violence. Overall, it is our desire to provide Our People and you, our patients and families, with the safest hospital possible.

J. Ensure Appropriate Information Is Given on Discharge – 10 percent improvement

(Improve from 57.1 percent to 63 percent)

When you are discharged from the hospital, we want to make sure that you have all the information you need to ensure a safe transition. One important element is knowing who to call should you become worried about your condition or have questions about your treatment. We intend to make sure you get this information by creating a safe discharge plan and implementing a bundle of items that we will standardize across the hospital. Our success will be measured by your responses to the patient experience survey 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"?*

K. Ensure Appropriate Supports in the Home for Palliative Patients – 3.7 percent improvement

(Improve from 89.7 percent to 93 percent)

In surveys of patients and caregivers in Ontario, most people say they would prefer to die at home, but we know that most patients in Ontario who receive palliative care die in hospital. Our goal is to ensure access to the best possible palliative care for all terminally ill patients when and where they need it. During consultation with our Corporate Patient and Family Advisor Committee (Corporate PFAC Committee), it was made clear that improving on this indicator is a priority for our community. We heard that there is a concern that supports in the home for palliative patients are sometimes not adequate and we could do better to meet the needs of patients. We know when discharge planning happens for palliative patients the hospital CCAC coordinator works with the hospital care team to define the supports required. Once the patient is returned to the community, the plan might be altered based on community services available and that this change in plans may not be communicated back to the hospital based care team. Working with our Corporate PFAC Committee, we agreed that this was an important area to improve. To improve our performance in this area: Creation of a team consisting of representatives from the hospital CCAC, community CCAC, a Patient and Family advisor (PFA), Medicine and Cancer Care Leadership and the Palliative Care Team to develop an understanding of the issues and to make recommendations to improve.

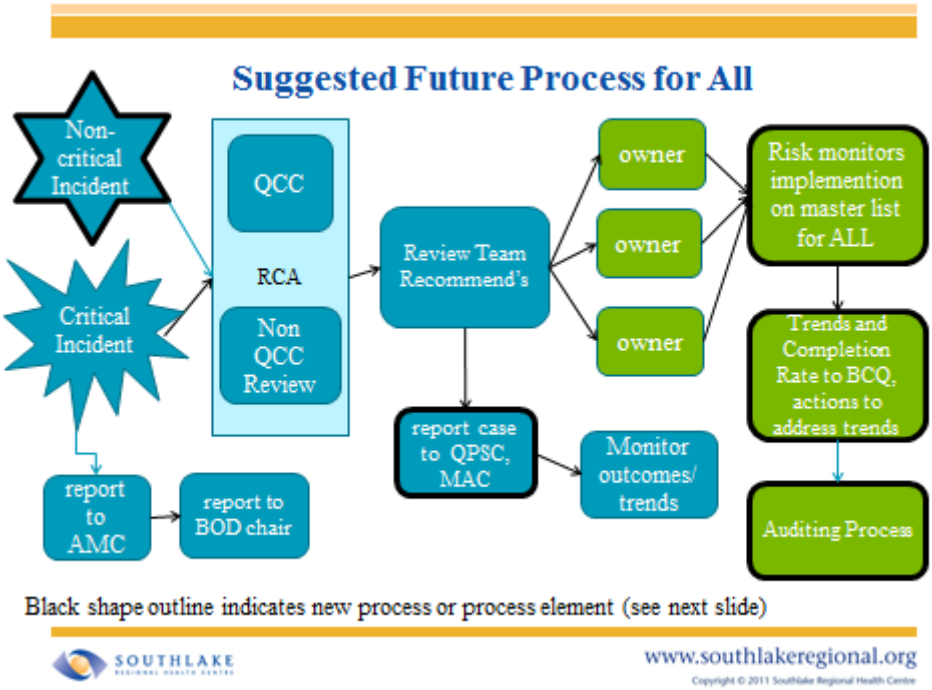
In conclusion, it is our desire to continue to identify, develop and deliver quality initiatives which will improve the care we deliver to you. Southlake's 2017/18 quality improvement objectives reflect our strategic plan and our goal to be recognized as a performance leader in the delivery of safe, quality healthcare services, embracing the principles of High Reliability Healthcare. Our chosen QIP indicators are aligned with our Hospital Services Accountability Agreement (H-SAA), obligations under the Ministry's Pay-For-Results program, the Health System Funding Reform (HSFR), and Accreditation Canada's standards. They are also informed by your feedback. Our Patient and Family Advisors also contributed to the creation of our QIP and took a passionate interest in developing the change idea for Home Supports for Palliative Care. Ultimately, our quality improvement objectives are set in order to keep our promise to you and our community to deliver "Shockingly Excellent Experiences."

QI Achievements from the Past Year

At Southlake, we are proud of the evolution of our learning approach to patient safety incidents. Even prior to the inception of the Quality of Care Information Protection Act (QCIPA) in 2004, our approach to reporting, learning and sharing included a focus on critical incidents. Thankfully infrequent, these occurrences were disclosed and reported to the affected patient as well as to our Senior Team, Medical Advisory Committee and Board of Governors. With QCIPA legislation, we struck a Quality of Care Committee (QCC) which was a body responsible for the review of critical incidents and provided a solid foundation for learning. We did review several cases under the umbrella of QCIPA but we were not satisfied with the restrictions on the sharing of information with you, our patients and with our Southlake family. Our values of transparency, learning and sharing, and our Journey to High Reliability caused us to cease using QCIPA legislation to keep our reviews confidential. We have not invoked QCIPA since 2013.

Although QCIPA is not used, the QCC was a valuable team with solid processes that we leveraged to evolve our approach to learning from patient safety incidents. In 2013, the process in Figure 1 below was presented to the Board Committee for Quality and adopted. We do however report more than simply trends to BCQ – we also report on root causes, causal factors and recommendations for improvement.

Figure 1

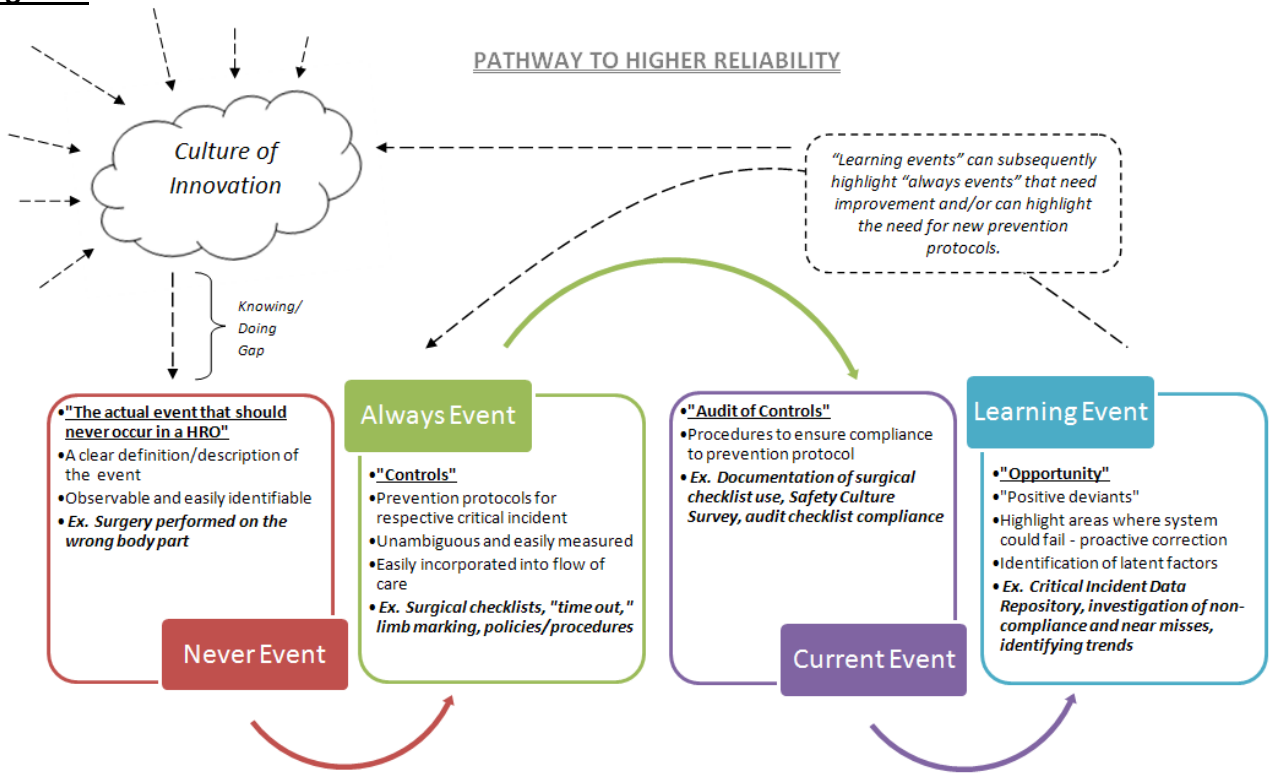


With this new process, non-critical incidents (Critical Near Miss Incidents) as well as critical incidents would be reviewed by QCC and reported throughout the hospital. This is a key turning point as we embraced the High Reliability concepts of Preoccupation with Failure, Reluctance to Simplify, Sensitivity to Operations, Commitment to Resilience, and Deference to Expertise. We know that most incidents are caused by flaws in our systems and that the goal of Safe Health Care could be achieved by understanding where these flaws existed and correcting them. Critical near miss incidents are considered a gift since, although no harm was done, flaws in our processes are revealed to us and made available for improvement. We also know that simply making a change in one area of the hospital and not translating this change across programs is a lost opportunity as most learnings in one program are of benefit to all. One of the mandates of our QCC is to ensure translation of learnings across the hospital. Through this attention at QCC, we have developed a Safety Alert approach to sharing urgent learnings and thus promoting situational awareness corporately and rapidly. The Safety Alert is disseminated to all members of the leadership team via e-mail with requirements to share at huddles and during rounding. Alerts typically include a poster that can be shared at huddle or communication boards. To ensure the Safety Alert is seen and acted on, we utilize our electronic bed boards to flash a message to leaders to immediately access this important e-mail and information.
In 2015, the Canadian Patient Safety Institute (CPSI) published a list of Never Events. At this time, Never Events were added to the QCC process and are now reported on across the hospital. Also in 2015, we developed the Southlake Incident Management System (IMS) and Toolkit that supports our Integrated Quality Management Framework. The IMS and Toolkit was developed to provide a framework, process and guidance to support those reporting, managing conducting and analyzing patient safety incidents. TapRooT© is a tool that we use to perform Root Cause Analysis in a consistent manner.

In the event of a critical incident, a near miss critical incident or a never event, disclosure is made to the patient and family immediately. Support is provided to both the patient and the care team who are seen as the second victim. An immediate Muddle (in the moment huddle) is convened to provide immediate support. The root cause analysis team is created and, when it is appropriate, the patient perspective is collected to inform the work of the team and an invitation is made to the patient and/or family to participate in the review to the extent they are comfortable. We assign a contact person that will continue to communicate with the patient and close the loop once we understand what caused the incident and what we are doing to correct our systems. Recommendations are assigned to a most responsible person (MRP) to implement and at the same time, a most responsible Vice President is assigned to ensure completion of the recommendation and to assist with removing any barriers. We track recommendations which are completed, on track and past due, on our Corporate Quality Scorecard and QIP. The MRP and the most responsible Vice President are held accountable to the Board for timely completion.

The value of learning from Never Events is of such importance at Southlake that we have developed a Southlake Never Event Elimination Initiative (Figure 2).

Figure 2



In this model we have adopted the CPSI list of Never Events and propose "Always Events" or controls that are prevention protocols for the respective Never Event. "Current Events" are the audit of these controls – these are procedures to ensure compliance with the "Always Events". The opportunity for learning from Never Events has been coined "Learning Events" and these highlight proactive correction and identification of latent factors. These "Learning Events" should be shared broadly. At this time, these learnings are communicated within Southlake but we strongly believe in the value of them for safety beyond our walls. To this end, we have shared this model with the Joint Centres as a suggested spread project.

Transparency, accountability, transferability and shared learning are embraced at Southlake and have underpinned our drive to achieve High Reliability and to provide Shockingly Excellent Experiences.

Population Health

Our hospital's Community Awareness Committee includes a mandate to review community demographics and health statistics annually in an effort to help inform the discussion of services provided by Southlake. An environmental scan is also completed as part of the annual operating plan process and individual programs are responsible for collecting data on patient needs. Through this work, we know that 2 unique populations require intensive focus in our community: Mental Health and our growing senior group.

The extensive list of mental health services at Southlake include inpatient and outpatient programs for adults, children and youth, delivered by a team of more than 100 experienced health care professionals that includes psychiatrists, social workers, nurses, psychologists, child and youth counselors, recreational and occupational therapists, dietitians, peer support worker, pharmacists, teachers and crisis workers.

Our Mental Health team notes the growing need for acute and crisis mental health services in the region has put tremendous pressure on Southlake, as it works to meet the needs of patients whose gateway to care is too frequently the emergency department.

Last year, more than 3,800 people experiencing a mental health crisis were admitted through Southlake's emergency department. There were over 30,000 visits to both child and adult mental health outpatient services. One factor that may help explain the increase in demand is the region's rapidly growing population. Another is that we have eight group homes in walking distance of the Hospital.

Southlake's inpatient beds are part of the region's new mental health bed registry, launched in December 2015, which aims to quickly identify available beds to improve timely admissions. The hospital also works with other acute facilities, some as far away as Kitchener-Waterloo, Hamilton and Cornwall when a patient urgently needs hospitalization and there are no available beds at Southlake or a nearby hospital.

The significant growth in volumes and acuity puts pressure on the hospital and, due to scarcity of available inpatient beds; patients can face long waits in the emergency department for assessment and admission. In an effort to ease some of the pressures of escalating need, innovative solutions are being created across programs to better address.

We see similar high volumes with our senior group of patients. Between 2011 and 2031, we expect to see an increase of 148% in the 65+ age group in York Region. For the first time in 2015 in York Region, the number of persons aged 65 years and older exceeded the number of children aged 0 to 14 years. We know that responding to the needs of an aging population will be the single most difficult challenge facing our health system as demand continues to grow. ALC is a problem as the number of medical patients continues to increase. There are several hospital strategies to address these challenges including improved partnerships, transitions and coordination of services in our community. We are also implementing best practice protocols for certain groups, for example, patients with strokes. There are several initiatives aimed at improving clinical efficiency, for example, shifting some inpatient procedures to day surgery.

Equity

At Southlake, our staff completes an annual training requirement (core curriculum) and for the past 3 years, we have achieved 100% compliance with its completion. One of the modules within the curriculum is called Accessibility: Customer Service Standard and Ontario Human Rights Code. Included in here is information on our polices, assistive devices and services, information on how to communicate with persons with disabilities, the use of service animals, the inclusion of support persons and the requirement to provide notice when facilities or services that people with disabilities usually use to access our service are temporarily disrupted. Through this training, we ensure that all of Our People are aware of the ways in which we can each ensure equity for all in our community.
One specific example of this is the South Simcoe Northern York Region (SSNYR) Health Link, as it aims to improve equitable access to care as one key priority aligning with the Central Local Health Integration Network (CLHIN) Integrated Health Service Plan (IHSP) 2016-2019 core mandates. We are in the midst of implementing an electronic Coordinated Care Plan (CCP) that involves community Health Service Providers across sectors to support our targeted population, and address Social Determinants of Health, Mental Health and Addictions. This electronic version of the CCP is allowing us to build and further solidify partnerships and improve collaboration across sectors and therefore improving equitability. With this tool, the SSNYR Health Link is able to develop a standardized process and integrated system of care that will result in improved patient centered outcomes based on your identified goals. Also, Health Links is committed to ensuring that you have a primary care physician and community services as you may require according to your action plan. Through our work with our partner Health Service Providers we have been able to identify and voice inequities in service delivery between rural and urban areas and economic status.

Our partners include the following: The Regional Municipality of York Emergency Medical Services (York Region EMS), York Regional Police (YRP), York Support Services Network, Addiction Services York Region, Canadian Mental Health Association (CMHA), Behavioural Support Organizations (LOFT: housing, employment), Family Health Teams (FHTs), Community & Home Assistance to Seniors (CHATS), Alzheimer Society of Canada, Geriatric Outreach Team, and Psychogeriatric Community Treatment Team (PACTT).

Integration and Continuity of Care

Southlake's 2017/18 Quality Improvement Plan (QIP) is aligned with Southlake's strategic directions, *"Create the Ultimate Hospital Experience, Transform Healthcare Relationships and Seek and Share Better Solutions".* Southlake has incorporated the Ministry of Health and Long Term Care priorities of integration and continuity, by designing improvement strategies which demonstrate Southlake's commitment to work with our system partners to achieve improved quality, both within and beyond hospital walls. Feedback from our patients and data from our staff satisfaction surveys have helped us develop our QIP and identify our priorities.

Here are some examples:

We have forged a strong partnership with CCAC to reduce the number of Alternate Level of Care (ALC) days (days spent in acute care beds that no longer require acute care resources) and a strategic initiative in partnership with CCAC to LEAN transitions to community, and reduce unnecessary hospital admissions through our Health Links commitments.

Southlake supports a philosophy called "There Is No Place Like Home" targeted at providing ALC patients, often with complex conditions and multiple comorbidities, with the supports they need to go home and stay well at home. Creative individualized care plans are often required to enable these patients to stay at home, challenging our teams to work closely with our community partners and agencies to support these patients and their families. When you do require hospitalization our goal is to have a length of stay at the 25th percentile and a comprehensive plan in place to enable a successful transition home. Readmission rates are our countermeasure metric which ensure we are safely transitioning our patients to home. A key to our success is a solid plan, established in partnership with you and your family, truly demonstrating our commitment to patient centered care.

As the lead organization for South Simcoe Northern York Region Health Link (SSNYRHL), Southlake facilitates a coordinated, integrated care delivery model for our complex patients. Our Health Link, as part of the provincial wide project testing an electronic version of the coordinated care plan, worked with all of our Health Service Providers, our Patient Advisory Council and our Steering Committee to co-design processes around the tool to improve collaboration and communication. SSNYRHL has over 500 coordinated care plans entered into the electronic tool, with the majority completed by Central CCAC, as well as those completed by CMHA, LOFT, CHATS, and the Alzheimer Society of Canada. We also worked collaboratively with the other Central LHIN Health Link's to standardize patient identification, care transitions, patient/provider engagement and care coordination. There is a continual focus on quality improvement and our Health Link works closely with Health Quality Ontario (HQO) to develop and support emerging best practices. Currently, SSNYRHL, in partnership with three community partners, York Region EMS, CMHA and LOFT, are participating in an IDEAS project.

We have also collaborated with Health Link and Tele-homecare in the prevention of readmission for patients with Chronic Obstructive Pulmonary Disease (COPD) and Congestive Heart Failure (CHF). Discharged patients are provided with an education package to improve self-management in the community and to ensure appropriate community support, including a referral to Health Link, as appropriate. We have also collaborated with CCAC to ensure appropriate referral to the CCAC rapid response team. An example of this is the CHF working group that meets monthly with community partners (Tele-homecare, CCAC Rapid Response, Health Link) to share information to ensure continuity of follow-up for CHF patients. The LACE (length of stay, acuity of admission, Charlson comorbidity index, CCI, and number of emergency department visits in preceding 6 months) readmission risk tool was implemented for this patient group on CAM (Cardiology) and follow-up by CCAC/Tele-homecare/Health Link and CCAC Rapid Response is encouraged daily and at Joint Inter-professional Discharge rounds. We are currently reviewing the Central Local Health Integrated Network (Central LHIN) best practices for transition from hospital to home to ensure our practices are aligned in the

Cardiac and Medicine departments as well as the Heart Function Clinic. In the near future, we will host a LEAN event in partnership with the Heart Function Clinic, patients and families.

To ensure continuity of care, we partnered with Georgina Health Centre to create our Diagnostic Imaging Satellite office which provides primary care physicians and patients in the community with seamless access to accredited hospital imaging services and IT systems, closer to home. Our Radiologist reporting turnaround times are second to none, meaning you will have answers from your primary care physician sooner than any other community clinic. In cases where you are referred to the hospital, your images are already part of your patient record, meaning you do not have to be re-imaged, saving the system money, and for you, unnecessary radiation.

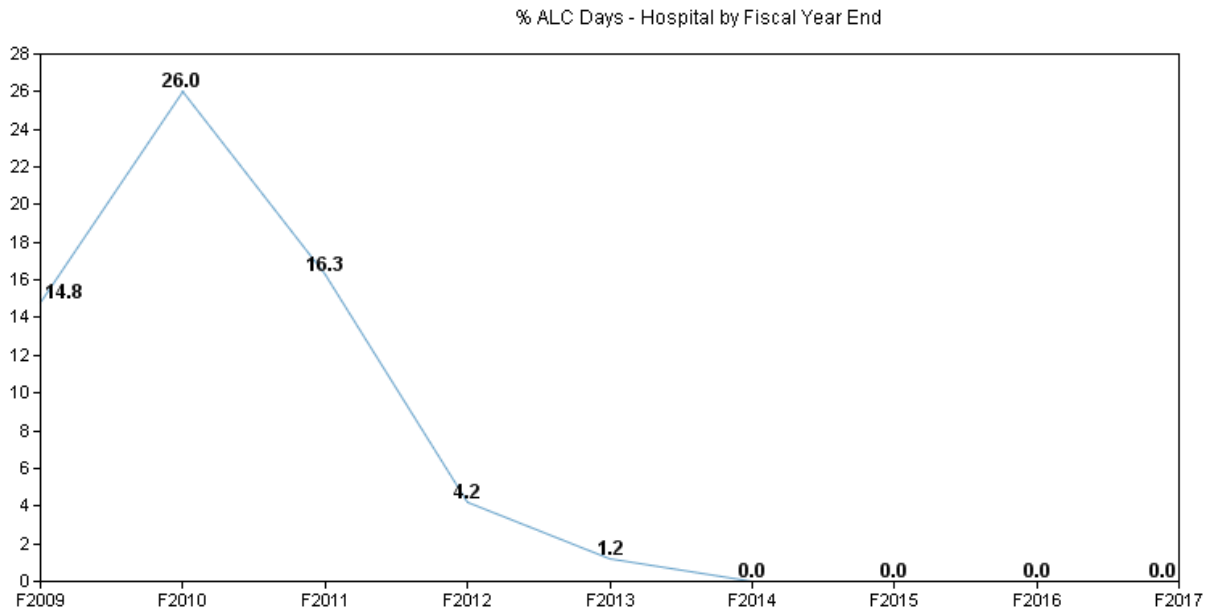
The Mental Health Department conducts Plan/Do/Study/Act (PDSA) rounds daily – patient rounds with community partners present to expedite transitions to community services and systems. All potential community partners have been identified to assist with the "high users" of the Emergency Department in order to participate in the transition planning and connect them with appropriate community services to support autonomy and optimize at home recovery. In addition, a rapid response working group with community partner services, including the police, will be starting soon to focus on patients with high mental health needs.

Access to the Right Level of Care - Addressing ALC Issues

Alternate Level of Care (ALC) refers to patients who no longer need treatment in a hospital, but who continue to occupy acute care hospital beds as they wait to be discharged or transferred to another care environment. ALC patients tend to need help with activities of daily living, which can range from house cleaning or cooking, to people who need round the clock care. ALC patients who remain in hospital do so because the supports they require outside of the hospital are not available. There is a shortage of options in the community. High numbers of ALC patients in acute care beds represents a challenge because these beds are not available for you if you were to become acutely ill and come to the emergency department for care. High numbers of ALC patients are an important cause of emergency department overcrowding. We have been able to develop key partnerships with community partners to help move our patients out of hospital sooner, when appropriate. We work together at joint discharge rounds with CCAC and the discharge planners and Patient Flow Navigators (PFNs). It's all about the right service, the right time, in the right place.

These community issues require solutions that hospitals have very little control over. There are issues however that are internal that hospitals can solve. At Southlake, some reasons for ALC days were caused by us! In fact, in 2010, 26% of ALC days were caused by hospital reasons such as delays in arranging a Physiotherapy referral. Today, and since 2014, 0% of ALC days are caused by hospital reasons (Figure 3). We did this through leveraging a tool called Medworxx.

Figure 3



Medworxx is a tool that our organization uses daily in our acute areas which includes the Medicine Department, the Surgical Department, the Cardiology department and the Mental Health Department. With engaged physicians and clinical leadership, we have tied utilization management to our daily work. We have used Medworxx to help us early identify patients and their needs and barriers to discharge. By being able to identify patient's earlier that may have barriers to discharge, we have been able to reduce the hospital reasons for ALC. Discharge Planners or PFN's work to spend the time up front to help you and your families make decisions about the best options after your stay in hospital.

Currently we are in the beginning phases of the Medworxx version 5 refresh. We are working with the people who enter the data to better help us identify patients ready for discharge or transfer and those who are here and waiting on a service delay. Utilization Management has also implemented the use of RM+R (Resource Matching and Referral) in the inpatient areas. The teams must complete a RM+R referral for inpatient general rehab, inpatient neuro rehab and complex continuing care. This is to help us place the right patient in the right bed.

Engagement of Clinicians, Leadership & Staff

In the creation of our 2013 – 2018 Strategic Plan, we engaged with thousands of internal and external partners via surveys, focus groups, workshops, planning summits, and face-to-face interviews to better understand their visions for healthcare. We also mined through satisfaction results and feedback reports. Through this engagement process, we have been able to create a document that we believe

truly reflects the needs, opinions, feedback, and ideas of the many individuals that we are privileged to serve: Our Patients, Our People, Our Partners. In the development of our Individual Management Performance Plans, our leaders come together to openly discuss our hospital priorities, including QIP priorities, and ensure that our annual goals are aligned in achieving our targets. During the development of this year's QIP, we engaged multiple groups including the various program teams; the Medical Advisory Committee, the Administrative Management Committee, our Quality Utilization Resource Management Committee, the Patient Care Leadership Committee, the Board Committee on Quality and our Corporate Patient and Family Advisor Committee.

The priorities of our patients and our partners — as defined through our engagement process — are the cornerstone of our strategic vision and Southlake's QIP. To achieve success, we regularly engage Our People in monitoring and acting upon the related metrics. For example, time from each weekly leadership meeting is devoted to understanding and evaluating each metric. All of our QIP priorities are tracked on the Quarterly Corporate Performance Scorecard, which is regularly monitored and reported on. Our Horizon Business Intelligence (HBI) tool is available to all and makes visible real time performance metrics for ongoing referral and action and is regularly monitored and reported on. Southlake's top priorities are also displayed on every computer home screen as a visual reminder about our current performance and targets. Each of these priorities has a lead assigned who continually updates information, works with stakeholders to carry out improvement plans and to constantly seek new solutions. These priorities are cascaded throughout all levels of our leadership team through our Management Performance Plan methodology which ensures that each of our annual goals is aligned in achieving our targets.

Resident, Patient, Client Engagement

Through our engagement strategy in the development of our 2013 – 2018 Strategic Plan, we were able to identify your priorities. We spoke to thousands of our community members via surveys, focus groups, workshops, planning summits, and face-to-face interviews. We also combed through satisfaction results and feedback reports. As already noted, Southlake's 2017/18 Quality Improvement Plan is aligned to Southlake's three strategic directions created through this engagement process; *"Create the Ultimate Hospital Experience, Transform Healthcare Relationships and Seek and Share Better Solutions".* Our Board Committee on Quality has been involved since early October with the development of our QIP and the community membership ensures the patient perspective is embedded in the final result. For example, your feedback and experience around the impact of developing a pressure ulcer have driven us to pursue an aggressive performance target and campaign to reduce their incidence.

Our patient satisfaction surveys, Ultimate Patient Experience Real Time Surveys and discharge phone calls provide a valuable source of information as we strive to embed your voice in our improvement efforts. Patient and Family Advisors currently sit on six Clinical service teams at the program level where goals, objectives and program scorecards are developed. In addition to our Corporate Patient and Family Advisory Committee (PFAC) we have 2 other formal Committees: the Cardiac Regional and

Cancer Centre Regional PFAC Committees. Patients are engaged at their admissions by setting goals in collaboration with the health care team. Using patient survey data to identify gaps (based on the Canadian Patient Experiences Survey (CPES) survey scores) we developed a team with a mandate to improve the discharge process by the introduction of a discharge bundle and to create related quality initiatives and performance measures. This work has largely informed the development of the change idea associated with the Discharge indicator on the 2017/18 QIP.

At Southlake, your voice is heard through the Corporate PFAC which serves as a forum for patients and families to partner with Our People to provide input and influence on how to improve the patient experience. The Corporate PFAC reports to our Ultimate Patient Experience Steering Committee (UPESC), whose purpose is to support Southlake in honoring its core commitments, strategic goals and objectives for creating the Ultimate Hospital Experience. The UPESC fosters a culture where our Value of "Putting Patients First" is recognized in everything we do, and from the patient's perspective there is "Nothing about me without me". Our drive to achieve our Quality Improvement Plan goals for 2017/18 will be supported by these important groups of dedicated staff and patients/family. A good example of this approach is our Inter-professional Model of Care project which will involve patient and family councils.

Staff Safety & Workplace Violence

Southlake's Corporate Workplace Violence Prevention Committee is committed to addressing concerns in relation to the safety of Our People, reduce the risk of workplace violence, and to create a safe environment for everyone who walks through our doors. As a leader in promoting safety in healthcare, awareness and embracing the evolution of safety legislation, this continues to be a significant priority to Southlake as we strive to establish a culture of safety throughout our Hospital.

There are 5 essential components of a comprehensive workplace violence and prevention program including Governance and Leadership, policies and procedures, training and knowledge transfer, physical environment design, and tools and technology. At Southlake we have structured our program with attention to all of these components. Our Leadership has articulated a zero tolerance for workplace violence and we have corporate level reporting and monitoring of incidents via our corporate workplace violence scorecard. This is a tool that tracks and trends performance related to workplace violence through reporting at a corporate level. It includes metrics such as the number of incidents, security response time to violence, and severity of incidents.

Our Executive team also engages in regular walkabouts with key questions for senior leadership being asked during visits to the units. This promotes discussion of issues related to safety with staff and allows front-line perspectives to be heard and demonstrates leadership commitment to action.
We have developed aggressive behavior alerts (a flagging process), a care plan strategy individualized to the patient that is based on the assessment of violence risk and strategies for managing those risks while providing safe, effective care to the patient. It is important to learn from the types of incidents we are seeing, which requires a robust incident investigation and analysis strategy. Our staff is very

engaged in careful and inclusive incident reporting, investigation and analysis and our Joint Health and Safety Committee (JHSC) is very involved in this work.

We know that training of our staff is of key importance as it imbeds the necessary prevention skills as well as the skills and judgement to prevent, mitigate or deal with incidents of violence. We raise skills and awareness through our annual core curriculum which is completed by 100% of our staff every year. Many of our staff, and all of our most at-risk staff, have completed Crisis Prevention Intervention (CPI) training. We have also engaged in simulation exercises with staff including York Region EMS and York Regional Police, followed by a debrief which has been an excellent source of learning.

The design of our physical environment is also an important consideration for safety. We have signage visibly displayed throughout the hospital describing zero tolerance for workplace violence. Whenever there is a change in use of an area and annually across the hospital, an environmental risk assessment is performed. Access to the Emergency Department is also controlled; all patients and visitors must enter through a security controlled entry.

Another key strategy at Southlake is the use of tools and technology to support our Programs. Patients are identified at the time of registration if there is a history of violence and the presence of a care plan. All staff wear a safety pendant that will provide an immediate alert to security identifying the location and staff at risk.

All of the above components are accessible to all Our People at the one stop virtual location on our intranet. We know that by working together, we can create a safe and respectful environment in which we can deliver *Shockingly Excellent Experiences* to everyone we interact with.

Performance Based Compensation

The Excellent Care for All Act (ECFAA) requires that the compensation of the CEO and executives reporting to the CEO be linked to the achievement of the performance improvement targets laid out in our QIP. This is meant to promote the accountability for the delivery of the QIP, enhance transparency and motivate our leadership.
For Executives and all Management Staff at Southlake:

1. Total variable pay linked to performance based compensation aligning to requirements in ECFAA plus the Management Performance Plans to be 10% of base salary.
2. Twenty to forty percent of the total variable pay will be linked specifically to achievement of the QIP component of the overall Management Performance Plan.
3. Sixty to Eighty percent of the total variable pay will be linked to achievement of the additional operational objectives aligned to Southlake's strategic goals and identified in each individual's Management Performance Plan.
4. The allocation linked to the QIP will be calculated utilizing the following terms:
    - All QIP indicators will be linked to variable pay
    - Achievement will be based on the percentage completed toward the targeted goal
    - Under-achievement from 'current' will result in a negative percentage achievement.
    - Over-achievement from targeted goal will result in a score greater than 100%
    - The QIP indicators are ranked as Improve or Maintain in the 17/18 QIP
        - The QIP indicators to be **improved** will be weighted x 2

- The QIP indicators to be **maintained** will be weighted x 1
- The calculation of all QIP indicator with the weightings will provide for a % achievement of 100%
- The % achievement will be used to determine the % of the performance-based pay related to the QIP component of each individual's Management Performance Plan.

Sign-off

I have reviewed and approved our organization's Quality Improvement Plan

Colette Nemni
Board Chair

Debra Dobson
Quality Committee Chair

Dr. Dave Williams
Chief Executive Officer

2017/18 Quality Improvement Plans for Ontario Hospitals

Improvement Targets and Initiatives

SOUTHLAKE REGIONAL HEALTH CENTRE

Southlake Regional Health Centre, 596 Davis Drive, Newmarket, ON L3Y 2P9

Lower is Better
Higher is Better

27-Mar-17

AIM		MEASURE				CHANGE				
Quality Dimension	**Issue**	**Measure/Indicator**	**Current Performance**	**Target for 2017/18**	**Target Justification**	**Planned Improvement Initiatives (Change Ideas)**	**Methods**	**Process Measures**	**Process Measure Target**	**Comments**
Safe	Reduce CDI	**CDI rate per 1,000 patient days:** Number of patients newly diagnosed with hospital-acquired CDI, divided by the number of patient days in that month, multiplied by 1,000 - Current Performance Jan-Dec. 2016, consistent with publicly reportable patient safety data	0.28	0.22	Last year target not met. Continue with last year's target.	Monitor environmental cleanliness	Assure System (Quality Assurance Audit Tool)	Audit test (pass or fail)	90%	The "Assure System" audit determines if a surface was cleaned properly.
						The reduction of Cdiff rate is a Joint Centres of Innovation Initiative				
	Hand Hygiene	**Hand hygiene compliance before patient contact:** The number of times that hand hygiene was performed before initial patient contact divided by the number of observed hand hygiene indications multiplied by 100 - Current performance Jan-Dec. 2016, consistent with publicly reportable patient safety data.	92%	100%	Continue with stretch target. We have improved significantly over last fiscal year. Sustain current performance.	Improve the frequency with which patients and families are encourage to "Speak Up" and remind staff to wash their hands prior to providing care.	Using the "Ultimate Patient Experience Survey" question: "Did you receive our *Tell Us, Ask Us, Help Us Keep You Safe* brochure?"	Percent answering "YES"	80% minimum	
	Hospital Acquired Pressure Injury	**Percent of patients with new pressure injury (stage 2 or higher)**. Current Performance FY 16/17 YTD Q2. Include adult acute care, complex care and rehab patients.	3.1%	2.8%	Target a 10% improvement over current performance	Continue implementation of corporate bed plan	Purchase process	Number of beds/mattresses delivered and in use ending fiscal year	Roll out per Corporate Bed Plan	

AIM		MEASURE				CHANGE				
Quality Dimension	**Issue**	**Measure/Indicator**	**Current Performance**	**Target for 2017/18**	**Target Justification**	**Planned Improvement Initiatives (Change Ideas)**	**Methods**	**Process Measures**	**Process Measure Target**	**Comments**
Safe	Medication Safety	**Medication reconciliation at admission:** The total number of patients with medications reconciled as a proportion of the total number of patients admitted to the hospital. Current Performance 16/17 Q2 YTD.	85.7%	90%	Current target met. Accreditation target to reach 100% by 2020/21. Incrementally 5% each year, we are better than forecast 17/18 85% target therefore target 90%	The addition of a resource (6 month contract) will investigate, recommend and implement improvements in Medication Reconciliation process on both mental health units	Monthly unit audit of patient documentation for BPMH and medication reconciliation completion	Unit % compliance of admitted patients receiving a completed med rec.	75% minimum Adult MH unit 60% minimum Child MH unit	
		Medication reconciliation at discharge: Total number of patients for whom a BPMDP (Best Possible Medication Discharge Plan) was created as a proportion of the total number of patients discharged. Baseline Sept 2016-Feb 2017	18%	36%	Implementation schedule if achieved should see a 100% increase across the hospital	Continuing our implementation plan across the organization	Monitoring of plan roll-out from Pharmacy administration	Unit and Program % compliance	70% minimum unit compliance	
Timely	Timely completion of recommendations	**The percent of completed or on target** recommendations of Incident Management/ (Quality Care Committee) QCC reviews Current performance FYYTD Q3	90%	100%	Target 100% recommendations complete or on target as designated by QCC.	QCC Process - Assignment of executive sponsor to QCC Recommendation	Monthly critical report to senior management team	The number of Due Date changes to a QCC Recommendation from start to completion	2 changes maximum	The measure helps to improve focus and engagement for all involved in the recommendation
	Timely access to care/services	**ER Wait times:** 90th Percentile ER length of stay or visit for patients with complex conditions. Jan - Dec 2016 CIHI NACRS	12.3 Hrs	8 Hrs	Target set by H-SAA.	Research Student will be tasked to perform a chart review - specifics for review to be defined. Common elements will be identified	Planned interventions	Audit completion of interventions	By end of FY 17/18	
Patient-centred	Person experience	**"Would you recommend this Emergency Department to your friends and family?"** Percent positive score. (question from EDPEC) Current Performance Q1 FY16/17	53.3%	58%	Peer benchmark not available until April 2017. We have targeted a 10% improvement from current performance.	Install 10 monitors in the Emergency Department waiting area for all patients to see. Provide real time information to patients. Enhance the patients experience by keeping them informed.	Purchase Process, installation of monitors	Number of monitors installed	Complete by end of fiscal year	Better educated patients will improve engagement with our care providers while improving their ER experience.

AIM		MEASURE				CHANGE				
Quality Dimension	**Issue**	**Measure/Indicator**	**Current Performance**	**Target for 2017/18**	**Target Justification**	**Planned Improvement Initiatives (Change Ideas)**	**Methods**	**Process Measures**	**Process Measure Target**	**Comments**
Patient-centred	Palliative care	**Percent of palliative care patients** discharges from hospital with the discharge status "Home with Support" Current performance FY 15/16	89.7%	93.0%	Our comparator hospital peer performance places us at the 76th percentile. The 90P is 93%	Establish a Working Group to explore and understand this new indicator. Include key hospital and community personnel.	Regular meetings with action items identified.	Action items percent completion	100% implementation by Q2 2017/8	Before establishing a QI strategy, we must first fully understand the measurement methodology
Effective	Effective transitions	**"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?"** Percent positive score. (question from CPES) Current Performance Q1 FY16/17	57.1%	63%	Peer benchmark not available until April 2017. We have targeted a 10% improvement from current performance.	Creating a Safe Discharge Plan	Scheduled meetings will oversee the implementation of the bundle items	Audits to verify successful implementation	75% score minimum	
		Risk-Adjusted 30-Day All-Cause Readmission Rate: (any Acute hospital) for CHF: As defined for quality-based procedure (QBP) Current performance Jan - Dec 2015	21.4%	We do not receive timely information (8-10 months lag) therefore this is not data that we can impact within the QIP timeline. The principals of a quality indicator should include the use of real time data. As a high reliability organization, we have adopted this principle and have developed the custom indicator "to Southlake only". (see below)						
		Non Risk-Adjusted 30-Day All-Cause Readmission Rate (Southlake only) for CHF: As defined for quality-based procedure (QBP) Current performance Apr-Oct 2016	14.70%	13.2%	Target to improve by 10% from current performance.	Perform a Value Stream Mapping with patients to identify gaps in the journey of care	Identify specific areas where changes can be implemented	Measure the completion of the changes implemented	Complete ending Q1 FY17/18	
						Transitions of Care Standards	Implementation schedule to be established	Implementation completion log	5 standards complete	

AIM		MEASURE				CHANGE				
Quality Dimension	**Issue**	**Measure/Indicator**	**Current Performance**	**Target for 2017/18**	**Target Justification**	**Planned Improvement Initiatives (Change Ideas)**	**Methods**	**Process Measures**	**Process Measure Target**	**Comments**
Efficient	Access to right level of care	**Percent ALC acute days:** Total number of ALC inpatient days contributed by ALC patients within the specific reporting period (open, discharged and discontinued cases), divided by the total number of patient days for open, discharged and discontinued cases (Bed Census Summary) in the same period. Current performance FY16/17 Q2	12.04%	This indicator is not a hospital indicator. In 2010, Southlake invested in a daily utilization tool that separates out community versus hospital reasons for ALC. In 2010/11, 26% of all ALC days at Southlake were attributable to 'hospital reason'. Southlake initiated a quality improvement initiative to decrease ALCs for 'hospital reasons'. Southlake achieved 0% ALC rate for hospital related reasons in fiscal 13/14 and has sustained a 0% hospital related ALC rate since that time. Southlake tracks the hospital related reasons daily with a target to maintain the 0% rate. Southlake continues to work with the CLHIN and the CCAC to identify and implement initiatives which can decrease the ALC days related to community wait reasons.				
		Percent ALC days: Total number of acute inpatient days designated as ALC in acute care beds due to "Hospital Reasons" divided by the total number of inpatient days. Current performance FY16/17 Q3YTD	0.0%	0.0%						
Equitable	Reduction in incidents of workplace violence	**The number of workplace violence incidents that result in lost days** is a count of the number of violent incidents in which an employee has lost more than the day of the actual incident (also known as a lost time incident). Current Performance FY16/17 Q1-Q3	1	0	Theoretical best practice of zero	NEW Prevention/Investigation tool for Staff Incidents	Roll out training and implementation schedule	Monitor use after implementation	Mandatory for all incident investigations (100% use)	