Quality Priority Plan 2021/22: Early Warning Scores

AIM		MEASURE			
Quality dimension	**Objective**	**Indicator**	**Current performance**	**Target for 2021/2022**	**Target justification**
Safe	Improve Escalation of Care at Sunnybrook via the implementation of an Early Warning Scores (EWS) system.	Completion of an Early Warning Score (EWS) Pilot on a high priority unit. Pilot results will inform wider EWS implementation across Sunnybrook.	N/A	EWS Pilot will be implemented and evaluated on a high priority acute care unit by March 31st, 2022	Implementation of an Early Warning Scoring system is reliant on full implementation of an electronic system to capture patient vital signs at the bedside. Given the pressures introduced by COVID, this foundational element may be delayed and as such, we feel development and pilot testing of the EWS system in a single area during pandemic recovery is a reasonable target.

CHANGE			
Change Ideas	**Methods**	**Process Measures**	**Goal for Change Ideas**
Select Sunnybrook's Early Warning Score (EWS) algorithm, alert thresholds, alert pathways and EWS Clinical Workflow	Sunnybrook's EWS Advisory Group will review, and inform the EWS algorithm selection, EWS alert thresholds & pathway development and EWS clinical workflow. This process will include: 1. Review of emergent EWS Literature 2. Engaging local subject matter experts and clinical practice leads 3. Integration of resources from peer organizations – including but not limited to Unity Health, University Health Network, William Osler, Hamilton Health Sciences 4. Review and integration of current Sunnybrook Escalation of Care resources and practices	Sunnybrook's EWS Advisory Group will define and endorse: 1. EWS Algorithm 2. EWS alert thresholds 3. EWS alert pathways 4. Defined EWS clinical work flow	Target Completion Q1 2021/22
Engage staff and patients in co-design of the processes	The voice and perspective of frontline interprofessional team members, and patients and family members will inform EWS solution design and implementation. Engagement of relevant Patient / Family Advisory Council (PFAC) groups will be conducted to obtain and integrate patient and family member feedback	1. Complete consultation with frontline interprofessional teams 2. # PFACs attended and recommendations obtained	1. Q2 2021/22 2. At least 2 PFACs consulted by Q2 2021/22
Complete a simulation of EWS algorithm & alert thresholds prior to pilot go live to evaluate EWS	1. Activate EWS algorithm scoring as a hidden field within the Philips Monitor and eVitals SunnyCare display and alert management system	1. Compliance with vital sign collections including AVPUC observations on the pilot unit	1. 95% compliance with appropriate vital sign collection on pilot unit

CHANGE			
Change Ideas	**Methods**	**Process Measures**	**Goal for Change Ideas**
algorithm performance and daily alert frequency	2. Implement level of consciousness observations (AVPUC Scale) within routine vital sign collection in simulation unit. 3. Utilization of eVitals data, Philips Canada, Biomed and Decision Support resources to perform a statistical simulation of the algorithm scoring model to determine specificity and sensitivity of the model, to review with the EWS Advisory Group	2. Completion of the statistical simulation of EWS algorithm performance and daily alert frequency	2. Completion of simulation by Q2 2021/22
Implement and evaluate Sunnybrook EWS solution impact within identified pilot unit(s)	Implementation will be lead jointly by Sunnybrook's Project Management Office and EWS Lead 1. Will include ongoing engagement and support from EWS Advisory Group – unit selection, pilot implementation and evaluation 2. Will require coordination and resource support from Philips Canada, Biomed, SunnyCare, Communication and Decision Support. 3. Will leverage and require eVitals implementation	1. Completion of the evaluation of EWS algorithm performance and daily alert frequency 2. % reduction CCRT calls, code blue events, Cardiac arrests and deaths	Completion of EWS pilot within identified unit(s) by Q4 2021/22 Target % reduction in CCRT calls, code blue events, cardiac arrests and deaths to be determined based on baseline rates (to be calculated during statistical simulation)

Quality Priority Plan 2021/22: Virtual ED

AIM		MEASURE			
Quality dimension	**Objective**	**Indicator**	**Current performance**	**Target for 2021/22**	**Target justification**
Seamless	Improve access to care for patients with acute, non-life-threatening health concerns using virtual care	Number of patients seen through the Virtual ED (Emergency Department) within a 12-month period	Number of visits between Dec 2020 and Jan 2021 were 300	Target is 1500 total visits in 2021/22	We believe that virtual care for EDs has become an essential patient care offering for urgent access for acute, non-life-threatening health concerns that enhances access, decreases wait times, and improves the patient experience. While we expect to see a rise in visits as virtual care becomes a core program of our ED, the duration of the COVID-19 pandemic, the uptake of vaccines, and overall COVID-19 numbers may increase or decrease use of virtual care. As a result, we are setting a conservative target of 1500 visits for next fiscal year. We also must confirm ongoing funding for this initiative to ensure sustainability.

CHANGE			
Change Ideas	**Methods**	**Process Measures**	**Goal for Change Ideas**
Tracking of Data: Partner with Sunnybrook's Decision Support to build a database and dashboard to track Virtual ED visits which allows for near real-time analysis of patient care trends and identification of actionable themes	Decision Support to provide monthly report to the Virtual ED leadership	Database and dashboard are in place and 1-2 themes identified and incorporated into further training/expansion efforts	Completed by March 31, 2022
Evaluate Patient & Provider Experience: Partner with Women's College Hospital Institute for Health Systems Solutions and Virtual Care (WIHV) to systematically assess the implementation and expansion of the Virtual ED from the patient, family, and provider perspectives through in-depth interviews, focus groups, and detailed feedback surveys	WIHV will be responsible for conducting interviews, focus groups, and detailed feedback surveys and providing findings back to Virtual ED leadership in September	Research Ethics Board approval including interview and survey protocols have been developed 1-2 themes identified will be used to make process improvements	Completed by September 1, 2021 Completed by March 31, 2022
Marketing & Communication: Collaborate with Sunnybrook's Digital and Visual Communications Department and previous Virtual ED patients/community members to develop an ongoing social, digital, and traditional media presence that help patients and their families navigate virtual emergency services	Digital and Visual Communications to plan ongoing communications campaign highlighting patient experience	Communications plan is in place and 2 patient stories have been incorporated into promotional materials	Completed by March 31, 2022

Quality Improvement Plan 21/22: Connected Care and Navigation

AIM		MEASURE			
Quality dimension	**Objective**	**Indicator**	**Current performance**	**Target for 2021/22**	**Target justification**
Seamless	Work with partners to improve continuity of care and connection to the community	Number of patients connected to Interprofessional Primary Care via the Baycrest EPIC team, LHIN Complex Transition Coordinators and Community Transitional Team (SPRINT / Sunnybrook Collaboration)	**Total # new connections to Interprofessional Primary Care in Q3 2020/21**: **21** Community Transitional Team referrals + **23** LHIN Complex Transition Coordinator new referrals + **390** Baycrest EPICS referrals **= 434 TOTAL in Q3 2020/21**	≥ 1720 new connections to interprofessional primary care in 2021/22	The target of 1720 new connections in 2021/22 aims to maintain current volumes of patients during the pandemic. The goal for this year is to understand current unmet patient needs, in order to set a growth target for the following fiscal year.

CHANGE			
Change Ideas	**Methods**	**Process Measures**	**Goal for Change Ideas**
Utilize formative evaluation data to identify opportunities for improvement from the patient and provider perspectives	A Post-doctoral Research Fellow will interview eligible patients and providers who have received care from both Complex Transition Coordinators and the Community Transitional Team to identify quality improvement themes and demonstrate proof of concept. Conduct a client experience survey with clients supported by the Complex Transition Team	1-2 improvement ideas identified through both the Patient/Provider interviews and client experience survey will be completed.	March 31st, 2022
Improve integration and coordination across ED One Team, LHIN Complex Transition Coordinators and Community Transitional Team members	Engage leadership across all groups to identify opportunities for improvement in integration of workflow and communication, supporting seamless transitions for patients and their families. Implement and evaluate process changes identified through collaborative discussions.	The number of ED One Team patients accepted to the Complex Transition Coordinator (CTC) Program. The CTC program started in Q3 of 2020 – 21 and the ED had 14 successful referrals.	Goal of 17 referrals per quarter by Q4 2021-22 (20% increase).
Introduce an Emergency Department (ED) Community Transitional Worker role, in collaboration with Sunnybrook and SPRINT Senior Care sites.	The ED Community Transitional Worker will act as a point-of-contact between community and hospital, supporting both community social workers when their clients present to the Sunnybrook ED as well as the ED One Team. The ED Transitional Worker works in collaboration with the ED team to assesses patient needs and helps connect patients to the appropriate services at SPRINT Senior Care and other interprofessional community supports.	Number of patients seen each quarter by the ED Community Transitional Worker	50-60 per quarter in Q4 2021/22

CHANGE			
Change Ideas	**Methods**	**Process Measures**	**Goal for Change Ideas**
Monitor performance through development of a dashboard	Partner with Sunnybrook Decision Support to create a dashboard of key performance metrics that include data from the LHIN regarding Sunnybrook patients connected to Complex Transition Coordinators, and the Community Transitional Team. The dashboard may also include relevant Ontario Health Team required indicators related to interprofessional primary care utilization. The dashboard will be reviewed regularly by key leaders across all partner organizations to ensure continuous, collaborative quality improvement discussions.	Dashboard completed	End of Q2 2021/22
Support primary care clinics with identified interprofessional team needs / gaps that can be met through a relationship with the EPICS team	a) Determine interprofessional team capacity across select NT OHT primary care clinics with the aim level-loading team composition (e.g., availability of Nurse Practitioners, Social Work, Registered Dietitians, home care, mental health professionals to fill needs). b) Using data from participating clinics' electronic medical records (EMRs), complete an analysis that will reveal the aggregate level of need for rostered patients.	a) Functional assessment complete b) Population needs assessment complete	End of Q3 2021/22
Recruit, develop, and motivate family physicians to provide comprehensive care in the community.	Train Family Physicians for a focused practice in Care of the Elderly and apply for GP Focused Practice Designations.	Identify one (1) Family Physician eligible to apply for a GP Focused Practice Designation every 6 months.	Two (20 physician applications by Q4 2021/22
Provide a seamless experience for access to primary care, specialized geriatrics, and psychogeriatric outreach care	Continue efforts to integrate three Baycrest outreach programs – the Geriatric Psychiatry Community Service (GPCS), Integrated Community Care Team (ICCT), and the Interprofessional Primary Care Team (IPCT).	Progression from Level 3 (Basic Collaboration Onsite) to Level 5 (Close Collaboration Approaching an Integrated Practice) as defined by the Center for Integrated Health Solutions	End of Q3 2021/22

Quality Priority Plan 2021/22: ED One team

AIM		MEASURE			
Quality dimension	**Objective**	**Indicator**	**Current performance**	**Target for 2021/22**	**Target justification**
Seamless	Increase ED One Team (ED1T)* engagement with our community partners.	Increase the number of patients the ED One Team consults with a discharge focus**.	2020/21 YTD Average 6.7/day	Average 12/day in Q4 2021/22	We have been continually meeting our target of an average 6/day throughout 2020/21. With the addition of a dedicated Team Leader to assist with case finding and community partner engagement a stretch goal would be to double last year's target

*The ED1T is an interprofessional team comprised of Sunnybrook Employees (Geriatric Emergency Management Registered Nurse (GEM-RN), Physiotherapist, Occupational Therapist, and Social Worker) and employees from our Health System Partner Organizations (SPO) (Home Care Specialist, LHIN Home and Community Support Coordinator, Psycho-geriatric Case Manager, and Community Social Worker). The team's major focus is preventing avoidable admissions to the hospital by leveraging our community partners to safely transition patients from the ED back to the community. The team is also able to support admitted patients boarded in the ED (when a patient is admitted to a service but remains in the ED) to try and prevent deconditioning and delirium, which can help to decrease the patient's length of stay in acute care; however their priority focus is to avoid unnecessary admissions.

** The ED1T consults are separated between those with a focus on discharging the patient and those where the team is supporting admitted patients in an attempt to decrease their overall length of stay by preventing deconditioning and delirium.

CHANGE			
Change Ideas	**Methods**	**Process Measures**	**Goal for Change Ideas**
1. Increase the number of accepted referrals to the Complex Transition Coordinators (CTC). (LHIN Navigators supporting complex patients)	ED1T to work with CTC and North Toronto Sub Region manager to clarify enrolment criteria and refer appropriate patients.	The number of patients accepted to the CTC team. The CTC program started in Q3 of 2020-21 and the ED had 14 successful referrals.	Goal of 17 referrals per quarter by Q4 2021-22 (20% increase).
2. Engage Home Care Specialists (HCS) from the ED1T in structured assessments of selected Better Care*** patients presenting to the ED with potentially avoidable reasons for ED visit. ***Better Care patients are patients who have 4 or more ED visits in a 6 month period. Patients are flagged upon arrival, allowing the program staff and care partners to explore opportunities to identify and address care gaps in the community, and develop coordinated care plans to meet the client's needs.	An interview tool was developed that the HCS can use to assess patients' reason for coming to the ED, home care supports, and home coping. This assessment can then lead to patient specific interventions to avoid future ED visits. Goal will be for HCS to interview 3 Better Care patients per day. As the HCS become more familiar with the types of Better Care patients that benefit from these interviews we hope that non-Better Care patients will also benefit from this assessment.	1. The number of patients interviewed 2. The number of patients where an intervention was performed. 3. Return visit rates (30 day) for all Better Care patients and those Better Care patients where an intervention was performed. Baseline (July 2020-Jan 2021) there were 2367 Better Care ED	1. Goal is 3 Better Care patients interviewed each day with additional patients interviewed as the process evolves. 2. To be determined as the process evolves. 3. Goal is a 10% reduction in 30 day return visits (target = 25% from 29%) for Better Care patients who are seen by a HCS and

CHANGE			
Change Ideas	**Methods**	**Process Measures**	**Goal for Change Ideas**
		Visits with a return visit rate of 29%.	have an intervention put in place.
3. Increase SPRINT Community Transitional Worker referrals	Improving case finding by refining the daily case-finding algorithm through WebER (an electronic database) and engaging with ED staff and consulting services regarding this unique role. Work is being done to refine the case finding algorithm by Decision Support.	Track number of referrals per quarter. Role started in 3rd quarter and had 13 cases. January 1-26, 2021 saw 18 referrals.	A stretch target of 30 cases per quarter by Q4 2021-22.
4. Increase Psycho-Geriatric Case Manager referrals (LOFT)	Improving case finding by refining the daily case-finding algorithm through WebER and engaging with ED staff and consulting services regarding this unique role. Work is being done to refine the case finding algorithm by Decision Support.	Track number of referrals per quarter. 2020-21 1st quarter 13 referrals, 2nd quarter 20, 3rd quarter 22	By Q4 2021-22, 25 referrals per quarter.

Quality Priority Plan 2021/22: Choosing Wisely – COVID Impact Study

AIM		MEASURE			
Quality dimension	**Objective**	**Indicator**	**Current performance**	**Target for 2021/22**	**Target justification**
• Sustainable	Colorectal cancer patients have regular surveillance CT scans after surgical resection. This study will analyze the impact of delayed scheduled outpatient CT scans during wave one of the pandemic. Outcomes will be studied and an intervention will be implemented to minimize unnecessary surveillance scans and unnecessary radiation. (Surveillance scan frequency for patients with stage II/III colorectal cancer should not be more frequent than yearly and do not need to extend beyond 3 years.)	Study Complete/Incomplete	Study in progress	Study phase complete by March 31 2022 Pilot to minimize unnecessary imaging to be implemented by March 31 2023	The study will assess frequency of surveillance scans following surgical resection. Surveillance imaging occurs yearly until year 3, the study will follow patients through their journey. As such, this will be a multi-year QIP.

CHANGE			
Change Ideas	**Methods**	**Process Measures**	**Goal for Change Ideas**
Among patients with stage II or III colorectal cancer treated at Sunnybrook, what is the frequency of surveillance CT scans following surgical resection? How often are patients receiving CT scans at an interval <1 year? How often are patients receiving CT scans beyond the 3rd year of follow-up?	Partner with decision support to analyze data	Analysis completed	Complete by May 31, 2021
Among patients with stage II or III colorectal cancer treated at Sunnybrook , how often do surveillance CT scans done at a time interval <1 year and >3 years detect an abnormality that leads to a curative intent treatment?	Partner with decision support to analyze data	Analysis completed	Complete by May 31, 2021
Identify baseline surveillance CT scan ordering rate	Partner with decision support to analyze data	Analysis completed	Complete by May 31, 2021
Engage staff in a root cause analysis and process mapping session to identify reasons surveillance CT scans are scheduled outside of guidelines.	Process mapping session to determine highest yield change idea	Analysis completed	Complete by August 31, 2021

Quality Improvement Plan 21/22: Palliative Care Access

AIM		MEASURE			
Quality dimension	**Objective**	**Indicator**	**Current performance**	**Target for 2021/22**	**Target justification**
Sustainable	**Improve timely access to needs-based palliative care** for patients with life-limiting illness (COPD, CHF, Pneumonia, Oncology, and Nephrology patients). This approach models provincial reporting by the Ontario Palliative Care Network (OPCN).	Decrease the % of patients with life-limiting illness (COPD, CHF, Pneumonia, Oncology, and Nephrology patients)* with at least one ED visit in last 90 days of life that did not necessitate a radiology procedure or cross-sectional imaging, and resulted in discharge from ED or admission less than 48 hours. ** This is the "QIP population" as referenced below in the document.* *Note – this is a lagging indicator. The patient population for each quarter is the patients who died in that quarter, who had an ED visit in the preceding 90 days. This means that the QI interventions put in place to prevent ED visits will be reflected in the data only when those patients die (up to 90 days following the intervention), and not in the period in which they were implemented.*	FY 19/20: 19.8%	17% for all of FY 21/22	17% represents a 15% improvement from baseline. Cumulative target selected considering seasonal fluctuations in last 3 years of data, and that indicator is a lagging indicator. FY 19/20 used as baseline for target-setting, to mitigate confounding impact of COVID (smaller denominator than previous 3 years).

CHANGE			
Change Ideas	**Methods**	**Process Measures**	**Goal for Change Idea Process Measures**
1. Implement and integrate the new **standardized Advance Care Planning (ACP) / Goals of Care (GOC) documentation note template** at Sunnybrook and in North Toronto Ontario Health Team (OHT) organizations caring for patients with life-limiting illness.	a) The Change Idea #1 Working Group will lead the adoption of the standard ACP/GOC template at Sunnybrook.	a) Percentage (%) of COPD, CHF, CAP, Oncology, Nephrology, and select Trauma patient inpatient encounters with either of the following: • A new or updated Advance Care Planning (ACP)/Goals of Care (GOC) note documented in SunnyCare during the inpatient encounter in the reporting period • An existing Advance Care Planning (ACP)/Goals of Care (GOC) note documented	a) At least **30%** of the QIP population at Sunnybrook will have a new or existing ACP/GOC note documented in SunnyCare by March 31, 2022. (NOTE: 2020/21 Target for this metric was ≥ 30%)

CHANGE			
Change Ideas	**Methods**	**Process Measures**	**Goal for Change Idea Process Measures**
		in SunnyCare within the last year of the inpatient encounter	
	b) The Working Group will promote and support the adoption of the template at other organizations through workshops and training.	b) Number of organizations who adopt (or align) the template	b) By March 31, 2022, the template will be implemented at Sunnybrook and **3** other organizations.
2. Spread implementation of the **Screening Tool for early identification of changing palliative needs** (developed in FY 20/21) to more organizations in North Toronto, to support access to needs-based palliative care in the community.	a) The Change Idea #2 Working Group will work with members of the Palliative Care Journey Committee to identify and support organizations to implement the Screening Tool. b) The Working Group will track the number of completed Screening Tools through Survey Monkey.	a) Number of organizations that have adopted the Screening Tool Baseline: 2 (YTD Q3 20/21) b) Number of patients screened (completed Screening Tools to be used as proxy) Baseline: 99 (YTD Q3 20/21)	a) **3** new organizations using the Screening Tool by March 31, 2022. b) **120** new Screening Tools completed by March 31, 2022.
3. Expand the North and East Toronto **"Code Palliative" pathway** to connect patients with urgent palliative care needs with appropriate palliative care services in a palliative care unit (PCU) in a timely manner.	a) The Change Idea #3 Working Group will monitor PCU admissions and Code Palliative activations through the Sunnybrook Emergency Department (ED). b) The Change Idea #3 Working Group will work with Paramedic Services to create a pathway for direct admission to the Palliative Care Unit at Sunnybrook and Baycrest from the community. The Working Group will track the proportion of patients admitted to the Sunnybrook PCU through the palliative care report (available in the data visualization warehouse [PowerBI]).	a) Decrease the proportion of deaths in acute care at Sunnybrook of patients with life-limiting illness (QIP population) with a referral to palliative care initiated (through Resource Matching & Referral system [RM&R], no earlier than 30 days before inpatient admission). Baseline: 15.1% (FY 19/20) b) Increase the proportion of patients admitted to the Sunnybrook PCU without an acute care admission (i.e. admitted from ED or community. Baseline: 30.3% (YTD Jan 20/21)	**a)** By March 31, 2022, decrease the proportion of QIP population deaths in acute care at Sunnybrook with a palliative care referral to **13%** b) By March 31, 2022, increase the proportion of patients admitted to the Sunnybrook PCU without an acute care admission to **35%**

CHANGE			
Change Ideas	**Methods**	**Process Measures**	**Goal for Change Idea Process Measures**
4. **Raise public awareness** about palliative care, advance care planning and goals of care.	a) The Change Idea #4 Working Group will develop awareness campaigns with subject matter experts, Palliative Care Journey Committee members, and Ontario Health Team (OHT) partners. b) The Working Group will explore methods for capturing "reach" of the campaign (i.e. number of partners engaged in distributing the campaign, number of website visits, etc.).	a) Number of awareness campaigns launched. b) Measure feedback from campaign (method to be determined by the Working Group).	a) At least 2 awareness campaigns launched by March 31, 2022. b) Target TBD