2014/15 Quality Improvement Plan for Ontario Hospitals
"Improvement Targets and Initiatives"

Joseph Brant Hospital 1230 North Shore Boulevard
PRIORITY INDICATORS

AIM		Measure								Change				
Quality dimension	**Objective**	**Measure/Indicator**	**Unit / Population**	**Source / Period**	**Organization Id**	**Current performance**	**Target**	**Target justification**	**Priority level**	**Planned improvement initiatives (Change Ideas)**	Methods	Process measures	Goal for change ideas	Comments
Access	**Reduce wait times in the ED**	ED Wait times: 90th percentile ED length of stay for Admitted patients.	Hours / ED patients	CCO iPort Access / Q4 2012/13 – Q3 2013/14	718*	54.57	39	Target set for 2013/14 as current performance is higher than target performance.	Improve	1) Implement daily *"take one patient"* strategy in programs as outlined in the Bed Management Policy to facilitate patient flow before 1000 hours	Daily *"pull"* of one appropriate admitted patient from the ED to other inpatient unit(s) to designated space on inpatient units before 1000 hours	One appropriate patient pulled from ED to other inpatient unit(s) each morning	70% YTD compliance with "take one patient" strategy	
										2) Establish no-bed admit threshold and criteria for opening over-census beds on inpatient units and integrate into Bed Management Policy	a) Determine criteria b) Develop escalation process to open beds based on criteria c) Trial and evaluate process	a) Development of criteria and b) Escalation process as part of Bed Management Policy	Process and criteria developed and approved	Provides for escalated response strategy based on objective criteria
										3) Performance Improvement Project (PIP) on patient turnaround times through *"real-time"* order-entry (O/E) of discharges from all inpatient units	a) Review current O/E rates b) Establish improvement plan to meet targets c) Re-measure and adjust plan as necessary across all units	a) Rates reported weekly at the Quality Wall b) PDSA cycles for improvements in measures	YTD average of 80% of discharges O/E as per established timelines	
Effectiveness	**Improve organizational financial health**	Total Margin (consolidated): % by which total corporate (consolidated) revenues exceed or fall short of total corporate (consolidated) expense, excluding the impact of facility amortization, in a given year.	% / N/a	OHRS, MOH / Q3 2013/14	718*	0.03	0	Provincial Mandate; consistent with provincial performance standard.	Maintain	1) Monthly variance analysis and development of mitigation strategies to ensure timely corrective action to budget deficits	a) Monthly review and discussion of financial reports/status with program leadership (director and medical director, managers) b) Corporate review of all cost centres by Senior Mgt	Monthly programmatic budget reviews are in place and reported to Senior Management	Monthly financial reporting and corrective action plans	Achieve and maintain 0% Total H-SAA Margin

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Integrated	**Reduce unnecessary time spent in acute care**	Percentage ALC days: Total number of acute inpatient days designated as ALC, divided by the total number of acute inpatient days.	% / All acute patients	Ministry of Health Portal / Q3 2012/13 – Q2 2013/14	718*	16.78	17	Target set to work towards achieving Corporate and LHIN priority that is linked to patient flow initiatives	Improve	1) Maintain ALC census sheet in partnership with CCAC to track all ALC patients for discharge planning purposes	Minimum of once-weekly review of all patients on census sheet among JBH selected providers and CCAC partners	Minimum of weekly review meetings and/or teleconferences	90% YTD weekly meetings held per year	Promotes shared accountability among JBH and community providers
										2) There is a discharge plan in place for all ALC patients on the census sheet	Target average 10% of patients on the ALC census sheet/list for discharge each week	All patients on ALC census sheet reviewed weekly to identify patients for discharge that week	Average 10% YTD of ALC patients to appropriate discharge destination	
										3) Establish ALC threshold to trigger escalation processes	Develop proposal for adoption by the CCAC and LHIN that outlines an escalation process for management of ALC volumes by January 31, 2015.	Proposal developed through collaboration with key internal and external stakeholders by January 31, 2015.	Proposal submitted to CCAC and LHIN by March 31, 2015	Intended to proactively manage episodic ALC pressures and prevent future IA requirements
	Reduce unnecessary hospital readmission	Readmission to any facility within 30 days for selected CMGs for any cause: The rate of non-elective readmissions to any facility within 30 days of discharge following an admission for select CMG's.	Readmission to any facility within 30 days for selected CMGs for any cause: The rate of non-elective readmissions to any facility within 30 days of discharge following an admission for select CMG's.	DAD, CIHI / Q2 2012/13-Q1 2013/14	718*	15.7	8	As target set for 2013/14 as current performance is higher than target	Improve	1) Continue to review readmissions (with same diagnosis) weekly and report findings to bed management group	Review readmissions (with same diagnosis) with focus on patterns and trends	# of readmits; # of readmits considered appropriate; # of readmits considered inappropriate	90% of reported readmits (with same diagnosis) are reviewed by the care team for improvement opportunities	
										2) Conduct reviews in collaboration with CCAC partners	Conduct one case review of one readmission per month with CCAC partners for identification of learning and improvement opportunities	Minimum of one case review per month conducted and presented back to bed management group	12 case reviews completed in the year	Promotes shared accountability among JBH and community providers
										3) Develop criteria for care plan development in ED for patients presenting frequently with the same primary complaint	Work with community partners to identify risk factors that result in ED visits, whether clinical or social in nature	Care plan criteria developed	90% of patients who fit the care plan criteria have a care plan in place	Patients with frequent ED visits can benefit from consistency in approach
	JBH Specific Indicator	Readmission within 30 days for selected CMG's to JBH	The number of patients with select CMG's readmitted to JBH for non-elective inpatient care within 30 days of discharge, compared to the number of expected non-elective readmissions.	DAD, CIHI / Q2 2012/13-Q1 2013/14	718*	21.7	21.5	Slightly improved from current performance for COPD readmissions to JBH	Improve	1) Case review of 1 COPD readmission per month with CCAC for learning and improvement	Focus on readmits with diagnosis of COPD as reason for readmission	Weekly readmits reported with focus on COPD	1 review completed by team monthly	Determine improvement opportunities to prevent future readmissions
										2) Participate in development of Health Links strategy with CCAC	Strategies to include focus specifically on management of the COPD patient within the community	Health Links Business Plan reviewed and supported by JBH Leadership	Corporate (JBH) *"sign off"* on Health Links Business Plan and strategy	

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Patient-centered	**Improve Patient Satisfaction**	From NRCC: "Overall, how would you rate the care and services you received at the hospital (inpatient care)?" (add together % of those who responded "Excellent, Very Good and Good").	% / All patients	NRCC - Q2 2013/14	718*	88.2	93	To meet Ontario Community Hospital Average (OCHA)	Improve	1) Focus on improving the patient experience for inpatients by engaging the care team to understand patient perceptions of their care	Socialize NRCC surveys to teams through program management structure	Quarterly results shared at program Quality of Care Committee meetings	Quality of Care Committees across the organization have reviewed patient experience surveys and results	Promotes shared accountability in the patient experience
		In-house survey (if available): provide the % response to the question: "Overall, how would you rate the care and services you received at the ED?" (add together % of those who responded "Excellent, Very Good and Good").	% / Other	In-house survey / Other	718*	New measure to include all three dimensions of excellent, very good and good.	85	2013 Dec results reported for Q2 2013/14 and consistent with NRCC OCHA for the same period	Improve	1) Use real-time surveys to drive change and improvements	Implement electronic enablers to obtain immediate feedback from randomly selected ED patients upon disposition.	Number of surveys completed in ED	At a minimum survey results are shared with team members monthly for learning and improvement	Providing timely feedback supports quality and performance improvement

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Safety	**Increase proportion of patients receiving medication reconciliation upon admission**	Medication reconciliation at admission: The total number of patients with medications reconciled as a proportion of the total number of patients admitted to the hospital.	% / All patients	Hospital collected data / Most recent quarter available (Q2 2013/14)	718*	New measure - no current performance measure	70	To establish baseline measures	Improve	1) Focus on mental health inpatient population	Review and evaluate current medication reconciliation processes for improvement opportunities	Number of completed BPMH (best possible medication history) upon admission compared to number of admissions	Long term goal is 100%	Start with specifically defined population
										2) Using medication reconciliation process in Mental Health as the template, develop strategy and plan for med rec on 3 more inpatient units for this year	Establish medication reconciliation plan that includes methodology and required resources for 3 selected inpatient units	Plan developed and resources approved for implementation	To allow for full organizational implementation within 3-4 year timeframe	Use results from evaluation of current processes to build new processes
	Reduce hospital acquired infection rates	CDI rate per 1,000 patient days: Number of patients newly diagnosed with hospital-acquired CDI, divided by the number of patient days in that month, multiplied by 1,000 - Average for Jan-Dec. 2013, consistent with publicly reportable patient safety data.	Rate per 1,000 patient days / All patients	Publicly Reported, MOH / 2013	718*	0.29	0.29	Consistent with provincial target and lower than LHIN target rate of 0.4	Maintain	1)Maintain current practices in relation to surveillance, monitoring, environmental cleaning, hand hygiene and antimicrobial stewardship	Current practices are based on PIDAC guidelines to reduce incidence of hospital-acquired infections and monitored through the Infection Prevention and Control Committee	Maximum of 3 hospital-acquired cases of *C. difficile* monthly	Long term goal is 0 per 1,000 patient days	Rate established to be in line with provinical targets
										2)Continue to report hand hygiene and c-diff rates weekly at the Quality Wall and in patient care areas	a) Hand hygiene and c-diff rates to target by unit are reported weekly b) Provider rates to target are reported monthly	Weekly reports include discussion of corrective actions required to meet or exceed target when below target	To meet or exceed target for hand hygiene and c-diff rates	Inadequate hand hygiene is recognized as a factor in hospital-acquired infections
		Hand hygiene compliance before patient contact: The number of times that hand hygiene was performed before initial patient contact divided by the number of observed hand hygiene indications for before initial patient contact multiplied by 100 - consistent with publicly reportable patient safety data.	% / Health providers in the entire facility	Publicly Reported, MOH / 2013	718*	88.61	90	Able to meet 2013/14 target and higher than provincial performance	Improve	1) Implement electronic auditing device and software for accuracy and timely reporting of hand hygiene audits	Minimum number of audits for data reliability	Defined # of audits performed on each unit on a weekly basis	Required audits are performed each week	Measurement and feedback intervention to support change
										2) Update hand hygiene strategies and plans to sustain momentum and increase consistent compliance	Strategies to focus on provider engagement, visual cues and to optimize social media as a means to reach a broader audience	Hand Hygiene Workplan developed and approved	Patient care spaces have visual reminders to engage patients and staff in hand hygiene practices, including ED, inpatient and outpatient areas	Awareness and participation in process improvement initiatives is critical to success
										3)Continue to report hand hygiene rates weekly at the Quality Wall and in patient care areas	Weekly reporting increases departmental accountability for improvement strategies, enhances visibility of metrics and encourages sharing of challenges and successes among leaders	Weekly reports include discussion of corrective actions required to meet or exceed target when below target	Leader attendance at weekly reporting at the Quality Wall and 100% weekly audit results are posted on unit/departmental Quality Boards	Awareness and participation in process improvement results in ownership for outcomes