Improvement Targets and Initiatives

Trillium Health Partners

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

AIM		MEASURE						CHANGE			
Quality dimension	**Objective**	**Measure/Indicator**	**Current performance**	**Current Target for 2012/13**	**Target for 2013/14**	**Target justification**	**Priority level**	**Planned improvement initiatives (Change Ideas)**	**Methods and process measures**	**Goal for change ideas (2013/14)**	**Comments**
Safety	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. 2012, consistent with publicly reportable patient safety data	0.44	≤0.34	≤0.42	0.42 per 1,000 patients days is the 25th percentile rate for hospitals with greater than 300 beds.	2				
		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. 2012, consistent with publicly reportable patient safety data	71%	≥80%	≥80%	Maintain our 2012-13 stretch target of 80%	**1**		• Improving provider hygiene by mandating that each new staff member be required to attend hand hygiene training during orientation. • Improving patient hygiene by teaching patients to clean their hands before meals. • Continuing to audit hand hygiene compliance and educate staff on the appropriate hand hygiene procedures.		
		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. 2012, consistent with publicly reportable patient safety data	0.31	≤1	≤0.5	0.75 is the provincial average for large hospitals (Q3 FY 11/12)	2				
		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. 2012, consistent with publicly reportable patient safety data	0	0	0	Best practice	2				
	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) - Q2, FY 2012/13, CCRS	1.6%	≤1.8%	≤1.6%	1.6% is slightly below the median of Q4 11/12 Ontario CCC data	2				
	Avoid patient falls	**Falls**: Percent of complex continuing care residents who fell in the last 30 days - Q2, FY 2012/13, CCRS	2.6%	≤2%	≤2%	Maintain 2012-13 stretch target	2				
	Reduce use of physical restraints	**Physical Restraints:** The number of patients who are physically restrained at least once in the 3 days prior to a full admission divided by all cases with a full admission assessment - Q4 FY 2010/11 - Q3 FY 2011/12, OMHRS	2.8%	≤2%	≤2%	Maintain 2012-13 stretch target	2				
	Reduce rates of deaths and complications associated with surgical care	**Rate of in-hospital mortality following major surgery:** The rate of in-hospital deaths due to all causes occurring within five days of major surgery - FY 2011/12, CIHI CHRP eReporting tool NEW	8.5	NA	7	75th percentile rate amongst GTA peer hospitals.	2				
		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. 2012, consistent with publicly reportable patient safety data	100%	100%	100%	Best practice	2				
	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 - Hospital-collected data, most recent quarter available (e.g., Q2 2012/13, Q3 2012/13) NEW PC	70%	≥80%	≥80%	Improvement	2				
Effectiveness	Reduce unnecessary deaths in hospitals	**HSMR:** number of observed deaths/number of expected deaths x 100 - FY 2011/12, as of December 2012, CIHI	92	≤100	≤100	National Benchmark	2				
	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 2012/13, OHRS	1.10%	0.0%	0.0%	Health Service Accountability Agreement (HSAA) target. Maintain a balanced financial position	**1**		• Examining case costs of high volume procedures to identify leading practices across all sites resulting in higher quality care at a lower cost		

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		amortization, in a given year. Q3 2012/13, OHRS				a balanced financial position.			higher quality care at a lower cost. • Improving inpatient bed utilization and appropriate inpatient length of stay. • Improving processes to utilize resources more efficiently in provincially designated Quality Based Procedures such as cataracts, hip and knee replacement, and chronic kidney disease treatments.		
Access	Reduce wait times in the ED	**ER Wait times:** 90th Percentile ER length of stay for Admitted patients. Q4 2011/12 – Q3 2012/13, iPort	46.3	≤42 hrs	≤42 hrs	While our overall ER length of stay has improved by 3.4 hours, we continue to experience continued annual growth of emergency visit volumes of 5.2 %.	**1**		• Strengthening our integrated Bed Management Protocol to include guidelines for the appropriate assignment of beds at admission and standard work for routine bed turnaround, and response to overcapacity. • Implementing a Discharge Protocol and Discharge Bundle, which will standardize discharge policies, practices and tools across sites to facilitate flow and support safe, effective and timely patient transitions to the community. • Participating with our LHIN partners in the Health Links initiative to identify high users who may require additional community resources to avoid admission. • Examining care models to ensure the appropriate resources required for the patient are available in a timely manner.		
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" or "Yes, definitely")	74.7% YTD Oct 12/13	≥77%	≥77%	Maintain 2012-13 stretch target of 77%	**1**		• Communicating with patients using an AIDET approach (Acknowledge, Identify, Duration, Explanation, Thank). • Improving rounding with admitted patients awaiting an inpatient bed. • Improving transitions by implementing post discharge follow up phone calls to patients to answer any questions about their post-acute care needs.		
		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")									
		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)									
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. Q3 2011/12 – Q2 2012/13, DAD, CIHI	12%	≤10%	≤10%	Maintain 2012-13 stretch target	2				
	Reduce unnecessary hospital readmission	**Readmission within 30 days for selected CMGs <u>to any</u> facility:** The number of patients with select CMGs readmitted to any facility for non-elective inpatient care within 30 days of discharge, compared to the number of expected non-elective readmissions - Q2 2011/12 – Q1 2012/13, DAD, CIHI	13%	≤12.5%	≤12.5%	Maintain 2012-13 stretch target	2				
	Reduce unnecessary hospital readmission	**Readmission within 30 days for selected CMGs <u>to own</u> facility**: The number of patients with specified CMGs readmitted to own facility for non-elective inpatient care within 30 days of discharge (Q2 11/12 to Q1 12/13)	12%	NA	≤11%	Improvement	**1**		• Screening patients for their risk of readmission by implementing a standardized risk assessment tool (LACE tool) across all sites. • Implementing a coordinated transition processes that include patient teach back, discharge information to community providers, and follow-up phone calls to patients to answer any questions about their post-acute care needs. • Participating with our LHIN partners in the Health Links initiative to identify high users who may require additional community resources to prevent readmission. • Improving medication reconciliation at discharge to ensure patients understand their medication treatment plan.		