2017/18 Quality Improvement Plan
"Improvement Targets and Initiatives"

Englehart and District Hospital 5th Street
Kirkland and District Hospital 145 Government Road West

CB = Collecting Base Line Data

AIM		Measure							Change				
Quality dimension	Issue	Measure/Indicator	Unit / Population	Source / Period	Organization Id	Current performance	Target	Target justification	Planned improvement initiatives (Change Ideas)	Methods	Process measures	Target for process measure	Comments
Effective	Coordinating care	Percentage of patients identified with multiple conditions and complex needs (Health Link criteria) who are offered access to Health Links approach	% / Patients meeting Health Link criteria	Hospital collected data / Most recent 3 month period	696*	CB	90.00	To ensure that complex in-patients and Emergency patients are identified	1)Track the number of multi-disciplinary referrals are made for patients prior to discharge in the in-patient and the Emergency departments.	A form was developed in partnership with the Family Health Team (FHT). If a patient is identified, a referral for a multi-disciplinary review will take place.	Track the number of referrals made	To ensure that all referrals are reviewed and managed by the FHT	The team will continue to meet on a regular basis to evaluate the form and the process and the benefits to the patients.
	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?	% / Survey respondents	CIHI CPES / April - June 2016 (Q1 FY 2016/17)	696*	CB	90.00	To ensure that discharged patients are well informed on post discharge care.	1)Provide a follow-up post discharge call with script	Patients will receive a post discharge telephone call 48 hours after discharge	Number of patients/family members surveyed over a 3 month period	90% of patients/family members will have the opportunity to be surveyed on post discharge information.	Will track the number of positive responses received and provide the opportunity for patients to communicate any concerns with their hospital stay.
		Risk-adjusted 30-day all-cause readmission rate for patients with Congestive Heart Failure (CHF) (Quality Based Procedure (QBP) cohort)	Rate / CHF QBP Cohort	CIHI DAD / January 2015 - December 2015	696*	30.83	20.00	To monitor readmission rates when the QBP is utilized	1)Monitor the number of patients admitted with CHF that were managed with the QBP	Data will be collected through THINK; reports will indicate how many times the QBP was used	Number of QBPs on admitting diagnosis reviewed by the quality team over the quarter	90% of patients with admitting diagnosis of CHF will have care managed with a QBP	
									2)Measure readmissions rates	For all patients managed with a QBP, review 7 and 30 day readmission rates	Number of patients readmitted after receiving care with QBP managment	Review all patients managed by a QBP readmission rates	To identify the impact on care of the QBP and evaluation the QBP care management and the rate of readmissions. This data will be shared with the Physician and Clinical group to promote the use of the QBP.
		Risk-adjusted 30-day all-cause readmission rate for patients with Chronic Obstructive Pulmonary Disease (COPD) (QBP cohort)	Rate / COPD QBP Cohort	CIHI DAD / January 2015 – December 2015	696*	18.1	15.00	To monitor readmission rates when the QBP is utilized.	1)Monitor patients that are admitted with the diagnosis COPD that were managed with the QBP	Data will be collected through THINK Research; reports will indicate how many times the QBP was used	Number of QBP initiated on admission reviewed by the quality team over the quarter	90% of patients admitted with COPD will have care managed with a QBP	
									2)Measure readmission rate	For all patients managed with a QBP, review 7 and 30 day readmission rates	Number of patients readmitted after receiving care with QBP Management	Review all patients readmission rates after managed with a QBP	To identify the impact on care of the QBP and evaluation the QBP care management and the rate of readmissions. This data will be shared with the Physician and Clinical group to promote the use of the QBP.
		Regional Palliative Care Program	Number / All acute patients	Hospital collected data / most recent 3 month data	696*	CB	CB	Monitor program development throughout the NELHIN	1)Measure the number of hospital sites that the regional hospice palliative care program has been established for.	Program development and Hospital Site adoption will be monitored and reported to the quality team	Number of hospital adoption of the palliative program established for the NELHIN over each quarter	Monitor progress of program established for hospice palliative care in hospital sites	Our hospital hospice palliative care was recognized with an honourable mention for a model of innovation and the model has been shared throughout the NELHIN hospital sites for program development.

AIM		Measure							Change				
Quality dimension	Issue	Measure/Indicator	Unit / Population	Source / Period	Organization Id	Current performance	Target	Target justification	Planned improvement initiatives (Change Ideas)	Methods	Process measures	Target for process measure	Comments
Safe	Medication safety	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.	Rate per total number of discharged patients / Discharged patients	Hospital collected data / Most recent quarter available	696*	80	90.00	Improve patient safety at all transitions	1)Measure the overall times that medication reconciliation was completed at discharge	Data from discharge summaries will be collected to analyze medication reconciliation on discharge	Number of times medication reconciliation was completed on discharge	90% of identified patients will receive med rec on discharge	We are analyzing all patients that med rec has been checked as not applicable to establish parameters for med rec on discharge.
									2)Track the number of times that pharmacy conducted a review of medications prior to discharge for complex patients	Review all discharge summaries to identify when med rec on discharge was completed by the pharmacist	Number of med rec completed by the pharmacist on discharge	90% of complex patients will have med rec completed by the pharmacist on discharge	
		Pharmacy Structure Development	Number / All acute patients	Hospital collected data / most recent 3 month period	696*	CB	90.00	Monitor the benefits of the relationship with NorthWest Telepharmacy	1)Measure the number of calls utilized by the hospital to NorthWest Telepharmacy	NorthWest Telepharmacy will report on call volume on a monthly basis	Number of times that NorthWest Telepharmacy was used for a pharmacy consult	Ensure NorthWest is utilized 90% of the time for after hours and holiday consults	We now have 2 Pharmacists at the Kirkland and District Hospital. This service will assist to alleviate the after hours management of callback for pharmacy consult.
									2)Analyze the call utilization to NorthWest Telepharmacy	NorthWest will provide a monthly call utilization report	Number of calls and type of call made to NorthWest on a quarterly basis	Ensure the best possible utilization of the service; staff utilize the service when needed	

Medication reconciliation is a formal process in which healthcare providers work together with patients, families and care providers to ensure accurate and comprehensive medication information is communicated consistently across transitions of care. Medication reconciliation requires a systematic and comprehensive review of all the medications a patient is taking (known as a BPMH) to ensure that medications being added, changed or discontinued are carefully evaluated. It is a component of medication management and will inform and enable prescribers to make the most appropriate prescribing decisions for the patient.

Quality–based procedures (QBPs) are specific groups of patient services that offer opportunities for health care providers to share best practices that will allow the system to achieve even better quality and system efficiencies.

The Health Links approach fosters an environment that helps healthcare teams develop new and better ways to integrate care delivery for the people of Ontario who live with complex chronic illness.