Session 4: Quality on the Front Lines: Innovative Approaches to Quality Improvement Planning, Measurement, and Sustaining Change

Moderator: Dr. Matthew Morgan



Presenter Disclosures

Presenters: Dana Hardy, Marilynne Gordon, David Girard, Brenda Carter, Dr. Hussein Moloo, Rebecca Brooke, Dr. Bruce Stanners, Gillian Kean

Relationships with commercial interests: None



Disclosure of Commercial Support

This session has received no commercial support



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Residents First

Did we really make a difference in Quality of Care?



Prepared by: Dana Hardy, National Director Quality Improvements Marilynne Gordon, Regional Manager Education and Resident Services



About Revera

- Leading seniors' accommodation, care and services company
- 50- year history, formed in 1961
- Approximately 28,500 employees
- 227 sites
 - 189 Canada
 - 38 US

- Approximately 28,000 clients served every day
- Four areas of business: Home Health, Retirement Living, Long Term Care and U.S. Nursing & Rehab
- Canadian owned and operated





Leadership Across Four Lines of Business



RETIREMENT LIVING

Our vibrant retirement communities offer accommodation, health and wellness, and hospitality services designed to help seniors live their life to the fullest



HOME HEALTH

Supporting individual independence, our home health personnel provide a full range of services in private homes, retirement residences, long term care homes and hospitals across Canada



LONG TERM CARE

Quality professional and compassionate care in a warm, friendly atmosphere



US NURSING & REHAB

We help our residents achieve the highest quality of life and independence possible, by offering both short term rehabilitation and long term care





Revera + HQO = Partnership







Experiential Learning

- Building capacity
- Clear aim statements
- Home Teams
- Engagement of all persons involved in the topic area
- Root cause
- Accept failures





Measures of Success

- Qualitative
- Quantitative
- System level
- Site level





Results- Celebrated Success

Wave I Falls Data







Wave II Responsive Behaviours Data

Responsive Behaviours in month
Aggregate (n = 7)



Aim: To reduce Falls by 43% from 21 to 12 per month on Hewson House by May 2013.

(ongratulations!



Aim: To reduce total physical responsive behaviours on the Brant home area by 85% from 278 (our median from baseline) to 42 by December 2013.

Congratulations!



Aim: To reduce the number of verbally aggressive behaviours on first floor by 25% from 56 to 42 by December 31, 2013.

Congratulations!



Month



Next steps

- Commitment
- Sustainability
- Spread



Improving Surgical Oncology Wait Time Performance at Kingston General Hospital Through a New Active Wait List Management Process

Brenda Carter, Vice President, Cancer Services and Diagnostic Imaging David Girard, Project Manager, Cancer Services

Background

May 2012

- Kingston ranked 32/35 CSA hospitals in Ontario
- 63% of cancer surgery cases completed in target
- Hospital Board, Leadership, community wanted improvement

Cancer Surgery Wait Times April 2012 - June 2012 Percent of Cases Within Target





Aim and Purpose

Aim To improve surgical oncology wait time performance from 63% to 80% within 12 months, and to 90% within 18 months.

Purpose

- Improve patient care
- Build cohesiveness
- "people-ize" the data
- Ensure data quality
- Reinstate confidence with the community
- Standardize and integrate processes





Results





Active Wait List Management



Tools





Lessons Learned

- Leadership support
- Project approach
- Large scale change takes time
- In-person communication
- Walk-in the patient's shoes



Photo: Matthew Manor/KGH

Analytical tools and accountability must go hand in hand



Thank You

Brenda Carter, Vice President, Cancer Services and Diagnostic Imaging <u>carterb@kgh.kari.net</u>

David Girard, Project Manager, Cancer Services girardd@kgh.kari.net



Photo: Matthew Manor/KGH



Appendix - Measures

Outcome Measures

• Percent of completed cases meeting wait time target: Priority 2 - 14 days, Priority 3 - 28 days, Priority 4 - 84 days.

Process Measures

- Completed surgery volume: # of surgeries for each priority category.
- Throughput ratio: The contrast between patients added to the wait list vs. patients that were treated (i.e. removed from the wait list).

Balancing Measures

- Priority distribution ratio: Distribution of priority 2, 3 and 4 cases.
- 90th percentile wait time: The number of days waited by the 90th percentile patient.



Appendix – Yellow Cases Report

Pre- OR Wait Time Audit (Active Approaching Target) Report									
Active patients <u>with</u> a scheduled surgery date: % expected to exceed wait time target				Active patients <u>without</u> a scheduled surgery date: % expected to exceed wait time target in 1-week's time					
Scheduled_Surgery_Date Over_Target_Flag	(Multiple Items) 0	7		Scheduled_Surgery_Date Over_Target_Flag	(blank) 0 				
SCHED OR Expected Over Target Flag	Data Patiant Count	0/		LINSCHED OR Expected Over TargetIn1Week	Data Dationt Count	0/			
No	43 4	91.49%		No Yes	36 2	94.74%			
Grand Total	47	100.00%		Grand Total	38	100.00%			
Patients with a scheduled OR date and not they wait until their scheduled OR date	currently over their t , will they be over tar	Patients without an OR date currently scheduled: if left for 7 days, would they be over target?							



Use of NSQIP Clinical Outcome Data and CUSP Quality Improvement Methodology to Reduce Surgical Site Infections at The Ottawa Hospital

Husein Moloo and Rebecca Brooke







A system produces the results it is designed to produce

Creating a Culture of Quality



THE FOUR ESSENTIALS OF QUALITY

In our research, we examined tools commonly used to make employees care about quality, including training, best-practices sharing, and monetary incentives. We concluded that only four attributes actually predict a culture of quality:

Leadership Emphasis

Managers are told that quality is a leadership priority.

Managers "walk the talk" on quality.

When evaluating employees, bosses emphasize the importance of quality.

Message Credibility

Messages are delivered by respected sources.

Workers find that communications appeal to them personally.

Messages are consistent and easy to understand.

Peer Involvement

Most employees have a strong network of peers for guidance.

Peers routinely raise quality as a topic for team discussion.

Like members of a sports team, peers hold one another accountable.

Employee Ownership

Workers clearly understand how quality fits with the job.

Workers are empowered to make quality decisions.

Workers are comfortable raising concerns about quality violations and challenging directives that detract from quality.

CUSP Comprehensive Unit-Based Safety Program

Presented by: Elizabeth Wick, M.D. Deborah B. Hobson, BSN







CUSP executive team



CUSP TEAMS – divisional/corporate



CUSP advisory committee

QI COORDINATORS KEY!!

Perioperative Logistics



SSI Interventions

Interventions tested or implemented by CUSP teams at The Ottawa Hospital

Category	Number of unique interventions		
Peri-operative Patient Warming	6		
Antibiotics	5		
Wound management	8		
Environmental sterility	11		
Blood glucose management	5		
Surgical instruments	4		
Fall risk	3		
Communication	4		
OR supply chain improvements (LEAN process)	5		



Example: Patient Warming





Results





Results





TOH NSQIP Unadjusted SSI Rate





Lessons Learned

Frontline Multidisciplinary Infrastructure Quality Improvement



Owen Sound Family Health Team Diabetes Strategy

Dr. Bruce Stanners Gillian Kean, RN, MN, NP-PHC candidate



Diabetes Prevention: History of the PCDPP

- The OSFHT Primary Care Diabetes Prevention Program was originally one of 6 pilot projects set up by the Ministry of Health and Long-Term Care as part of the Ontario Diabetes Strategy in 2011.
- The PCDPP is based on the Group Lifestyle Balance curriculum which was designed by the University of Pittsburgh Diabetes Prevention Program.
- The program is offered to those at high risk of developing diabetes.
- Funding has been extended to March 2015
- Total # of participants to enter the program is 466 (2011-2014)



Program Requirements

• Participants are referred to the program by Primary Health Care Providers based on the following criteria:

- 1) Pre Diabetes and/or
- 2) Metabolic Syndrome and/or
- 3) CANRISK score >33

PRINT REFERRAL -Place in Dr. B. Stanner's Mailbox									
currentDate.default	1		Phone:(H)						
Patient Name:			Phone: (W)						
Date of Birth:			Phone: (C)						
ealth Card No#			Fible. (C)						
Address:	Sex	:	Select Ethnic Background for increased diabetes risk						
	MU	ST MEET TH	IE FOLLOWING CRITERIA FOR ELIGIBILITY						
Patient must eit	her have Pre-D	iabetes, Metabo	blic Syndrome or otherwise to be deemed at high risk for developing diabetes						
(1.) Pre- Diabete	es Impaired fa	asting glucose ((IFG) or Impaired glucose tolerance (IGT)						
IEG		FPG (mmol/L)) 2 hour PG in the 75 mg OGTT (mmol/L)						
IFG (is	olated)	6.1-6.9	<7.8						
IGT (is	olated)	<6.1	7.8-11.0						
IFG a	nd IGT	6.1-6.9	7.8-11.0						
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Program Structure

- The program consists of the following:
 - 12 core sessions offered on a weekly basis
 - 7 maintenance sessions offered bi-weekly
 - 3 maintenance sessions offered monthly
 - Monthly meetings are offered after program completion for additional support
- Session topics include: healthy eating, physical activity, problem solving and dealing with social cues, healthy behaviour strategies, stress management, sedentary behavior reduction and mindfulness.
- Sessions are taught in group format and are one hour in length.
- Supervised exercise sessions are offered before or after the weekly meetings for 40 minutes in length.



RESULTS

In 2013, 114 participants enrolled. There was a drop out rate of 31.6%

The following data is for participants who completed Maintenance phase of the program between 2013 and July 2014:



Weight Loss Goal Completed by Program End (%)

Weight Loss Goal NOT Reached by Program End (%)

57.7%

Start & End Results

A1c Level

"Average Participant reduced their A1c Level by 0.02

A1c Level at Program Start A1c Level at Program Completion 0.056 0.058 0.060 (Average)

A1C RESULTS (AVERAGE)

FASTING BLOOD SUGAR **RESULTS (AVERAGE)**



AVERAGE WEIGHT & WEIGHT LOSS VALUES



AVERAGE WAIST CIRCUMFERENCE



Diabetes Management: Diabetes Clinic Days

- 35,000 patients
- 2,900 patients with diabetes
- 20 physicians, 5 NPs
- Nurses, clerical & allied health staff
- Beginning of quality improvement journey for diabetes management
- All physicians participating in quarterly diabetes clinic days





Population

Staff

2009

2013

Clinic-Wide Standardization

Diabetes Action Team

	Collaboration with local diabetes community resources			
Quarterly visit encounter form	Quarterly visit encounter form Clinic-wide auto- generated reminders Patien		In-house referral process to allied health professionals	Continuing staff education programs
Patient report cards	Physician report cards	Patient educational resources	Tracking outcome & process measures	



Planning: Diabetes Clinic Days



Process Flow: Diabetes Clinic Days



Measurement & Sustainability

LDL completed annually HbA1C completed quarterly Blood pressure twice annually Retinal eye exam completed annually Foot exam completed annually

LDL at target Statin therapy > age 40 or diabetes r > 15 years & over age 30 BP < 130/80

ACEI or ARB \geq age 55 and/or microvascular or macrovascular disease Quarterly data collection & reporting to physicians via Physician Report Card

> Identification & reporting of goals, outcome & process measures

Quarterly reporting of patientspecific outcome & process measures via Diabetes Report Card





Questions & Discussion

