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

Trillium Health Partners 2200 Eglinton Avenue West

Goal		Measure							
Quality dimension	Objective	Measure/Indicator	Unit / Population	Source / Period	Organization Id	Current performance (QIP Reporting Period)	Target	Target justification	Priority level
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	975*	31.5	≤39*	We will continue to look for operational efficiencies to deal with the ever increasing demand on our emergency department which is expected to grow between 3-6% in 2014/15. A decrease in the number of inpatient beds due to our Phase III redevelopment project will have a significant impact on this metric.	Maintain *between 36-46 hours depending on bed impacts
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	975*	7.3%	≥0%	Stewardship of the hospital's resources is crucial to the organization's ability to sustain delivery of high quality care to our community. The target in LHIN-Hospital Service Accountability Agreement is 0%. Accordingly, our target for the coming year will continue to be a balanced financial position.	Maintain
	Reduce unnecessary deaths in the hospital	HSMR: Number of observed deaths/number of expected deaths x 100.	Ratio	DAD, CIHI/ 2012/13	975*	86	100	National Benchmark	
Integrated	Reduce unnecessary hospital admissions	ED Admission Rate: Total ED Admissions divided by total ED Visits	% / All patients	NACRS, CIHI/ YTD 2013/14	975*	10.6%	≤10.5%	As a new indicator, the organization will need to thoroughly understand the drivers of this indicator and identify true operational opportunities.	Improve
	Reduce 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 Patients	DAD, CIHI/ Q3 2012/13 – Q2 2013/14	975*	12.8%	≤10%	THP has and continues to implemented many quality improvement initiatives working closely with our community partners. THP has a low %ALC rate compared to the rest of the province. Continued focus on improvement in ED Wait Times for Admitted patients will require improvement in patient flow and subsequently a low number of ALC patients to increase bed capacity for acute patients. Therefore, although we will continue to monitor % ALC Rate and have quality initiatives that indirectly improve the metric, it will not be a priority indicator for 2014/15. Target is set at 10.0%, to continue to work towards pre-determined 2013/14 goals.	
	Reduce unnecessary hospital readmission	Readmission to any facility within 30 days for selected CMGs for any cause: The rate of non-elective readmissions to <u>own</u> facility within 30 days of discharge following an admission for select CMG's.	%	DAD, CIHI/ Q2 2012/13-Q1 2013/14	975*	12.1%	≤12.5%	THP has one of the lowest readmission rates amongst large community and teaching hospitals in Ontario. ED Admission Rate will be the central focus for 2014/15 and will have an impact on patient flow and ultimately on this metric . Therefore, although we will continue to monitor readmission rates and sustain related improvement activities, it will not be a priority indicator for 2014/15. Target is set at 12.0%, to adjust from the stretch target set in 2013/14.	
Patient-centred	Improve patient satisfaction	From NRC Picker: "Would you recommend this hospital (inpatient care) to your friends and family?" (add together % of those who responded "Definitely Yes" or "Yes, definitely").	%	NRC Picker / Oct 2012- Sept 2013	975*	76.6%	≥77%	Maintain stretch target. Performance target remains above large community hospitals.	Maintain
Safety	Increase proportion of patients receiving medication reconciliation upon admission	Medication reconciliation at admission (for LOS ≥ 24 HOURS): 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 (Q3 2013/14)	975*	92%	≥87%*	We continue to strive for full compliance, and consider this indicator a very important indicator to improve patient safety in our organization; our target for 2014/15 accounts for the resource intensity required to achieve that level of performance, and efforts required to expand this indicator in the coming years to include Medication Reconciliation at Discharge and Ambulatory.	Improve **For LOS ≥ 24 HOURS** YTD 13/14 performance is 84%, but due to pre-Accreditation Canada Survey push of activities, performance rose to 92% in Q3 13/14.
	Reduce hospital acquired infection rates	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 / Jan 13 - Dec 13	975*	80.8%	≥82%	Our target is set to sustain the pre-accreditation performance achievements while recognizing the aggressive targets we have set in other priority focus categories	Improve
	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 1000 Patients	Publicly Reported, MOH / Jan 13 - Dec 13	975*	0.36	≤0.39	By focusing on Hand Hygiene Compliance prior to patient contact as a priority indicator we have selected a key driver of infection prevention. Target is set at 0.39, which represents an upward trend in performance relative to last year's target of 0.42	
	Reduce hospital acquired infection rates	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 - consistent with publicly reportable patient safety data.	Rate per 1000 ventilator days	Publicly Reported, MOH / Jan 13 - Dec 13	975*	0.1	≤0.5	Maintain performance target of 2013/14	
	Reduce hospital acquired infection rates	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 - consistent with publicly reportable	Rate per 1,000 central line days	Publicly Reported, MOH / Jan 13 - Dec 13	975*	0.1	0	Maintain current performance	
	Reduce incidence of new pressure ulcers	Percent of complex continuing care (CCC) residents with a new pressure ulcer in the last three months (stage 2 or higher).	%	CCRS, CIHI/ Q2 FY 13/14	975*	2.5%	≤1.6%	Maintain performance target of 2013/14 as this is a stretch for the organization.	
	Avoid patient falls	Percent of complex continuing care (CCC) residents who fell in the last 30 days.	%	CCRS, CIHI/ Q2 FY 13/14	975*	1.7%	≤2%	Maintain performance target of 2013/14.	
	Reduce rates of deaths and complications associated with surgical care	Rate of 5-day in-hospital mortality following major surgery: The rate of in-hospital deaths due to all causes occurring within five days of major surgery.	Rate per 1,000 major surgical cases	CIHI/FY 12/13	975*	8.6	≤7	Maintain performance target of 2013/14 as this is a stretch for the organization	
		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 - consistent with publicly reportable patient safety data.	%	Publicly Reported, MOH / Jan 13 - Dec 13	975*	99.2%	100.0%	Maintain performance target of 2013/14.	
	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.	%	OMHRS, CIHI/ Q3FY12/13 to Q2FY13/14	975*	3.1%	≤2%	Maintain performance target of 2013/14 as this is a stretch for the organization	

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AIM			Change				
Quality dimension	Objective		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.	The focus of the 2014/15 Planned Improvement Initiatives will be to strengthen relationships with community partners to deal with the ever increasing demand on our emergency department. 2014/15 Planned Improvement Initiatives: Alignment of discharge model across sites including re-launch of Home First Approach Implement standardized response to overcapacity Continue to enhance engagement and formalize partnership with CCAC and community agencies for post-acute support Strengthen linkages with Primary Care, Seniors Health and Seniors Mental Health Program Enhance community partnerships through Health Links Ambulatory Care Strategy & Patient Flow Strategy	Committee discussion and performance tracking Program on a Page Reports (LOS data, admission, etc.) Daily capacity messaging Daily Huddles at Quality Board(s)	# of ambulatory care clinics enhancing services to support early discharge or diversion of admission from ED # of Days ED at Overcapacity Related Integrated Indicators: Readmission Rate/ED Admission Rates %ALC Days ED LOS	Reduce number of days at overcapacity Increased number of patients utilizing enhanced services to support early admission Achieve pre-determined targets for Readmission, %ALC Days, and ED Admission	
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.	Planned Improvement Initiatives will be focused on continuing to adopt best practices encouraged by the Ministry of Health and Long Term Care's Health System Funding Reform. 2014/15 Planned Improvement Initiatives: Examining case costs of high volume procedures to identify leading practices across all sites resulting in 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 THP Health System Funding Reform Strategy Service Planning	Program on a Page Reports HSFR Action Plan	X percentile within province comparing case costing within high volume procedures	X Percentile performance within province for high volume procedures – case costing	
Integrated	**Reduce unnecessary hospital admissions**	ED Admission Rate: Total ED Admissions divided by total ED Visits	As a new priority indicator for Trillium Health Partners in 2014/15, the planned improvement initiatives will be a mixture of assessing opportunities and identifying change ideas. 2014/15 Improvement Initiatives: Clinical Programs to identify opportunities for specific patient populations to receive the right care in the right place at the right time, with a focus on those with short lengths of stay and those who might be better cared for in an ambulatory setting Track DART progress for reducing admissions Continue to develop ambulatory care design options	Committee discussion at various senior operations levels	Number of clinical areas identified high opportunity areas Track LOS <48 hours for specific clinical categories Compare chest pain admissions trending pre and post DART implementation	Development of accurate driver diagram	
Patient-centred	**Improve patient satisfaction**	From NRC Picker: "Would you recommend this hospital (inpatient care) to your friends and family?" (add together % of those who responded "Definitely Yes" or "Yes, definitely").	To better select and drive specific patient experience improvement initiatives, a focus in 2014/15 will be to continue to evaluate real-time measurement systems that will help guide those decisions. 2014/15 Planned Improvement Initiatives: Define optimal measurement approach to track patient experience more accurately and in a more timely way Further develop patient-centred design strategy and initiatives	Scan and evaluation of best practices in patient experience data collection, including review of real time solutions Task force activities Quality Boards	Completion of needs assessment and evaluation of data collection system	RFP released for measurement system (if applicable) Approved Task Force Terms of Reference and work plan	
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.	As a new priority indicator for 2014/15, Medication Reconciliation will look to continue to build upon the high standards set from performance building up to the 2013 Accreditation. 2014/15 Planned Improvement Initiatives: Rollout of electronic database to all inpatient units Identify efficiencies within the current model Confirm accountabilities of involved professionals Educate staff on importance of consistently executing processes Increase public awareness on importance of medication list present on admission Partner with community providers to reinforce medication checks	Best Possible Medication History Audits	% of staff completing electronic database education Number of Rapid Cycle Improvement sessions completed	X% education compliance amongst pharmacy technicians 1 Rapid Cycle Improvement session per quarter	
	Reduce hospital acquired infection rates	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.	Continued diligence is required to ensure achievements due to existing initiatives are sustained. The planned improvement initiatives are a mixture of ongoing activities and new change ideas. 2014/15 Planned Improvement Initiatives: Handley award for area with highest hand hygiene compliance Staff recognition at team huddles Ongoing hand hygiene education Mandatory annual e-learning modules on hand hygiene Use of multi-modal strategies Ongoing engagement of leadership/board members Standardize auditing and reporting of hand hygiene compliance	Evaluation of Multimodal strategies Team Huddles / Quality Board Huddles Program on a Page Reports	% Completion rate among staff of e-learning module % of daily huddles taking place - of those Programs using Hand Hygiene on their Quality Boards	X % compliance rate for education opportunities X % of units completing daily huddles 5 times per week	