Cohort 11 Abstracts

Title:	**Improving Cervical Cancer Screening Rates at Carea Community Health Centre**
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Aim/ Objectives

Increase cervical cancer screening in women ages 21-69 from 55.2% to the LHIN's target of 73.4% by December 2017.

Intervention/ Change Ideas

We determined that the primary cause of our low screening rates was related to data issues. As a result, we focused most of our change ideas on how data was entered, extracted, and reviewed. One of our change ideas was to advocate for providers to have direct access to a list indicating which clients were overdue for a Pap test. Access to this list allowed providers to review and determine their client's eligibility for a Pap test on a more frequent basis. This helped ensure the accuracy of our data.

Evaluation/ Measures

The rate of completed Pap tests before and after the implementation of our change ideas were, and continue to be, measured and compared. As a balancing measure, the rate of declined Pap tests is also being monitored.

Spread/ Sustainability

- Our QI Committee continues to meet monthly
- The creation of a work plan is progressing and action items are being addressed
- Staff are sharing knowledge and skills with each other
- Senior staff are sharing this knowledge as they mentor new staff

Key Lessons Learned

- All key players need to be informed, engaged, and committed from the start of the project
- Data analysis and access to QI tools are essential for this work
- It is important to ensure new staff receive comprehensive training in system access and documentation so that data remains accurate and up-to-date

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Aim/ Objectives

By June 30, 2018, the total number of injuries to staff will be decreased by at least 50% compared to a baseline of 166 incidents during the 2014-2015 and 2015-2016 school years.

Intervention/ Change Ideas

The change ideas we implemented were:

- Personal Protective Equipment (PPE) procedure
- Rapid Incident Review (RIR)

Evaluation/ Measures

- Outcome: Total number of incidents (i.e., staff injuries) reported
- Process: Proportion of RIRs completed within requisite time
  Staff feedback on the RIR process
  RIR action items completion (e.g., consistency, timeliness)
- Balancing: Staff feedback on the RIR process

Spread/ Sustainability

Integrated RIR results with WSIB incident reporting

- Established electronic notification for monitoring action item completion
- QI methodology is being applied to broader organizational initiatives including waitlist management

Key Lessons Learned

- The IDEAS project highlighted the following lessons:
  - Additional sources for improved clinical understanding (e.g., behavioural data) need to be captured
  - The value of early engagement with stakeholders
  - QI is a continuous, iterative process as our theories of change evolve and new insights are gained
  - A change in one area has an impact in another area

Title:	**Examining and Improving FIM® Data Quality for Stroke Patients on the Integrated Stroke Unit at Royal Victoria Regional Health Centre**
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Aim

To improve data quality for the FIM® assessment by ensuring assessments are completed in a timely, accurate, and reliable manner.

Context

An inconsistency in comparison of two data points, median FIM® Efficiency and Percentage of patients achieving a 20-point change in the FIM®, led to a discovery process to examine the issue. As a result, several primary drivers were identified. It was identified that FIM® data quality was the driver that should be addressed first.

Intervention/ Change Ideas

Changes ideas developed and implemented include:

- create a FIM® aware environment by developing a series of information posters;
- ensure FIM® assessors are trained and credentialed including establishing FIM® trainers;
- establish a process to enforce FIM® timelines by reassigning FIM® activation responsibility; and
- establish sustainable accountability mechanism by assigning a FIM® timeline champion.

Evaluation/ Measures

To determine whether interventions resulted in an improvement several measures were identified and monitored including:

- percentage of charts without data quality issues;
- rate of errors per chart per month;
- completeness and timeliness of FIM® data;
- time from admission & discharge to NRS Module Activation;
- percentage of staff confident/very confident in their FIM® assessment skills; and

- percentage of staff proficient in FIM®.

Sustainability

Sustainability plans include:

- FIM® training for staff on the Integrated Stroke Unit to ensure a level of proficiency;
- training process for new hires and mandatory re-credentialing;
- hardwiring a FIM® aware culture, where FIM® data is reviewed regularly and used to inform decisions; and
- identification of measures to monitor, and assignment of responsibility.

Spread

- This project has been limited to the stroke population. All outputs from the project will be applied to other populations.
- Learnings will be shared with partner organizations within the Central East Stroke Network and with provincial counterparts.

Key Lessons Learned

- The outcome of the change idea must have perceived value for staff to support buy in.
- To support sustainability, change ideas must address adaptive aspects (e.g. staff knowledge and culture shift). Focusing only on technical changes is not enough.

Title:	**Pharmacist-Led Medication Reconciliation to Improve Transition of Care from Hospital to Home**
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Aim/ Objectives

By October 31, 2017, 80% of patients within the Northumberland Family Health Team will be seen within 7 days of discharge for an appointment with a pharmacist for medication reconciliation and review in addition to physician check in.

Intervention/ Change Ideas

1) Improving communication between the hospital and the Family Health Team, post-discharge.
2) Increasing access to appointments post-discharge for patients of the Family Health Team by offering a supplementary appointment with the pharmacist, in addition to the primary care appointment, for medication reconciliation and review.

Evaluation/ Measures

We measured the number of days between patient discharge and their first appointment with either the pharmacist or primary care provider. In all three clinics, we saw immediate decreases to the number of days between discharge and follow-up appointment. We also implemented a Patient Experience Survey to be administered after the Pharmacist appointment to capture the patient's perspective and to ensure that an additional appointment was adding value for the patient. 100% of patients agreed or strongly agreed that after meeting with the pharmacist, they had a better understanding of their medications and felt safer taking them.

Spread/ Sustainability

The initial project focused on one of three FHT clinics, but early success resulted in a faster spread to the second clinic than anticipated. Implementation in the third clinic is expected in early Fall. Pharmacist workload, patient satisfaction and PCP feedback have been captured and addressed as needed to ensure sustainable processes are developed. Other factors that have contributed to the spread include the front line staff being engaged early in the process, as well as commitment and support from Senior Management.

Key Lessons Learned

When you think you know, assume you don't! We all started the project with assumptions about what would work and quickly realized there were many more contributing factors and considerations when developing processes than we had anticipated. We also learned that collaboration is key to success and although it is not always easy to work across organizations, a common belief and commitment to the project, as well as continuous communication, engagement, and relationship building were key factors to a successful project team.

Title:	**Identifying Existing Health Link Patients**
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Aim/ Objectives

IDEAS team members were looking to improve the identification process of existing Health Link patients that were admitted to both of the hospital's medical units as well as those that presented to the ED consistently. Improving this identification process would allow staff to navigate patients with a Health Links approach more quickly and consistently.

Intervention/ Change Ideas

IDEAS team members implemented the use of a decision tree for discharge planners on both medical units as well as the attendance of staff of daily discharge rounds. Additionally there has been ongoing collaboration with the hospitals IT department to implement a flagging system to help identify Health Link patients upon presentation to the ED and medical units.

Evaluation/ Measures

IDEAS team members completed PDSAs for all improvement ideas. The implementation of the decision tree was followed by a staff survey to evaluate effectiveness. Data collection was used to track effectiveness of attending daily discharge rounds and data collection will be used to track effectiveness of the new flagging systems once implemented.

Spread/ Sustainability

Our IDEAS project has led to discussions with both Acute Mental Health and Rehab Units with regards to implementation of an identification process, the engagement of ED physicians and hospitalists re: making ongoing orders to use Health Links approach, and the ongoing education of hospital staff re: Health Links approach. IDEAS staff has continued to attend daily discharge rounds to hold gains on medical units.

Key Lessons Learned – Patient's stories motivate change!

Title:	**Reducing Facility Acquired Pressure Injuries at Cedarvale Terrace**
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Aim/ Objectives

We were working to reduce the number of facility acquired pressure injuries throughout our facility.

Intervention/ Change Ideas

We tried several different interventions to reduce the number of facility acquired pressure injuries within our home including repositioning clocks, a “thought jogger tool” to facilitate smooth admissions, readmissions, significant changes, and palliative care. We worked to change the focus from reactive to proactive. We changed the way we complete our care plan rounds and our shift reports. We completed a PDSA where we removed all of the under pads in the building which we found to be unsuccessful.

Evaluation/ Measures

We collected a variety of types of data including number of newly identified pressure injuries on each unit per month. We collected staff, family, resident responses to our PDSA’s, and we collected the number of pressure injuries that were healed throughout the home.

Spread/ Sustainability

We have implemented our strategies throughout the home, and we continue to develop new PDSA’s and change ideas to work toward our goal. We are currently noticing a significant downward trend in the number of facility acquired pressure injuries.

Key Lessons Learned

We learned the value of data collection and documentation in chart form. We learned that documenting the information in a graph provides a quick visual representation of the data and encourages others to “get on board.” We also learned just how important the entire inter-professional team is to any QI initiative.

Title:	**Improving Patient/Caregiver Experience in Care Coordination at the South Simcoe Northern York Region (SSNYR) Health Link**
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Overall Project Aim:

To improve the patient/caregiver care coordination experience in the SSNYR Health Link (HL) by 20%, by June 2018.

IDEAS Project Aim:

By October 31st, 2017, 90% of HL patients will report that they first reach out to the single point of contact to support their Coordinated Care Management needs.

Intervention/ Change Ideas:

1. A revised version of the Patient Experience Survey (PES) in order to have an appropriate and measurable outcome.
2. A standardized follow-up letter for all the organizations involved provided by the HL administration to remind patients of their Care Coordinator/ Case Manager and their respective agency with contact information.
3. A Health Links Skills day for providers to ensure a minimum level of competence for care coordination/case management.
4. Care Coordinators/Case Managers standard processes to ensure that they provide clients/ patients/caregivers their contact information and to contact them appropriately for care support.
5. SSNYR HL process guide for care coordination was revised and reviewed with the partner organizations.

Evaluation/ Measures:

Each of the interventions was measured in a phased approach, using PDSA cycles, to determine whether the specific intervention made an improvement. Our key outcome

measurement resulted in achieving our goal: 90% of HL patients/caregivers reported that they first reach out to the single point of contact to support their coordinated care management needs.

Spread/ Sustainability:

Spread:

The SSNYR HL will continue these change ideas in our HL process within our region as part of our standards of operation. We have shared our outcomes with Central LHIN and the other HL regions and we will incorporate them into the CLHIN processes.

Key Lessons Learned:

1. There has been a lot of work done prior to the IDEAS Project. As a team we needed to clearly agree on: our project aim and how we can obtain the desired impact.
2. Utilizing the QI tools has helped our team in:
    a. Developing a SMART Goal,
    b. Understanding the root cause of the gaps or problems – fishbone,
    c. Learning how to develop the ideas using change concepts – driver diagram,
    d. Taking it a small test at a time- PDSA and then being able to improve the change prior to implementation,
    e. Learning from our mistakes when assumptions are made.

Title:	**Multi-disciplinary treatment program for chronic non- cancer pain**
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Aim/Objectives:

Our Community Health Centre (CHC) had no formal coordinated pathway for treatment of chronic non-cancer pain. Our goal was to develop and evaluate a multidisciplinary knowledge-based treatment pathway. Our aim was that 50% of Dr. Holder's clients with chronic-non-cancer pain who attended an educational treatment pathway will report at least a two point increase in self-efficacy and functionality.

Intervention/Change Ideas:

We developed a multi-disciplinary education session on chronic non-cancer pain and made information on a variety of treatment options easily accessible. Our three PDSAs were; 1.use of proper measure, 2. Use of reminders and minimize handoffs, 3. Developing a contingency plan and changing targets**.**

Evaluation/Measures:

Measures we used for evaluation were:

- Stanford Self-Efficacy for Chronic Disease States,
- Functionality using American Chronic Pain Association Ability Chart,
- Generalized Anxiety Disorder-7 screening questions and
- Patient Health Questionnaire-9 depression.

Clients were evaluated both before the education session and 2 months after attending the education session. There was a marginal increase in self-efficacy and functionality as well as a marginal decrease in anxiety and depression.

The clients who identified as having chronic-non-cancer pain but did not sign up for the education session were surveyed to determine their reasons for not attending. The reasons for not attending were:

- felt pain was already managed;
- did not think it would work; and
- logistical issues.

Of these 37 clients who responded, 26 were currently using medications of which 13 were taking opioids.

Spread/Sustainability:

Our intent is to spread the project across both of our CHC sites, and include all the providers' clients. To make the project sustainable, we decreased the number of clinicians presenting the education session. Streamlining the process to decrease staff work is being addressed. Client recruitment is our greatest challenge.

Key lessons learned:

We found client recruitment difficult but an integral part for success. A key challenge revolves around expectations and beliefs around chronic non-cancer pain. Clients believe they are already managed on medications alone. The new guidelines for treatment of chronic non-cancer pain will be integrated into the program. Even though a small sample size, clients had positive experiences and marginal improvements over a short time.

Title:	**Improving Access to Community Rehabilitation for Stroke Patients**
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Aim/ Objectives

Current service at the Trillium Health Partners (THP) Outpatient Neuro Rehab (OP) department is not meeting the Canadian Stroke Best Practice recommendation of patients beginning rehabilitation services within 48 hours of discharge from acute care and 72 hours from inpatient rehabilitation. Currently patients wait an average of 58 days.

By the beginning of December 2017, there will be a decrease in the amount of time stroke patients wait for the OP Neuro Rehab program by 50% (from 58 days to 29 days).

Reduce the maximum length of stay in the OP program from 12 weeks to 8 weeks by May 31, 2017.

Reduce the amount of time clinical team spends on tasks related to waitlist management by 30% (compared to baseline) by June 2017.

Intervention/ Change Ideas

- Shorten maximum Length of Stay (LOS) from 12 weeks to 8 weeks
- Streamline Process for Waitlist Management

Evaluation/ Measures

Process Measures

- Proportion of patients at or below 8 week LOS target.
- Total minutes clinical teams spends on tasks related to waitlist management.

Balancing Measures

- Patient satisfaction survey results reported quarterly.
- Clinician rating of feasibility of goal setting within 8 weeks of LOS.

Spread/ Sustainability

Streamlined process for referring to OP program (within THP) is spreading beyond initial unit (Comprehensive Stroke Unit).

Process for waitlist management is being shared with other OP centres in the West GTA Region.

West GTA Stroke Network hosting QI Workshop for health professionals working in stroke care September 2017.

Key Lessons Learned

Even though the clinical team is a highly motivated group there are still some concerns about increased workload related to data collection.

It is important to share data with the clinical team on an ongoing basis for the team to lend their narrative to it, and to celebrate even small successes.

There will be uncontrollable issues that arise (staffing changes, management changes, workload, staff illness) and may impact on quality improvement projects.

We did not develop a communication plan to keep Executive Sponsors/Senior Leadership updated from the outset: we quickly became aware of the need to keep them in the loop on a regular and structured basis.

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Background

Medication reconciliation (MedRec) is known to improve patient safety, but is challenging to implement in ambulatory care settings. As an accredited health care organization, the Canadian Forces Health Services Group (CFHSG) is required to implement MedRec in its various clinics. Unfortunately, previous attempts to establish MedRec in our system have not been sustained over time.

Aim

To implement an effective MedRec process in a designated CFHSG clinic that allows drug therapy to be documented and discrepancies to be identified and reconciled for military personnel presenting at a clearly identified "transition point". For this project, the selected transition involves individuals who are releasing from the Canadian Armed Forces (i.e., transitioning to civilian health care systems at conclusion of their employment).

Measures

The primary outcome measure was the proportion of releasing personnel who underwent documented MedRec. The number of discrepancies identified was used as a process measure, while pharmacist time devoted to MedRec and feedback from patients and clinicians were used as balancing measures.

Change Concepts

Several change concepts were identified as being necessary to support successful MedRec implementation, including clear policy direction on high-priority transition points, functional tools to support the documentation of drug therapy and discrepancies, and standardized work processes that allow tasks to be balanced among clinic staff. Several of these change concepts were tested over three separate PDSA cycles.

Impact

During the first two PDSA cycles, a user-friendly form was developed and refined, and work processes at the initial clinic were realigned to ensure releasing personnel had scheduled visits with a pharmacist to document and discuss their drug therapy. Feedback from both patients and clinicians has been positive to date, and discrepancies are being detected regularly.

Key Lessons Learned

Monitoring is ongoing to determine if staffing changes and seasonal variation will affect the quantity or quality of MedRec that is performed. Future work will address change concepts at the system level (e.g., policy changes), and efforts will be made to replicate results at other clinics in our health care system.

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Aim/ Objectives

To ensure the equitable distribution of Outreach Attendant Services in the Waterloo Wellington LHIN.

By July 1, 2017 20% of WWLHIN Attendant Service Outreach consumers will have received a standard assessment for service allocation.

Intervention/ Change Ideas

Understanding not all of our consumers start from the same place, we identified the following change ideas to promote equity within our Outreach programs:

- Research, develop and implement a standard assessment for the allocation of Outreach Attendant Service hours.
- Adopt or develop standard service guidelines.
- Educate stakeholders on scope of services offered through Attendant Services.
- Identify solutions and partnerships.

Evaluation/ Measures

Outcome Measure- the number of Outreach consumers whose service hours fall within identified service ranges.

Process Measure- the number of Outreach consumers assessed using a standard assessment tool.

Balancing Measure- consumer satisfaction score about service delivery will remain over 90%

Key Lessons Learned

Accepting this project would not follow "a traditional QI approach."

Unable to show quick changes, we felt as though we were not progressing at times.

Creating something new is difficult; requiring our team to spend a great deal of time going back and forth in creating a standard assessment tool which works for our population.

Other Independent Living (IL) providers across Ontario currently use a similar process as ILCWR and GIL to allocate Outreach hours – does this mean it works? Is there a more equitable solution?

Next steps include

Expanding testing of our standard assessment form to include other Ontario IL providers

Trending results to identify characteristics specific to attendant services (i.e. provision of controlled acts) and determining appropriate service ranges.

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Aim/ Objectives

To reduce the percentage of patients readmitted to hospital within 30 days following discharge from Medicine Telemetry from 11.5% to 10% per month by December 2017.

Intervention

This project built upon previous quality improvement work in transferring patients safely to and from the Medicine Telemetry department.

Change Ideas

- Complete discharge phone calls:
  to proactively interact with patients within 72 hours, reducing the risk of deterioration at home and offer additional supports,
- Fax Discharge Medication Reconciliation:
  improve communication and handover to community pharmacy and Primary Care Provider,
- Develop Standard Work:
  Clearly define role and scope of each role within the department,
- Educate Medicine Telemetry Staff:
  Use the Registered Nurses Association of Ontario (RNAO) Best Practice Guideline (BPG) “Developing and Sustaining Interprofessional Health Care” to provide role clarity education to enhance understanding of roles, promoting collaboration.

Evaluation/ Measures

- Discharge Phone Calls between May 8 and August 15:
  44 discharge phone calls completed = 95% positive responses,
- Discharge Medication Reconciliation:
  Being faxed to community pharmacy and Primary Care Provider for all patients discharged from Medicine Telemetry,
- Role Clarity Education completed for Medicine Telemetry:
  100% of staff participated,
- Standard work developed for all Medicine Telemetry staff for each shift.
- Percentage of patients readmitted to hospital within 30 days following discharge from Medicine Telemetry.
- Percentage of patients who answer “completely,” “quite a bit,” “partly” or “no” to the 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?”
- Overall staff engagement scores on Medicine Telemetry (captured every two years on National Research Corporation (NRC) Health tool).

Spread/ Sustainability

- All other inpatient units to fax Medication Reconciliation
- All other inpatient units to complete Discharge Phone Calls
- Provide Role Clarity education to all inpatient and outpatient clinical units

Key Lessons Learned

What went well:

- Staff included in identifying the processes to reduce unit readmission rates and improve the patient experience

Opportunities:

- Continue to update and expand Standard Work processes as changes occur

Title:	**Erie St. Clair Convalescent Care**
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Activation and Restoration is a level of therapy offered in the Convalescent Care Program to *promote activity, increase strength, endurance, independence and ability to manage activities of daily living* by providing access to therapies with a focus on restoring function. These include functional practice opportunities, wellness and self-care activities that

support the return of patients to their previous living environment or other appropriate community environment (Rehab Care Alliance, 2014). By increasing utilization of CCP, this will allow more patients to benefit from this therapy and remain at home.

Aim/ Objectives

Trillium Villa Nursing Home and Vision Nursing Home in Sarnia will improve their occupancy rate in 2017 by reaching the 80% occupancy goal by December 31, 2017.

Intervention/ Change Ideas

The CCP criteria was enhanced to reduce subjectivity and to align with the Rehabilitative Care Alliance Framework definition of Activation and Restoration.

Evaluation/ Measures

Gemba days with the multi-disciplinary teams using the criteria and a PDSA was used to test the enhanced criteria with these teams.

Spread/ Sustainability

The enhanced criteria is being spread across the ESC LHIN region. Also the report by each LTCH with estimated end dates of current CCP patients has been adopted across the ESC LHIN region and is shared weekly with external partners.

Key Lessons Learned

The two key lessons learned are: 1) Subjectivity is affecting the interpretation of the CCP criteria leading to inappropriate applicants; and 2) community referral sources need to increase.

Title:	**Brant Six Nations Health Link: Scale and Spread to Primary Care**
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Aim/Objectives

Big Dot Aim: 30% reduction in ER/Urgent Care (UCC) visits and hospital readmissions for PrimaCare Community Family Health Team (PCCFHT) patients***** with a Coordinated Care Plan (CCP) by June 30, 2018.

Project Aim: By September 2017, 100% of adult PCCFHT patients***** with complex medical conditions will have a CCP developed in collaboration with Hamilton Niagara Haldimand Brant Local Health Integration Home and Community Care (HNHB LHIN H&CC), PCCFHT and primary care provider within 30 days of referral.

***** *In scope patients include those:*

- ✓ *with 5+ER/UCC visits in the past 365 days*
- ✓ *who were determined to be appropriate for Health Link approach by their primary care provider*
- ✓ *who have consented to referral to HNHB LHIN H&CC for CCP development*

Intervention/ Change Ideas

- Identification of patients with 5+ ER/UCC visits to the Brant Community Healthcare System (BCHS) by the primary care provider on record.
- Collaborating with the primary care provider to identify those patients who may benefit most from the Health Link approach and linking them with the HNHB LHIN H&CC for care plan development.
- Development and utilization of a standard communication tool to communicate with primary care provider.

Evaluation/ Measures

- # of days to receive a response from physician or designate.
- # of days from referral to home visit.
- % of patients who declined involvement with HNHB LHIN H&CC.
- % of patients not referred to HNHB LHIN H&CC.

Spread/ Sustainability

- Continued mentoring of Health Link champions from partnering organizations/agencies by the Brant Six Nations Health Link consultant through regular meetings via teleconference.
- Establish a process to review list of patients with frequent hospital utilization at scheduled intervals to identify those who may benefit from the approach.
- Apply learnings to spreading the HL model of care with local CHC and then other Family Health Organizations (FHOs) through the identification of patients who may benefit from coordinated care planning both in the community and during an encounter at BCHS.

Key Lessons Learned

- Organizations require multiple Health Link champions.
- Defining, tracking and sharing pre/post hospital utilization (UCC/ER visits/hospital admissions) as key measures with primary care provider/partners pre/post.