

# **2020/21 Quality Improvement Plan**

## **Narrative**

**Performance Monitoring & Quality Committee**

# 2020/21 QIP Narrative | Table of Contents

	Page
<b>Overview .....</b>	<b>1</b>
Summary of 2020/21 QIP Portfolio.....	4
<b>Our greatest 2020/21 QI achievement .....</b>	<b>5</b>
<b>Collaboration and Integration.....</b>	<b>7</b>
<b>Patient Partnering and Relations .....</b>	<b>8</b>
<b>Workplace Violence Prevention .....</b>	<b>10</b>
<b>Alternate Level of Care.....</b>	<b>11</b>
<b>Virtual Care.....</b>	<b>12</b>
<b>Sign-off .....</b>	<b>13</b>



Michael Garron Hospital (MGH) is a division of Toronto East Health Network. We are a full-service community teaching hospital serving a diverse population in the south-east of Toronto.

## Who we serve

MGH serves a community of over 375,000 people. With 22 distinct neighbourhoods, there is diversity in income, ethnicity, socioeconomic status and health across our community. Within our catchment, some of the highest need and most culturally varied neighbourhoods in Toronto are adjacent to those of privilege and wealth. Our catchment area includes five neighbourhoods identified as improvement or priority areas by the City of Toronto's Toronto Neighbourhoods Strategy. When identifying our organizational priorities and areas for improvement, we closely considered the diversity of our community to ensure that we meet a multitude of care needs and facilitate equitable access to care.

## Snapshot of the MGH Community

- Immigrants comprise 40% of the population, with some neighbourhoods as high as 65% (Thornccliffe Park)
- Over 50 languages spoken, with some areas having up to 8% of residents with “no knowledge of the official languages”
- 75% of districts have high rates of low-income seniors, 32% of whom live alone
- Diverse housing conditions: 387 Toronto Community Housing buildings, 18 of which are Seniors Buildings, and two shelters for homeless individuals
- Significant numbers of individuals who are uninsured, with 714 accessing Community Health Centres (CHCs) in East Toronto in 2016/17
- High fertility rates, with 48% of babies born to mothers not originally from Canada
- High rates of chronic diseases, including diabetes rates in Thornccliffe Park of 14.7% compared to the Toronto-average of 10%
- 19 of the 22 neighbourhoods have higher than Toronto-average visit rates for mental health conditions
- One-fifth of the community does not have a regular family physician

## Our QIP Planning Process

Our QIP planning process is designed to ensure the selected initiatives are appropriately aligned and have had appropriate involvement by all stakeholders, including patients and care providers.

The factors considered for appropriate alignment include:

1. Our Corporate Strategic Plan
2. Our Quality & Patient Safety Strategic Plan
3. System mandates and priorities (eg: TC-LHIN, OHQ, MOHLTC, OHT)
4. Local needs, priorities and potential risks
5. Change readiness of service area(s), including resource capacity
6. Identification of current QIP indicators that are ready to be operationalized, and tracked in our “Monitor & Sustain” portfolio
7. Feedback from patients and families



# 2020/21 QIP Narrative | Overview *(continued)*

## Alignment with our Quality & Patient Safety Plan

Our Quality & Patient Safety (QPS) Plan ensures that everyone in the organization is focused on a shared vision of creating a culture of patient safety and exemplary quality of care enabled through partnerships with patients and families.

A key consideration as we selected QIP improvement initiatives was alignment with and support of the priorities, commitments and behaviours outlined in our QPS Plan. The change ideas for each improvement initiative also reflect the QPS priorities and further reinforce our drivers for an organizational quality culture.

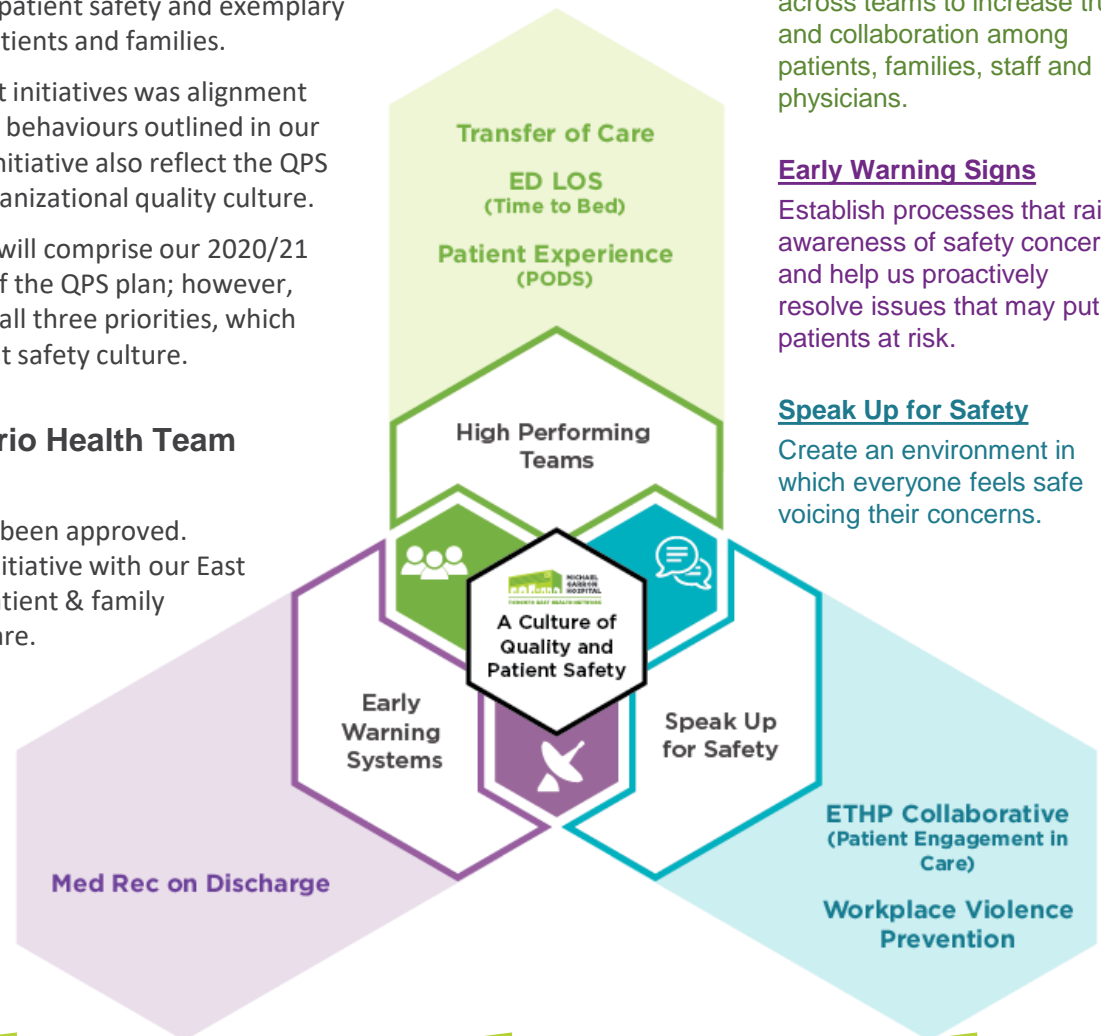
This graphic shows the improvement initiatives that will comprise our 2020/21 QIP and their primary alignment with the priorities of the QPS plan; however, each improvement initiative involves an interplay of all three priorities, which reflects the complexity of a strong quality and patient safety culture.

## Collaborative QIP Initiative with our Ontario Health Team partners

Our application to form an Ontario Health Team has been approved. Accordingly, we have launched a collaborative QIP initiative with our East Toronto Health Partners organizations to improve patient & family engagement across the entire spectrum of patient care.

## Our 2020/21 QIP Portfolio on a Page

The following page presents a summary of the objective, target, and change ideas for each of our 2020/21 QIP improvement initiatives.



### High Performing Teams

Enhance role clarity within and across teams to increase trust and collaboration among patients, families, staff and physicians.

### Early Warning Signs

Establish processes that raise awareness of safety concerns and help us proactively resolve issues that may put patients at risk.

### Speak Up for Safety

Create an environment in which everyone feels safe voicing their concerns.

# 2020/21 QIP Narrative | Overview *(continued)*

QIP Indicator	Improvement Measure	Baseline	Target	Notes
Med Rec on Discharge	% Discharged patients for whom a Best Possible Medication Discharge Plan was created	50	≤ 58	<ul style="list-style-type: none"> <li>Scope: All inpatient units (last year: only Medicine, Surgery, Mental Health)</li> <li>Ultimate goal is 100% once fully implemented and data is consistently captured</li> </ul>
Transfer of Care	% correct completion of IPASS at shift handover	Audit data to be Collected	+ 10% of baseline	<ul style="list-style-type: none"> <li>Scope: All inpatient units (same as last year)</li> <li>Baseline to be established in Q1 after implementation and target will be confirmed</li> <li>Ultimate goal is 100%</li> </ul>
Patient Experience - PODS (Pt. Oriented Discharge Summary)	% Patients completely satisfied with discharge information	56	> 58	<ul style="list-style-type: none"> <li>Scope: Respiratory units (last year: Cardiology units)</li> </ul>
<b>NEW</b> OHT Collaborative QIP (Developmental Indicator)	% Percent of persons satisfied with their involvement in their planning of care and treatment	Not Available	Collecting Baseline	<ul style="list-style-type: none"> <li>Scope: Seniors with complex/chronic needs and their caregivers (focus on integrated care, eg: H2D)</li> <li>Partners: Providence, Woodgreen, VHA, South Riverdale, SETFHT, Bridgepoint FHT</li> <li>"Developmental" – baselines and targets part of F2020/21 work plans</li> </ul>
<b>M</b> Workplace Violence Prevention (1)	# reported workplace violence incidents (average per month)	26	> 26	<ul style="list-style-type: none"> <li>Scope: All patients and staff (same as last year)</li> <li>Baseline for Lost Time revised for new legislated inclusion criteria</li> </ul>
Workplace Violence Prevention (2)	# reported incidents resulting in Staff Lost Time (total for year)	13	≤ 12	
<b>M</b> ED Length of Stay	Hrs. wait time for inpatient bed	17	≤ 14	<ul style="list-style-type: none"> <li>Scope: All admitted ED patients (same as last year)</li> <li>ED and Medicine collaboration</li> </ul>

**M** OHQ Mandatory Indicator

# 2020/21 QIP Narrative | Our greatest 2019/20 QI Achievement

One of Michael Garron Hospital's (MGH) greatest quality improvement achievements over the last year has been the successful implementation of a deprescribing pilot program that is improving patient outcomes and saving hospital and system resources through a collaborative review and recommendation process.

Deprescribing uses a planned and supervised approach to the reduction or stopping of medication that may no longer be beneficial to a patient or may cause harm with continued usage. Reducing the usage of such medications also positively impacts both healthcare facilities and the larger healthcare system by decreasing costs and increasing available resources.

Recognizing the many benefits of this process, MGH implemented a pilot deprescribing program at the end of 2018 in the general internal medicine (GIM) unit. The program's team was made up of staff throughout the hospital and included a few notable positions: a deprescribing pharmacist (a first-of-its-kind role), a deprescribing physician champion which capitalized on the culture of MGH's engaged physicians and an MGH patient experience partner.

The program's streamlined process took a patient-focused, individualized approach to medication changes. Every day, the team conducted a review of all patients admitted into GIM and crosschecked their active medication orders with a targeted list of 5 overprescribed medications/medication classes. Patients that were on the listed medications underwent a medical history review by the team for validation, before being engaged in a conversation about their proposed medication changes. In addition to any in-person conversations, both patients and their family physicians were provided with letters outlining the recommended medication reductions along with the perceived benefits. The team ensured that attending physicians were included throughout the process as well.

In order to help incoming patients and support the hospital's deprescribing culture, the team has also used a multi-modal approach that includes diverse interventions such as deprescribing targeted blood tests, formulary alterations, order set adjustments and changes in dispensary processes to reduce waste.

## 2020/21 QIP Narrative | Our greatest 2019/20 QI Achievement (continued)

The program has been immensely successful in its short lifetime. Since implementation, there has been \$67,000 in annual cost savings from inhaled corticosteroid and other drug interventions. The team currently reviews an average of 200 patients a month, with 35% of patients being given deprescribing recommendations and 80% of those recommendations accepted by primary care providers. Hospital staff have also seen an improvement in resources, with 200 hours of nursing time made available due to reduced capillary blood glucose (CBG) testing.

In addition to the abovementioned data, the program has also been recognized for exemplifying the hospital's commitment to collaboration and partnerships in various ways: engaging patient experience partners to review the process, working with community pharmacy partners to see if recommendations are being implemented by family physicians and capitalizing on the hospital's culture of engaged physicians and floor pharmacists to create sustainability and growth strategies for other areas of the hospital.



# 2020/21 QIP Narrative | Collaboration and Integration

The East Toronto Health Partners (ETHP) is our recently approved Ontario Health Team (OHT). It consists of six Anchor Partners together with 50+ Engaged Partner organizations who serve patients and clients, and their families, in East Toronto communities.

Our 2020-21 QIP includes a collaborative quality improvement initiative with several of our ETHP partners. This custom indicator will focus on patient and family satisfaction with their involvement in care planning and treatment.

The six Anchor Partners within the East Toronto Health Partners OHT are:

- **East Toronto Family Practice Network**
- **Michael Garron Hospital (Toronto East Health Network)**
- **Providence Healthcare (Unity Health Toronto)**
- **South Riverdale Community Health Centre**
- **VHA Home HealthCare**
- **WoodGreen Community Services**

During the past two years, the ETHP's commitment to shared values, accountability and collaborative action has helped strengthen trust across the partnership, enabling us to focus on tangible efforts to improve care in our community. The ETHP anchor partners commit to sharing organizational resources to create an East Toronto health and community care system that places the needs of our community above the interests of our individual organizations.

Beginning in fall 2018, the ETHP developed a collaborative approach to quality improvement, focused on our shared priority populations (seniors with chronic care needs and their caregivers, youth mental health and wellness, adult substance use and health), and initiatives to reduce hospital surge during flu season. This work reflected our early recognition that cross-sector partnerships better enable us to achieve our desired impact.

The partners are also invested in enhancing local, front-line quality improvement capacity, with integrated teams attending the IDEAS and the CFHI XTRA programs to work together to reduce hospital admissions and length of stay. In 2019, ETHP signed a four-year agreement with RNAO around implementation of Best Practice Guidelines within and across our organizations. . The implementation of the ***Person and Family Centred Care*** Guideline in 2020 will generate change ideas to improve patient and family satisfaction with involvement in care planning and treatment.

We have continued to build on our history of partnering with patients, caregivers and families during the development of our QIP and the implementation of our quality improvement initiatives. Throughout the QIP's annual cycle, patients, caregivers and families are continuously engaged using our Patient and Family Engagement Framework, through approaches that include information sharing, consultation, and collaboration. Working together ensures an appropriate and meaningful approach to integrating the patient, caregiver and family voice. It ensures that the priorities we pursue reflect their needs, enables a better understanding of the problem we are attempting to solve through insights from their lived experience, and encourages the co-design of innovative and patient-centered solutions. Examples of some of the ways patients, caregivers and families are engaged in the QIP process are described below:

## **Patient Experience Partners on QIP working groups**

All QIP teams work to enhance patient engagement. For example, the Emergency Department (ED) Quality Improvement team meets monthly to engage frontline staff in quality improvement initiatives. The ideas generated from this group are presented to the ED virtual Patient Experience Panel for feedback and on-going participation in quality improvement projects.

## **Patient Experience Partner on Leadership Committees**

The membership of the Medical Quality & Patient Safety Committee includes a patient partner, who participates in monthly leadership discussions and helps to ensure that the patient perspective is continuously considered. In addition, this patient partner, along with additional community members, are part of the Performance Monitoring & Quality Committee of the Board, and help reframe the hospital's thinking through questions and input that are unique to their backgrounds and experience.

## **Patient Experience Panels (PEP)**

Patient Experience Panels are comprised of former patients and family members who meet regularly to share insights, provide input to and help co-design organizational initiatives. MGH currently has five active panels. The first was formed in 2012 and partners with MGH stakeholders to improve quality, safety and patient experience across the organization. Since then, four other panels have been established, each with a specific scope: the Hemodialysis Patient Experience Panel (2014), the Mental Health Patient Experience Panel (2016), Maternal Newborn Patient Experience Panel (2019) and the virtual ED Patient Experience Panel (2019). Over the last two years, the Patient Experience QIP team has engaged the MGH Patient Experience Panel and over 150 patients/caregivers/family members to co-create improved "patient friendly" discharge summaries and conversations (Patient Oriented Discharge Summaries), staff education and a process for automated post-discharge phone calls.

## **Community Advisory Council (CAC)**

Members of CAC represent cross-sectoral organizations and communities across the MGH service area. They provide insights gleaned from their experiences within their respective organizations and/or communities and, most recently, have provided valuable perspectives as patients of MGH and other healthcare providers at the system level. These insights help us to identify quality improvement opportunities.

## **Feedback from patients via Patient Relations Office and on Units**

The patient relations process is a critical source of insight into the drivers that contribute to a positive or negative patient experience. The stories that are shared enable us to better understand the patient, caregiver and family experience. Insights are also obtained through day-to-day interactions between care providers, leadership, and patients. For example, a patient expressed concern regarding communication between MGH diagnostic testing departments and the referring physician. This feedback prompted our information technology and diagnostic testing teams to design and implement an automated notification to referring physicians when their patient does not show up for a scheduled appointment, enabling the physician to follow up directly with the patient and thus improving patient care and safety.

## **Patient Videos**

The Patient Video Program captures brief interviews with patients and staff, providing them the opportunity to share their experiences at the hospital. These videos are shared with individuals and teams throughout the organization and are integrated into the majority of leadership meetings. Hearing directly from patients serves to deepen our understanding of the patient, caregiver and family experience and directs our quality improvement work. Our Patient Video program has rapidly gained international recognition. To facilitate the spread of this program to other healthcare organizations, we have developed a tool-kit with guidance for issues like patient consent, protection of privacy, interviewing techniques, and methods for sharing outcomes. To date, we have connected with over 40 organizations internationally to support their interest in developing patient video programs.

## **Patient Stories**

Care providers regularly share stories about patients with their teams. This is an extension of, and a complement to the Patient Video program. Through the time spent reflecting on each patient story, staff and leadership are able to connect more meaningfully to patients and to their work. Patient stories help enhance the culture of the organization; they help build a foundation that enables greater engagement in improvement activities as staff and leaders are more easily able to see the value of improvement work through a perspective that focuses on the positive impact for patients, care givers and families.

# 2020/21 QIP Narrative | Workplace Violence Prevention

The prevention of workplace violence has been an organizational priority at MGH for more than 10 years. We were among the first to address this issue with targeted educational programs, awareness campaigns, and reporting systems to monitor frequency and type of occurrences. Workplace Violence Prevention (WVP) strategies and improvement initiatives are imbedded in our People Strategic Plan and are regularly reported to our Board.

We continue to be a system leader in the area of WVP. Members of the hospital's leadership were consulted and contributed to the province's 2017 *Workplace Violence in Health Care Progress Report*, a joint commitment from Ontario's Ministries of Labour and Health and Long-Term Care to make hospitals safer. We are regularly called upon to share WVP best-practices at conferences and throughout a number of healthcare organizations across Ontario and internationally. Examples of collaborative initiatives that are helping to inform WVP initiatives across the broader system include:

- Completion and dissemination of the *Workplace Violence Playbook*. The *Playbook* is a collection of tactics from each Joint Centre hospital related to practices that help to reduce WPV and encourage a zero tolerance of all forms of violence
- Participation in a research project on workplace violence reporting and quality in partnership with the Institute for Work and Health
- Research and development of a common approach to creating alerts for risk of violence, such as the Alerts for Behavioural Care (ABC) tool and processes
- Ongoing participation in a research project on workplace violence reporting and quality in partnership with the Institute for Work and Health
- Organizing a WVP Think Tank Day – a collaboration of leaders from several organizations to brainstorm innovations and practical solutions. Several innovations and practical solutions were generated to inform our improvement initiatives.

While this will be the third consecutive year that WVP will be a part of our Quality Improvement Plan, we've been focused on our vision of a "violence-free" care environment for more than 10 years. We routinely assess the impacts of our various initiatives to learn, adapt, and continuously improve. This year, along with on-going refinements to our Zero Tolerance education and communication strategies, we are extending our implementation of the Behavioural Care Plan Alert tool and processes and strengthening our proactive approach with our electronic risk assessment tool. Moreover, we continue to develop performance indicators beyond the mandatory count of incidents reported. We measure and routinely report to senior leaders and our Board the number of incidents resulting in staff lost time, and other indicators designed to measure severity of incidents.

Minimizing the number of acute care beds occupied by ALC patients continues to be a high priority for MGH. We have a long-standing (8+ years) cross-functional ALC meeting with representation from internal and external community partners. This team meets twice weekly to identify and implement continuous improvement initiatives aimed at streamlining safe patient transitions into the community.

Our recently approved Ontario Health Team application (East Toronto Health Partners, or ETHP) has enabled additional improvement opportunities.

Initiatives underway or in the planning stages include:

- **Home 2 Day program:** To-date, the equivalent of 2-3 beds have been freed up as result of reduced hospital length of stay. This program is currently focussed on Chronic Obstructive Pulmonary Disease (COPD), Congestive Heart Failure (CHF) and Community Acquired Pneumonia (CAP) patients, with plans to expand to frail elderly patients
- **Patient Access & Transition Hub (PATH):** By co-locating MGH and Community partners, we plan to free up additional inpatient beds by more quickly matching patient needs with community supports
- **Transition of Care to Community Program:** By creating transition pathways with partners (eg: Home & Community Care, Woodgreen, VHA, St. Elizabeth) early in patients' hospital stay, we plan to further speed up transitions to community care
- **Partnerships with retirement homes:** We are exploring funding for dedicated beds in retirement homes to act as transition beds
- **Virtual Care programs:** Expansion of programs, for example: virtual care navigator for CHF, COPD, & Surgery patients, following patients after discharge to avoid readmission and support earlier discharges from acute care
- **Reintegration Care Unit (RCU):** We are exploring opportunities in partnership with Scarborough Hospital and other East Toronto organizations to create dedicated, non-acute beds for the East Toronto region.

Michael Garron Hospital is developing a plan for integrating virtual visits into traditional care pathways and home specialist visits. In addition to the hospital to home care program (Home 2 Day), there is an initiative underway to engage children and youth who are too anxious to leave their homes. Opportunities are being assessed to use virtual care to improve overall transition of patients into community such as post-discharge follow-ups, health literacy, and self-care management. Starting in 2019, we have implemented a Secure Instant Messaging tool that connects primary care and community and in-home providers to improve care integration.

Across the East Toronto Health Partners (an approved Ontario Health Team), we have strong existing digital infrastructures, many common systems across East Toronto primary care partners, and an interest in better integrating digital approaches to improve care delivery.

Various virtual care options are available through the ETHP. For instance, physicians and care providers have access to eVisits and Ontario Telemedicine Network (OTN) offerings (telemedicine, telehomecare, teleophthalmology). Citizens in the region have access to OTN's Big White Wall, and Toronto Seniors' Helpline.

The ETHP has proposed a number of performance measures to determine the success of virtual care, including:

- percentage of all visits that are delivered virtually (ministry target: 2-5%)
- patient reported experience measures related to virtual care visits
- overall growth of virtual care interactions, stratified by type and population
- provider satisfaction as it relates to virtual care offerings and alignment with clinical workflow

## 2020/21 QIP Narrative | Sign-off

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



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Andrew Steele  
Board Quality Committee Chair



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Susan M. Armstrong  
Board Chair



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Sarah Downey  
Chief Executive Officer