PART B: Improvement Targets and Initiatives 2012/13

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lower is better
higher is better

Please do not edit or modify provided text in Columns A, B & C

AIM		MEASURE						CHANGE			
Quality dimension	**Objective**	**Measure/Indicator**	**Current performance**	**Provincial Target**	**Target for 2012/13**	**Target justification**	**Priority level**	**Planned improvement initiatives (Change Ideas)**	**Methods and process measures**	**Goal for change ideas (2012/13)**	**Comments**
Safety	Reduce clostridium difficile associated diseases (CDI)	**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. 2011, consistent with publicly reportable patient safety data	0.23	0.34 (avg. Jan - Dec 2011)	0.15	as target set for 2011/12 and lower than provincial target	3	Sustain current Quality Improvement (QI) initiatives including surveillance, monitoring, environmental cleaning and hand hygiene			Long term goal is 0 per 1,000 patient days
	Reduce incidence of Ventilator Associated Pnemonia (VAP)	**VAP rate per 1,000 ventilator days**: the total number of newly diagnosed VAP cases in the ICU after at least 48 hours of mechanical ventilation, divided by the number of ventilator days in that reporting period, multiplied by 1,000 - Average for Jan-Dec. 2011, consistent with publicly reportable patient safety data	1.68	1.17 (avg. Jan - Dec 2011)	1.22	as target set for 2011/12	3	Sustain current QI initiatives including use of VAP bundles directed at best practices in decreasing incidences of VAP			Long term goal is 0 per 1,000 patient days
	Improve provider hand hygiene compliance	**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 - Jan-Dec. 2011, consistent with publicly reportable patient safety data	69% (Jan - Dec) based on internal audits; 65.14% for FY 2010/2011 as publically reported	72.14% (Apr 2010 to Mar 2011)	85%	evidence of ongoing improvement with increase of 10% over 2011/12 target	1	enhance reporting infrastructure and train more auditors including managers, directors and staff on all units and set targets for number of audits performed on each unit on a weekly basis	# of audits performed on each unit, and achievement of weekly targets	100% target completion each week	Measurement and feedback intervention to support change
								weekly unit audit results to be rolled up into program results and reported via mandatory weekly leadership rounds that include physician participation	# audits reported that meet target or when target is not met, corrective action is implemented to achieve targets	100% attendance at weekly leadership rounds except for illness or vacation	Awareness and participation in process improvement initiatives is critical to success
								weekly unit and program results to be posted on units and reviewed by all staff during daily huddles	# times daily huddles performed - tracked by managers and reported as part of audits	daily huddles performed 90% of the time	Awareness and participation in process improvement results in ownership for outcomes
	Reduce rate of central line blood stream infections	**Rate of central line blood stream infections per 1,000 central line days** : total number of newly diagnosed CLI cases in the ICU after at least 48 hours of being placed on a central line, divided by the number of central line days in that reporting period, multiplied by 1,000 - Average for Jan-Dec. 2011, consistent with publicly reportable patient safety data	0	0.76 (avg. Jan - Dec 2011)	0	consistent with theoretical best levels	3	maintain best performance plus or minus random variation			Remain at 0%
	Reduce incidence of new pressure ulcers	**Pressure Ulcers**: Percent of complex continuing care residents with new pressure ulcer in the last three months (stage 2 or higher) - FY Q3 2011/12, CCRS	9.3% (Q3 - adjusted for risk).	2.1% (Q3 - adjusted for risk)	5.50%	as target set for 2011/12	2	Maintain improvement efforts to decrease incidence of pressure ulcers in this population			Long term goal is 0%
	Avoid patient falls	**Falls**: Percent of complex continuing care residents who fell in the last 30 days - FY Q3 2011/12, CCRS	12.6% (Q3 - adjusted for risk)	8.4% (Q3 - adjusted for risk)	7.50%	50% incremental improvement of best performers among peer hospitals	3	Maintain falls reduction programming and include falls risk in bedside Transfer of Accountability (TOA)			Long term goal is 0 %
	Reduce rates of deaths and complications associated with surgical care	**Surgical Safety Checklist:** number of times all three phases of the surgical safety checklist was performed ('briefing', 'time out' and 'debriefing') divided by the total number of surgeries performed, multiplied by 100 - Jan-Dec. 2011, consistent with publicly reportable patient safety data	99.98%	99.06% (Jan to Dec 2011)	100%	consistent with theoretical best levels	3	Maintain high levels of performance			Achieve and remain at 100%
	Reduce use of physical restraints	**Physical Restraints:** The number of patients who are physically restrained at least once in the 3 days prior to initial assessment divided by all cases with a full admission assessment - Q4 FY 2009/10 - Q3 FY 2010/11, OMHRS	5.7% Prevalence of physical restraint use (eOMHRS) *Note that OHA is working with OMHRS to refine calculation so subject to change	5.6% Prevalence of physical restraint use (eOMHRS)	5.60%	consistent with provinical target	3				

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	JBMH- specific indicator	**Falls** - with injury as determined by risk assessment categories contained in internal occurrence reporting system (rating of 4 and above)	9 falls rating 4 and higher as of Q3	N/A	4 falls rating 4 and higher	improvement from current performance by more than 50%	2	Maintain falls reduction programming and include falls risk in bedside Transfer of Accountability (TOA)			Long term goal is 0 falls
Effectiveness	Reduce unnecessary deaths in hospitals	**HSMR:** number of observed deaths/number of expected deaths x 100 - FY 2010/11, as of December 2011, CIHI	78 for 2010/11 using previous methodology; realigned current performance using new methodology is 89	100 (Standardized Provincial Rate). Note that HSMR methodology used by CIHI is changing in 2012/2013 which may reflect higher rates, on average by about 10 points	73 using previous methodology; 85 realigned target using new methodology	50% incremental improvement to previous best internal score of 67 (previous methodology); realigned to 80 using new methodology	2	Continue to examine coding opportunities, and standardize death review processes among programs			Long term goal is < 65
	Improve organizational financial health	**Total Margin (consolidated):** Percent 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. Q3 2011/12, OHRS	0.97 (Q3 2011/2012 RESULTS)	0 (HSAA Performance Standard)	-0.39%	total margin as measured in the H-SAA	3	maintain best performance plus or minus random variation			Achieve and maintain 0% total margin
	Space for additional indicators										
Access	Reduce wait times in the ED	**ER Wait times:** 90th Percentile ER length of stay for Admitted patients. Q3 2011/12, NACRS, CIHI	45.5 hours (Q3 2011/2012) 49.8 hours (Q3 2011/2012 YTD) - ERNI Level 1 Reports	8 hours or less	39 hours	improvement from current performance by 15%; corporate and LHIN priority linked to patient flow initiatives	1	Maintain Daily Performance Action Team (DPAT) meetings and bi-weekly Patient Flow Review Committee (PFRC) meetings to engage all leaders, including physician leaders in patient flow; introduce weekly leadership rounding and reporting of metrics	monitor attendance via meeting records and minutes; follow-up as required to ensure participation	average of 80% attendance for all participants over a one-year period	Awareness and participation in patient flow discussions is critical to success
								Introduce Patient Order Sets, including admission order sets to standardize expected date of discharge, ensure early discharge planning and engagement of community providers as needed	% of patients admitted with a completed admission order set on chart	100%	Engages patient, family and team members in setting discharge goals
								Establish Acute Medical Unit (AMU) with dedicated physician leadership to move patients from ED to inpatient unit according to established timelines	% patients meeting admission and discharge targets	80% of patients meet established admission and discharge timeframes	Process improvement initiative
	Space for additional indicators										
Patient-centred	Improve patient satisfaction	*Please choose the question that is relevant to your hospital:*									
		From NRC Picker / HCAPHS: "Would you recommend this hospital to your friends and family?" (add together percent of those who responded "Definitely Yes")	IP 61.7% ED 41.1% (Q1)	OCHA IP 69.2% ED 56.7%	IP 70% ED 65%	to exceed Ontario Community Hospital Average	2	Emergency Services processes identified as a corporate priority for 2012/13			
		From NRC Picker: "Overall, how would you rate the care and services you received at the hospital?" (add together percent of those who responded "Excellent, Very Good and Good")	IP 88.96% ED 79.82	OCHA IP92.4% ED 84.7%	IP 93% ED 90%	to exceed Ontario Community Hospital Average	2	Emergency Services processes identified as a corporate priority for 2012/13			
		In-house survey (if available): provide the percent response to a summary question such as the "Willingness of patients to recommend the hospital to friends or family" (Please list the question and the range of possible responses when you return the QIP)	N/A								
	JBMH- specific indicator	Patient "yes definitely" response to the question, "In general, after you used the call button, was the time you waited for help reasonable?"	IP 57.98% IP surgery 56.36%	N/A	IP 70%	as target set for 2011/12	2	Continue with spread of process improvement initiatives established in 2012/13 across all units			

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Integrated	Reduce unecessary time spent in acute care	**Percentage ALC days:** Total number of inpatient days designated as ALC, divided by the total number of inpatient days. Q2 2011/12, DAD, CIHI	19.63% (Q2 2011/12)	11% (HSAA) - 14.07% (provincial rate for Q2)	17%	Corporate and LHIN priority linked to patient flow initiatives	1	Maintain Daily Performance Action Team (DPAT) meetings and bi-weekly Patient Flow Review Committee (PFRC) meetings to engage all leaders, including physician leaders and CCAC in patient flow; introduce weekly leadership rounding and reporting of metrics	monitor attendance via meeting records and minutes; follow-up as required to ensure participation	average of 80% attendance for all participants over a one-year period	Awareness and participation in patient flow discussions is critical to success
								Establish ALC avoidance and management strategies: pilot the HELP program in ED to prevent delirium and deconditioning in admitted patients	# patients referred and assessed by HELP program	100%	Deconditioning is a major factor in determination of ALC status
								For inpatients, promote early mobilization through a "sit-to-stand" protocol	% patients introduced to "sit-to-stand" protocol	100% of appropriate patients	Family engagement is a critical success factor in this initiative to encourage safe discharge
								Introduce a delirium screening protocol for at-risk patients	% patients screened for delirium	100% of identified high-risk patients	Patients with delirium are difficult to return to home or to appropriate community placement
								Introduce a continence management protocol for at-risk patients	% patients on continence management protocol	100% of identified high-risk patients	Maintenance of normal functioning while in hospital
	Reduce unnecessary hospital readmission	**Readmission within 30 days for selected CMGs to any facility:** The number of patients with specified CMGs readmitted to any facility for non-elective inpatient care within 30 days of discharge, compared to the number of expected non-elective readmissions - Q1 2011/12, DAD, CIHI	10.43% (Q1 2011/12)	15.79% (Q1 2011/12)	8.00%	improvement from current performance by 25%	1	expand current discharge planning processes to identify patients most at risk of readmission and implement care coordination strategies that prepare patients for discharge (d/c) upon admission. Ensure information is provided to family physicians within 24 hours of d/c and ensure appropriate family physician follow-up is arranged upon discharge; ensure patients receive clear d/c instructions	# patients receiving follow-up instructions with follow-up visit arranged; # charts with information provided to family physicians as per retrospective chart audits	80% of patients receive discharge information and a scheduled follow-up visit; 100% of family physicians receive patient information	Requires manual data collection and reporting
								engage with CCAC to ensure early identification of required discharge supports so planning is complete by the time the patient leaves hospital	# patients assessed by CCAC within 24 hours of admission	80% of identied patients seen within 24 hours of admission	Patients must be assessed quickly in order to have appropriate d/c supports in place and allow for shortened length of stay (LOS) in hospital
								ensure completion of medication reconciliation upon discharge and look to ways to collaborate with community pharmacies in medication management	# medication reconciliations completed upon discharge	80% of patients with med rec completed upon discharge	Medication reconciliation assures appropriate medications and dosages are clarified
	Space for additional indicators										