Quality Improvement Plan (QIP)

Narrative for Health Care Organizations in Ontario

March 22, 2023

OVERVIEW

Organization Overview

The University of Ottawa Heart Institute's (UOHI) mission is to promote heart health and lead in patient care, research, and education. Inspired by a unique culture of excellence and innovation; The Heart Institute is a unique academic facility committed to researching, treating, and preventing heart disease. The UOHI is the only cardiac center (and ECMO center) in what was formerly known as the Champlain Local Health Integration Network and serves as a cardiac center for the 16 hospitals in this area, as well as Western Quebec and Nunavut, and has an agreement with the Province of Newfoundland and Labrador to supplement their program in providing cardiac surgical care.

The UOHI is dedicated to continually improving quality and patient safety. We consider both data and patient experiences when planning for patient care and when making decisions regarding programs and services. We have designed a quality framework that addresses the needs of patients, providers, and the community. The framework defines quality through six dimensions - safety, equity, efficiency, continuity, people-centered care, and wellness. It serves as the foundation for our annual quality improvement planning and drives all quality improvement efforts.

Purpose of the Quality Improvement Plan

The UOHI will use the objectives and the improvement initiatives outlined in the quality improvement plan to enhance the standard of patient care and the overall patient experience.
This quality improvement plan is an all-inclusive approach that identifies areas for improvement while considering the Institute's strengths and limitations. It serves as a road map to quality and safety for the Institute and it strives to offer the best possible care to its patients and maintain its position as a pioneer in high-quality heart care

Ensuring Patient-centered QI Projects

Our medical personnel submit their quality improvement ideas through the Quality Project program along with:

- a completed Research or Quality Improvement Checklist,
- a Research Ethics Board exemption letter or clearance when needed,
- and a Health Equity Impact Assessment (HEIA).

The HEIA is used to identify and address potential unintended health impacts (positive or negative) from QI initiatives. This tool is used to reduce inequities that result from barriers in access and to increase positive health outcomes.

The Quality Department through its Patient Partner Program facilitates the engagement and inclusion of patients and families in QI projects and advises on care and service improvements from the patient/family perspective before reviewing all submissions and providing feedback when there are duplicate project ideas.

The projects' progress and outcomes are also monitored by the Quality Department.

PATIENT/CLIENT/RESIDENT ENGAGEMENT AND PARTNERING

The Patient Partnership Committee (UPP) provides insight and advice on the selection of Quality Improvement Projects throughout the year, and we included several initiatives that are co-led by patients on UPP in our QIP this year.

We have patient members on many committees, including on our Board Quality of Care Committee, to ensure that the patient voice is heard at all levels of our organization. Patient Partners on UPP and as part of our Patient Engagement Program regularly provide feedback on quality improvement initiatives and their partnership is mandatory for projects registered through the Quality Department. Heart Institute staff and patients work together on quality initiatives throughout the year. Some recent initiatives include: Finalization of the Patient Engagement Framework, Creation & Devlopment of a Caregiver Guide, a review of what tools and resources are currently in use at UOHI for Caregivers & a review of the TAVI Guide & Cardiac Surgery Guide.

PROVIDER EXPERIENCE

During our evaluation of the UOHI pandemic response, we assessed the effectiveness of protecting patients and employees while maintaining essential functions and services. Additionally, we gained insight into the views and job satisfaction of healthcare workers. Our findings revealed two main themes: inadequate staffing and the balance between workload and personal wellbeing. To address these issues, the process recommended improvement initiatives in the form of a staffing re-engineering approach, which includes redeploying staff to high-need areas, providing proper orientation for redeployed staff, and ensuring that work requirements are balanced with staff personal wellbeing.

WORKPLACE VIOLENCE PREVENTION

UOHI recognizes the importance of occupational health and safety and is committed to providing all persons working on the premises with a safe and healthy work environment in which all workers are treated with dignity and respect and in which they are able to work in an environment free from violence. UOHI does not tolerate any acts of violence against its workers including violent acts by members of the public directed towards its workers while in the workplace or in the process of carrying out work on behalf of the Institute.

UOHI implements a Violence Prevention Program that aims to prevent incidents of violence against workers from occurring in the first place. If an incident does occur, the program ensures that a timely and objective investigation of the circumstances takes place to identify root causes and to implement effective corrective action as well as providing appropriate support for victims of workplace violence.

PATIENT SAFETY

• Move-in the Tube: Our team successfully piloted an alternate, more flexible prescription for sternal precautions to improve the functional outcomes for post-cardiac surgery patients and reduce the complications of strict sternal precautions. The next step is staff education and the development of patient resources for full implementation of this modality.

• Enhanced Recovery After Surgery (ERAS): This is a compilation of 22 evidence-based strategies to improve surgical outcomes. Although ERAS began with a focus on colorectal surgery, the strategies are now rolling out to other surgery types, notably, Cardiac Surgery. The UOHI has assembled an ERAS Cardiac Committee to develop an ERAS pathway for UOHI patients. So far, we have adopted 18 of the 22 strategies, 12 are fully implemented and we are working to implement the 6 left.

• Pandemic Planning: Our pandemic plan has been reviewed taking into consideration the latest evidence and the experience from the COVID-19 pandemic response that was gathered through a senior management survey and several focus group discussions with various categories of employees & patients.

HEALTH EQUITY

• Equity, Inclusion & Diversity (EDI): In January 2021, Ontario Health released its Equity, Inclusion, Diversity & Anti-Racism Framework with a focus on addressing anti-Indigenous and anti-Black Racism. In our first phase of implementation, we are focusing on the 4 foundational components of the framework: Collect Equity Data, Embed it in Strategic Plan, Partner to Advance Indigenous Health Equity, and Invest in Implementation. So far, we have established

an EDI Committee in charge of leading all EDI changes in the organization, we have adopted an EDI framework to guide all EDI activities at UOHI, we have adopted a UOHI land acknowledgment developed in collaboration with an indigenous leader/elder and partnered with an Indigenous artist to bring to life the UOHI land acknowledgment. We also have designed a Staff Experience Survey as well as a Patients Experience Survey both with race-based questions to be rolled out in the coming fiscal year.

• Women's Heart Health Education Group: Women with microvascular dysfunction have higher rates of myocardial infarction and death. Spontaneous coronary artery dissection (SCAD), myocardial infarction with non-obstructive coronary arteries (MINOCA) disease, and angina with non-obstructive coronary artery disease (ANOCA) are much more prevalent in women than in men. In a clinic developed specifically for women's heart health, the patients with SCAD, MINOCA, and ANOCA are referred for further assessment and follow-up. We have successfully established and held monthly group education sessions with a minimum of 10-15 patients of all ages and rolled out satisfaction surveys for participants to address their questions and concerns, better understand their needs and views, and actively engage them in their care.

• Women’s Heart Health Registry: Cardiac disease in Women is underdiagnosed, undertreated, and under-researched. The UOHI has embarked on the development and operationalization of a women’s heart health registry which captures data to give a rich source for improving patient care and research in Women’s Heart Health.

EXECUTIVE COMPENSATION

The Excellent Care for All Act mandates that CEO and top executive pay be tied to performance goals outlined in our Quality Improvement Plan (QIP). We have ensured that our performance-based compensation remains consistent with other institutions of our size.
For each of our executives, the percentage of salary at risk is as follows:

• CEO – 10% of base salary is linked to achieving targets set out in our QIP.
• VP – 5% of base salary is linked to achieving targets set out in our QIP.

Considering their significance for the organization and provision of exceptional care, the following metrics are proposed for performance evaluation:

• LEAN FMEA for the Ottawa Model for the Smoking Cessation Program
• Prospective review of the outcomes in minimally invasive robotic coronary surgery using STS database
• Equitable: Women's Heart Health Clinic Interactive Voice Response

CONTACT INFORMATION

Mailing Address:
Quality Department, Room 2411
University of Ottawa Heart Institute
40 Ruskin Street
Ottawa, ON K1Y4E9

Email:
quality@ottawaheart.ca

Phone:
613-696-7000 ext.19305

OTHER

Efficiency

• Patient Guide Refresh: The UOHI has established a Patient Guide Refresh working group that includes patients' partners. The group has created standards to guide content owners in the creation and revision of patient education guides for UOHI patients and their family & caregivers. The working group has reviewed Patient Education Survey results and completed the review of the "TAVI" and "Recovering from Cardiac Surgery" Guides.

Continuity

• Virtual Surgical Transitions in Care (VSTIC): The UOHI set to decrease readmissions of its post-op patients through the expansion of the Telehome Monitoring (THM) Program to monitor high-risk readmission post cardiac surgery patients. Our inpatient post cardiac surgery multidisciplinary team can refer any patient at high risk of re-admission to VSTIC as an in or outpatient. All surgical patients at high risk of re-admission can be referred. The goal of this project is to determine whether close follow-up by telemonitoring of these post-op cardiac surgery patients allows for prompt assessment and follow-up of the post-op cardiac surgery patient intervention to decrease risk of complications (SWIs) and readmission rates. This project also seeks to examine and evaluate the impact of virtual care on patient outcomes and health resource utilization.

• Prehab IVR (Interactive Voice Response): The UOHI Prevention and Rehabilitation Program, working with the Advanced Practice Nurse for Cardiac Surgery and the Surgical Triage Office, has developed a best practice, multi-disciplinary algorithm that screens for "at risk" patients immediately after acceptance for cardiac surgery. This is within the waiting for cardiac surgery phase or Cardiac Surgery "Prehabilitation" phase. We have done on-site or virtual assessment of all pre-op patients who use tobacco to increase their rates of cessation to meet the best practice target of 4 weeks smoke free before surgery. Has of December 2022, a total of 101 were referred to the Smoking Cessation Prehab program after a positive screen, of those 87 had at least 1 appointment. After intervention we have recorded an overall quit rate of about 50.8% and 26.2% had a quit rate of at least 4 weeks.

• Cardiology Program LEAN/FMEA: The UOHI Quality Team conducts an annual Failure Modes and Effects Analysis (FMEA) within a program or department to determine risks or gaps and opportunities to improve. Part of this process also involves a Value Stream Map which is derived from LEAN. Last year, the Quality Department completed a Cardiology program review using the

LEAN/FMEA tools, including gathering a team from various areas of Cardiology to develop a process stream map and a work plan to address gaps. One project, emanating from this process is this year's project: Improving the efficiency of the discharge process and eliminating End-of-Stay Delays.

People-centered care

• Implementation of Obesity Guidelines: A working group has been developed to integrate the new "Canadian Clinical Practice Guideline for Obesity in adults" into clinical practice within UOHI, both in-patient and out-patient areas. A baseline survey of UOHI healthcare professionals' attitudes and beliefs regarding obesity was completed and an education strategy was developed based on the survey's findings. This was followed by the integration of 5 Steps in the HCP practice of care of patients with obesity, there are also structural changes assessment being done as part of a larger Accessibility Working Group.

• Heart Failure Cardiac Rehabilitation Program: There is a vast body of literature demonstrating the benefits of a program like this one, on cardiovascular mortality and hospital readmission. Following focus group discussions, UOHI has developed a targeted virtual cardiac rehab heart failure education and exercise program that has the potential to reach patients within the entire LIHN. So far, we have enrolled 80 women (41%); 116 men (59%). The program evaluation done in October 2022 revealed a 131% increase in self-reported moderate to vigorous minutes of physical activity, the Duke Activity Status Index (estimate of functional capacity) increased by 20%, in terms of nutrition we noticed an 25% increase in fruits and vegetable intake; and the Mental Health Screeners: PhQ (depresssion) – improved 31%; GAD7 (anxiety) – improved 34%. We however did not see any change in the smoking status.

• Measures and Meaning: Due to the COVID-19 pandemic, virtual visits replaced the majority of in-person visits worldwide. The positive effect of self-monitoring of blood pressure has already been established. We provided virtual education to assess the accuracy of blood pressure measurement on all patients in the HTN Clinic who have access to MyChart. 78% of patients voiced their preference for video visits as compared to phone visits and 100% believed virtual visits are at least equivalent to in person visits. Some of the advantages of virtual visits voiced by patients were avoidance of 'white coat syndrome', less stress from driving in winter or finding parking at the hospital, and greater ability to see their providers' facial expressions in comparison to in person visits during the pandemic when the masks covered their faces. They also felt more comfortable sharing information while in the safety of their own home, than in a clinic setting. Overall, patients felt that they gained knowledge about how to measure their BP accurately, and how and when to seek medical help. This exercise allowed us to develop a patient education booklet promoting hypertension self-care.

• Supporting Caregivers: This project is an initiative of the UOHI Patient Partnership Council, which is co-chaired by a staff member from research, clinical services, and a patient. This project aims to ensure that caregivers receive the resources, tools, and support that are required to be effective support persons to UOHI patients.

To this effect we have developed a "How to talk to your kids" resource guide; a "Communication with patient's family" guide, as well as a "Care Giver Guide".

Wellness

• Live Exercise Streaming Program: We brought cardiac rehabilitation to patients' homes with Live-streamed or on-demand exercise classes. 9 participants joined our pilot program; 5 had classes with equipment and 4 without equipment. We have translated the feasibility into both an RCT and clinical care. We are now offering two choices of programs: classes with equipment (indoor cycles, resistance bands) and classes without equipment for low and moderate intensity patients.

SIGN-OFF

It is recommended that the following individuals review and sign-off on your organization's Quality Improvement Plan (where applicable):

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

Board Chair

Board Quality Committee Chair

Digitally signed by Dr. Thierry Mesana
DN: cn=Dr. Thierry Mesana, o=University of Ottawa Heart Institute, ou=President and CEO, email=tmesana@ottawaheart.ca, c=CA
Date: 2023.03.30 15:17:52 -04'00'

Chief Executive Officer

Other leadership as appropriate

Theme I: Timely and Efficient Transitions

Measure

Dimension: Efficient

Indicator #1	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Standardization of Best Practices in Out-patient Cardiac Rehabilitation (Level of Clinical Practice Consistency among Clinical Staff in the Cardiac Rehabilitation Program).	C	% / Worker	Other / 2023 - 2024	CB	90.00	The performance of standardized care with consistency should be close to perfection for care efficiency, patient safety, and satisfaction. These are at the core of the UOHI Corporate Quality Framework	

Change Ideas

Change Idea #1 Development of audit tool for cardiac rehabilitation care best practices. Randomly audit for standardized, consistent best-practice care by program leads using the audit tool on a monthly basis.

Methods	Process measures	Target for process measure	Comments
Review literature and compile audit tool. Randomly audit using the predeveloped audit tool.	Completion of audit tool development and monthly audits conducted.	1 audit tool developed; number of monthly audits conducted.	

Change Idea #2 Provide quarterly de-identified information to staff identifying areas that require further education. Staff identified as having significant education gaps will be supported.

Methods	Process measures	Target for process measure	Comments
De-identified information provided to staff quarterly via support sessions. The clinical manager and/or professional practice leads will support the identified staff.	Support sessions conducted, number of staff provided support. Percentage practice consistency.	Quarterly support sessions. 90% of staff provided support, and 90% consistency amongst all staff.	

Measure

Dimension: Efficient

Indicator #2	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Ensuring Standardized Best Practices within the inpatient physiotherapy portfolio (Level of Physiotherapy Practice Consistency among UOHI Physiotherapists).	C	% / Worker	Other / 2023 - 2024	CB	90.00	The performance of standardized care with consistency should be close to perfection for care efficiency, patient safety, and satisfaction. These are at the core of the UOHI Corporate Quality Framework	

Change Ideas

Change Idea #1 Development of audit tool for physiotherapists care best practices. Randomly audit for standardized, consistent best-practice care by program leads using a predeveloped audit tool on a monthly basis.

Methods	Process measures	Target for process measure	Comments
Review literature and complete audit tool, randomly audit using the predeveloped audit tool.	Completion of audit tool development, monthly audits conducted.	1 audit tool developed & monthly audits conducted.	

Change Idea #2 Provide quarterly de-identified information to staff identifying areas that require further education. Staff identified as having significant education gaps will be supported.

Methods	Process measures	Target for process measure	Comments
De-identified information provided to staff quarterly via support sessions. The clinical manager and/or professional practice leads will support the identified staff.	Support sessions conducted, number of staff provided support, percentage practice consistency.	Quarterly support sessions. 90% staff provided support, 90% consistency amongst all staff.	

Measure

Dimension: Efficient

Indicator #3	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
LEAN-FMEA for the Ottawa Model for Smoking Cessation Program (Value stream maps, LEAN-FMEA, Project Plans)	C	Number / Other	Other / 2023 - 2024	CB	CB	The UOHI Quality Team conducts 1-2 annual Failure Modes and Effects Analysis (FMEA) within a program or department to evaluate processes for possible failures and to prevent them by correcting the processes proactively rather than reacting to adverse events after failures have occurred.	

Change Ideas

Change Idea #1 Establish a value stream map and conduct a LEAN-FMEA session with representatives from the Ottawa Model for Smoking Cessation (OMSC) program.

Methods	Process measures	Target for process measure	Comments
Consultative meetings with MRPs in the OMSC program. Group LEAN-FMEA session.	Number of consultative meetings held & the group LEAN-FMEA session complete.	All planned consultative meetings held and 1 LEAN-FMEA session held.	

Change Idea #2 Prepare a workplan from prioritized issues and disseminate the workplan.

Methods	Process measures	Target for process measure	Comments
Workplan Write up. Communication to all OMSC of the prioritized change ideas in the workplan.	Work plan creation & disseminated.	100% of the staff from OMSC are aware of the workplan.	

Measure

Dimension: Timely

Indicator #4	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Improving the efficiency of the discharge process and eliminating End-of-Stay Delays (Length of Stay, Waiting time for discharge task completion).	C	Days / All inpatients	EMR/Chart Review / 2023 - 2024	CB	CB	Improving the patients' discharge planning will positively impact patients' Length-of-Stay and Bed availability; which are indicators of efficient service delivery.	

Change Ideas

Change Idea #1 Ensure reliable discharge date prediction through the establishment of a standardized process.

Methods	Process measures	Target for process measure	Comments
We will review the discharge prediction strategies commonly used to reduce length of stay and adopt one that we will use in conjunction with the EPIC Discharge tool.	Adoption of a discharge prediction strategy	1 Discharge prediction strategy adopted	

Change Idea #2 Establish a forecasting process for post-acute needs and destination

Methods	Process measures	Target for process measure	Comments
We will review patient data including referral patterns and establish set processes and test the processes before implementing the processes to all patients.	Forecasting process establishment	1 forecasting process established	

Change Idea #3 Implement the EPIC planning discharge tool

Methods	Process measures	Target for process measure	Comments
Review the EPIC planning discharge tool and adapt it to the realities of the UOHI, for its efficient use.	Usage EPIC Planning Discharge Tool	90% usage of EPIC Planning Discharge Tool	

Change Idea #4 Coordinate End-of-Stay processes

Methods	Process measures	Target for process measure	Comments
Revisit the End-of-Stay processes and establish the actual waiting time as well as a checklist with timelines to facilitate the End-of-stay coordination of activities.	Waiting time for discharge task completion	Reduced Waiting time for discharge task completion	

Theme II: Service Excellence

Measure

Dimension: Patient-centred

Indicator #5	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of respondents who responded "completely" to the following 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?	P	% / Survey respondents	CIHI CPES / Most recent consecutive 12-month period	CB	CB	We are initiating a new survey tool through Qualtircs this year. the tool will be electronic and we are considering this year as the new baseline. Will set target after six months of data.	

Change Ideas

Change Idea #1 Development and roll out of survey (including CIHI question 38).

Methods	Process measures	Target for process measure	Comments
Working with Qualtrics & Atlas Alliance in development of survey. All in patient and day surgery patients will receive an e-mail with a survey link for completion. Extract data from Qualtrics and analyze data quarterly.	Survey developed. Number of surveys completed. Data analysis and result produced.	1 survey development completion. Quarterly report.	

Change Idea #2 Conduct 1 patient focus group & generate change ideas.

Methods	Process measures	Target for process measure	Comments
Present survey completion results after six months at Patient Partnership Committee (UPP) and gather possible change idea suggestions.	Focus group conducted and change ideas generated.	Complete 1 focus group.	

Measure

Dimension: Patient-centred

Indicator #6	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
HeartWise Exercise mobile app patients' usage (survey completion level).	C	% / Patients	Other / 2023 - 2024	CB	25.00	There is no baseline performance for this project. This is a new initiative. 25% is determined using industry standards when looking at this type of surveys completion	

Change Ideas

Change Idea #1 Development & roll out of a survey evaluation for the CardioPrevent mobile app.

Methods	Process measures	Target for process measure	Comments
We will develop an evaluation survey based on literature review on Heart Health Programs that help people with risk factors, lower their chances of developing cardiovascular disease. We will have an anonymous survey, sent to the participant approximately 4 weeks after they first download the app and track de-identified usage of the app using simple metrics found on the HWE app database (UOHI server). To see if CP patients are interested in using this app to assist with physical activity and to gain CP patients' insight and feedback about the app itself.	Survey Development. Completion of feedback surveys.	1 survey development completed. 25% of survey response rate.	

Change Idea #2 Track de-identified usage of the app.

Methods	Process measures	Target for process measure	Comments
Track de-identified usage of the app using simple metrics found on the HWE app database (UOHI server).	App usage report.	1 Quarterly progress report.	

Change Idea #3 Modification to the APP based on the survey results and progress reports.

Methods	Process measures	Target for process measure	Comments
Incorporating results from completed surveys into the App.	Result incorporation.	Results incorporated into App.	

Measure

Dimension: Patient-centred

Indicator #7	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Talking to Children About Heart Disease (Focus groups conducted, Patients reached, Children reached, Education material including findings produced).	C	Number / Family	Other / 2023 - 2024	CB	CB	There is no baseline performance for this project. This is a new initiative. The development of supportive learning materials for patients living with cardiovascular disease with a better understanding of the needs of the patients, their partners/caregivers, and their children is aligned with the UOHI Core Values of Patients Comes First, Excellence as well as the UOHI Corporate Quality Framework which defines equity, people-centered care, and efficiency as three cornerstones to the framework.	

Change Ideas

Change Idea #1 Conduct virtual focus groups with UOHI patients and/or their spouses/caregivers with children of various ages.			
Methods	Process measures	Target for process measure	Comments
Conduct 5-6 virtual focus groups (via Zoom) with approximately 25-30 UOHI patients and/or their spouses/caregivers (~5 participants per focus group) with children of various ages (children, preadolescents, adolescents).	Completion of focus groups.	5-6 focus groups completed.	

Change Idea #2 Arranging and conducting 1:1 interview with the children.			
Methods	Process measures	Target for process measure	Comments
Ask participants if their child would be willing to participate in an individual interview via zoom, with the parent present, regarding their experiences. Approximately 10 children (> age 10) will participate in the interviews.	1:1 interview with children conducted.	Approximately 10 children to participate in the interviews.	

Change Idea #3 Analyze the interview data.			
Methods	Process measures	Target for process measure	Comments
Transcribe, de-identify, and interpret the focus group and interviews results.	Interview data analyzed.	1 report produced based off of data.	

Change Idea #4 Produce educational material for families on how to talk to children about heart disease.			
Methods	Process measures	Target for process measure	Comments
Include the findings from the project in the UOHI education materials for families.	Guide produced.	1 completed guide with the findings from the project.	

Measure

Dimension: Patient-centred

Indicator #8	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Evaluating the UOHI Quit Smoking Program Using Patient Feedback Survey Results (Percentage of patient feedback received)	C	% / Patients	Other / 2023 - 2024	CB	30.00	There is no baseline performance for this project. This is a new initiative 30% is determined using industry standards when looking at this type of surveys completion	

Change Ideas

Change Idea #1 Development & roll out of a survey to evaluate the UOHI Quit Smoking Program.

Methods	Process measures	Target for process measure	Comments
The UOHI Quit Smoking Program (QSP) will develop a Patient Feedback Survey with the input of patient partners that seeks to better understand patient needs after completing the program, identifying areas for improvement or change. A link to the heart survey will be sent via MyChart or secure e-mail to patients completing dropping out of the QSP program who have completed at least three visits.	Survey Developed in Heart Survey. Number of surveys completed.	1 survey development completed. 30% of feedback received from target population.	

Change Idea #2 Quarterly data analysis and presentation to the HIPRC Quality of Care Committee and project stakeholders.

Methods	Process measures	Target for process measure	Comments
The Smoking Cessation's Advanced Practice Nurse will analyze the data quarterly and present it to the HIPRC Quality of Care Committee and project stakeholders.	Quarterly report of program evaluation.	1 Quarterly Report Completed.	

Change Idea #3	Quit Smoking Program (QSP) annual update.		
Methods	Process measures	Target for process measure	Comments
QSP Program update will be made based on patient feedback results.	QSP annual update.	1 QSP annual update completed.	

Measure

Dimension: Patient-centred

Indicator #9	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Harvard (PMAT checklist) Review of 1 patient guide	C	Number / Other	Other / 2023 - 2024	CB	1.00	In order to improve access to patients' education material and improve their content, the UOHI has set the target of having at least one measure guide reviewed annually.	

Change Ideas

Change Idea #1	Identify guide to be updated.		
Methods	Process measures	Target for process measure	Comments
Quality Department will select based on update list of guides.	Selection of guide.	1 guide selected for review.	

Change Idea #2	Content owner to evaluate and update the selected guide. Guide to be provided to the Patient Educational Materials Task Force (PEM) for review. Once this has been done, it will be sent back to the content owner for finalization.		
Methods	Process measures	Target for process measure	Comments
Updates and best practices reviewed in the selected guide.	Updates and incorporate best practices.	1 guide reviewed & updated.	

Theme III: Safe and Effective Care

Measure

Dimension: Effective

Indicator #10	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Medication reconciliation at discharge: Total number of discharged patients for whom a Best Possible Medication Discharge Plan was created as a proportion the total number of patients discharged.	P	Rate per total number of discharged patients / Discharged patients	Hospital collected data / Oct–Dec 2022 (Q3 2022/23)	CB	95.00	We are above 90% for all our reports and would like to close the gap and improve our performance further	

Change Ideas

Change Idea #1 Establish a Medication reconciliation review task group

Methods	Process measures	Target for process measure	Comments
All Inpatient floor manager will convene regularly to review medication reconciliation data and brainstorm strategies for improvement.	Number of meeting held by the task group	At least 1 meeting quarterly	

Change Idea #2 Establish data on the patient groups missing Medical reconciliation at discharge

Methods	Process measures	Target for process measure	Comments
Chart review to determine the population of patients that are missing the DMR and determining if they should be out of scope (DC AMA, short stay patients-less than 24hrs)	Established Characteristics of patients missing Medical reconciliation at discharge	This is a baseline assessment to be determined	

Change Idea #3 Implement Corrective measures based on the identified groups missing medication reconciliation at discharge

Methods	Process measures	Target for process measure	Comments
The task group will established corrective measures based on the collected evidence	Number of corrective measures put in place	Number to be determined since this is a baseline	

Measure

Dimension: Safe

Indicator #11	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Number of workplace violence incidents reported by hospital workers (as defined by OHSA) within a 12 month period.	P	Count / Worker	Local data collection / Jan 2022–Dec 2022	0.00	5.00	There is no baseline. For Quality Improvement purposes, hospitals are asked to track the number of workplace violence incidents in a 12 month period.	

Change Ideas

Change Idea #1 Track the number of workplace violence incidents.

Methods	Process measures	Target for process measure	Comments
The manager of Occupational Health & Safety will track the number of workplace violence incidents.	Number of workplace violence incidents in a 12-month period.	There is no baseline. This measure will be for the 23-24 reporting period.	FTE=0

Change Idea #2 Making better medication choices in high-risk patients to prevent violent incidents.

Methods	Process measures	Target for process measure	Comments
Providing education & best practices to pharmacists & physicians on better medication choices for high-risk patients.	Number of pharmacists & physicians provided education.	80% of pharmacists & physicians provided education.	

Measure

Dimension: Safe

Indicator #12	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Complications and Outcomes of Paraoxysmal Supraventricular Tachycardia Ablations	C	Rate / All patients	Hospital collected data / March 31, 2024	CB	CB	The Continuous tracking of Post-PSVT ablation complications can be used as a KPI	

Change Ideas

Change Idea #1 Establish a Paroxysmal Supraventricular Tachycardia (PSVT) ablation and complications database.

Methods	Process measures	Target for process measure	Comments
Data will be collected by eletronic medical record search using EPIC and populated into the database.	Database created.	1 PSVT database completed.	

Change Idea #2 Identify Paroxysmal Supraventricular Tachycardia (PSVT) ablation outcomes and complications data & update the database.

Methods	Process measures	Target for process measure	Comments
Track prospectively the PSVT ablation outcomes and complications through EPIC chart review. Routinely update the PSVT ablation outcomes and complications database for quality assurance and patient awareness.	EPIC chart review. Monthly database updates.	EPIC chart review completed. 1 monthly database update completed.	

Change Idea #3 Complete a yearly report on procedural complications and outcomes of PSVT ablations at UOHI for quality assurance and patient awareness.

Methods	Process measures	Target for process measure	Comments
Data generated from the PSVT ablation complications database to be analyzed and a report will be compiled.	Yearly report to be generated.	1 yearly report completed.	

Measure

Dimension: Safe

Indicator #13	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Cardiac implantable device procedure outcomes and complications	C	Number / Other	EMR/Chart Review / 2023-2024	CB	CB	The Continuous tracking of Cardiac implantable device procedure outcomes and complications can be used as a KPI.	

Change Ideas

Change Idea #1 Establish a Cardiac Implantable device procedure outcomes and complications database.

Methods	Process measures	Target for process measure	Comments
Data will be collected by electronic medical record search using EPIC and populated into the database.	Database created.	1 Cardiac Implantable device procedure outcomes and complications database completed.	

Change Idea #2 Identify Cardiac implantable device procedure outcomes and complications data & update database.

Methods	Process measures	Target for process measure	Comments
Track prospectively the Cardiac implantable device procedure outcomes and complications through EPIC chart review and routinely update the database for quality assurance and patient awareness.	EPIC chart review & Monthly database updates.	EPIC chart review completed. 1 monthly database update completed.	

Change Idea #3 Complete a yearly report on procedural complications and outcomes of Cardiac Implantable Devices at UOHI for quality assurance and patient awareness.

Methods	Process measures	Target for process measure	Comments
Data generated from the Cardiac Implantable Device Procedure and Outcomes database to be analyzed and a report will be compiled.	Yearly report to be generated.	1 yearly report completed.	

Measure

Dimension: Safe

Indicator #14	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Prospective review of outcomes in minimally invasive robotic coronary surgery using the STS database	C	Other / All patients	Hospital collected data / 2023-2024	CB	CB	Continuous tracking of Minimally invasive robotic coronary surgery outcomes and complications report	

Change Ideas

Change Idea #1 Assess previous cardiac surgery robotic quality performance.

Methods	Process measures	Target for process measure	Comments
Fill out and submit data request form to assess previous cardiac surgery robotic quality performance since 2018.	Data request submitted; data provided.	Assess completed.	

Change Idea #2 Identifying cardiac surgery robotic procedures patient outcomes and technical successes.

Methods	Process measures	Target for process measure	Comments
Track prospectively the cardiac surgery robotic procedures patient outcomes and technical successes through the STS database.	STS database review.	STS database review completed.	

Change Idea #3 Establish and track patient satisfaction of the cardiac surgery robotic program.

Methods	Process measures	Target for process measure	Comments
Roll out patient satisfaction survey. Satisfaction survey to be e-mailed to patients after surgery.	Survey sent out to patients in the cardiac surgery robotic program.	Review patient satisfaction survey results.	

Change Idea #4 Complete a yearly report on the Cardiac Surgery Robotic Program outcomes at UOHI for quality assurance.

Methods	Process measures	Target for process measure	Comments
Data generated from the STS database to be analyzed and a report will be compiled.	yearly report to be generated.	1 yearly report completed.	

Equity

Measure

Dimension: Equitable

Indicator #15	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Women's Heart Health Clinic Interactive Voice Response (Number of patients/diagnosis entered into IVR pre-clinic visits, 6, 12, and 24 months, SF-12 Patient QOL pre-clinic vs. post-visit data, Patients' level of knowledge of heart health, symptoms, Health care utilization Level (visits to FMD, cardiologist), Patients satisfaction level).	C	Other / Patients	Hospital collected data / 2023-2024	CB	CB	A high number of women need to be reached to reduce the risks of myocardial infarction and death in women with microvascular dysfunction (SCAD, MINOCA, and ANOCA) and subsequently improve their QOL.	

Change Ideas

Change Idea #1 Develop an Interactive Voice Response (IVR) with specific assessment goals

Methods	Process measures	Target for process measure	Comments
The Interactive Voice Response will be developed based on reviewed evidence to mitigate the higher risks for myocardial infarction and death that women with microvascular dysfunction (SCAD, MINOCA, and ANOCA)present.	Interactive Voice Response (IVR) development	1 Interactive Voice Response (IVR) developed	

Change Idea #2 Ensure that all patients referred to the Heart Health Clinic have access to the Interactive Voice Response

Methods	Process measures	Target for process measure	Comments
Enter all patients referred to the Women's Heart Health Clinic into the Interactive Voice Response register	Number of patients referred women entered in IVR	90% of the patient followed at the Women's Heart Clinic entered in IVR	

Change Idea #3 Conduct patients assessments of microvascular dysfunction risks at specific intervals

Methods	Process measures	Target for process measure	Comments
Assessments will be conducted at the pre-clinic visit as well as between the 6-24 months follow-up visits: patients' frequency of symptoms, need for follow-up at ED/Primary doctor, preparation for the first visit at the clinic). All IVR calls will also have Quality of Life (QOL) questions	Number of successful assessment series conducted & quarterly progress reports provided.	90 % assessment series successfully conducted. 1 Quarterly progress report.	

Measure

Dimension: Equitable

Indicator #16	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Increasing the knowledge of healthcare providers on Women's Heart Health within the UOHI (Surveys, Number of staff attending these events, Manuscripts published education added to corporate orientation).	C	Other / Worker	Hospital collected data / 2023-2024	CB	CB	The UOHI would like to increase the knowledge of Health Care Professionals on Women's Heart Health to better support patients.	

Change Ideas

Change Idea #1 Creation & roll out of Women's Heart Health knowledge survey for healthcare providers.

Methods	Process measures	Target for process measure	Comments
Perform a literature search to better understand what has already been developed and create a survey based on the literature review. Share heart survey link with staff.	Literature search, survey development & roll out.	Creation & roll out of survey complete.	

Change Idea #2 Establish opportunities for staff education.

Methods	Process measures	Target for process measure	Comments
The Women's Heart Health will conduct: - staff education day on Women's Heart Health - Nursing rounds on Women's Heart Health - A half day workshop on Women's Heart Health - Women's heart health champions. post survey of staff knowledge. Women's Heart Health (WHH) learning modules will be developed based on staff knowledge and attitude gaps identified.	Number staff education opportunities established	3 staff education opportunities established	

Measure

Dimension: Equitable

Indicator #17	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Equity, Diversity and Inclusion Climate Staff Survey/Survey results (Completed Survey)	C	Other / Worker	Staff survey / 2023-2024	CB	CB	This survey is important to establish baselines, identify and monitor areas of growth, develop data-driven action steps, and track progress over time.	

Change Ideas

Change Idea #1 Develop and roll out an Equity, Diversity, and Inclusion climate staff survey.

Methods	Process measures	Target for process measure	Comments
Review literature and compile survey based on literature findings and incorporate Inclusion, Diversity, Equity, Accessibility and Anti-Racism (IDEA) committee input into the survey design. Use various communication platforms and tools to advertise the survey. A survey link will be shared with all staff, and collected data will be analyzed.	Develop survey in Heart survey.	1 survey developed and rolled out.	

Change Idea #2 Provide survey results report to senior management team.

Methods	Process measures	Target for process measure	Comments
VP, CNO, Quality, Risk & Privacy to present report to the senior management team.	Presentation to senior management team.	Results reported to senior management team.	

Change Idea #3 Incorporate senior management recommendations.

Methods	Process measures	Target for process measure	Comments
Incorporate senior management recommendations from the results presentation into Inclusion, Diversity, Equity, Accessibility & Anti-Racism (IDEA) committee workplan.	Recommendation additions to the workplan.	Recommendations added to the Inclusion, Diversity, Equity, Accessibility & Anti-Racism (IDEA) committee workplan.	

Measure

Dimension: Equitable

Indicator #18	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Equity, Diversity and Inclusion Climate Patients Survey/Survey results (Completed Survey)	C	Number / Patients	In-house survey / 2023 -2024	CB	CB	This survey is important to establish baselines, identify and monitor areas of growth, develop data-driven action steps, and track progress over time.	

Change Ideas

Change Idea #1 Develop and roll out an Equity, Diversity, and Inclusion Climate Patient Survey.

Methods	Process measures	Target for process measure	Comments
Review literature and compile survey based on literature findings and incorporate inclusion, diversity, equity, accessibility and anti-racism (IDEA) committee input into the survey design. Use various communication platforms and tools to advertise the survey. A survey link will be shared with all staff, and collected data will be analyzed.	Develop survey in Heart Survey.	1 survey developed and rolled out.	

Change Idea #2 Provide survey results report to senior management team.

Methods	Process measures	Target for process measure	Comments
VP, CNO, Quality, Risk & Privacy to present report to the senior management team.	Presentation to senior management team.	Results reported to senior management team.	

Change Idea #3 Incorporate senior management recommendations.

Methods	Process measures	Target for process measure	Comments
Incorporate senior management recommendations from the results presentation into Inclusion, Diversity, Equity, Accessibility & Anu-Racism (IDEA) committee workplan.	Recommendation additions to the workplan.	Recommendations added to the Inclusion, Diversity, Equity, Accessibility & Anti-Racism (IDEA) committee workplan.	

Measure

Dimension: Equitable

Indicator #19	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Improving rehab intake for indigenous population (Enrollment rate, pre and post program metrics (outcomes), Collaboration with patient partners for program development and with community Indigenous services such as OHSNI, Patient satisfaction survey outcomes).	C	Rate / Patients	Hospital collected data / 2023-2024	CB	CB	Improve rehab intake for indigenous populations	

Change Ideas

Change Idea #1 Adapt a rehab specific process for the indigenous population.

Methods	Process measures	Target for process measure	Comments
Focus groups for indigenous patients will be arranged to learn how to meet their needs & make recommended changes and develop the process fully.	Number of indigenous peoples accessing rehab services.	Collecting baseline data.	