Theme I: Timely and Efficient Transitions | Timely | Mandatory Indicator

Indicator #6

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 inpatient bed or operating room. (Grand River Hospital Corporation)

Last Year		This Year	
18.93	**17**	**19.93**	**17**
Performance (2019/20)	Target (2019/20)	Performance (2020/21)	Target (2020/21)

Change Idea #1

Standardize the discharge process. Will be initiated on the medicine unit first.

Target for process measure

- EDD was set for 100% of patients admitted in the Medicine Program Within 24 hrs of admission 25% of patients admitted in the medicine program will be discharged by 11 am

Lessons Learned

To coordinate ED admission peak times with medicine department work flow, we have attempted to increase the % of patient discharged by 1100. We have characterized staff roles, responsibilities, workflows, and operational processes. We have reviewed current discharge processes and policies. We have performed gap analyses against current best practices and conducted peer benchmarking. We have implemented EDDs to assist staff in prioritizing discharge processes and actions. We have developed discharge huddles to help inform staff about pending discharges and prioritize action towards discharge barriers. We have also created communication strategies to promote communication and discharge awareness. Staffing and physician models have been identified as a major opportunity to optimize the and facilitate future state discharge processes. We have started our implementation processes of this future state plan within the medicine department.

Theme I: Timely and Efficient Transitions | Efficient | Custom Indicator

Indicator #3

Emergency Department time to physician initial assessment in hours - 90th percentile (Grand River Hospital Corporation)

Last Year		This Year	
5	3.30	4.90	--
Performance (2019/20)	Target (2019/20)	Performance (2020/21)	Target (2020/21)

Change Idea #1

The time of day when PIA time is longest will be established, and a zone physician will be scheduled during this time to focus on assessments for patients with the longest wait.

Target for process measure

- A 2 hour reduction in LOS of CTAS IV, V by Q3 Greater than or equal to a 3% reduction in left without being seen rate by Q3

Lessons Learned

We did a comprehensive data analysis to schedule the surge on call physician shift.
A surge on-call physician shift was scheduled at 1400-2000 utilizing P4R dollars mid May 2019
Initially, the surge on-call shift showed favorable results and improved PIA in Q1, into Q2 of 2019. PIA 90th percentile was dropped from 5.1hrs in Q4 of 2018, to 3.7 in Q1 of 2019, and 4.6 hours in Q2 2019).
Cerner implementation significantly impacted overall ED performance, impacting PIA (Q3 2019 PIA at the 90th was 6.0).

Indicator #2

Conservable beds equivalent - the total number of acute LOS days - expected LOS days for an acute patient (excluding those where the value is negative)/total number of days in the reporting period using the HIG methodology. (Grand River Hospital Corporation)

Last Year		This Year	
34.45	32	42.80	--
Performance (2019/20)	Target (2019/20)	Performance (2020/21)	Target (2020/21)

Change Idea #1

Investigate the use of the Medworxx electronic white board

Target for process measure

- 100% investigation complete for Medworxx electronic white board by 31st of March 2020

Lessons Learned

Following the recent transformation of our new HIS, we have determined that the current Medworxx white board will not meet our current needs. The use of visual performance metrics provided in real/near real time is an important tool which will improve proactive decision making. As such we have been exploring various technologies.

Change Idea #2

Specifying and identifying LOS for complex medical patients within 24 hours

Target for process measure

- *70% of the strategies selected to reduce conservable days completed by 31st of March 2020

Lessons Learned

We have had success in implementing estimated discharge dates (EDD). Regularly, >90% of our admitted patients will receive an EDD within the first 24 hours of being admitted. EDDs have been estimated depending upon admission location with the assistance of the HIGs methodology. Accuracy of the EDD is also being tracked. A better understanding of variables causing deviation from the initial EDD are being characterized and will be used to guide further quality improvement initiatives.

Indicator #1

ALC Bed Equivalent - the total number of patient days where a patient is designated as ALC (acute and post acute)/total number of days in the reporting period. (Grand River Hospital Corporation)

Last Year		This Year	
84	**62**	**80.20**	**--**
Performance (2019/20)	Target (2019/20)	Performance (2020/21)	Target (2020/21)

Change Idea #1

Continuation of the implementation of CCO's Alternative Level of Care Leading Practices

Target for process measure

- 100% of strategies for selected leading practices to be implemented by March 31, 2020.

Lessons Learned

Appropriate ALC designation and confidence in the escalation process has become an identified knowledge and practice gap. We have provided physician and staff education opportunities, created designation decision trees, created intranet links with supporting CCO and ALC policies. In return we have not observed an improvement in the appropriate use of ALC designations. As such, education efforts will continue with the assistance of LHIN and community partners. In addition, education, mentoring and policy guidance has been provided and will continue to evolve to improve the understanding of the ALC designation and escalation processes. We will be working with legal and ethics teams to develop strategies to improve confidence and understanding of ALC best practices.

Theme I: Timely and Efficient Transitions | Timely | Custom Indicator

Indicator #4

Hip and knee replacement surgery percentage completed within target wait 2 (Grand River Hospital Corporation)

Last Year		This Year	
CB	CB	59	--
Performance (2019/20)	Target (2019/20)	Performance (2020/21)	Target (2020/21)

Change Idea #1

Review data quality, education to team for using "DART", monitor regular performance and prioritize cases

Target for process measure

- 100% review on data quality. 100% scorecard distribution to individual surgeon by Q1-Q2, 2019. 100% discussion complete with surgeon about prioritizing the cases.

Lessons Learned

Having this indicator as one the of our QIP indicator helped us prioritizing and improving it continuously. In November 2019, the hip replacement surgery percentage completed within target wait 2 was 64.9% and for knee was 40.3%.
53 more cases were identified with “DART” as an outcome of education and follow up with patients by surgeons office. Reviewing data quality and engagement with surgeons office helped us removing more than 50 cases which were in the list due to various reasons as data entry error/ patient refused/ operated elsewhere/ surgery done etc. Monthly detailed reports were also sent to each surgeons office with action items to help them monitoring and managing their performance.
Regular monitoring, prioritizing cases and engagement with surgeons office and LHIN helped us managing performance better.

Theme III: Safe and Effective Care | Safe | Mandatory Indicator

Indicator #5

Number of workplace violence incidents reported by hospital workers (as defined by OHSA) within a 12 month period. (Grand River Hospital Corporation)

Last Year		This Year	
217	205	182	176
Performance (2019/20)	Target (2019/20)	Performance (2020/21)	Target (2020/21)

Change Idea #1

Increase reporting of workplace violence incidents

Target for process measure

- 100% of identified changes implemented by Q2 0 employee incidents documented in risk pro by Q4

Lessons Learned

In order to target improvement in reporting of incidents,a staff survey to identify reporting barriers was conducted. One key finding was that there was confusion over the multiple options available for reporting (eg. Risk Pro - an internal reporting platform, paper form). We identified Risk Pro as the preferred method for reporting, and are developing and testing an updated environment. This new reporting environment is on track to be available to staff in April 2020.

Change Idea #2

Define zero tolerance and increase awareness

Target for process measure

- 100% of assigned locations will have signs posted by Q1

Lessons Learned

Violence prevention signage was developed and posted hospital wide in August 2019 and includes reference to zero tolerance for abusive language and behavior.

Change Idea #3

Complete an RFP process for new personal panic alarm system, and expand areas of use.

Target for process measure

- No target entered

Lessons Learned

RFP completed, and new alarm system purchased. Implemented within Mental Health areas (where previous system was in use), and expanded to several other areas including emergency department and medicine.