2015/16 Quality Improvement Plan for Ontario Hospitals
"Improvement Targets and Initiatives"

Trillium Health Partners 2200 Eglinton Avenue West

AIM		Measure									
Quality dimension	**Objective**	**Measure/Indicator**	**Unit / Population**	**Source / Period**	**2015 Current Performance**	**2015/16 Target**	**2015/16 Target justification**	**2015/16 Planned improvement initiatives (Change Ideas)**	2015/16 Methods	2015/16 Process measures	2015/16 Goal for change ideas
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 / Jan 1, 2014 - Dec 31, 2014	35.5	39	The target remains the same as the previous year and continues to represent a stretch target as a decrease in the number of inpatient beds due to our Phase III redevelopment project will have a significant impact on this metric.	Planned improvement initiatives for 2015/16 will focus on improving flow both internally and working with external partners, in order to maintain ED wait times that will be compounded by a decrease in the number of inpatient beds due to our Phase III redevelopment project. This will include: standardizing the processes for complex discharges and ALC patients, successful roll out of an overcapacity policy, and developing a real time flow dashboard that will provide information to facilitate patient flow within the organization.	QIP scorecard; regular status updates to corporate Quality Committee, Patient Services Committee, and Board Quality Committee	Average length of stay; # of ALC (by unit); % of patients in bed within 1 hour of assignment	Average length of stay (targets set by respective units) - 100%; # of ALC (by unit) - zero; % of patients in bed within 1 hour of assignment - 100%
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 FY 2014/15 (cumulative from April 1, 2014 to December 31, 2014)	4.2	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.	Planned improvement initiatives for 2015/16 will continue to be focused on adopting best practices encouraged by the Ministry of Health and Long Term Care's Health System Funding Reform.	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	% / All patients	CIHI portal / 2014/15 (Performance YTD Q3 2014/15)	10.5	10.4	This target represents a more aggressive target than the previous year. Since this indicator is measured based on the number of ED visits, anticipated increases in the volumes of our ED visits will be a challenge.	Planned improvement initiatives for 2015/16 continue to be a mixture of assessing opportunities and identifying change ideas. This will include: reviewing patients that are designated as ALC within 24 and 48 hours of admission, reviewing admission patterns of retirement homes and long term care patients, and exploring patient populations that are currently being admitted and can be managed/treated at an ambulatory setting.	QIP scorecard; regular status updates to corporate Quality Committee, Patient Services Committee, and Board Quality Committee	# of patients designated ALC within 24 and 48 hours of admission; admission patterns of retirement homes and long term care patients; patient populations that are currently being admitted and can be managed/treated at an ambulatory setting	Opportunities identified from results of data mining.
Patient-Centred	Improve patient satisfaction	From NRC Canada: "Would you recommend this hospital (inpatient care) to your friends and family?" (add together % of those who responded "Definitely Yes" or "Yes, definitely").	% / All patients	NRC Picker / October 2013 - September 2014	75.5	80	This target represents a stretch target as we strive for excellence in this area, and has been set based on internal and provincial benchmarks.	Planned improvement initiatives for 2015/16 will focus on improving staff engagement and skill building through leadership training, leveraging best practices from high performing areas internally, developing a strategy and implementing solutions to collect and share real-time data with units, and providing multiple channels for gathering patient and family input.	QIP scorecard; regular status updates to corporate Quality Committee, Patient Services Committee, and Board Quality Committee; Patient and Family Partnership Council; Leverage Quality Boards on the front line to reinforce learnings from patient satisfaction data	Leadership training for all managers in the organization; Rounding for excellenc through "Advancing Excellence" initiative; collecting and sharing real-time data with front line care teams; increase the number of patients and families who are surveyed each month	Completion of leadership training; all managers round on staff and report on progress; standard tool developed and implemented to collect real-time data; all units are discussing patient satisfaction results through their Quality Board huddles

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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 (patients admitted for longer than 48 hours).	% / All patients	Hospital collected data / most recent quarter available	86.2	95	This target has been set to reflect our focus on safe medication practices as we continue to strive for full compliance in this area.	Planned improvement initiatives for 2015/16 will build on efficiencies gained to date and will focus on innovative resourcing (e.g. training and leveraging pharmacy students). As we move towards preparing for accreditation we will also initiate the processes to enhance our performance in the outpatient setting including developing customized medication reconciliation processes for outpatient areas.	QIP scorecard using BPMH audits; regular status updates to corporate Quality Committee, Patient Services Committee, and Board Quality Committee	Rates of medication reconciliation completion upon admission in the Inpatient areas . Over time, we will be looking at developing a similar measure for outpatient medication reconciliation compliance and rates.	Inpatient: Facilitation of nursing compliance enhancement and maintenance Outpatient: Implementation plan developed for each outpatient area where the need for medication reconciliation has been identified
Safety	Increase proportion of patients receiving medication reconciliation at discharge	Medication reconciliation at discharge: The total number of patients with medications reconciled as a proportion of the total number of patients discharged from the hospital.	% / All patients	Hospital collected data / most recent quarter available		75	This is a new priority indicator for the organization and is a measure of both safe medication practice as well as care integration once patient's leave the hospital. The target has been set based on current performance, as we strive towards full compliance.	Planned improvement initiatives for 2015/16 will focus on educating physicians on the electronic software (Iatrics), and increasing adoption of the software.	QIP scorecard; regular status updates to corporate Quality Committee, Patient Services Committee, and Board Quality Committee	Staff/professional staff educated on electronic software	Increase the number of staff/professional staff educated on electronic software.
Safety	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 / 2014	82.9	84	This target represents an improvement from the previous year, as we continue to focus on improving hand hygiene practices.	Planned improvement initiatives for 2015/16 will continue to focus on strategies including, but not limited to: advocating for all directors/managers to have hand hygiene compliance as a performance measure in their goals and objectives; investigating the opportunity to publicly display in designated locations unit specific hand hygiene compliance rates at entrances of every patient care unit; reviewing and revising the hand hygiene e-learning module; implementing a sustainable hand hygiene auditing program across all sites; evaluating, standardizing and implementing the hand care program; developing hand hygiene improvement strategies for physicians; and continuing with regular education, providing feedback, and reporting of hand hygiene rates.	Quarterly reports on manager/director goals and objectives; hard copy and/or electronic display of hand hygiene compliance rates; survey measuring awareness and effectiveness of mandatory e-learning module; evaluate impact of standardized approach to hand hygiene compliance rates; product review and standardization of hand care resources; collaborate with Medical Administration department to develop hand hygiene strategies for physicians; continue to promote Handley Award competition, World hand hygiene day, IPAC Week and other events.	100% of managers/directors have hand hygiene compliance as a performance measure in their goals and objectives; monthly reporting of hand hygiene compliance online and on unit quality boards; adoption of public display of hand hygiene compliance rate in selected units of Medicine and ED program; report outcome of survey and revise materials as required; identified physician specific hand hygiene initiatives; award and recognition of unit with highest hand hygiene compliance; participation in promotional events	Improve overall Hand Hygiene compliance across sites; measure compliance with completion of mandatory hand hygiene e-learning module; publish improvement initiatives in hand hygiene.
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. *100	% / All acute patients	Ministry of Health Portal / Oct 1, 2013 - Sept 30, 2014	12.5	10	THP has a low %ALC rate compared to the rest of the province. We will continue to monitor %ALC rate, and have quality improvement initiatives that involve working closely with our community partners, but it will not be a priority indicator for 2015/16. This target maintains the performance benchmark of 2014/15.				
Integrated	Reduce unnecessary hospital readmission	Readmission within 30 days for Selected Case Mix Groups	% / All acute patients	DAD, CIHI / July 1, 2013 - Jun 30, 2014	14.47		THP is achieving close to benchmark for this indicator. We have selected to focus on ED admission rates as an indicator of Integration.				

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Patient-Centred	Improve patient satisfaction	From NRC Canada: Would you recommend this ED to your friends and family?" (add together % of those who responded "Definitely Yes" or "Yes, definitely")	% / ED patients	NRC Picker / October 2013 - September 2014			We have selected to focus on improving patient satisfaction for the inpatient population				
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. 2014, consistent with HQO's Patient Safety public reporting website.	Rate per 1,000 patient days / All patients	Publicly Reported, MOH / Jan 1, 2014 - Dec 31, 2014	0.36	0.39	We have selected to focus on a key driver of preventing hospital acquired infection rates (hand hygiene compliance prior to patient contact) as a priority indicator. This target maintains the performance benchmark of 2014/15.				
Effectiveness	Reduce unnecessary deaths in hospitals	HSMR: Number of observed deaths/number of expected deaths x 100.	Ratio (No unit) / All patients	DAD, CIHI / 2013/14	83	100	National Benchmark				
Safety	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 1,000 ventilator days / ICU patients	Publicly Reported, MOH / 2014	0.07	0.5	Maintain performance target of 2014/15.				
Safety	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 patient safety data.	Rate per 1,000 central line days / ICU patients	Publicly Reported, MOH / 2014	0.14	0	Maintain performance target of 2014/15.				
Safety	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).	% / Complex continuing care residents	CCRS, CIHI (eReports) / Q2, 2014/15	5.1	2	Maintain performance target of 2014/15.				
Safety	Avoid Patient falls	Percent of complex continuing care (CCC) residents who fell in the last 30 days.	% / Complex continuing care residents	CCRS, CIHI (eReports) / Q2, 2014/15	4.6	2	Maintain performance target of 2014/15.				
Safety	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 / All patients with major surgery	CIHI eReporting Tool / 2013/14	9.8	7	Maintain performance target of 2014/15.				
Safety	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 - consistent with publicly reportable patient safety data.	% / All surgical procedures	Publicly Reported, MOH / 2014	99.45	100	Maintain performance target of 2014/15.				
Safety	Reduce use of physical restraints in Mental Health	Physical Restraints: Number of admission assessments where restraint use occurred in last 3 days divided by the number of full admission assessments in time period	% / All patients	OMHRS, CIHI / Q3 2013/14 Q2 2014/15	3.31	2	Maintain performance target of 2014/15.				