

Let's Make Healthy
Change Happen.



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

2017-2018



London Health Sciences Centre

March 29, 2017

ontario.ca/excellentcare

Overview

Work of today builds the foundation for tomorrow. London Health Sciences Centre (LHSC) continues to work diligently in building a foundation that allows LHSC to take a leading role together with our system partners in planning for the future needs of health care in our community. We strive to ensure that everyone we serve receives the highest quality of care, demonstrating value for our patients, families, physicians, staff and community.

Murray Glendining, CEO, notes that, “As one of Canada’s largest acute care hospitals we are committed to systems solutions, including working with community and health-care partners to take advantage of opportunities to improve care for all patients”.

For any organization to accelerate systematic improvement efforts in quality and patient experience, there needs to be a consistent understanding of what “*quality*” and “*patient experience*” means. It is critically important to define *Quality* and *Patient Experience* in order to provide clarity of purpose, direction and vision. In 2016/17 LHSC sought to engage individuals towards re-defining and re-affirming our meaning of these important imperatives.

Through a series of consensus sessions held over September and October 2016, physicians, staff, leaders, patients and families have contributed to our collective understanding of how LHSC will define and move forward with advancing quality and patient experience at LHSC.

Interviews	Environmental Scan	Consensus Summits	Outcomes Dissemination
Individual and group formats	good guidance from across the health system & peers	N = 3 held	<ul style="list-style-type: none"> ✓ Our definitions ✓ Our commitments ✓ Our time lines for action
MAY/JULY 2016	AUGUST 2016	SEPTEMBER & OCTOBER 2016	NOVEMBER 2016 →
<ul style="list-style-type: none"> • n > 300 individuals engaged • varied perceptions of meaning • Call to action – commitment was evident 	<ul style="list-style-type: none"> • 5 definitions of quality emerged • 5 definitions of patient experience emerged 	<ul style="list-style-type: none"> • n > 110 participants • new definition of quality • Blended/renewed definition of patient experience 	<ul style="list-style-type: none"> • LHSC community inclusive of staff and physician partners, SLT, patients, families, learners, etc. • LHSC Board committees • LHSC Board



Through this consultation process, which built upon previous consultations and was informed by current hospital wide groups, the affirmed LHSC Definition of *Quality* that received strong endorsement is as follows:

Quality encompasses three equally important parts;

- *Care that is clinically effective – not just in the eyes of clinicians but in the eyes of patients themselves;*
- *Care that is safe; and*
- *Care that provides as positive an experience for patients as possible.*

The definition of *Patient Experience* that was adapted and affirmed for LHSC is as follows:

Patient experience is the sum of all interactions that influence the patients' perception of care. Patient experience is the outcome of a person focused approach to the planning, delivery, and evaluation of health care that is grounded in respect, dignity, choice and mutually beneficial partnerships among health care providers, patients, and families.

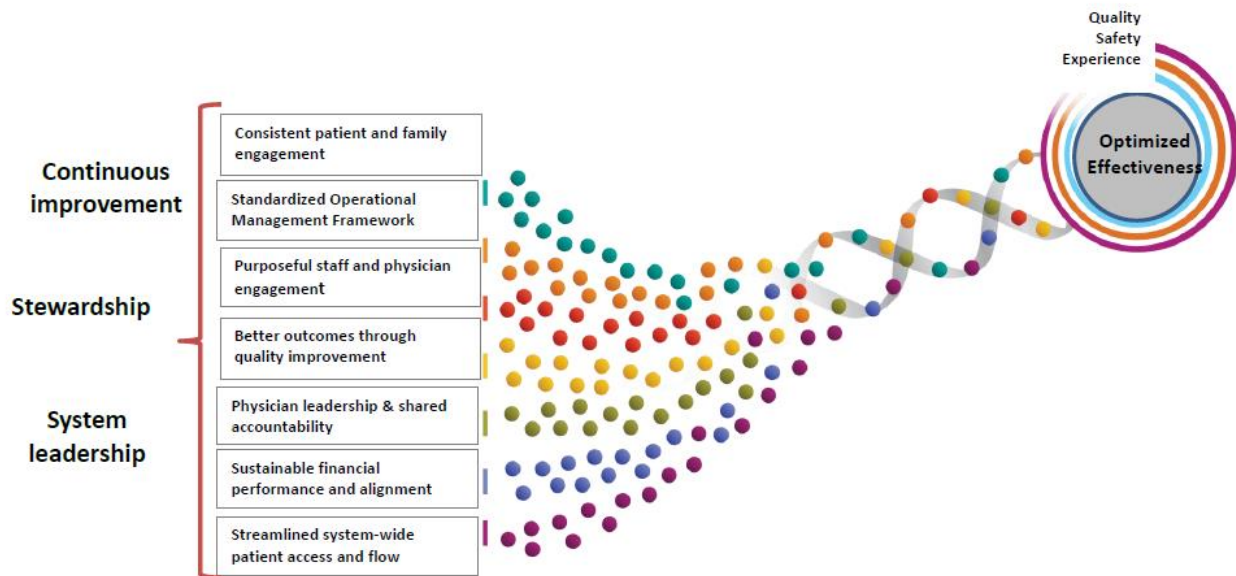
With these definitions in mind, a renewed road map for *Quality* and *Patient Safety* has been developed. This road map includes strong partnerships and a shared accountability model with physicians. Working together, we will create positive and lasting change to improve care for the patients we serve, in addition to ensuring standardization of practices and processes within the hospital.

OVERRIDING PRIORITIES: QUALITY, SAFETY AND THE PATIENT EXPERIENCE

Patients are at the centre of all we do; our entire organization from the bedside to the board room is focused on serving our population. To be certain that all work strengthens patient-centred care, a two-year transitional plan was implemented in 2016/2017. The transitional plan (the plan) uses a quality, safety and patient experience lens as its guidepost. All current and new initiatives associated with the transitional plan will be assessed for alignment and the ability to positively impact the provision of safe, high-quality patient-centred care.

Interconnectivity

Each theme is dependent upon the success of the other.



...these interrelated initiatives can provide the DNA needed to excel

The overarching goal of the Transitional Plan is **to deliver a focused, relentless and standardized approach to improving the quality, safety and consistency of care and the patient experience across our organization**. The chart above depicts the key elements of the Transitional Plan. All of the identified components are needed to drive our work forward. This will lead to a:

- More consistent and mature culture of quality, safety and patient experience
- Holistic and standardized approach to continuous quality management and improvement
- Consistent improvement in each domain of quality, safety and patient experience across all LHSC programs and departments
- A focus on financial sustainability by living within our means

QI Achievements from the Past Year

Building on our proud legacy of care and innovation this past year, LHSC celebrated a number of medical firsts and award-winning initiatives, and also realized important outcomes through dynamic partnerships. Through these achievements, LHSC helped improve patient care and the patient/family experience, and strengthen system capacity to better support population health-care needs. Some of our achievements showcase our ongoing work in the area of surgical quality of care.

Ontario Surgical Quality Improvement Network (ON-SQIN)

LHSC is an active participant in the Ontario Surgical Quality Improvement Network (ON-SQIN) - a community of surgical teams across Ontario that shares a commitment to achievement of long-term surgical quality improvement goals.

Led by a surgeon champion and supported by the CEO of each member hospital, participating teams in the network:

- Access an online collaborative space where surgical teams can discuss best practices, share innovations, and discover ways of improving surgical care in Ontario
- Benchmark surgical outcomes and contribute to the comparison of outcomes from across Ontario
- Empower providers to implement quality improvement initiatives
- Establish common improvement goals

A key aspect of participating in the Network is the implementation of the American College of Surgeon's National Surgical Quality Improvement Program (ACS-NSQIP). NSQIP-ON, Ontario's version of this internationally recognized program is designed to measure and improve the quality of surgical care and is applicable in academic, community and rural hospital settings. LHSC benefits by having an opportunity to look at our practices and facilities to examine and benchmark how we are performing and ensuring quality relative to our peers. This allows us to continue to improve the quality of care.

Health Quality Ontario supports the spread of NSQIP across the province in order to help hospitals collect high quality clinical data. This data is then utilized to inform and develop a quality improvement program designed to decrease surgical complications, improve patient care and outcomes, and decrease the cost of health-care delivery. NSQIP uses a prospective, peer-controlled, validated database to quantify 30-day, risk-adjusted surgical outcomes, enabling the comparison of outcomes among all hospitals in the program. This information helps organizations measure and understand their outcomes, and compare their outcomes to benchmarks and to those of other participating sites. Collaboration between participants accelerates improvement through shared learning.

Surgical Quality Improvement Plans

To ensure our planned actions are achieved, a Surgical Quality Improvement Plan is developed. This plan is a programmatic initiative for members of the ON-SQIN. The high-quality clinical data extracted from NSQIP can be used to determine where there may be opportunities for improvement, enabling surgical teams to develop programmatic Surgical Quality Improvement Plans (SQIPs) and to identify and implement specific quality improvement initiatives. Creating a SQIP will allow ON-SQIN members to track baseline data, change ideas, process measures and outcomes.

By developing a SQIP and submitting it to the Surgical Quality Improvement Network, common barriers to improvement can be identified and teams that have identified similar quality improvement goals can be connected through the Network.

This year, LHSC has focused its SQIP on surgical site infections. A specialized team meets every two weeks to address issues related to preventable infections. This includes looking at giving patients

antibiotics before their surgery as well as making sure those antibiotics are the right dose at the right time to best prevent infections after surgery.

This work plays a role in the provincial common quality agenda and contributes to Ontario's vision for a high-performing health care system.

Population Health

In 2015, seniors (adults 65 and older) accounted for just more than 18 per cent of the South West LHIN's population, compared to 16 per cent in 2010. By 2021, 20.5 per cent of the population will fall within that age group. The South West LHIN (SWLHIN) continues to have a higher proportion of adults aged 65 years or older than the provincial average of 6 per cent.

It is not entirely surprising then that prevalence of chronic disease in the SWLHIN is also high, as there is a higher prevalence of complex chronic disease in the over 65 population. Across all age groups, approximately 39 per cent of the residents in the SWLHIN have a chronic condition, including 4.8 per cent with chronic obstructive pulmonary disease (COPD). The SWLHIN also has higher mortality rates and more average time spent in hospital for chronic conditions than the provincial average. Given this reality, LHSC is partnering in important work with system partners to improve care for patients with chronic diseases. Through intentional partnership and engagement, LHSC is striving to increase the quality of care for individuals with a chronic disease by reducing the amount of time spent in the hospital and increasing the amount of time preventing and managing chronic disease in the home before the need for hospital care is required.

Connecting Care to Home (CC2H): Integrated Clinical Pathway improves care for COPD & CHF chronic patients in London Middlesex

In October 2015, the Connecting Care to Home (CC2H) project team introduced an integrated clinical pathway for patients with chronic obstructive pulmonary disease (COPD), which is a long-term incurable lung disease.

Partners in this program include:

- London Health Sciences Centre
- South West Community Care Access Centre
- St. Joseph's Health Care London
- Thames Valley Family Health Team
- Primary care physicians
- South West Local Health Integration Network

Some of the benefits of the Integrated Clinical Pathway are:

- A much more streamlined and effective care pathway across hospital, homecare and patient self-management, based upon consistent, leading practice clinical education for all providers across care settings
- Two new roles: Navigator and Clinical Care Coordinator to help transition from hospital to community to self-management

- Consistent leading practice self-management education used and reinforced by providers across all care settings
- Physician Specialist remains Most Responsible Physician for a period post discharge with virtual, warm hand-off to Primary Care/Ambulatory Care Clinics
- Technology enabled Home Care intervention using real-time shared patient record (CHRIS/eShift) with dashboard in the home enabling monitoring. Direct care and virtual collaboration across care settings (MD and care team) to predict and pre-empt crises/ED
- Consistent providers, 24/7 LIVE answer by primary homecare nurse leveraging shared medical record
- Providing info and referrals to community resources, updating hospital chart and update to primary care
- Further supporting self-management with Tele-Homecare

To date, this integrated care pathway has led to improved quality of care and patient experience, with reductions in:

1. Hospital length of stay
2. Emergency Department visits
3. Readmission rates for these patients.

“Many people have partnered together to make this successful, including the patients themselves. Working with an integrated care team and participating in the patient care conferences has proven beneficial. It has significantly decreased gaps when transitioning from hospital to home. With the extra support and education provided patients now don’t just know that they have COPD, but truly understand the disease and implications; feeling empowered to participate and take ownership of their chronic disease.”

Caitlin Schultz, COPD Patient Navigator at LHSC.

CC2H implemented evidence-based tools to assist in stratifying these patients into low, moderate and high intensity levels of community-based care upon discharge from hospital. The focus of this care pathway is on those with moderate intensity care needs. Patients enrolled in the CC2H care pathway are discharged with enhanced homecare supports in place. Patients are provided a robust care plan with CCAC care coordination, in home supportive care and telehome monitoring by a Registered Nurse in a graduated e-care model for up to 60 days. Through a more comprehensive discharge planning process and enhanced collaboration among all care providers, patients and their families, CC2H ensures smoother transitions from hospital to home.

In early 2017, a Patient Navigator was introduced for patients managing Chronic Heart Failure.

Equity

While there are no specific equity indicators provided by HQO for this year’s QIP, LHSC is working with a representative from the Schulich Interfaculty Program in Public Health at Western University to identify a monitoring indicator related to health equity for consideration for inclusion in our balanced scorecard. This will ensure that as LHSC moves forward in its quality initiatives it is inclusive of all

residents and sensitive to groups that may experience disparities in their health status. One initiative that LHSC has been instrumental in establishing and supporting is the Community Health Collaborative.

Community Health Collaborative (CHC)

The Community Health Collaborative involves a broad range of partners across the continuum of health, education and social services that impact population health in London and Middlesex. The CHC believes that, by leveraging our collective strengths, we can better utilize system resources to create positive change for healthier communities. Member organizations are making a long-term commitment to partner in developing new capacity to enhance wellbeing in our communities through a population health lens.

The CHC adheres to a strengths-based approach (versus focusing on gaps and creating stigmas) and wherever possible builds on proven examples of resilience to build enhanced capacity across communities. They actively engage experts in the community, including those with the lived experience of inequity, and/or direct service providers, to partner in developing and implementing solutions. The CHC seeks evidence-based and sustainable outcomes, but the strongest measure of success is the positive feedback of the people we are working to help and the direct service providers who support them every day.

Currently, the CHC has identified MH and Addictions and Poverty and Homelessness as two areas of primary focus. The group is in the research phase, after which evidence-informed action plans will be developed.

Integration and Continuity of Care

System level integration and continuity of care has been an increasingly important focus at LHSC over the last several years as we recognize that we are an important partner in work that happens throughout the health-care system.

In 2016/17, LHSC initiated a number of transformational projects in three key areas: Emergency Department, Mental Health and Medicine Admission/Discharge. The process involved active engagement with staff, physicians, community partners, along with patients and families. In 2017/18, the key areas of focus remain on the Emergency Department's length of stay, transition of care and overall patient experience. Additionally, patient safety in the areas of medication reconciliation on admission and discharge is a top priority for LHSC. The overall goal continues to focus on improving access and flow through the system and delivering a more patient centred experience. Integration and continuity of care are key themes in each of these areas of focus.

In 2016/17, the Mental Health Care Program at LHSC implemented a Transitional Planning Protocol focused on strengthening navigation services between LHSC (acute care) and the Developmental Services System in London/Middlesex and Elgin counties. The main objective was to establish a coordinated response of defined roles and accountabilities between Community Developmental Services within London Middlesex and the Health System (Mental Health Services) on behalf of each individual supported within these guidelines who is admitted to the hospital for intensive short-term treatment and/or crisis intervention and stabilization.

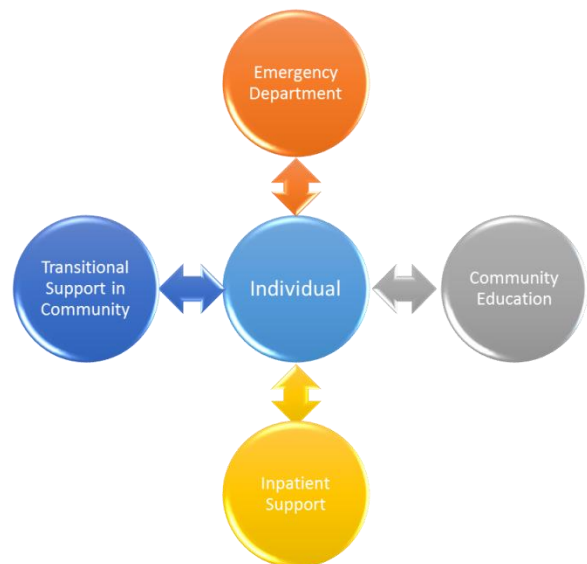
One key element established this year, which will continue in 2017/18, is the utilization of a Mental Health Navigator. The Navigator was implemented because it was recognized that there are many services and teams who serve individuals, often all at once and unaware of the other services caring for the individual.



With the patient/client at the core, the Mental Health Navigator focuses on four key components to ensure quality of care is achieved and sustained. Each component is anchored in continuous engagement with the patient/client by the appropriate care team as well as high degrees of collaboration between all services.

- I. **Purposeful collaboration with the Emergency Department (ED)** staff working with the patients ensures that we continue to provide 1:1 interventions to assist with minimizing behaviours and increasing quality of life during the time spent in the ED. Additionally, the MH Navigator collaborates with Long Term Care (LTC) homes to establish if goals can be met in the community, and discharge from hospital whenever possible.
- II. **Collaboration within-patient care** teams (Psychiatry, Nursing, OT, Recreation, CCAC) to develop a care plan proactively facilitates both 1:1 interventions and group opportunities to assess what activities will provide meaning and purpose on the in-patient unit. Staff is also coached to develop successful interventions to minimize behaviours and increase success in activities of daily living (ADL) care.

- III. Great emphasis is on **establishing Transitional Support in the community**. A significant effort is made to coach staff at LTC homes by utilizing the non-pharmacological care plan developed specifically for the patient while in the hospital. Home visits are conducted on the day of transition from the hospital, to support patients and staff in the transition with regular communication occurring for 12-72 hours after leaving the hospital. Transitional support continues for approximately one month depending on how the individual is settling.



- IV. Community education is provided on the **Gentle Persuasive Approach (GPA)** about responsive behaviours in dementia to staff in LTC and retirement homes and community outreach workers such as Personal Support Workers and nursing staff. Additionally, through collaborations with community support agencies such as Alzheimer Society and McCormick Dementia Care, formalized education about responsive behaviours in dementia is provided to informal caregivers such as family.

Access to the Right Level of Care - Addressing ALC Issues

Ensuring that patients are in the right place at the right time is key to providing high quality care throughout the health system. When patients no longer need acute services at LHSC we want them to move as quickly as possible to the next stage of their health-care journey. This past year LHSC implemented a more standardized approach to designating patients as Alternate Level of Care (ALC). This means that discharge and other policies related to ALC are applied consistently across all of our programs. In addition, weekly reports of longer stay patients are provided to leaders to ensure that they can support their clinical teams in addressing barriers to accessing the right level of care.

In addition, the Home First philosophy was re-launched to include emphasis on home as the discharge destination and clarity of roles and responsibilities to frontline staff and physicians. An ongoing education strategy for Medicine Residents is being planned with the Senior Medicine Residents. LHSC continues to promote earlier involvement of CCAC and community partners to maximize discharge supports for patients with complex care needs, such as Intensive Hospital to Home (IH2H) for the frail elderly, and Canadian Mental Health Association (CMHA) Addiction Services for patients with chronic injection drug use addictions. In the third quarter of this last year we decreased the number of ALC patients by 192 over the previous year third quarter, and have surpassed the South West LHIN target rate for ALC days.

These successes reflect strengthened partnerships across the health continuum and the engagement of a wide range of teams and disciplines, establishing a strong foundation to build upon in 2017/18. Although reducing ALC occupancy in-hospital is not an identified area for formal Quality Improvement Plan work, it has significant benefits for patients and their journey of care, and improves overall hospital access and flow for those awaiting an acute care bed. As such, it will remain a key organizational focus within our performance framework to ensure results are sustained.

Engagement of Clinicians, Leadership & Staff

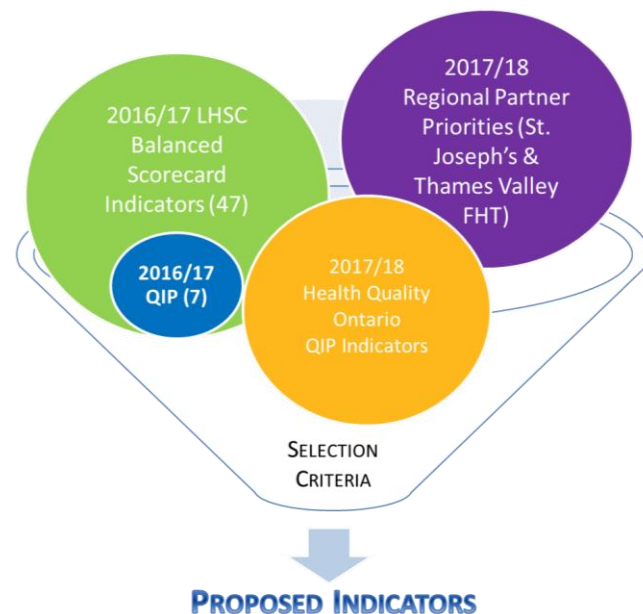
This year, LHSC continues to enhance our level of engagement with all levels of leadership, physicians, clinicians and staff. One key initiative is the development and implementation of a shared accountability model. This model has proactively linked and enabled co-ownership of decision making between administrative and physician leadership.

Over August and early September 2016, a systematic review/analysis of our past LHSC QIP indicator selection practice was completed. Feedback from varied stakeholders (including prior year LHSC indicator development leads, physicians, executive team members, Health Quality Ontario (HQO), South West Local Health Integration Network (SWLHIN) quality documents, and select peer hospital quality leads) were components of the review. The review identified areas of past successes as well as areas for potential opportunity. The LHSC 2017/18 QIP indicator selection process revisions were introduced with the aim of enhancing our ability to establish priorities that balance alignment with LHSC's Transitional Plan, and Balanced Scorecard (BSC) areas of focus, in concert with regional and

system priorities as identified by HQO and the SWLHIN. Additionally, the process components related to target setting evaluation and rationale have been revised to enhance standardization.

For the 2017/18 QIP development a detailed and standardized vetting process for identification of proposed indicators was completed. This process included a review of all 2016/17 Balanced Scorecard (BSC) Indicators, current 2016/17 QIP indicators and proposed 2017/18 QIP Indicators from Health Quality Ontario (HQO), in concert with critical incident data and patient experience information. All of these indicators were evaluated against a standardized set of selection criteria designed to take into consideration a number of factors including alignment with the strategic direction of the organization,

ability to measure and influence the indicator and potential for regional collaboration.



Extensive stakeholder consultation was completed where the indicators were reviewed with Patient and Family Advisory Councils, the Patient Experience Coordinating Council, Physician Chair/Chiefs, staff and leaders. New this year, LHSC is partnering with St. Joseph's Health Care and the Thames Valley Family Health Team to identify criteria where collaboration will drive success at the system level.

Resident, Patient, Client Engagement

Patient and family-centred care is a key strategic focus at LHSC. The 2016-18 Transitional Plan includes a goal of increasing patient and family voice throughout all areas of the hospital using standardized approaches. Engaging patients and families in the QIP process is one example of bringing this goal to life.

In the 2017-18 QIP development process patients and families played a central role in the selection of priority areas of focus. Through the use of four Patient and Family Experience Committees (which also included staff, physicians and leaders), we were able to narrow our focus to these key areas:

- Ensuring a positive experience in the Emergency Department, including reduced wait times for sicker patients
- Ensuring medication safety through a standardized approach to checking medicines both when patients arrive at the hospital and when they go home
- Ensuring that patients and families have all the information they need at the time of discharge

Here is what our patients and families said about being involved in this important process:

“Having an opportunity to include a patient voice in LHSC directions builds trust which is the foundation of collaboration between patients/ people and health-care providers. It is also a plus for LHSC as they gain a complete view of what is most important to monitor for safety and quality in the health care they provide. The opportunity to have input into the QIP was very much appreciated.”

Theresa Malloy-Miller, Co-Chair of the Patient Experience Committee (Patient/Family Advisor)

“It was a great opportunity to take part in the consensus activity for QIP - it makes me as a patient feel that I am having some input into the direction the hospital is taking and they are listening to the patient voice.”

Bonnie Field (Patient Advisor)

“As a participant in PECC, my voice represents also a voice for others, who may not have a forum to do so. Having direct input to possible changes in QIP is appreciated! Knowing our voice is important and valued, opens the door to building a relationship of trust and caring. It is the principle of patient and family-centred care.”

Bev McDonald (Family Advisor)

Within the organization, the knowledge and application of patient and family-centred care (PFCC) principles is more prevalent today than ever before, with over 200 patient/family volunteers serving on advisory committees across the hospital. Involving patients and their families in the care provided and garnering their thoughts and feelings related to the quality of care is becoming embedded in the culture at LHSC.

Staff Safety & Workplace Violence

Keeping our staff, physicians, and volunteers safe at LHSC is an important part of what we do each and every day. Some of the steps we take to reduce incidents of harm and violence include:

- Extensive mandatory training for all staff
- Transparent reporting of incidents and trends on the AEMS intranet website
- Diligent investigation into each and every adverse event to identify root cause(s) and corrective action(s)
- Actively involving our leaders and Joint Health & Safety Committee in ensuring a safe workplace

Work ahead in 2017-18 includes:

- Review of the standards of civility and code of conduct
- Development of policies and procedures for our Emergency Departments to reduce the risk of violence in relation to contraband items including weapons entering their areas. This builds on work already in place in our Mental Health programs, and will include physical changes that create clear visual tools to assist patients in understanding what they may or may not bring into the Emergency Department.

Performance Based Compensation

ECFAA requires that the compensation of the CEO and executives reporting to the CEO be linked to the achievement of performance improvement targets laid out in your QIP. The purpose of performance based compensation related to ECFAA is to drive leadership alignment, accountability and transparency in the delivery of QIP objectives.. ECFAA mandates that hospital QIPs must include information about the manner in and extent to which executive compensation is linked to achievement of QIP targets.

The proposed compensation plan for the 2017-2018 QIP is for 10% of the CEO's annual salary to be directly based on the organization's ability to meet or exceed the targets as outlined on the three compensation based indicators. For the remaining executive staff, 3% of their annual salary will be at risk. Compensation, as it relates to the three indicators, will be awarded as follows:

1. The three indicators below carry an equal weight of 33.3%.
2. For the three compensation based indicators, there are three levels of achievement
 - Less than 50% of target achieved - no compensation awarded for that particular indicator.
 - Midpoint between current and target, to approaching target performance - prorated compensation will be awarded for that particular indicator equal to the percent towards target achieved.
 - Equal to or greater than 100% of target achieved - 100% of compensation awarded for that particular indicator.

Measure			Compensation			
Indicator	Baseline	Target	Missed (<50%)	Partial (50-99%)	Met (>=100%)	Weight
Medication Reconciliation at Admission (%)	82.8%	85.0%	< 83.90%	83.90% to 84.99%	>= 85.00%	33.3%
Medication Reconciliation at Discharge (%)	72.0%	77.0%	< 74.50%	74.50% to 76.99%	>= 77.00%	33.3%
Emergency Department Wait Times: 90th%ile ED LOS for Complex Patients (hrs)	11.40 hrs	10.30 hrs	> 10.85 hrs	10.31 hrs to 10.85 hrs	<= 10.30 hrs	33.3%

Sign-off

It is recommended that the following individuals review and sign-off on your organization's Quality Improvement Plan (where applicable):

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

ORIGINAL SIGNED BY

Mr. Tom Gergely
Board Chair

Mr. Lawrence McBride
Quality Committee Chair

Mr. Murray Glendining
Chief Executive Officer