Let's Make Healthy Change Happen.

Quality Improvement Plan (QIP) Narrative for Health Care Organizations in Ontario

Glengarry Memorial Hospital
Hôpital Glengarry Memorial

3/10/2014

This document is intended to provide health care organizations in Ontario with guidance as to how they can develop a quality improvement plan. While much effort and care has gone into preparing this document, this document should not be relied on as legal advice and organizations should consult with their legal, governance and other relevant advisors as appropriate in preparing their quality improvement plans. Furthermore, organizations are free to design their own public quality improvement plans using alternative formats and contents, provided that they submit a version of their quality improvement plan to HQO (if required) in the format described herein.

Ontario

Hôpital Glengarry Memorial Hospital's Quality Improvement Plan for 2014-2015 continues to focus on the quality dimensions selected for Ontario Hospitals under the Excellent Care for All Act 2010: Access, Effectiveness, Integration, Patient-Centred and Safety.

These remain aligned with our HGMH Balanced Scorecard Quadrant of Quality, which contains the sub quadrants of Access, Appropriateness (Effectiveness), Patient Safety, and Patient Satisfaction. Recently, the Patient Safety Quadrant has been reviewed under our Patient Safety Strategy Plan, including expansion of this quadrant to include the 6 Domains of Patient Safety as described in the Canadian Patient Safety Institute's (CPSI) document "The Safety Competencies – Enhancing Patient Safety Across the Health Professions (First Edition 2009). Currently, Goals and Objectives for each of the 6 Domains of Patient Safety are being selected.

Our mission statement at the core of our Balanced Scorecard states that "We provide innovative, accessible, safe, and quality patient-centred primary health care services in both official languages".

Using the Excellent Care of All Act (ECFAA) as a guide, our Quality Improvement Plan for 2014-2015 reflects our commitment to providing safe, quality patient-centred care. The objectives include:

1. To reduce wait times in our ER for admitted patients to 16.5 hours. We have been steadily reducing wait times in ER from 24.3 hours in 2011-12 to 20.6 hours in 2012-13 to 18.5 hours in 2013-14. Our change plan for 2014-15 to attain 16.5 hours will continue to improve patient flow and ensure patients are admitted within a reasonable time frame.
2. To maintain our organizational financial health. We are targeting a total margin of 0.00 as we do not expect to have any surplus in the upcoming year. We plan to continue to provide all current services and clinics.
3. To reduce unnecessary time spent in acute care by patients requiring ALC from a current ALC percentage of 22.6% to 19.0%. We plan to achieve this by continuing to educate and engage our physicians of the financial impact of ALC days by providing anonymous peer comparison of wait times and the associated costs monthly during Medical Advisory Committee meetings. We also plan on further developing our Geriatric Rehabilitation Service proposal as a means of reducing ALC percentages.
4. To reduce Length of Stay (LOS)on our Medicine unit for typical cases from 7.0 days to 6.8 as a continuous improvement stretch target by maintaining the process of utilizing clinical protocols upon admission as well as the sharing of the results.
5. To reduce unnecessary hospital readmission rate within 30 days for provincially-selected CMGs from the current 18.0% (retargeted as our goal of achieving 10.0% in 2013-14 was not realized) by implementing Patient Order Sets for COPD, CHF and Stroke and by tracking readmissions of patients discharged to home on the Cardiac Telehealth Program. Additionally, the change ideas

presented in the 2013-14 QIP will include the HealthLinks Collaboration to track identified high user patients for readmission.

6. To continue to improve patient satisfaction rates as reflected on the NRC Picker reports for both our Inpatients and our ER patients. We intend to raise the rate of positive results to 88% for both Units.
7. To maintain at 100% the number of patients receiving medication reconciliation upon admission.
8. To reduce hospital-acquired infection rates by the implementation of 5 change plan ideas:
    a. Introducing probiotic food items into the patient diets.
    b. Tagging equipment that is cleaned and/or disinfected after each use.
    c. Displaying all 4 Moments of Hand Hygiene performance rates for staff to view, instead of Moment #1 only.
    d. Implementing double room cleaning on discharge or transfer of all patients with suspected or confirmed cases of C. difficile.
    e. Introduce and implement Hygie® Bags for disposal of waste from patients with suspected or confirmed cases of C. difficile.

These objectives remain aligned with the HGMH Strategic Plan 2013-2016; each of these strategic directions has a number of objectives to be achieved over the next 2 years.

- Strategic Direction #1: Strengthen and affirm our health service delivery to meet the needs of our community and patients through integrated primary care using all available technology, including telemedicine, to allow care closer to home.
- Strategic Direction #2: Improve the patient experience through quality and patient safety.
- Strategic Direction #3: Strengthen our team with a comprehensive Human Resources Strategy.
- Strategic Direction #4: Be a leader in championing integration in our local community and regionally.
- Strategic Direction #5: Optimize our resources to sustain our clinical programs.

Our Quality Improvement Plan is also aligned with Ontario's Action Plan for Health Care, the Champlain LHIN's Priorities for 2013-2016, and Accreditation Canada's Required Organizational Practices as they apply to HGMH from 2014 to 2017, the date of our next Accreditation Canada review.

The HGMH QIP allows for integration and continuity of care as we follow the patient from admission to discharge and into the community:

- Safety measures to prevent nosocomial infections
- The "Home First" model has been educated and implemented within HGMH and in the surrounding Retirement Homes by our Home First Staff Lead. We have updated all job descriptions and interview guides to include the Home First Philosophy in an effort to reduce the ALC rate.

- The discharge review process allows objective assessment for the physicians to determine the patient's ability to return home.
- There continues to be close collaboration and integration of the CCAC staff through a shared position of Case Manager and Discharge Planner.
- HGMH participates in the Champlain Alliance of Small Hospitals (CASH) and Transformation Fund projects of TxConnect and QBP (Quality Based Procedures).
- A number of CNOs and Quality Leads from the small, rural hospitals in the Champlain LHIN met in Almonte, ON on January 31st, 2014 to share ideas and resources, evaluate our current QIPs and develop our next QIPs. This group plans on meeting again.
- A shared electronic medical record (EMR) amongst 6 regional hospitals (CHAMP – Champlain Association of Meditech Partners), a shared risk incident management system (RIMS) amongst 11 regional hospitals, an E-learning repository, and a Regional Pharmacy are among the current integrated projects that HGMH is participating in.

Challenges and Risks:

1. Steps taken to interest and involve the staff in various programs and initiatives have been somewhat successful, but staff engagement remains a challenge. Statistics relating to our Quality Indicators, surveys, appeals in our Hospital Post newsletter, face-to-face appraisals and discussions will continue to be offered in order to ensure that the HGMH staff are exposed to the elements of the Quality Improvement Plan and buy in to it.
2. Physician engagement in infection control, hand hygiene and discharge planning have improved in the past year; but we continue to be vigilant regarding these, especially ALC rates by demonstrating statistics at monthly intervals.
3. With no funding dollars, implementing Quality Programs is a challenge to HGMH.

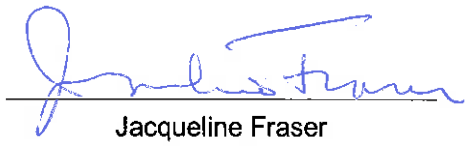
The Link to Performance-based Compensation of Our Executives

2014-2015		
Indicator	**Target**	**Weight of Tied Executive Compensation**
Patient Satisfaction from NRC Picker - Would you recommend this hospital?	88%	25%
CDI Rate per 1000 patient days	0.2	25%
Medication Reconciliation	100%	25%
Total Margin	0	25%

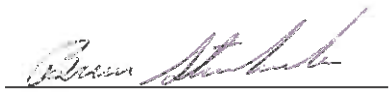
Sign-off

It is recommended that the following individuals review and sign-off on your organization's Quality improvement Plan (where applicable):

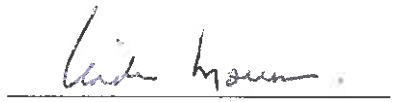
I have reviewed and approved our organization's Quality Improvement Plan



Jacqueline Fraser
Board Chair



Bruce Starkauskas
Quality Committee Chair



Linda Morrow
Chief Executive Officer

Board Chair Jacqueline Fraser
Quality Committee Chair Bruce Starkauskas
Chief Executive Officer Linda Morrow

Instructions: Enter the person's name. Once the QIP is complete, please export the QIP from Navigator and have each participant sign on the line. Organizations are not required to submit the signed QIP to HQO. Upon submission of the QIP, organizations will be asked to confirm that they have signed their QIP, and the signed QIP will be posted publically.

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

Measure								Change				
			Organization					**Planned improvement initiatives**				
Measure/ Indicator	**Unit / Population**	**Source / Period**	**Id**	**Current performance**	**Target**	**Target justification**	**Priority level**	**(Change Ideas)**	Methods	Process measures	Goal for change ideas	Comments
ED Wait times: 90th percentile ED length of stay for Admitted patients.	Hours / ED patients	CCO iPort Access / Q4 2012/13 – Q3 2013/14	802	16.5 (Target for 2013-2014 was 18)	16.5	Within current performance	3	ER Unit Supervisor will be notified of cases >14 hours remaining in the ER.	Notification via phone or e-mail	# cases >14 hours divided by the # of notifications per month	Reported monthly to the Quality, Patient Safety, & Utilization Committee	Implement April 1, 2014. Report monthly.
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	802	0.00 (to date) (Target for 2013-2014 was 0.00)	0	Maintain. Surplus not expected.	3					
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	802	22.6 (Target for 2013-2014 was 13.5%)	19	Within current performance Champlain LHIN target	1	a) Continue to engage physicians in understanding & collaborating in the reduction of the ALC rate.	a) Continue presentation of indivicual physician ALC rates with comparison (anonymously) to peers.	a)Monthly, reported at the Medical Advisory Committee (MAC) meeting.		
								b) Continue developing the HGMH Geri-Rehab Service proposal in order to convert 2-4 of the CCC/Med Unit beds to Geri-Rehab beds.	b)Data collection plan incorporating both DAD Abstracting System and NRS.	b)Capture the # of ALC patients waiting for admission to Rehab from Date of Referral to Date of Admission (days). This will be reported to the Quality, Patient Safety, and Utilization Committee monthly.		b)Create a new line on the HGMH Dashboard for demonstrating the ALC breakdowns for Rehab.
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.	% / All acute patients	DAD, CIHI / Q2 2012/13-Q1 2013/14	802	20 (Target for 2013-2014 was 10.0%)	18	Not achieved in 2013-2014. Retargeted.	1	a) Implement Patient Order Sets: COPD, CHF, Stroke	a) Track HGMH readmissions of patients with CHF who have been discharged home on the Cardiac Telehealth Program.		a) Patient Order Sets will be utilized 90% of the time; reported monthly.	**Issue:** This indicator data is only reported by the MOH once annually.
								b) HealthLinks collaboration				
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").	% / All patients	NRC Picker / Oct 2012-Sept 2013	802	Oct-Dec 2012 No data Jan - Mar 2013 75.0 % Apr - Jun 2013 93.8% Jul-Sept 2013 94.0% **AVERAGE: 87.6%**	88%	Maintain.	3					
From NRC Picker: 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 / 2013	802	Oct-Dec 2012 70.0% Jan-Mar 2013 85.4% Apr-Jun 2013 95.2% Jul-Sept 2013 97.7% **AVERAGE: 87.0%**	88%		3					
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 (e.g. Q2 2013/14, Q3 2013/14 etc)	802	Q2 2013-2014 100%	100%	Maintain target	3					
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	802	Jan 0 Feb 0 Mar 0 Apr 0 May 0 Jun 0 July 1.53 Aug 0 Sept 0 Oct 0 Nov 0 Dec 0 **Average for Jan - Dec = 1.53/12 = 0.13 (Target for 2013-2014 was 0.20 representing 2 cases/year) Target Met!**	0.2	Represents 2 cases per year, on approximation.	2	1. Introduce Probiotics into diets. 2. Cleaned Equipment Tagging	1. Discuss at Medical Advisory Committee Meeting and the Product Evaluation Committee. 2. Annual education on Housekeeping Best Practice to the HK staff.			Implement April 1st, 2014
								3. Hand Hygiene Compliance Rates - all 4 Moments displayed on the HGMH Dashboard for staff to view 4. Double Room Cleaning on Discharge/Transfer of all CDIFF suspected or confirmed cases.	3. Discuss at Board Quality. 4. Activity recorded on the Housekeeping Log Sheets.		4. Audits will indicate this occurring 85% of the time; reported monthly.	Implement April 1st, 2014 Implement April 1st, 2014
								5. Implement use of Hygienic Bags for Disposal.			5. Use 90% of the time once implemented.	Implementation Date TBA.
Average LOS Jan-Dec 2013 HGMH	Days		802	Jan 6.6 Feb 8.3 Mar 6.9 Apr 7.7 May 7.4 Jun 7.6 July 7.1 Aug 6.3 Sept 4.6 Oct 7.2 Nov 7.1 Dec 7.7 Average Jan - Dec = 7.04%. (Target for 2013-2014 was 7.0 days) TARGET MET!	6.8	Continuous improvement; Stretch Target	3					