Let's Make Healthy Change Happen.

2019/20 Quality Improvement Plan (QIP)

Narrative for Health Care Organizations in Ontario

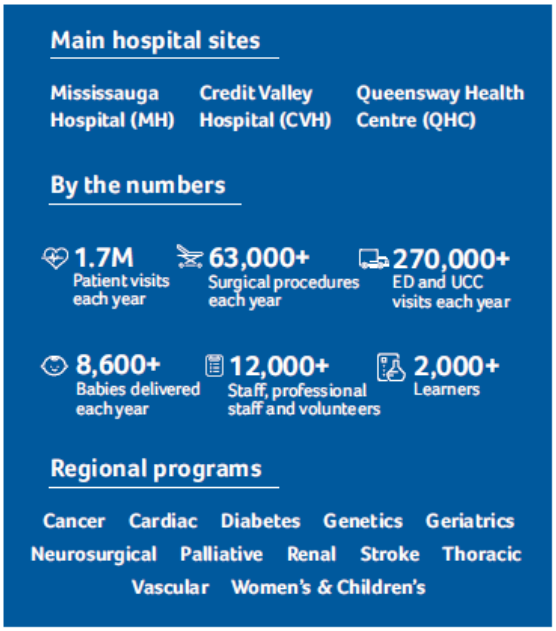
Trillium Health Partners

Better Together

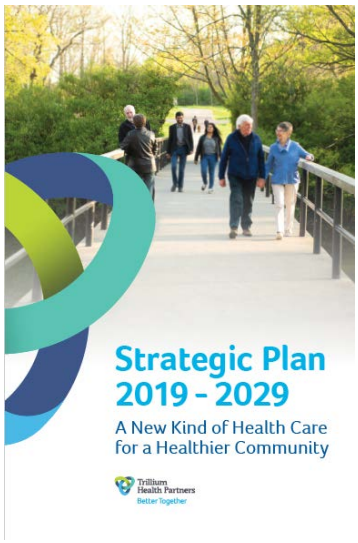
March 31, 2019

This document is intended to provide health care organizations in Ontario with guidance as to how they can develop a Quality Improvement Plan. While much effort and care has gone into preparing this document, this document should not be relied on as legal advice and organizations should consult with their legal, governance and other relevant advisors as appropriate in preparing their quality improvement plans. Furthermore, organizations are free to design their own public quality improvement plans using alternative formats and contents, provided that they submit a version of their quality improvement plan to Health Quality Ontario (if required) in the format described herein

Overview



As an organization entrusted with providing health care services to a growing, diverse community, Trillium Health Partners (THP) is continuously seeking new ways to improve and deliver the highest quality, most efficient, safest, patient centered care and an exceptional experience. We are proud to present our Quality Improvement Plan (QIP) for 2019-20, which focuses on our Acute Care commitments to our growing community offered through our three (3) main hospital sites. We also share our Long-Term Care (LTC) goals for our 21 LTC beds located at the McCall Centre of the Queensway Health Centre site.



This year, we launched our new 2019-2029 Strategic Plan, developed through engagement with over 180,000 people including patients, family members, partners and other members of the community that THP serves. The Strategic Plan outlines our organizational focus on quality, access and sustainability – for today and tomorrow. We plan to achieve these goals by focussing on our priorities: delivering high quality care; partnering for better health outcomes; and shaping a healthier tomorrow. Our plan will enable us to create a new kind of health care for a healthier community.

THP's Quality Improvement Program (QIP) is aligned with our strategic goals, and shapes how we hold ourselves accountable to achieving them. Our QIP for 2019-20 builds on the quality improvement efforts we have made in our first several years as an organization, and sets the foundation for the transformational work to come over the next ten years. In 2019-20, we will focus our improvement efforts on the most critical elements of the patient experience, in the face of the capacity pressures we are currently managing.

THP continues to face significantly high patient volumes and managing capacity is our greatest challenge. Over the next ten (10) years, THP will experience more growth in demand for service than any other hospital in Ontario. Since 2011, THP has seen significant increases in patient volume and acuity and has experienced an increase in the number of patients requiring alternate levels of care (ALC). As a response to unprecedented patient volumes, we have opened additional patient care spaces and are actively monitoring and filling vacancies for nurses, physicians, and Allied Health staff. While we plan for the future, we continue to feel this pressure on a daily basis.

THP has received approval for a hospital expansion project that will add approximately 600 new hospital beds at the Mississauga Hospital (MH) and Queensway Health Centre (QHC) by 2027. However, there is a major gap in capacity needs between today and when these beds will become available. Our predictions indicate that we will continue to face bed pressures until the completion of the hospital expansion project in order to continue to meet the growing health care needs of our community.

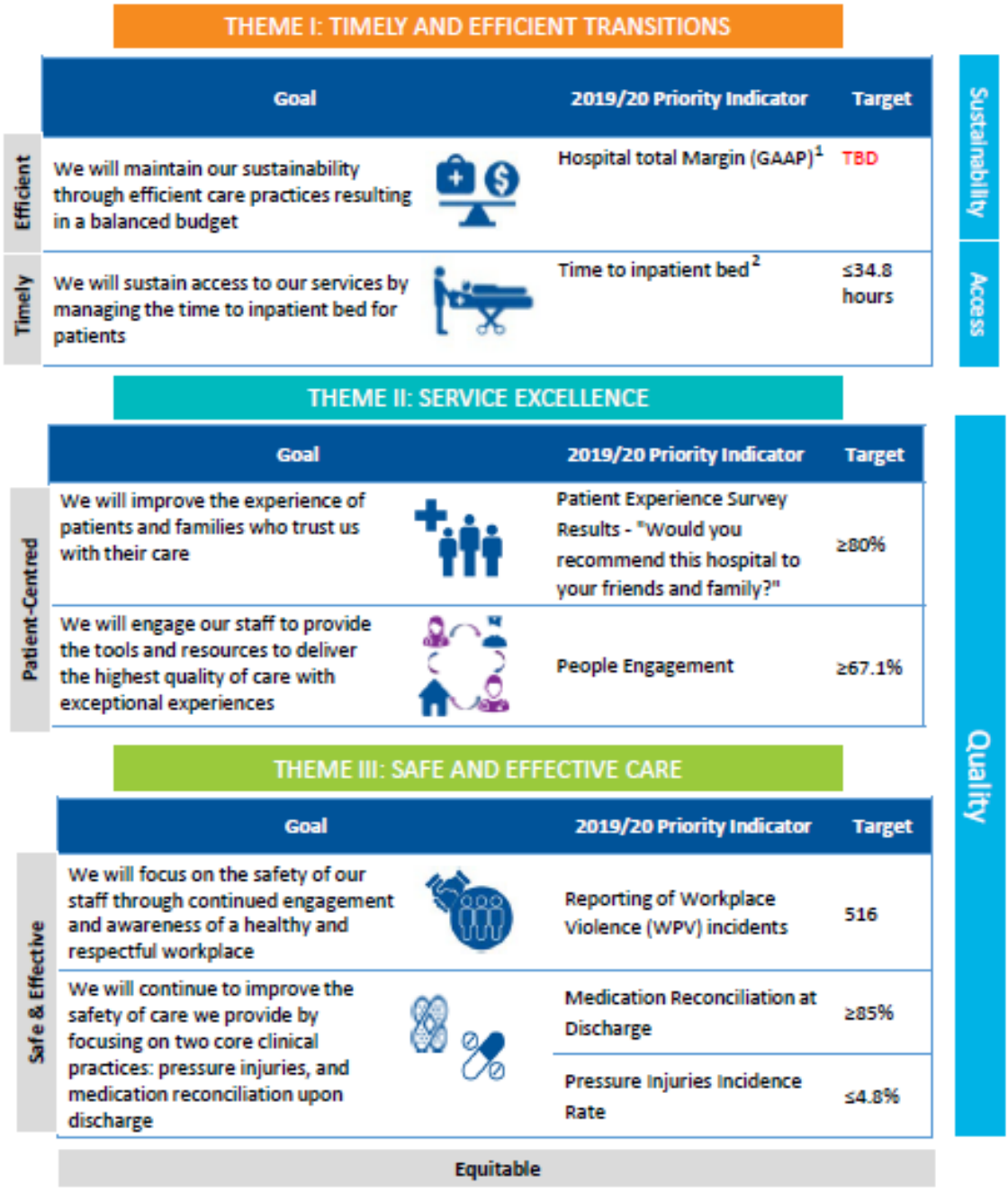
To guide improvements in quality, access and sustainability, while managing the increasing capacity, acuity and budget pressures, we look to our new THP Quality Model to guide us:

Our Quality Model is predicated upon: high reliability built into all processes and services; the delivery of exceptional experience through patient-centeredness, evidence-informed leading practices and innovation; and, a continual drive for excellence and improvement.

We have set targets in our 2019-20 Quality Improvement Plan (QIP) that reflect our commitment to continuous improvement, building on the progress that we have made since the merger, and driving toward the achievement of our strategic goals. The QIP represents only one of the vehicles containing measures at a governance level that are subject to board over-site. In addition, management reviews additional indicators through quarterly reporting and as part of the CEO and Presidents reporting to the Board of Directors.

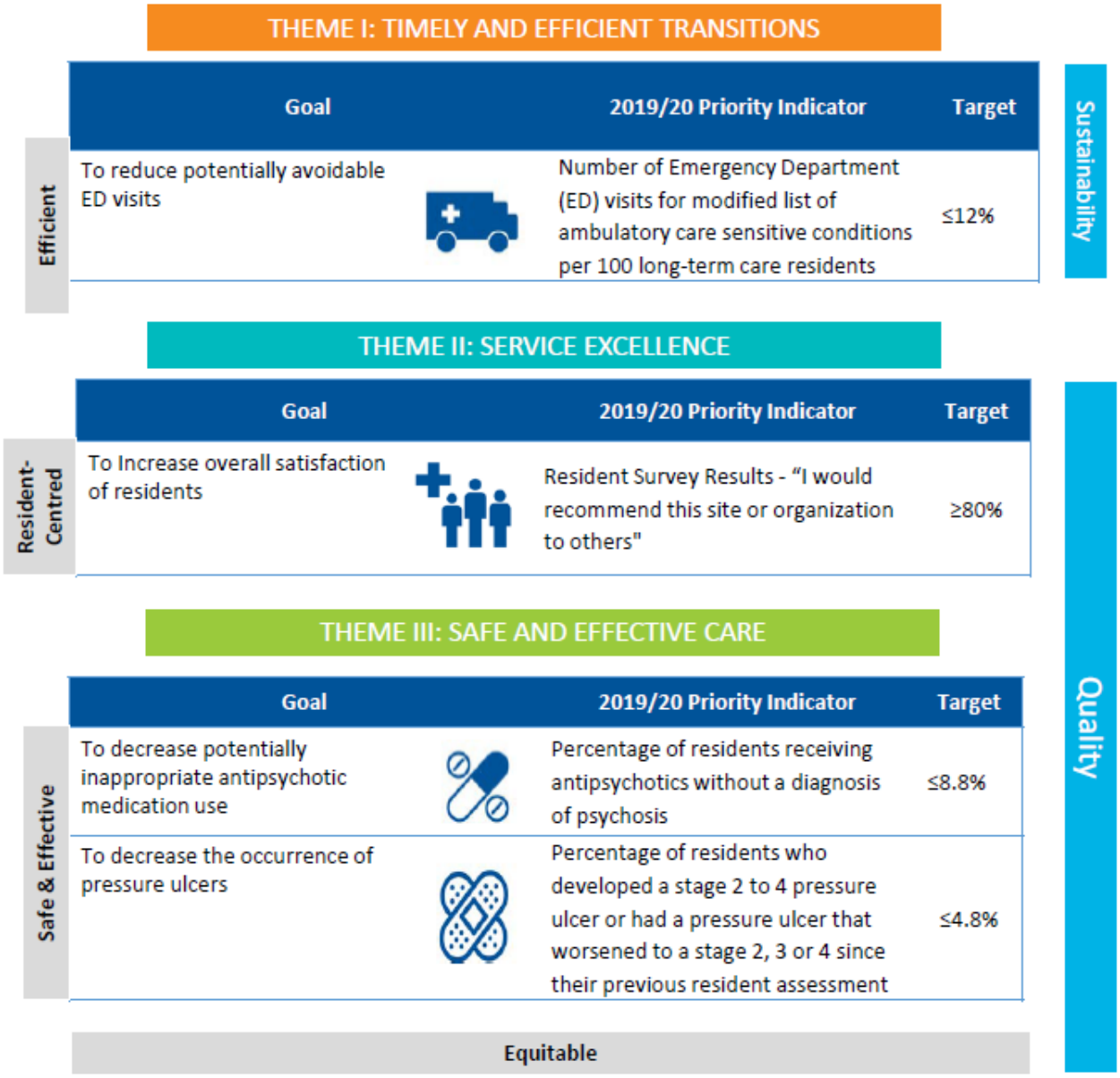
At the time of this submission, we do not have confirmation regarding 2019/20 funding (March 31, 2019). If in the event we do not receive the funding associated with our H-SAA, it would necessitate a recalibration of this plan.

Acute Care at Trillium Health Partners



[1]Hospital Total Margin (GAAP) indicator target assumes forecasted funding expectations.
[2]Time to inpatient bed indicator target assumes maintenance of funding for existing beds and surge beds.

Long-Term Care at Trillium Health Partners[3]



[3] There are 21 Long Term Care (LTC) beds at Trillium Health Partners which are located at the McCall Centre of the Queensway Health Centre site.

Quality Improvement Achievements from the Past Year

In November 2017, THP was awarded an Exemplary Standing by Accreditation Canada, the highest possible level of hospital survey performance. As an organization, we continue to build on this momentum with our commitment to quality and better patient outcomes as we implement our new Strategic Plan.

In partnership with Saint Elizabeth (SE) Health Care, THP was awarded the prestigious 2018 Minister's Medal Honouring Excellence in Health Quality and Safety for our innovative cardiac partnership, Putting Patients at the Heart (PPATH). The theme for the award was Innovating Integration, honouring innovative initiatives undertaken across Ontario that achieve better experiences and outcomes for patients, through better value in health care delivery.

The PPATH program is a great example of the power of teamwork and partnerships in creating better health outcomes by bridging gaps inside and outside of the hospital, while increasing acute care capacity to meet the growing health care demands of the community. Through PPATH, THP and SE Health redesigned the care journey for cardiac surgery patients, streamlining and simplifying access to follow-up care for patients. PPATH patients are able to return home, on average, one day sooner after cardiac surgery, with a 33% reduction in post-surgery Emergency Department visits, and 25% fewer re-admissions. The program has achieved health system savings of $1.7 million over two years and 3.5 times more patients received care.

Through our commitment to partnership as a strategic priority, we continue to find innovative, collaborative solutions to address various challenges, including capacity and ALC. Since 2014, THP's partnership with Runnymede Healthcare Centre has provided access to 33 Complex Continuing Care (CCC) beds for patients requiring Low Tolerance Long Duration (LTLD) rehabilitation care. This year, we expanded the Runnymede partnership further, and will now

provide High Tolerance Short Duration (HTSD) Rehab care to referred THP patients. The Runnymede partnership will enable us to further expanded acute care capacity within the hospital.

THP recently partnered with West Park Health Centre (WPHC) to provide services that help patients requiring chronic ventilation transition from long-stay Intensive Care into a more appropriate care setting. Thanks to funding from the Ministry of Health and Long-Term Care, this partnership was expanded as a part of the Capacity 99 Project. The Capacity 99 project, brought 99 beds of new capacity on-stream throughout the Mississauga Halton LHIN.

These accomplishments were made possible by strong local partnerships, which we continue to grow and develop, along with the deep commitment of our staff and professional staff to continuous quality improvement as we work to prepare for the growing and changing needs of the future.

Major Projects and Quality Improvement

One of the key challenges we are facing at THP is aging infrastructure. To address the need for improved technology infrastructure, THP is investing in a new Hospital Information System (HIS) Project in 2019-20 with a target go-live date of summer of 2020. Guided by our Quality Model, inter-professional health teams across our hospital sites, will build and implement a new EPIC technology platform. This modern technology platform and single patient record will provide reliable information, enabling best practice clinical performance, and ensure the delivery of exceptional patient experience. The HIS Project will be the largest quality improvement initiative at the hospital in 2019-20.

To mitigate the challenge of serving our growing and aging population, the need for increased capacity for care in our region, and the reality of our aging physical infrastructure, THP is in the process of planning for a major redevelopment project: the redevelopment and expansion of our Mississauga Hospital (MH) site and a new patient tower for post-acute patients at our Queensway Health Centre (QHC). These redevelopment projects will add over 600 new beds of acute and post-acute care capacity within our walls resulting in approximately 2,000 hospital beds across our sites by 2026-27. We are also planning to develop over 500 new long-term care beds and transitional care beds, which will be complemented by co-located community based services, creating two community health hubs.

Partnering With Patients and Residents

Patients and families contribute recommendations on quality and patient experience concerns through Patient and Family Partnership Councils and Clinical Program Committees. Every major project we embark on, and every major decision we make, involves a patient voice at the table. Across the hospital, we have 80 Patient and Family Advisors providing guidance from the corporate to clinical program level. Similarly, in our Long-Term Care unit, a Resident Council is engaged on the care and experience issues that matter most to residents.

Patient and Resident Councils are consulted on service and planning across the hospital. Every day we engage with patients, residents and their families on how their care is managed and delivered through patient rounding, and patient and resident surveys. THP hosts regular community telephone town hall meetings where senior executives connect directly with over 13,500 community members and speak with them about the hospital and the health care system.

Workplace Violence Prevention

At THP we aspire to create a healthy, safe and respectful environment for healing that is based on our values of compassion, excellence and courage. To be *Better Together*, we commit to fostering a respectful workplace culture that promotes a safe and supportive environment for everyone who provides care, supports caregiving, receives care, or, visits the hospital.

In 2017, we established a frontline inter-professional working group that created a framework promoting a healthy, safe, respectful and healing culture at THP. Together, we have successfully implemented an organization-wide Declaration of Respect, suite of policies, mandatory training and refreshed electronic incident reporting system. All of these tools provide clear expectations and standards, as well as a process by which incidents or threats of workplace violence can be prevented, reported, and addressed.

Reporting of workplace violence, workplace sexual harassment, or workplace harassment incidents through our electronic incident reporting system is embedded in our practices. We encourage staff to report such incidents. Through education, we anticipate that staff, learners, professional staff, and volunteers, will become increasingly aware of the importance of reporting workplace violence. Workplace violence reports are reviewed and analyzed regularly to ensure that the appropriate level of support is provided, and that the right level of action is taken to address the situation and prevent similar incidents from happening again. Over time, with the Declaration of Respect and appropriate training, we anticipate a decrease in the number of incidents that are occurring.

Performance Based Compensation

All executives and leaders at THP have a portion of their Performance Based Pay tied to the quality indicators outlined in the QIP. With oversight from the Board of Directors, the leadership team is held accountable for the overall performance of the organization through quarterly reviews of these priority targets, along with formal annual performance reviews.

Sign-off

I have reviewed and approved our organization's 2019/20 Quality Improvement Plan:

Dr. Dante Morra
Chief of Staff

Ms. Kathryn Hayward-Murray
Chief Nursing Executive

Ms. Michelle DiEmanuele
Chief Executive Officer

Mr. Alan MacGibbon
Board Chair

Mr. Nick Zelenczuk
Board Quality Committee Chair

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

Trillium Health Partners 2200 Eglinton Avenue West

AIM		Measure									Change				
Issue	Quality dimension	Measure/Indicator	Type	Unit / Population	Source / Period	Organization Id	Current performance	Target	Target justification	External Collaborators	Planned improvement initiatives (Change Ideas)	Methods	Process measures	Target for process measure	Comments
M = Mandatory (all cells must be completed) P = Priority (complete ONLY the comments cell if you are not working on this indicator) C = custom (add any other indicators you are working on)															
Theme I: Timely and Efficient Transitions	**Timely**	**The time interval between the Disposition Date/Time (as determined by the main service provider) and the Date/Time Patient Left Emergency Department (ED) for admission to an**	**MANDATORY**	**Hours / All patients**	**CIHI NACRS / October 2018 – December 2018**	**975***	**40.45**	**34.80**	**Setting our target at our target to maintain average time to inpatient bed while managing capacity and increasing acuity of**		**1)Build on work for ED LOS indicator by continuing to implement patient flow initiatives.**	**1) Trial Expected Date & Time of Discharge (EDD) to maximize the number of patients assigned to beds by midnight 2) Improve the escalation procedure for delayed repatriation of patients 3) Pilot new Inter-professional Team Rounds and new discharge pathway in Inpatient Medicine 4) Pre-pandemic Surge Plan for identified areas 5) Continue implementing telemedicine consults in Long-Term Care Homes to decrease avoidable ED admissions**	**1a) % of patients who have an EDD assigned within 48 hours of admission 1b) # of empty inpatient beds by midnight 2) # of days a patient spends in bed due to delayed repatriation 3a) % of patients discharged on or before EDD 3b) % of discharge planners/social workers educated on new escalation process 4) % of Surge Plans completed 5a) % of telemedicine consults that led to an avoidable ED admission 5b) # of telemedicine consults**	**1a) 100% 1b) 0 2) Reduction of 50% 3a) 80% 3b) 100% 4) 100% 5a) Reduction of 50% 5b) Increase of 50%**	**At THP we classify an inpatient bed as any bed a patient is admitted to - this includes an ED hallway, other hallways, surge spaces (for example**
Theme II: Service Excellence	**Patient-centred**	Patient experience: Would you recommend inpatient care?	C	% / All inpatients	CIHI CPES / 2018/19	975*	67.2	80.00	Maintain target and measure program-level initiatives to improve patient		1)Alignment of initiatives across THP with an overall focus on improving patient experience.	Changes are targeted via the following initiatives: 1) Promote AIDET (Studer method) 2) Refresh practice re whiteboards in patient rooms 3) Promote Transfer of Accountability at bedside 4) Leader Rounding 5) Ensuring patient's Primary Care Practitioner is	1) % of time AIDET is completed (audited) 2) % of whiteboards completed (audited) 3) % of TOA completed at bedside (audited) 4) % of Leader rounding with Staff completed (audited) 5a) # of "not my patient" faxes received from Primary Care	1) 80% 2) 80% 3) 80% 4) 80% 5a) Reduction of 50% 5b) Reduction of 50% 6) 80% 7)	
Theme III: Safe and Effective Care	**Effective**	Medication reconciliation at discharge: Total number of discharged patients	P	Rate per total number of discharged patients / Discharged	Hospital collected data / October - December 2018	975*	86.72	85.00	Focus on sustaining discharge med rec to ensure safe patient		1)Sustaining the medication reconciliation policy and initiative	1) Provide education to medical school students working with physicians on med rec best practices 2) Continue compiling quarterly reports on med rec compliance 3) Continue formal recognition of prescribers who have high med rec rates 4) Educate	1) % of medical school students working with physicians that receive med rec education 2) % of physicians receiving proactive feedback regarding discharge medication reconciliation rate. 3) # of physicians that receive formal recognition for high med	1) 100% 2) 100% 3) Increase by 50% 4) 100%	
	Safe	**Number of workplace violence incidents reported by hospital workers (as by defined by OHSA) within a 12 month period.**	**MANDATORY**	**Count / Worker**	**Local data collection / January - December 2018**	**975***	**516**	**516.00**	**We have set our target at our current actual rate in order to continue establishment of our baseline for this indicator, while**		**1)To continue building on the work from 2018/19 to implement the next phase of Respectful Workplace Program to drive prevention and education across the organization, as well as encourage reporting.**	**1) Prevention and Skills training 2) Engagement on expectations across Programs 3) Improve RL6 incident reporting 4) Peer Support/Post-Incident Support**	**1) % of ED and Mental Health units trained in coordinated approach to Crisis Intervention 2) % of staff in targeted programs, with GPA training 3) % increase in the number of hazards/risk assessments completed 4) % increase in the number of staff assigned with peer supports**	**1) 100% 2) 100% 3) 25% 4) 25%**	**FTE=7205 A review of the incident reporting system found double entries, and reporting for incidents outside the scope of WPV. Our target has**
		Composite score for the Opinion Survey based on scores achieved across dimensions including:	C	% / All employees (FT, PT, casual and active, Associate and Courtesy	In-house survey / Annual	975*	67.1	67.10	Maintain target and measure real-time program-level patient		1)Continue to implement the action plan as per 18/19 QIP with changes as per recommended in the 2018 pulse survey.	1) Continue to roll-out action plan to address opportunities for improving engagement across the organization. 2) Develop a standardized In-Patient Chemotherapy process to account for the increase in volumes and more complex chemo regimens 3) Create	1a) % of action plans implemented 1b) % of Leader rounding with staff completed 2) % of staff satisfied with new chemotherapy drug administration process 3) % of staff satisfied with the new communication process and standardized workflow 4a) Average # of	1a) 100% 1b) 100% 2) Increase in 50% 3) Increase of 50% 4a) 30 days 4b) 80%	
		Hospital Acquired (HA) Pressure Injury Incidence	C	% / All inpatients	In house audit conducted with third party / Annual Audit	975*	7.9	4.80	To maintain target from 2017/18 to improve on pressure injury		1)To revamp education on pressure injuries across the organization using the results from the annual P&I audit.	1) Review of annual P&I audit results to identify key areas of focus 2) Use of focused mini P&Is to track rates throughout the year	1) % of Braden scales completed on Admission 2) % of Minis completed per quarter for at risk units	1) 100% 2) 100%	Current performance for 2019 is preliminary until final audit results
Equity	**Equitable**	Total Margin	C	% / N/a	In house data collection / 18/19	975*	CB	CB	Target to be updated in Q1 upon confirmation of budget		1)Continue to build on progress with standardization of processes across the organization, specifically to	1) Continue developing Standard Operating Procedures (SOPs) for staff Targeted initiatives focused on sustainability: 2) Mandatory reporting of overtime and agency hours by management 3) Ongoing implementation of attendance management and sick	1) % of completed SOPs 2) % of agency to regular staff used 3) % of employees sent sick time letters 4) % of staff requested to work overtime	1) 100% 2) Reduction by 10% 3) Reduction by 10% 4) Reduction by 10%	

2019/20 Quality Improvement Plan for Ontario Long Term Care Homes
"Improvement Targets and Initiatives"

McCall Centre LTC Interim Unit 140 SHERWAY DRIVE

M = Mandatory (all cells must be completed) P = Priority (complete ONLY the comments cell if you are not working on this indicator) C = custom (add any other indicators you are working on)

AIM		Measure									Change				
Issue	Quality dimension	Measure/Indicator	Type	Unit / Population	Source / Period	Organization Id	Current performance	Target	Target justification	External Collaborators	Planned improvement initiatives (Change Ideas)	Methods	Process measures	Target for process measure	Comments
Theme I: Timely and Efficient Transitions	**Efficient**	Number of ED visits for modified list of ambulatory care–sensitive conditions* per 100	P	Rate per 100 residents / LTC home residents	CIHI CCRS, CIHI NACRS / October 2017 – September 2018	54760*	X	5.00	Realistic and attainable target		1)Continue to involve NPStat in decision making, and ethicist as needed.	Prior to transfer to ED, NP will be contacted to come and assess the resident.	# of residents seen by NP prior to transfer. # of transfer averted due to NP visit.	At least 80% of residents will be assessed by NP prior to transfer to ED	current performance does not match LTCHomes.net data; will
Theme II: Service Excellence	**Patient-centred**	Percentage of residents responding positively to: "I would recommend this site or organization to others." (InterRAI QoL)	P	% / LTC home residents	In house data, interRAI survey / April 2018 - March 2019	54760*	80	85.00	corporate target		1)To improve resident experience during their stay at McCall interim LTC unit before the resident transitions to their	ED to improve communication and encourage ongoing feedback during their stay at McCall by conducting daily walkabout and talking to residents so they are familiar with her. ED to continue to attend residents council as invited and to address concerns in a timely	# of residents completing survey in 2019. # of times ED attends Resident's Council	Increase the response rate by residents to the Resident Satisfaction survey	
											2)Improve evening programs as identified on resident satisfaction survey.	Program manager to review current evening programs. Conduct applicable recreation program evaluation to identify which programs are enjoyed by residents. Liaise with Program Consultant from corporate for additional recommendations. Will interview residents	# of new evening programs introduced in 2019. # of residents suggestions for programs implemented.	AT least 5 new programs will be introduced in 2019.	
		Percentage of residents responding positively to: "What number would you use to rate how well	P	% / LTC home residents	In house data, NHCAHPS survey / April 2018 - March 2019	54760*					1)				We do not use this question on our survey
		Percentage of residents who responded positively to the question: "Would you	P	% / LTC home residents	In house data, NHCAHPS survey / April 2018 - March 2019	54760*					1)				We do not use this question on our survey.
		Percentage of residents who responded positively to the statement: "I can express my	P	% / LTC home residents	In house data, interRAI survey / April 2018 - March 2019	54760*					1)				We will continue with our current processes as we are performing at 100% for this
Theme III: Safe and Effective Care	**Effective**	Proportion of long-term care home residents with a progressive, life-threatening illness who have had their palliative care needs identified early through a comprehensive and	P	Proportion / at-risk cohort	Local data collection / Most recent 6-month period	54760*	CB	80.00	New indicator		1)Upon admission, new residents will be assessed to identify those who will benefit from an individualized palliative	Staff to be educated on how to conduct My Wishes. Staff will meet with residents within 2 weeks of admission to determine their individualized needs. A My Wishes care plan will be completed.	# of staff trained. # of residents with My Wishes care plan.	80% of residents will have My Wishes completed when appropriate by Dec. 2019	
											2)registered staff will be educated and trained on using palliative care early identification tools.	registered staff to receive education on palliative care program. RAI coordinator to review CHESS scores quarterly. If CHESS score greater than 3, a PPS will be performed and a palliative care plan will be initiated when appropriate.	percentage of staff who receive education and training on the Palliative Care program. # of palliative care plans created as a result of in-depth assessment. # of residents coded as end stage disease(J5c)	25% of registered staff on the Interim LTC unit will receive proper training on the	
		Percentage of long-term care home residents without psychosis on antipsychotics in the last 7 days	C	% / LTC home residents	CIHI CCRS / Q2 2018-Q2 2019	54760*	12.1	8.80	Home specific target		1)Education of full time and part time registered staff on antipsychotic use and possible alternatives.	BSO staff to work with full-time/part-time registered staff and provide education on alternative therapies	number of full-time/part-time registered staff who receive education	100% of full-time/part-time registered staff to receive education	
											2)Introduce Montessori programming to the home area.	Trillium to provide funds to educate selected staff on Montessori programming. Home to set up mobile cart with Montessori activities for use by front line staff.	# of staff educated. # of residents with Montessori programming care plans	Montessori programming will be introduced in 2019.	
	Safe	Percentage of long-term care home residents who developed a stage 2 to 4 pressure ulcer or had a pressure ulcer that worsened to a stage 2, 3 or 4	C	% / LTC home residents	CIHI CCRS / Q2 2018-Q2 2019	54760*	2.6	2.00	Corporate target		1)Audit PCC documentation on altered skin integrity weekly.	registered staff to complete skin/wound assessments and weekly audits to ensure all altered skin documentation is completed.	# of residents who do not have an altered skin and/or wound assessment completed weekly	All residents with altered skin integrity will have an appropriate assessment	
											2)Early identification of altered skin integrity.	Educate PSWs on how to identify Stage I areas. Report findings to Registered staff and document on daily care record. Registered staff to check daily care record and review at report any altered skin integrity reported.	# of PSWs educated. # of Stage I areas reported by front line staff. # of audits monthly with deficiencies	All PSWs on LTC unit will be educated on early identification of altered skin	