

2012/13 Quality Improvement Plans: An Analysis for Improvement

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Executive Summary

In April 2012, Ontario hospitals submitted their Quality Improvement Plans (QIPs) for 2012/13, the second year of provincially mandated QIPs under the *Excellent Care for All Act* (ECFAA), 2010. It was recommended that hospitals focus on five key attributes of quality care — safety, effectiveness, access, patient-centred and integrated — and to include at least one core recommended indicator from each of these attributes. Indicators were to be assigned a priority of 1, 2 or 3.

Hospitals' executive compensation is linked to the achievement of quality improvement goals. This requirement drives both improvement and accountability for the delivery of QIPs, and increases motivation at all levels of the organization to achieve aggressive, but realizable, targets. Hospitals were also asked to provide a report on the progress made since the 2011/12 QIPs.

This analysis of the 143 QIPs submitted includes the background to QIPs under ECFAA, looks at the progress achieved over 2011/12 and outlines key findings regarding priority setting, detailing how many hospitals selected each indicator and how targets were set as compared to current performance. A selection of good change ideas is provided for four of the most selected indicators.

In 2012, Health Quality Ontario (HQO) put forward a new Strategic Plan, or roadmap, to guide the agency as it works to achieve an overarching quality aim in Ontario's healthcare system — better outcomes, better experience, better value for money. Analysis and feedback on QIPs are key ways that HQO can assist individual hospitals to achieve and exceed their improvement targets: If the majority of hospitals meet or exceed targets in key areas, there is an opportunity to push the provincial

average to new (and better) levels of performance. For patients and staff, this means better patient outcomes and more reliable care delivery.

This analysis also serves as a learning tool for hospitals going forward: It will help them share innovative change ideas, effective strategies and success stories; communicate progress achieved; and highlight continued areas for improvement. The appendices include a summary of the suite of supports available to hospitals as they complete their QIPs, and a technical report.

Overall, hospitals made progress since the initial year for submitting QIPs under ECFAA, 2011/12. Three key areas of progress include:

- A perfect compliance rate with submitting QIPs and progress reports, as well as more consistency in completing specific elements of the QIPs.
- Clear aims aligned with hospitals' strategic priorities, which were identified by a number of hospitals and included appropriate measures and motivational targets, and change plans that the hospitals intend to implement to achieve their aims.
- Innovative and thought-provoking change ideas, which were submitted by a number of hospitals.

While the completeness of QIPs has improved this year, there were still gaps in some plans, including targets that did not appear to be stretch targets and instances where little or no detail was provided about change ideas. In the spirit of quality improvement, hospitals are encouraged to review their existing plans and compare them to the exemplary plans identified in this document, and to look for opportunities to adopt the best practices for QIP development that their peers are using.

Background

QUALITY IMPROVEMENT PLANS (QIPS): WHAT THEY ARE, WHY THEY MATTER AND HQO'S ROLE

Under the *Excellent Care for All Act* (ECFAA), 2010, every hospital in Ontario (as defined in the *Public Hospitals Act*) must submit an annual QIP. The QIP is a tool that enables hospitals to identify, report on and achieve QI objectives in a structured way. The improvement attained by hospitals is the result of clearly and consistently focusing on the principles outlined in the Model for Improvement (see page 4).

Each hospital's Quality Committee oversees the preparation of the QIP, which must be certified by the Board Chair and the Chief Executive Officer, submitted to HQO and made available to the public. The Ministry of Health and Long-Term Care (MOHLTC) has compiled a number of resources to support Quality Committees (see http://www.health.gov.on.ca/en/ms/ecfa/pro/updates/qualitycommittee/bp_resources.aspx).

In 2012, HQO set in place a new Strategic Plan, or roadmap, for moving ahead with our mandate. This plan is a transformative document for HQO. It consolidates and makes explicit the agency's *raison d'être*: to work with others to drive a quality agenda for Ontario that is provincial in scope, rooted in collaboration and supportive of integrated and coordinated efforts across all segments of the healthcare system.

Hospital QIPs are the key way in which HQO works with its hospital partners to drive improvement in the system and to help hospitals measure success, introduce innovative change ideas and reach excellence in care.

The transformative objectives outlined in the Strategic Plan include an overarching quality aim in Ontario's healthcare system — better outcomes, better experience, better value for money.

Health Quality Ontario, together with its partners across the system, has been the driving force behind making the quality of healthcare in Ontario an explicit and shared priority supported by system leaders, providers and patients. QIPs are one important component of change, but they are by no means the only one: HQO is a key catalyst of system-wide change. Moving forward, HQO will:

- Focus the system on a common quality agenda (establish priorities, goals and targets and mobilize system leadership around a common agenda).
- Build evidence and knowledge (generate or access the evidence and knowledge needed to provide quality care and improve population health).
- Broker improvement (develop the tools and supports needed to accelerate the adoption of evidence-based best practice, and foster the development of quality improvement capacity in the system).
- Catalyze spread (guide, support and collaborate within the system to spread knowledge about best practices, measurement tools and implementation strategies).
- Evaluate progress (provide timely and relevant health system monitoring, measurement and reporting, and assess progress and report to the public).

ECFAA lays the groundwork for a significant cultural shift in Ontario's healthcare system. Excellent QIPs and well-executed improvement plans will strengthen the hospital sector's ability to deliver high-quality patient care. The goal of the legislation is to blend quality and value in such a way that patients move to the centre of the healthcare system — their needs are prioritized and services are designed to meet these needs. Ontarians should expect high-quality, person-centred care now, and in the future. Patient outcomes, patient experiences and the quality of care delivered will drive the way services are delivered, the way the system plans services and how it is held accountable.

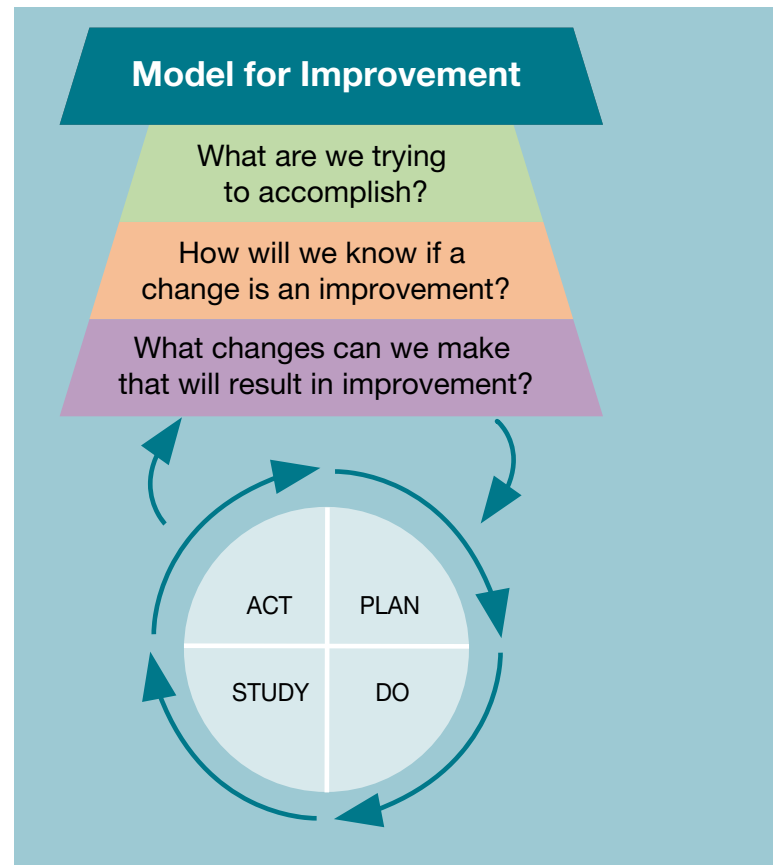
Developing and implementing QIPs should ultimately help create a healthcare system that focuses on keeping Ontarians healthy, provides appropriate and timely access to excellent primary healthcare, and provides the right care at the right time in the right place, all the while promoting focused improvement, building capacity to deliver person-centred care, and striving to meet theoretical best.

QUALITY IMPROVEMENT PLANS AND THE MODEL FOR IMPROVEMENT

The concept and format of Ontario's QIPs are based on the Model for Improvement framework for quality initiatives originally developed by thought leaders at the Institute for Healthcare Improvement (IHI). The Model asks three simple questions. The first two questions — “What are we trying to accomplish?” and, “How will we know if a change is an improvement?” — are embodied in ECFAA. Hospitals are required to set clear aims: a specific numeric target for improvement to be accomplished by a specific time frame in the fiscal year. Hospitals are also required to select process and outcome indicators to help them measure progress towards their aims and targets.

The answer to the third question — “What changes can we make that will result in improvement?” — describes the organization's change strategy. When developing their change strategies, hospitals should consider two change dimensions:

- Specific changes to clinical practices or activities that, according to scientific evidence, will lead to improvement (e.g., ordering the right drug or performing a test at the right time for a patient).
- Specific changes to organizational practices that will ensure best clinical practices are adopted not just some of the time but all of the time (e.g., ensuring that people have the right skills to perform a task or redesigning the way care is delivered to ensure that key information is always passed from one person to the next).



SETTING TARGETS

Target setting is an important part of every hospital's QIP. Part of HQO's role is to provide guidance for hospitals on how they can set “stretch” targets — challenging, forward-thinking but achievable results that surpass a hospital's past performance and set the stage for achieving their best possible performance in their priority areas for improvement.

Although HQO works with hospitals to challenge them to meet excellent stretch targets, we do not decide what those targets should be. Every hospital must decide the stretch targets it will set for each fiscal year, according to the hospital's strategic vision and the level of performance it currently sits at and chooses to aspire to, or to attain.

Health Quality Ontario encourages hospitals to consider what level of performance is acceptable to them and to their patients, and what it will take to achieve this level. Hospitals need to ask themselves if maintaining the same level of performance from one year to the next is good enough: Is being at or below the provincial average acceptable to the patients they serve and the staff who provide these services? Hospitals will be asked to include their rationale for selecting targets on priority indicators. (Note: some thought-provoking questions can be found in the charts that are included for each of the indicators, beginning on page 31.)

For a more detailed understanding of stretch targets, and why they are important, see page 24.

ANALYSIS OF 2012/13 QIPS: YEAR-TWO SUCCESSES AND CHALLENGES

In this second year of ECFAA implementation, hospitals were asked to focus on five key attributes of quality care: safety, effectiveness, access, patient-centred and integrated. It was recommended that at least one core indicator be included from each of these attributes and that indicators be assigned a priority of 1, 2 or 3. Hospitals' executive compensation is linked to the achievement of quality improvement goals. This requirement drives both improvement and accountability for the delivery of QIPs, and increases motivation at all levels of the organization to achieve aggressive, but realizable, targets. A description of planned improvement initiatives (change ideas) was requested for objectives where hospitals intended to improve quality. Hospitals were also asked to provide a report on the progress made since their 2011/12 QIPs.

Health Quality Ontario received and reviewed the QIPs and progress reports submitted by 143 hospitals this year,ⁱ which provided a snapshot of hospital activity and performance across the province.

This year's plans were stronger overall than last year's in terms of their completeness and the robustness of change plans; a selection of change ideas has been shared within this report. In the spirit of quality improvement, we have also identified areas for improvement that could increase the impact of the QIP as a QI tool.

PURPOSE OF THE ANALYSIS FOR IMPROVEMENT

This analysis of the 2012/13 QIPs is designed to be a learning tool. Its purpose is to:

- Disseminate innovative change ideas, and highlight strong improvement plans and success stories from the field.
- Communicate progress achieved from year one (2011/12).
- Highlight examples of plans that fulfill the Model for Improvement's components and adhere to quality improvement science.
- Highlight continued areas for improvement in QIPs.

The analysis examines the following aspects of quality improvement plans:

- **Progress achieved:** What improvements were sustained over 2011/12? What changes led to improvement?
- **Priority setting:** How many priorities did hospitals typically choose in their QIPs, and what topics did they choose?
- **Target setting:** What types of targets did hospitals set? Are there examples of well-articulated "stretch" targets? How can hospitals improve their target setting?
- **Change plans:** What types of change ideas do hospitals describe? How can hospitals strengthen their change ideas?

ⁱ This number is lower than last year's 152 plans due to a number of mergers in the hospital sector.

Progress Achieved Over 2011/12

Hospitals made progress this year. In April 2012, hospitals reported interim results on indicators chosen in their 2011/12 QIPs. The tables below highlight examples from those progress reports, where hospitals had clear strategies for change and achieved important improvements. Given that the reporting periods for some indicators fell within 2010/11 or Q1 2011/12 and would not have reflected changes implemented in 2011/12, some indicators — pressure ulcers, falls, HSMR and readmission — have not been included within this section of the report. A complete analysis of the progress achieved will be possible once end-of-fiscal-year data become available, and will be shared with hospitals in next year's analysis. The final results will likely be even better than these interim results.

CENTRAL LINE ASSOCIATED BLOOD STREAM INFECTION AND VENTILATOR ASSOCIATED PNEUMONIA RATES IMPROVEMENT

Improvement in central line blood stream infection (CLI) and ventilator associated pneumonia (VAP) rates were noted when the best practice *Safer Healthcare Now!* bundles were applied consistently. Implementation challenges were overcome by providing ongoing practice evaluations, visual cues and frequent feedback to point-of-care staff (see Tables 1 and 2). Plans for improvement include change ideas that include the use of visual cues.

TABLE 1: SUCCESS EXAMPLE[†] — CENTRAL LINE ASSOCIATED BLOOD STREAM INFECTION

Hospital	Baseline (Jan.–Dec. 2010)	Target for 2011/2012	Change Ideas	Result (Jan.–Dec. 2011)
The Scarborough Hospital* (large community)	1.93	0.75	• Ongoing monitoring of <i>Safer Healthcare Now!</i> insertion and maintenance bundle. • Chlorhexidine dressings to help prevent CLIs. • Chlorhexidine baths for high-risk patients and those with central lines in situ. • Establish percentage of infected central lines by line type. • Establish percentage of infected central lines by patient type.	1.14

[†] Success examples were derived from the reports on progress that hospitals submitted on April 1, 2012. Success was acknowledged when significant progress against the targets set out in the 2011/12 QIPs had been achieved.

* Further details on change initiatives and contact information can be found at the HQO Quality Improvement Map (www.hqontario.ca/en/ecfaa.html).

TABLE 2: SUCCESS EXAMPLES — VENTILATOR ASSOCIATED PNEUMONIA

Hospital	Baseline (Jan.–Dec. 2010)	Target for 2011/2012	Change Ideas	Result (Jan.–Dec. 2011)
Kingston General Hospital* (acute teaching)	2.02	1.82	• Consistent application of VAP prevention bundle. • Checklist placed at every bedside and discussed on multidisciplinary rounds. • Daily physician champion assigned. • Preprinted admission order set developed. • Oversight of data/trends by patient safety coordinator. • Review on quarterly basis by critical care program, QI and safety committee. • Celebration held during patient safety week	1
London Health Sciences Centre (acute teaching)	1.6	0.99	• Full implementation of the <i>Safer Healthcare Now!</i> bundle. • Statistics, checklists and case reviews by critical care staff and physicians.	0.31
St. Michael's Hospital* (acute teaching)	0.44	0.44	• Improve upon the existing compliance with VAP safety bundle. • Start measuring compliance with oral care. • Development of spontaneous breathing trial and sedation protocols. • VAP and bundle compliance rate added to unit dashboard. • Use of visual cues marked on beds as reminders for staff and families. • Development of a best practice checklist incorporated into critical care flowsheets.	0

* Further details on change initiatives and contact information can be found at the HQO Quality Improvement Map (www.hqontario.ca/en/ecfaa.html).

TABLE 2: SUCCESS EXAMPLES — VENTILATOR ASSOCIATED PNEUMONIA (CONTINUED)

Hospital	Baseline (Jan.–Dec. 2010)	Target for 2011/2012	Change Ideas	Result (Jan.–Dec. 2011)
Toronto East General Hospital (large community)	4.47	4.25	- Publicly post hand hygiene audit rates in the ICU. - Develop a strategy to identify points of transmission. - Develop a strategy to standardize knowledge about and implementation of the sedation vacation protocol. - Investigate the feasibility of using subglottic trach tubes. - Determine incidence of ICU patients without oral gastric tubes.	1.96

At times, significant change occurs as a result of a crisis, which generates the need for improvement; this is often the case with hospital-acquired infections. Muskoka Algonquin Healthcare, for example, successfully reduced its CDI rate (after experiencing its first outbreak in 2010) by undertaking major infrastructure changes and implementing the changes summarized in Table 3. Additionally, strategies employed to reduce one hospital-acquired infection will often result in improvements in all hospital-acquired infections, as was the case at Chatham-Kent Health Alliance. Chatham-Kent

improved its CDI rate by investigating and acting on the root cause of the high rate of VRE. Chatham-Kent determined that the hospital's bedpan management practices were contributing to higher infection rates, and put strategies in place to address the issue, resulting in a reduction in rates of both CDI and VRE (see "CDI Case Study: Chatham-Kent Health Alliance," page 10). (Note: Case studies included in this analysis were gathered by HQO from hospitals that were asked to complete success story templates and clarifying information based on those template submissions, when necessary.)

TABLE 3: SUCCESS EXAMPLES — *CLOSTRIDIUM DIFFICILE* INFECTION

Hospital	Baseline (Jan.–Dec. 2010)	Target for 2011/2012	Change Ideas	Result (Jan.–Dec. 2011)
Muskoka Algonquin Healthcare* (large community)	0.51	Equal to or better than provincial rate (0.34 per 1,000 patient days for 2011)	• Improve compliance with high-touch surface cleaning. • Improve turnaround times for lab results. • Consistent utilization of standard orders for the management of confirmed CDI patients. • Monthly performance reviewed across the organization as a key corporate indicator linked to executive compensation. • Updates on progress shared with all staff via an internal newsletter.	0.31
Chatham-Kent Health Alliance* (large community)	Chatham: 0.62; Sydenham: 0.81	Chatham: 0.46; Sydenham: 0.55	• Use best practices for treatment when <i>C. difficile</i> is suspected by having the <i>C. difficile</i> order set print automatically in the ED every time an order is entered for a <i>C. difficile</i> specimen. • Initiate UV marker audits of patient room cleaning as a measure to ensure improved and appropriate cleaning in patient rooms. • Increase bedpan flusher units across hospital by seven units. • Staff engagement for development of safer bedpan management methods.	Chatham: 0.50; Sydenham: 0.06
Royal Victoria Regional Health Centre (large community)	0.52	0.35–0.49 per 1,000 patient days	• Awareness: CDI rate reported publicly every month on website and annually on QIP. • Screening: daily (Monday–Friday) review of IPAC admission screening tool completion on selected inpatient charts by IPAC practitioners. • Surveillance: inpatient unit-specific rates posted monthly. • Corporate rate posted monthly on website. Quarterly rate shared with Board. • Prevention: annual required hand hygiene and PPE education completed by direct care staff. • Process: implementation of Infection Control Resource Team recommendations wherever possible.	0.18

* Further details on change initiatives and contact information can be found at the HQO Quality Improvement Map (www.hqontario.ca/en/ecfaa.html).

CDI Case Study: Chatham-Kent Health Alliance

Chatham-Kent Health Alliance (CKHA) is a large community hospital operating through three hospital sites. The Alliance serves the residents of Chatham-Kent, South Lambton and Walpole Island in Southwestern Ontario.

Chatham-Kent's battle against CDI began in 2009-10, when an investigation into high rates of hospital-acquired vancomycin-resistant *enterococcus* colonization led to the discovery of problematic bedpan management practices. It is well understood that the patient care environment can become contaminated during routine activities, and so a second focus — on environmental cleaning — became part of CKHA's 2011/12 QIP.

Challenges and Strategies

Environmental: The 60-bed patient care unit had only one bedpan flusher, and it was located quite far from many of the patient rooms. A multi-disciplinary team was formed to address bedpan management practices. After conducting a staff survey on infection prevention practices, and a literature review, a safer method of automated washer-disinfectors was adopted in 2010. Because of the prohibitive cost of adding washer-disinfectors in all patient care areas, a second, interim method — using bedpan liners — was also used over the 2–3-year period it took to purchase all of the capital equipment.

Behavioural: Many staff did not like the idea of walking down the hall with a full bedpan. Staff were shown videos outlining current bedpan management practices, in order to garner their support for change and to identify educational needs related to best practice bedpan management. Subsequently, 90% of the nurses stated that they wanted a safer, less time-consuming approach to managing bedpans. Complete removal of spray wands and bedpan holders from patient bathrooms also helped ensure the unsafe practice did not continue.

Knowledge: Personal protective equipment was not being used consistently. All units were provided education on the appropriate use of personal protective equipment, and a safe human waste-management policy has been developed. A UV marker auditing system was used to educate housecleaning staff, and to help improve the percentage of high-touch surfaces cleaned on a regular basis.

Mechanical: Many staff noted that the flusher was often out of service for maintenance and repair; this was mainly due to user error, however.

Resources: The cost of additional washer-disinfectors was substantial. To secure leadership support for the capital equipment, a cost-benefit analysis was conducted, examining the cost of continuing to manually wash bedpans (while wearing personal protective equipment) versus the cost of purchasing washer-disinfectors.

HAND HYGIENE IMPROVEMENT

Hospitals with demonstrated success in improved hand hygiene had a strong organizational commitment to improvement. Characteristics of these hospitals included accountability for results at each level of the hospital, constant monitoring of their tests of change and accompanying results, and immediate and individualized feedback to staff (see Table 4).

Bluewater Health's change plan for improving compliance with hand hygiene protocol included the use of champions

from nursing, physician and support services staff. These leaders were given formal hand hygiene auditor training — peers audited peers — and immediate feedback was given to the individual who may have missed one of the "Four Moments." Including hand hygiene within the Most Responsible Physician (MRP) collaborative provided funding for additional handwash stations and facilitated physician participation (see "Hand Hygiene Case Study: Bluewater Health," page 12).

TABLE 4: SUCCESS EXAMPLES — HAND HYGIENE

Hospital	Baseline (Jan.–Dec. 2010, Unless Otherwise Indicated)	Target for 2011/2012	Change Ideas	Result (Jan.–Dec. 2011)
Baycrest (CCC & rehab)	30.67% (2009/10)	70%	- Implement patient empowerment on all patient care units. - Unit-specific hand hygiene results posted on patient care units.	75.70%
Bluewater Health* (small community)	45% (2009/10)	Increase compliance amongst nurses, support staff and physicians within two targeted areas to 75% or better	- Increase rates through the implementation of a detailed action plan and campaign specific to each target group (nurses, physicians and support staff). This plan includes job-specific education and intervention auditing, in addition to other actions. - Linked with the MRP physician collaborative for focused physician compliance.	82.76%
Grand River Hospital (large community)	45% (2009/10)	Improve by 5% per quarter	- Hand hygiene audits with “real time” educational moments, publication of results by clinical program/service. - Develop marketing plan to increase awareness and compliance. - Implement hospital lead for hand hygiene. - Develop sustainability plan for late-career nurses’ engagement as champions. - Develop interactive hand hygiene education series.	79.78%
Holland Bloorview Kids Rehabilitation Hospital* (CCC & rehab)	53.6% (2009/10)	80%	- Board-driven initiative after increased nosocomial outbreak episodes. - Observation audits using MOHLTC “Just Clean Your Hands” protocols. - Audits of completion of e-learning module, Hand Hygiene Awareness Day. - All staff and families included in the hand hygiene strategy. - Process control charts used to monitor changes with results cascaded through all levels of the hospital. - Initiative tied to the strategic plan. - Dedicated auditor added to staffing.	90.75%

* Further details on change initiatives and contact information can be found at the HQO Quality Improvement Map (www.hqontario.ca/en/ecfaa.html).

Hand Hygiene Case Study: Bluewater Health

Bluewater Health is a small community hospital comprising Bluewater Health in Sarnia and Charlotte Eleanor Englehart Hospital in Petrolia.

Despite intensive efforts, year after year, Bluewater's annual overall hand hygiene compliance rates remained stubbornly low. While numerous strategies to influence compliance had resulted in small gains, Bluewater was struggling to sustain those successes and achieve further improvements, including hand hygiene within the Most Responsible Physician (MRP) collaborative facilitated physician participation.

Challenges and Strategies

Behavioural: It was difficult to change employees' habits. The plan implemented in 2011/12 was different from previous approaches in that it had three distinct yet coordinated streams of focus, targeting the different employee groups — nursing, physician and support service staff. The hand hygiene initiative partnered with the MRP collaborative and developed a focused action plan to improve physician compliance. To test intensive actions across all three streams, Bluewater further focused on the rehab and surgical in-patient units. Hand hygiene champions were identified within each stream and provided with formal hand hygiene auditor training — peers audited peers, and immediate feedback was given to the individual who may have missed an opportunity. Leaders within the targeted areas were given specialized education on how to model the right behaviours, and a checklist was provided to the leaders to remind them of key activities. Hand hygiene reminders on the "Four Moments" were added to existing safety briefings, and the briefings' data sheets were monitored to ensure hand hygiene was listed as a topic for discussion. A Pin Campaign was also added, to recognize good hand hygiene practices.

Environmental: The number and location of handwash stations were insufficient. Approximately 200 alcohol hand-rub stations were added throughout the organization. The locations of these stations were based on physician input, for improved visibility and ease of use.

Knowledge: Many staff were unaware of their lack of compliance with the Four Moments. The infection prevention and control team (IPAC) provided targeted education for each stream on the importance and expectations for hand hygiene compliance. They also shared stories, to help convey why staff should be concerned. IPAC addressed specific questions pertinent to the staff group — for example, What are the hand hygiene expectations during delivery of meal trays? Education packages about hand hygiene were delivered to each physician. A new Winning with Hand Hygiene contest ran every three months; it drove staff to the Intranet, where they received information on the Four Moments before accessing and printing ballots. A standardized quarterly report detailing major activities and a summary of the compliance results by employee stream were broadly shared across the organization.

Resources: The cost of developing and implementing the QI project was re-examined. CEO and executive compensation was tied to improving hand hygiene compliance, which helped garner leadership support and interest in the progress of the initiative, including hand hygiene within the Most Responsible Physician (MRP) collaborative facilitated physician participation.

EMERGENCY DEPARTMENT WAITS IMPROVEMENT

Many emergency departments (EDs) in Ontario are challenged by wait times, with the lack of available beds for admitted patients playing a significant role in prolonged waits. Cambridge Memorial Hospital improved its wait times for admitted patients by implementing a “pull philosophy” (in which the inpatient unit

“pulls” the patient from ED by ensuring that his or her bed is ready exactly when needed), using flow coaches on patient units monitoring emergency patients. Cornwall Community Hospital invested in process improvement and project manager training for its middle managers, and Hawkesbury and District General Hospital encouraged teamwork between services (see Table 5).

TABLE 5: SUCCESS EXAMPLES — EMERGENCY DEPARTMENT WAITS

Hospital	Baseline (Jan.–Dec. 2010)	Target for 2011/2012	Change Ideas	Result (Jan.–Dec. 2011)
Cambridge Memorial Hospital (large community)	42.9 hours	30 hours	• Implement process to ensure discharge plan is completed for each patient on the medical unit within 48 hours of admission. • Conduct a focused review of hospitals with leading performance to identify strategies for CMH. • “Pull philosophy” implementing flow coaches and unit managers to monitor emergency department patients. • Email sent to flow coach automatically when an inpatient is discharged. • Weekly flow-operations meeting to review and resolve placement delays.	26.3 hours
Cornwall Community Hospital* (large community)	72.9 hours	65.6 hours	• CCH is a successful applicant to the Emergency Department Process Improvement Program (ED PIP) Wave IV Full Program (2011/12). ED PIP provides hospitals with an intensive structured approach and resources to improve patient flow from the point at which patients arrive in the ED through to discharge from inpatient units. • Implementation of a rapid assessment zone and daily access reporting tool. • Manager training in Lean process improvement, project management and change management strategies. • Emergency department waiting room rounds every hour.	42.2 hours

TABLE 5: SUCCESS EXAMPLES — EMERGENCY DEPARTMENT WAITS (CONTINUED)

Hospital	Baseline (Jan.–Dec. 2010)	Target for 2011/2012	Change Ideas	Result (Jan.–Dec. 2011)
Hawkesbury & District General Hospital (large community)	57.4 hours	37 hours	• Assisted-living initiative with LHIN. • Bed-management meetings twice daily at change of shift to optimize bed utilization. • Meet LOS benchmarks. • Establish hospital avoidance initiative for the patients of FHT. • Participate in ED/ALC LHIN steering committee. • Ongoing GEM initiative with RGP, monitor and review ALC. • Ongoing review of patient satisfaction survey results for a patient perspective. • Development of general clinical pathways for patients meeting CDU inclusion criteria. • Organizational priority; leadership including MAC representation on the improvement committee.	36.7 hours

ALTERNATIVE LEVEL OF CARE DAYS IMPROVEMENT

Many hospitals in Ontario are struggling to place people who no longer require acute care into community-based or long-term care. Beginning at admission, planning for

discharge using individualized care plans and involvement of patient families has demonstrated success. For continued improvement, integration across the healthcare system is essential (see Table 6).

TABLE 6: SUCCESS EXAMPLES — PERCENTAGE OF ALTERNATE LEVEL OF CARE DAYS

Hospital	Baseline (Q2 2010/11)	Target for 2011/2012	Change Ideas	Result (Q2 2011/12, Unless Otherwise Indicated)
Leamington District Memorial Hospital (small community)	31.60%	20%	- Continue to implement flow initiatives on inpatient units. - Focus the organization on discharges before 11 a.m. - Implement regional utilization management system.	10.90%
North Wellington Health Care (small community)	21.70%	15%	- Participation in Home First program. - Partnership with CCAC for all discharge planning. - Continue to support GEM Nurses in the ED. - Advocate for continuity in rural community services.	11.80%
Northumberland Hills Hospital* (large community)	17.50%	16.80%	- Implement a restorative care program. - Enhance staffing to enable seven-day-a-week rehabilitation services. - Implement the Hospital Elder Life Program (HELP). - Implement the Home First philosophy hospital-wide. - Develop and implement a formal discharge planning framework and processes.	5.00%
Royal Victoria Regional Health Centre (large community)	17.07%	13.8–16.3%	- Admission management: partnership with NSM CCAC for ED Client Care Coordinator seven days/week to reduce percentage of ED patients admitted primarily due to ALC status. - Discharge management: partnership with NSM CCAC to implement Home First approach to support discharge homes with community support where appropriate, to await choice of long-term care bed in the community. - Appropriateness: work with regional partners to facilitate timely transition of CC patients at RVH to regional CCC beds.	11.88%

* Further details on change initiatives and contact information can be found at the HQO Quality Improvement Map (www.hqontario.ca/en/ecfaa.html).

TABLE 6: SUCCESS EXAMPLES — PERCENTAGE OF ALTERNATE LEVEL OF CARE DAYS (CONTINUED)

Hospital	Baseline (Q2 2010/11)	Target for 2011/2012	Change Ideas	Result (Q2 2011/12, Unless Otherwise Indicated)
West Lincoln Memorial Hospital* (small community)	15.40%	11%	• Bed Management/Patient Flow Team implemented to enhance flow through entire hospital. • Close collaboration with CCAC partners to assist the Home First process.	7.8% (April 2011– Feb. 2012)
Woodstock General Hospital (large community)	18%	15%	• Continue to participate in FLO project in all acute in-patient units. • Maintain regular meetings with CCAC to investigate barriers to discharge of ALC patients. • Develop education for ED physicians and nurses to increase knowledge of CCAC services and role within the hospital. • Develop liaison role at WGH to liaise with CCAC to review patients who are waiting for admission in the community and to consider augmentation of CCAC services or geriatric assessment.	13.60%

* Further details on change initiatives and contact information can be found at the HQO Quality Improvement Map (www.hqontario.ca/en/ecfaa.html).

PATIENT EXPERIENCE IMPROVEMENT

In order to achieve significant improvement in patient experience, hospitals are encouraged to focus on a handful of specific areas that correlate with the complaints and compliments they have received,

as well as feedback from patient satisfaction surveys. There were several good examples where hospitals raised patient satisfaction scores by improving communication and coordination at discharge (see Table 7).

TABLE 7: SUCCESS EXAMPLES — PATIENT SATISFACTION

Hospital	Baseline (Most Recent 12-Month Period, Unless Otherwise Indicated)	Target for 2011/2012	Change Ideas	Result (Most Recent 12-Month Period, Unless Otherwise Indicated)
North Bay Regional Health Centre (large community); ED: “Would you recommend...?”	ED, Q2 2010/11: 54.1%	55.20%	• Staff education on requirement of verbal/written patient safety teachings before discharge to home. • Update and make easily available to staff discharge instruction sheets and provide to patients at discharge. • Revisit/research software programs for discharge instruction sheets. • Develop “drill-down” questions from the “discussed danger signals to watch for” survey question and add to NRC Picker ER survey to identify gaps. • Develop action plan to address any identified gaps and implement.	65.2% (Oct. 2010–Sept. 2011)
Peterborough Regional Health Centre (large community); “overall care received”	93.60%	≥96%	• Implement strategies to improve satisfaction with access to services and responsiveness. 2011/12 initiatives include: (a) implementing new services such as the radiation bunker and cancer care navigator; and (b) regular rounding by staff and leaders in acute care patient areas. • Implement post-discharge phone calls in surgical services. 2011/12 initiatives include implementing post-discharge phone calls with script for same-day surgery patients identified as high risk for admission and spread to inpatient area as appropriate. • Implement improved pre-admission and pre-discharge patient education and communication processes in Maternal Child Services. 2011/12 initiatives include: (a) “Purple Crying” and (b) pre-admission education and electronic resources.	98.5% (Q1 2011/12)

TABLE 7: SUCCESS EXAMPLES — PATIENT SATISFACTION (CONTINUED)

Hospital	Baseline (Most Recent 12-Month Period, Unless Otherwise Indicated)	Target for 2011/2012	Change Ideas	Result (Most Recent 12-Month Period, Unless Otherwise Indicated)
St. Francis Memorial Hospital (small community); “Would you recommend...?”	80% (Q3 2010/11)	≥80%	• Promote a positive, patient-centred environment. • Improve signage for patient instructions, wait times, etc. • Develop educational material for patients on discharge.	90.1%
St. John’s Rehab Hospital (CCC & rehab); “Would you recommend...?”	94.7%	>92%	• Focus on three dimensions of care: participation in decision-making and goal setting; coordination; and continuity and transitions using a variety of written and verbal tools, e.g., whiteboards, documented explanation of meds, written med side effects, discharge checklist, etc. • Implement integrated goal sheet.	98.9% (March–Sept. 2011)

Overview: Priority Setting, Target Setting and Change Plans

PRIORITY SETTING

A QIP is an important place to identify key priorities for improvement. Priorities help organizations focus on what they want to accomplish. Hospitals have the option of designating a priority level of 1, 2 or 3 to the objectives identified in their QIPs. It is recommended that indicators where performance has been below organizational goals be given the strongest consideration as Priority 1 or 2. Priority 1 indicators must be closely aligned with organizational strategic priorities, and will receive a greater emphasis in terms of change plans and resources for implementation than lower-priority indicators. When results have been sustained at rates that are consistent with organizational goals, or performance is at or near theoretical best, a Priority 3 rating should be considered.

Considerations When Setting Priorities

Priority setting can be a complex process that requires organizations to consider and balance a number of different factors. Organizations often consider the following issues when choosing topic areas as priorities:

- How does the proposed topic align with our strategic objectives?
- In which areas are we currently performing below desired performance?
- Which quality problems are occurring most frequently, and what are the most serious consequences when they do occur?

Many hospitals did a good job explaining how their QIPs aligned with their strategic priorities within the Part A Short Form, including Lady Minto Hospital, Lake of the Woods District Hospital, The Royal Ottawa Health Care Group, St. Joseph's Continuing Care Centre of Sudbury, Listowel Memorial Hospital and Providence Care. (This is not a comprehensive list, but rather a selection of good narratives.)

EXCERPTS FROM QIP PART A SHORT FORMS

The Quality Improvement Plan and selected indicators are aligned with the NELHIN [North East Local Health Integration Network] Integrated Health Services Plan, Hospital Service Accountability Agreement, Network 13 Strategic Plan, our community partners' strategic plans, Accreditation Canada and the MIC Group of Health Services Strategic Plan.

– Lady Minto Hospital

The LWDH Quality Improvement Plan for 2012/13 is in alignment with LHIN objectives and the H-SAA agreement with the MOHLTC. It is coordinated with organizational strategic goals, the mission/vision/values of the organization and the LWDH Integrated Quality/Risk Framework. It is also aligned with governance policies and ends of the Board of Directors. The Quality Improvement Plan supports best practices as defined by Accreditation Canada. The plan incorporates consultation with and participation by our health care partners to achieve the planned objectives.

– Lake of the Woods District Hospital

Most Common Priorities for Improvement

For 2012/13, it was recommended that hospitals include in their QIPs selections from a core set of indicators, with at least one indicator in each of the five quality attributes:

safety, effectiveness, access, patient-centred and integrated (see Table 8).

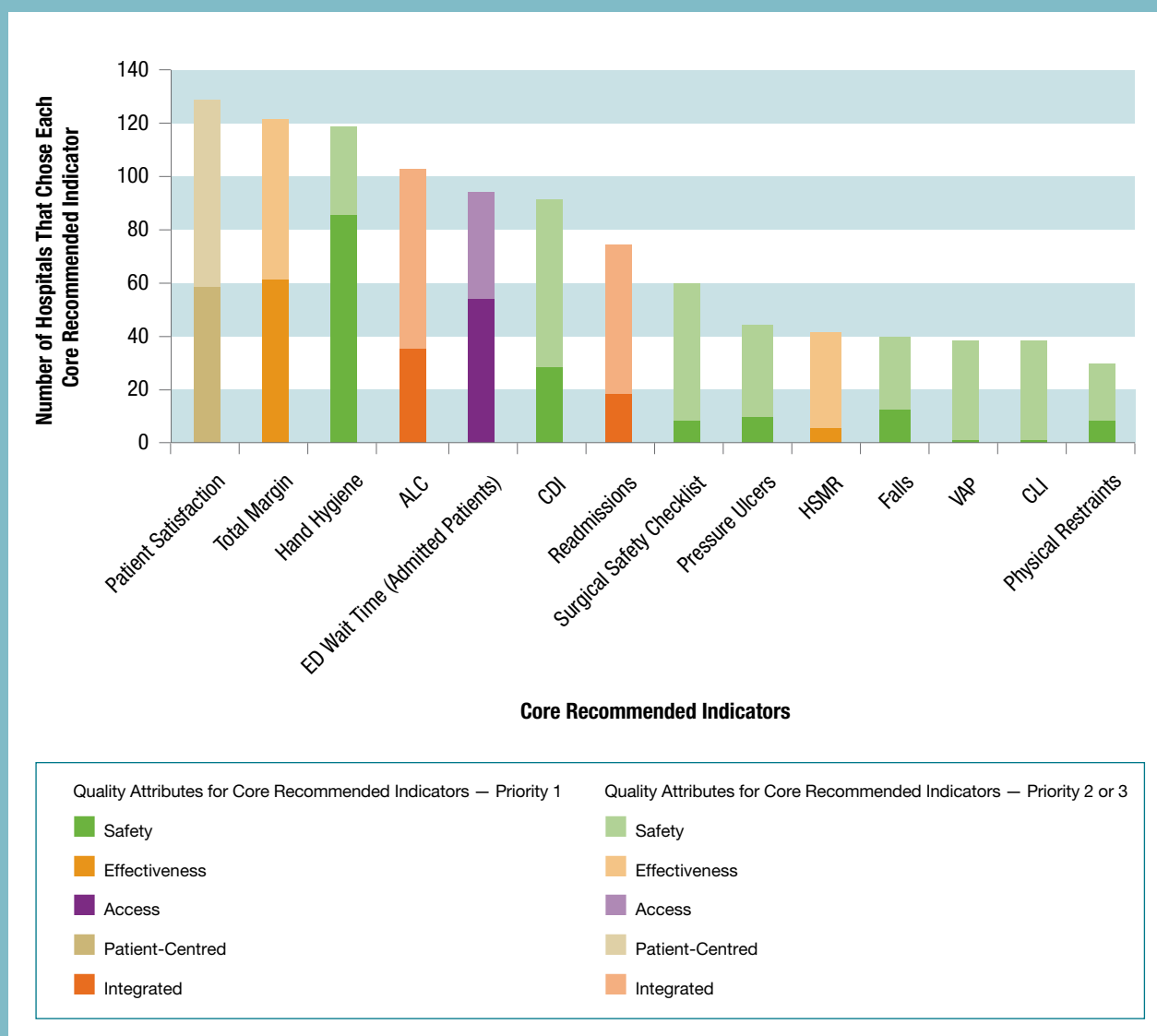
TABLE 8: CORE INDICATORS FOR 2012/13

Quality Attributes	Core Indicators
Safety	<i>Clostridium difficile</i> infection (CDI) Ventilator-associated pneumonia (VAP) Hand hygiene compliance before patient contact Central line associated blood stream Infection (CLI) Pressure ulcers Falls Surgical safety checklist Restraints
Effectiveness	Hospital standardized mortality ratio (HSMR) Hospital – total margin
Access	90th percentile ED length of stay for admitted patients
Patient-centred	Patient satisfaction
Integrated	30-day readmission rate to any facility (specific case mix groups) Percentage of alternative level of care (ALC) days

Figure 1 shows how often hospitals chose each core indicator as Priority 1, 2 or 3 in 2012. There was little variation in the choice of core indicators between acute care hospitals of different sizes. The most common topics were hand hygiene, total margin, patient satisfaction, emergency department (ED) waits and percentage of alternate level of care (ALC) beds. Among mental health hospitals, restraint use was one of the most common indicators. Falls and pressure ulcers were common topics among rehabilitation and complex continuing-care (CCC) facilities.

In general, topics that hospitals can focus on independently (e.g., hand hygiene) were much more popular than topics that require coordination between hospitals and community-based services (e.g., ALC and readmissions). Hospitals have been working hard to improve outcomes and performance in these areas. In the future, it will be important for hospitals to work closely together, to develop community-wide quality improvement plans with these external partners if Ontario is to make progress on the most important challenges facing the healthcare system.

FIGURE 1: FREQUENCY OF INDICATORS CHOSEN AS PRIORITY 1, 2 OR 3 IN 2012/13 ONTARIO HOSPITAL QUALITY IMPROVEMENT PLANS (N = 143)



Among Priority 1 indicators chosen by hospitals, 57% were core indicators and 43% were additional indicators representing local priorities (see Table 9). The most frequently chosen additional indicator was medication reconciliation. Because medication management is a critical area of patient safety, HQO recommends that a core indicator for medication reconciliation be added for

selection within the *Quality Improvement Plan Guidance Document for 2013/14* (see www.health.gov.on.ca/en/ms/ecfa/pro/updates/qualityimprove/qip_update_20111122.pdf). Standardizing the definition of this indicator will be important, because hospitals used many different methods this year for tracking progress on medication reconciliation.

TABLE 9: ADDITIONAL INDICATORS SELECTED BY HOSPITALS FOR 2012/13 (GROUPED BY QUALITY ATTRIBUTE)

Safety	Medication reconciliation (29) Medication incidents/errors (14) Falls (14)* Hospital-acquired infections (12) VTE prevention (8) Safe work environment (6) Patient safety (8) Pressure ulcers (5)* Hand hygiene (4)* Restraint (2)*
Integrated	Improve discharge and transitions (13)
Effectiveness	Increase efficiency and effectiveness (25) Reduce non-value-added work in process (13) Staff satisfaction (9) Compliance with established guidelines (9) Overtime pay, sick time, vacancy (7) Length of stay (3)
Access	Wait times (15) Access to specialized services (16)
Patient-centred	Patient satisfaction (17)*

Notes: Figures in parentheses indicate frequency.

*These definitions differed from the definitions used for the core recommended indicator: e.g., falls — falls with injury; patient satisfaction — improve pain management.

Number of Priorities Selected

This year, Ontario hospitals selected a similar number of indicators as they did in 2011/12 — on average, between four and five Priority 1 indicators, four Priority 2 indicators and three Priority 3 indicators. The number selected did not differ significantly across different hospital types. Although the guidance document encourages hospitals to select at least one core indicator from each dimension, seven hospitals chose just one Priority 1 indicator, 11 hospitals chose nine or more Priority 1 indicators and

two hospitals chose no Priority 1 indicators. Some (but not all) of these hospitals have multiple sites, with priorities set across the sites.

We do not yet know if there is an “ideal” number of priorities for organizations to set. Future analyses could examine whether there is a relationship between the number of different priorities and success in implementing changes that have demonstrated improvement.

TARGET SETTING

Target setting is an important component of QIPs: Organizations are more likely to achieve major improvement when they set a stretch target — that is, one that is challenging but achievable. Stretch targets can be inspirational. They motivate staff and, when accomplished, can engender confidence in staff's ability to tackle the next major challenge.

Determining an appropriate stretch target is a challenging exercise: What constitutes significant change, but not so much change that it will be impossible to implement? Hospitals are encouraged to develop target setting processes that engage all stakeholders, including front-line staff. Modelling of different scenarios may be helpful for hospitals to project the impact of planned changes, allowing hospitals to set targets with greater confidence.

The relentless pursuit of excellence underpins the *Excellent Care for All Act* and is a central tenet of quality improvement. Setting aspirational improvement and/or performance targets is a critical first step. Excellence can only occur when hospitals are fully accountable — to the public, their staff, their boards and their peers — to achieve the targets articulated in their QIPs and continually strive to achieve higher levels of performance.

Hospitals should distinguish target setting for accountability agreements from target setting for quality improvement. Targets contained in accountability agreements represent the basic level of quality for an organization that must be achieved. Setting targets for quality improvement is about challenging providers and staff, your organization as a whole and eventually the system to achieve higher levels of performance and to reliably deliver high-quality care.

Areas for Improvement Identified in Target Setting for QIPs

The careful consideration that went into target setting in many hospitals was evident within the 2012/13 QIPs. Some suggestions are offered for hospitals with plans that had missing baseline measures or targets, missing

or unclear target justification or targets set at or below baseline performance.

1. Missing Baseline Measures or Targets

In some cases, hospitals did not provide a figure for baseline performance. This occurred most commonly when a hospital was aiming to improve in an area where no data had previously been collected. Lack of baseline data makes it difficult to set a realistic target.

In other cases, hospitals did not set a specific numeric target. Instead, they stated that the target was to be “better,” “meet the average” or, “reduce by X cases.” In most cases, the hospitals did not provide a clear justification for the lack of a numeric target.

Suggestions

If a hospital does not have baseline data, it could consider including a data collection plan in its QIP along with specific timelines pinpointing when it will finish collecting the baseline data, and make an updated plan with a numeric target available to the public and to staff.

Having a clear, numeric target and setting a specific time frame within which to reach that target are essential to success. When the target is vague (e.g., “just do your best” or, “do better”), there is no shared understanding amongst staff of what success means.

2. Missing or Unclear Target Justification

For some targets, hospitals did not provide a clear indication of how their target was selected. In some cases hospitals stated *what* target was selected but did not reflect on *why* the target was selected. For example, “We have set a target of 5% improvement” provides no information about how this target was selected. A well-written target justification might read as follows: “Given current performance of 60% for hand hygiene, we are targeting 80%, in order to cut our defect rate in half. We believe this is an aspirational target that can be achieved through concerted effort to implement our change plan.”

Suggestions

It is recommended that hospitals clearly describe the rationale for the targets set in the target justification component of their QIPs, in order to ensure a consistent process for target setting.

3. Targets Set at or Below Baseline Performance

As Table 10 illustrates, several hospitals set targets for Priority 1 indicators that were below their baseline performance.

Hospitals provided a variety of different justifications for these targets:

- Some are anticipating that changing circumstances will make it more challenging to achieve a given performance, compared to the previous year.
- Some are in a “monitoring stage” after concerted QI effort, and are focused on sustaining their changes and improvement.
- Some have set targets based on the Ontario or LHIN average, even though their performance was already better than average.

Suggestions

In the spirit of improvement, it is suggested that indicators for Priority 1 should generally have stretch targets associated with them. Where performance is already better than average, organizations are encouraged to set targets that represent at least maintaining results, rather than accepting the average as a target.

When hospitals believe that maintaining current performance will be a significant stretch due to changing circumstances, and they choose to target below baseline performance, it is particularly important to substantiate the target with a clear target justification. This will avoid sending an unintentional message to the public or to hospital staff about the hospital’s quality improvement goals.

HQO has developed six guidelines for hospitals to consider when setting stretch targets (see page 25), and has identified several examples chosen from the 2012/13 QIPs of hospitals that appeared to follow these guidelines.

TABLE 10: EXAMPLES OF TARGETS SET BELOW BASELINE PERFORMANCE

Indicator	Direction Better	Hospital Type	Current Value	Target	Target Justification
Hand hygiene	↑	Large community	84%	80%	Exceed provincial rate of 72%
ED waits	↓	Acute teaching	21.0	23.0	Maintain achievement of Toronto Central LHIN target
ED waits	↓	Large community	10.6	23.0	LHIN goal has increased over the past year from 9.3 to 23 hours
ALC	↓	Small community	11%	21.64%	Comparison with North West LHIN hospitals

1: Aim for the Theoretical Best

Application	Examples from 2012/13 QIPs
The theoretical best represents the maximum or optimal performance. It is most applicable in areas that measure defects, wait times or use of a best practice (e.g., aim for zero defects, zero wait time or 100% compliance with best practice bundle).	- Stevenson Memorial Hospital set a target of 100% for hand hygiene compliance (baseline = 84%). - Carleton Place & District Memorial Hospital set a target of 100% for surgical safety checklist compliance (baseline = 97%).

2: Aim for Best Achieved Elsewhere

Application	Examples from 2012/13 QIPs
Any organization may seek to match the best achieved elsewhere, but this may be of particular relevance to those organizations that already have above-average performance and still wish to do better.	- Weeneebayko Area Health Authority, Moose Factory site, set a target of 92% for hand hygiene compliance, the best achieved to date in Ontario (baseline = 87%). - Kingston General Hospital set a target of 99% for the patient satisfaction indicator, the best achieved to date in an Ontario academic hospital (baseline = 94%).

3: Aim for 90th Percentile Among Peers

Application	Examples from 2012/13 QIPs
The Centres for Medicare and Medicaid suggest aiming to be in the 90th percentile among peers as a stretch goal. ⁱⁱ This could be appropriate if the hospital's baseline falls well short of this level; otherwise, a target of best achieved elsewhere or theoretical best may be a more appropriate stretch target.	There are no examples of this approach to date; examples may appear in the future as these data are not yet available to hospitals.

4: Aim to Cut a Defect or Waste in Half in the Current Planning Cycle

Application	Examples from 2012/13 QIPs
An organization may decide that the theoretical best is not achievable in this year and so may target to reduce the gap between baseline and theoretical best by half (e.g., baseline = 90%, or a defect rate of 10%; target to improve by 5%). Mainly used with indicators for which the theoretical maximum can be readily defined, such as zero defects, zero wait times or 100% adoption of a best practice.	West Lincoln Memorial Hospital has a baseline of 79.3% for the surgical safety checklist, and is targeting to improve by 10% (half of the approximate 20% room for improvement towards 100%).

ⁱⁱ U.S. Department of Health and Human Services. *Report to Congress: Plan to Implement a Medicare Hospital Value-Based Purchasing Program*. <http://www.cms.gov/AcuteInpatientPPS/downloads/HospitalVBPPlanRTCFINALSUBMITTED2007.pdf>. Accessed October 17, 2011.

5: Aim to Match the Rate of Improvement Achieved by Other Organizations

Application	Examples from 2012/13 QIPs
Looking at the best rates of improvement achieved by high-achieving organizations is useful when it is hard to compare performance to peers because of differences in case mix or where, historically, it has been difficult for organizations to achieve large improvements in a given year.	- There are precedents in Canada and abroad of hospitals that have been able to achieve a 5- to 10-point-per-year reduction in HSMR. - Rouge Valley Health System is aiming to reduce HSMR from 102 to 90 by focusing on improving patient outcomes for CHF and COPD through standardized order sets and by developing a standard process for documenting and validating palliative status.

6: Aim to Match the Average (Only in Situations Where an Organization is Far Below Average)

Application	Examples from 2012/13 QIPs
Average or median performance in the sector may be an appropriate stretch when an organization's baseline falls well below this figure. In most instances, however, average quality is not desirable and is far from the optimal or best demonstrated elsewhere	One hospital set its target for hand hygiene at the provincial average of 72.1% (baseline = 57.7%).

CHANGE PLANS

Hospitals were asked to identify change ideas for all Priority 1 indicators in their QIPs. These change ideas are important, because they represent an organization's strategy for improvement. There are many sources of change ideas, including:

- Evidence-based best practices;
- Creative thinking by front-line staff, providers and patients;
- Learning from others; and
- Using change concepts, which are general approaches that must be adapted according to circumstances in order to result in a situation-appropriate change idea.

One of the most important steps in choosing the right change strategy is to first understand the root causes of quality problems. There are many tools available to assist with examining the root causes, including fishbone (cause and effect) diagrams or the "Five Whys" technique (see www.hqontario.ca/en/analysing_system.html).

Once the root causes of quality problems have been identified, change ideas that correspond with the most important root causes should be selected. This is a logical approach to strategy development: linking specific system problems with targeted solutions. Table 11 lists some common generic root causes of quality problems and the change concepts associated with each root cause.

TABLE 11: ROOT CAUSES AND CORRESPONDING CHANGE CONCEPTS

Root Cause	Change Concepts
Providers unaware of how poor performance actually is	Measurement and feedback systems
Easy to forget, busy, too complicated, unaware of best practice	Reminder systems, clinical decision supports
Poor processes, non-standardized	Redesigned processes
Lack of skill to perform best practice, or deterioration over time	Training <i>and</i> skills verification, “on-boarding” of new staff or creation of specialized staff or teams
Wrong, or lack of, resources or capacity	Targeted investments or shifting of capacity to where it is needed
Patients unaware of their role or options, not engaged	Patient engagement — education, involvement in design
No incentive or motivation to change	Recognition, rewards, inspiring leadership, accountability, executive compensation tied to quality

For more information on change concepts, see *The Improvement Guide: A Practical Approach to Enhancing Organizational Performance*.ⁱⁱⁱ

Areas for Improvement Identified in Change Plans

The 2012/13 QIPs included a wide variety of change ideas that demonstrated the ways in which a number of hospitals have carefully examined their systems and processes and developed change plans that reflect both best practices and creative innovation. Some QIPs were not complete for reasons that include absent or limited change ideas, a lack of corresponding process measures and root cause analysis as the change strategy.

The following suggestions are offered to assist hospitals with strengthening their QIP change plans.

1. Inclusion of Strong Change Ideas

Some hospitals did not provide change plans for all of their Priority 1 indicators, or provided little detail. Specific examples include:

- Repeating the aim in the change section instead of a specific idea for improvement: e.g., “Maintain 0% CLI rate.”
- Including only one change idea or providing sparse detail on the change idea: e.g., “Processes to analyze and reduce readmission rates.”

Over-reliance on staff training as the sole change strategy deserves particular mention. Staff training, while important, does not necessarily lead to improvement. Not all staff will attend the training and, once the training is over, they may not necessarily implement the new skill or carry it out in the way it was intended. If staff skills are included in the change plan, it may be helpful to describe the methods that are in place to verify that the skill has been learned and applied consistently (see Table 12).

In most instances, there is more than one root cause of a quality problem (see Table 11). The likelihood of an organization achieving breakthrough improvements is greatly increased when a clear strategy to address the most important root causes is well articulated.

Health Quality Ontario strongly encourages hospitals to include more detail about their change ideas. This makes change plans more transparent to staff and to the public, and allows HQO to share knowledge between hospitals about what strategies other organizations are using; this facilitates peer-to-peer learning.

ⁱⁱⁱ Gerald R. Langley et al. (2009), San Francisco: John Wiley & Sons.

See the “Quality Improvement by Indicator” section for examples of good change ideas submitted in this year’s QIPs for four of the most selected indicators: hand hygiene, patient satisfaction, ALC and ED waits.

2. Root Cause Analysis as a Key Part of the Change Strategy

In some QIPs, hospitals did not specify any change ideas. Instead, they set out a plan to collect data, do a root cause analysis and then identify change ideas — for example, “Analyze data from client experience survey.” While it is good practice to identify root causes *before* specifying a change strategy, we recommend that this process be done before hospitals complete their QIPs. If this is not possible, then hospitals may consider specifying a target date for when specific change ideas will be put forward, and then commit to making them public at that time.

3. Inclusion of Process Measures to Support Implementation of Change Ideas

The Model for Improvement’s second question, “How will we know if a change is an improvement?” can be answered through measurement. There are two main types of measures for quality improvement: outcomes and process. An **outcome measure** is the measure of overall performance. It looks at high-level results: the effect of a number of things that have happened — e.g., patient satisfaction, hand hygiene rates or CDI rates. Isolated activities influence the outcome measure. A **process measure** describes how well an organization

is executing a particular action or best practice that is known to have a positive impact on improving outcomes.

In many instances, hospitals identified a change idea but did not link it to a process measure or a target that could measure success. Some hospitals listed a change idea instead of a process measure in the process measure column. This may have occurred because:

- Organizations may not be clear what information belongs in this column, or what a process measure is; or
- It may be difficult for hospitals to define these measures for their change ideas.

Process indicators are important for monitoring whether the change strategy is implemented according to plan, and whether a course correction in the middle of the year is needed. For example, an organization might decide to conduct staff training on “teach back,” a method of verifying that patients understand discharge instructions. A process measure might include the number of staff that have been observed to be using the method correctly, or an audit on a sample of patients, asking them if the teach-back method was actually used. Without such a process measure, a hospital will never know whether the staff training was effective or not.

Table 12 lists some specific examples of process measures that organizations can consider.

TABLE 12: EXAMPLES OF POTENTIAL PROCESS MEASURES PER CHANGE CONCEPT

Change Concepts	Example of Process Measure
Measurement and feedback systems	Number of leadership walkabouts per month, number of audits performed per month, number of on-the-spot feedbacks provided per month
Reminder systems, clinical decision supports	Percentage of time reminder system was used, number of times decision-support system used per day
Redesigned processes	Percentage of time the “new” process was used appropriately, or implemented correctly the first time (i.e., first-time pass)
Training <i>and</i> skills verification, “on-boarding” of new staff or creation of specialized staff or teams	Percentage of staff that attend training, percentage of staff that pass the quiz/test, percentage of staff observed performing skill correctly “on the job”
Targeted investments or shifting of capacity to where it is needed	Percentage of patients admitted with assessments complete, percentage of patients seen by appropriate triage team, number of appropriate referrals received per month
Patient engagement — education, involvement in design	Percentage of patients that can “teach back” to healthcare provider, percentage of patients/families that receive educational brochure, number of outreach sessions provided per month
Recognition, rewards, inspiring leadership, accountability, executive compensation tied to quality	Number of rewards distributed quarterly, number of success stories printed in hospital newsletter per month, number of champion roles developed

Quality Improvement by Indicator

This section provides an overview of how many hospitals selected each indicator and how targets were set as compared to current performance.

For each indicator, we have included the following information to assist hospitals in their target setting process:

- How many hospitals chose the indicator as Priority 1, and as any other priority;
- A definition of the indicator;
- A target setting table that includes best achieved performance to date (if available), the theoretical best, provincial average and relative improvement targets by hospitals (including the average target submitted, and the highest and lowest target submitted); and
- A graph that allows hospitals to compare their current performance to their peers and to the provincial average, and to set targets that meet or exceed their peers' performance or the provincial average.

Examples of change ideas provided within 2012/13 QIPs have been included for four of the most-selected indicators: hand hygiene, patient satisfaction, ALC and ED waits. North Bay Regional Health Centre produced an excellent QIP in support of ALC reduction, which has been included in its entirety (see Table 31). These tables outline key change ideas proposed by different hospitals, and therefore illuminate how, by pooling ideas from different hospitals, we can see the full range of ideas that are available — an important way for hospitals to

learn from their peers. See the HQO Quality Improvement Map (www.ohqc.ca/en/ecfaa.html) for further change ideas and links to useful tools and resources.

Some things to look for and consider when examining the tables and charts for each indicator include:

- Whether targets were set above current performance;
- How stretch targets were set (e.g., best achieved in Ontario, theoretical best, provincial average);
- The relative improvement values that were set (i.e., the percentage increase/decrease that target represents relative to current performance);
- Where your hospital sits in comparison to your peers; and
- If your target is below current performance, or below the provincial average, whether this is an acceptable level of performance.

For every indicator, each hospital's current performance and target are identified, as well as the provincial average and benchmark (where they exist). Note that the number of hospitals that chose each indicator as a Priority 1 and the number of hospitals included in the graphs may differ slightly. This is due to insufficient data submitted by hospitals (missing or unclear data, or different reporting periods than what was recommended in the instructions outlined in the *Quality Improvement Plan Guidance Document for 2012/13*.) You will also note that the graphs contain guidance about how to interpret the information provided, as well as some thought-provoking questions to consider.

Safety: *Clostridium Difficile* Infection (CDI)

Thirty hospitals chose CDI as Priority 1 and 91 hospitals chose it as any priority.

Definition

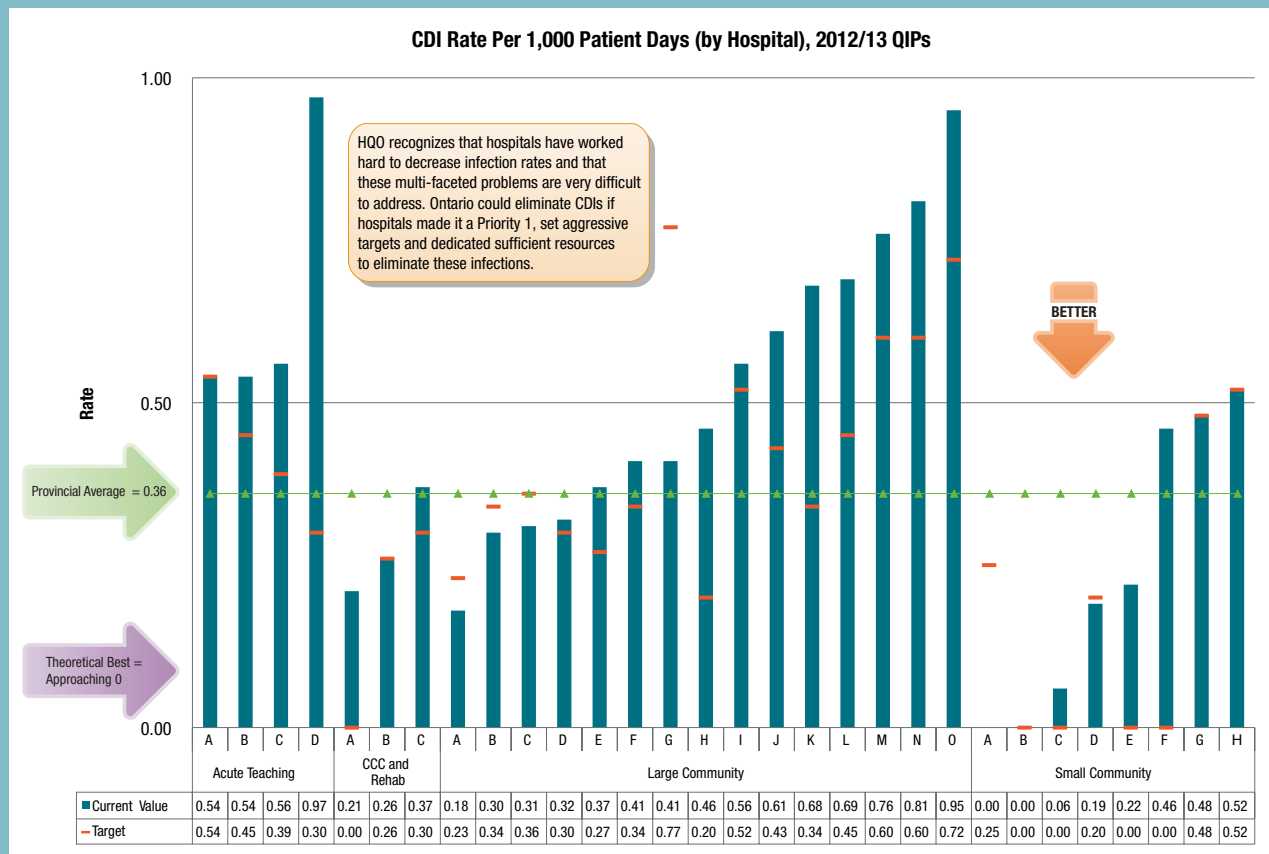
The CDI rate is defined as the number of patients newly diagnosed with hospital-acquired CDI, divided by the number of patient days in that month, multiplied by 1,000, consistent with publicly reportable patient safety data.

TABLE 13: CDI TARGET SETTING, 2012/13 QIPS

Best Achieved to Date in Ontario	Theoretical Best	Provincial Average	Relative Improvement Targets by Hospitals That Selected as Priority 1		
			Average Target	Lowest Target	Highest Target
Benchmarks under development	Approaching zero	0.36 (Dec. 2011)	24%	-88%*	100%*

*Negative values reflect the fact that some hospitals set targets that were lower than baseline performance.

FIGURE 2: CDI RATE — CURRENT PERFORMANCE AND TARGETS WITHIN 2012/13 QIPS



Safety: Ventilator-Associated Pneumonia (VAP)

One hospital chose VAP as Priority 1 and 38 hospitals chose it as any priority.

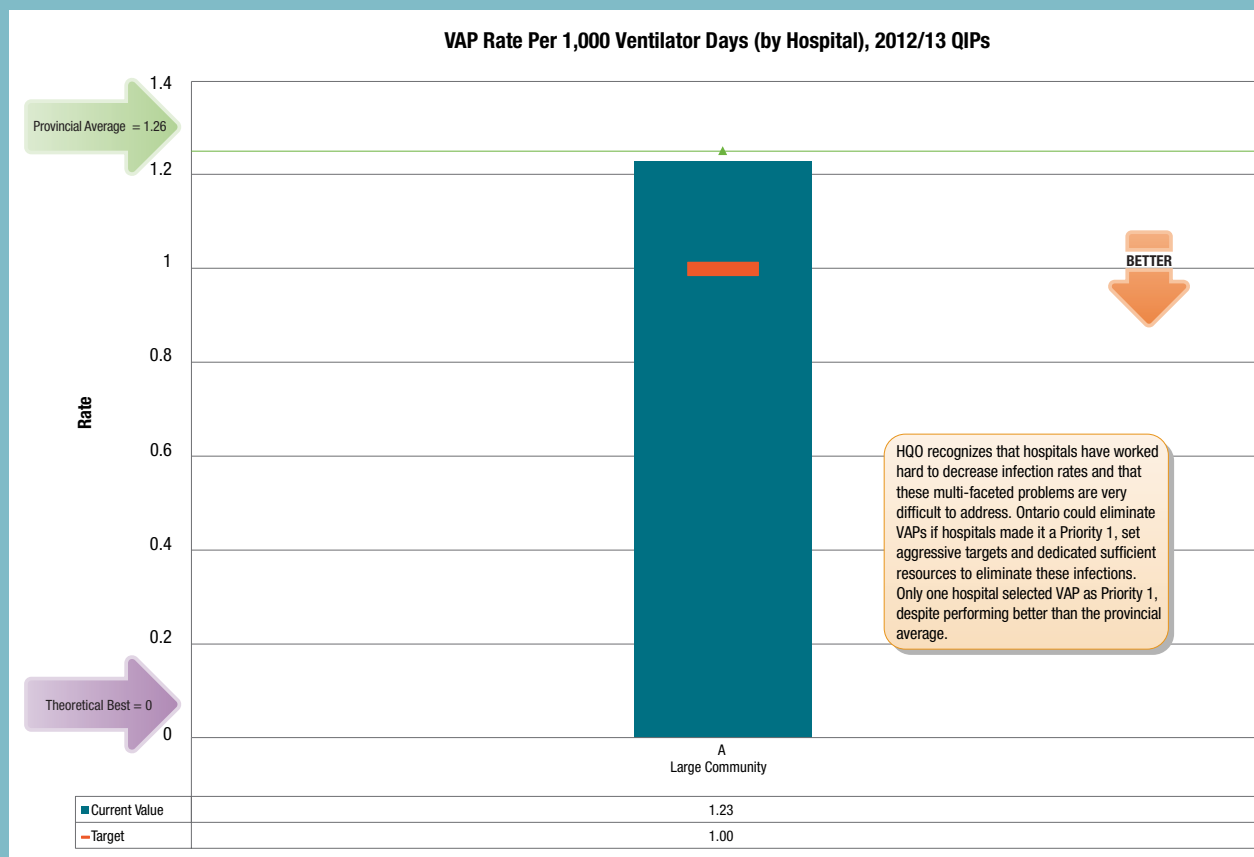
Definition

The VAP rate is defined as 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.

TABLE 14: VAP TARGET SETTING, 2012/13 QIPS

Best Achieved to Date in Ontario	Theoretical Best	Provincial Average	Relative Improvement Targets by Hospitals That Selected as Priority 1		
			Average Target	Lowest Target	Highest Target
Zero for teaching, large, and small hospitals; not applicable for CCC & rehab and mental health	Zero	1.26 (Q3 2011/12)	19%	19%	19%

FIGURE 3: VAP — CURRENT PERFORMANCE AND TARGETS WITHIN 2012/13 QIPS



Safety: Hand Hygiene

Eighty-five hospitals chose hand hygiene as Priority 1 and 119 hospitals chose it as any priority.

Definition

The hand hygiene compliance rate is defined as the number of times that hand hygiene was performed before initial patient contact divided by the number of observed hand hygiene indications before initial patient contact, multiplied by 100, consistent with publicly reportable patient safety data.

TABLE 15: HAND HYGIENE TARGET SETTING, 2012/13 QIPS

Best Achieved to Date in Ontario	Theoretical Best	Provincial Average	Relative Improvement Targets by Hospitals That Selected as Priority 1		
			Average Target	Lowest Target	Highest Target
92% for teaching, large community, CCC, mental health hospitals; 100% for small hospitals.	100%	72% (FY 2010/11)	9%	-19%*	40%

*Negative values reflect the fact that some hospitals set targets that were lower than baseline performance.

FIGURE 4: HAND HYGIENE — CURRENT PERFORMANCE AND TARGETS WITHIN 2012/13 QIPS

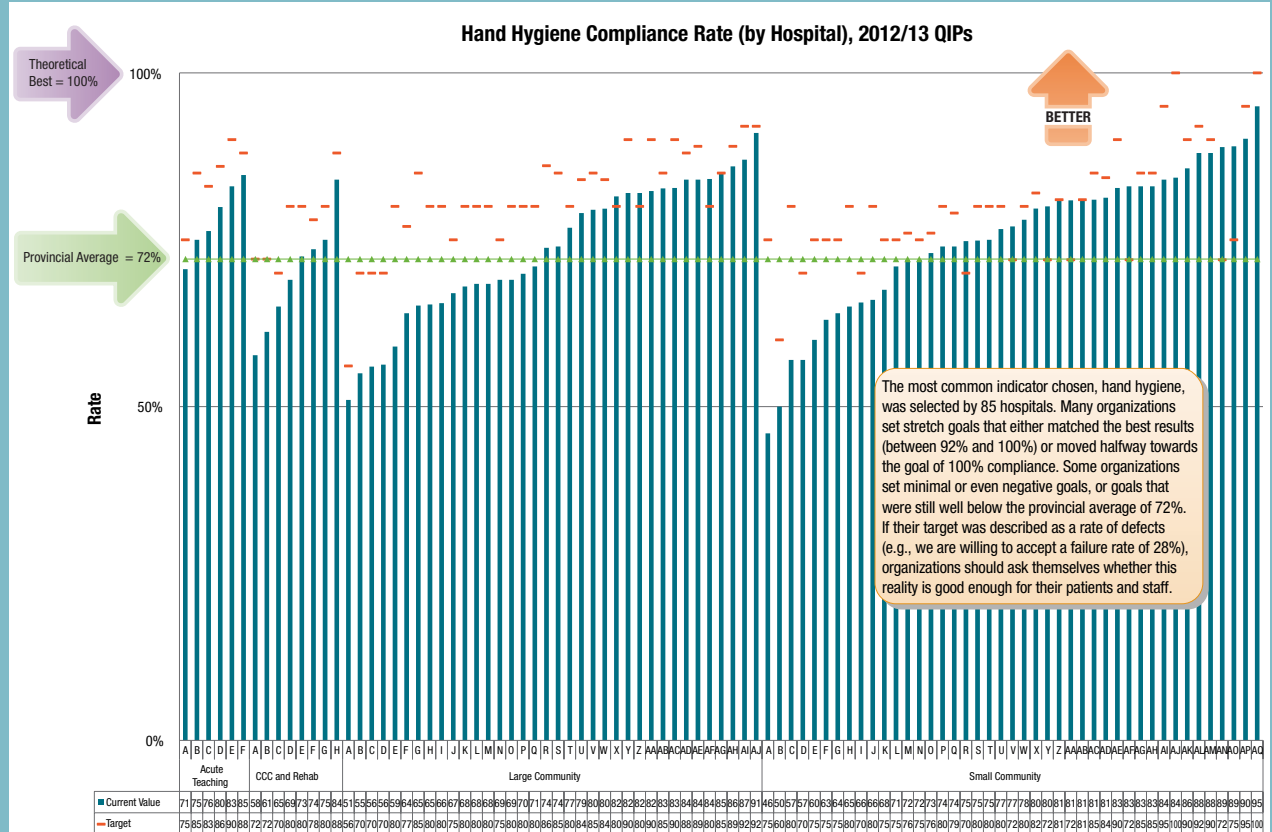


TABLE 16: CHANGE IDEAS TO IMPROVE HAND HYGIENE

Change Concept	Change Sub-Category	Change Idea	Process Measure	Process Target	Hospital (Type)
Measurement and Feedback	Frequent (e.g., monthly or quarterly measurement)	Unit-specific data reporting	Computer monitors are linked to display compliance with monthly organizational and individual unit audit compliance rate. Unit-specific results will be posted on all units' performance boards		Stevenson Memorial Hospital (small community)
	Feedback to individual departments, staff groups or individuals	Distribution of hand hygiene report cards, which provide immediate feedback following hand hygiene compliance audits, to promote improved practices	Percentage of audited staff receiving a report card		Sunnybrook Health Sciences Centre (acute teaching)
	Use of innovative methods for frequent audits	Utilize tablet technology (e.g., iPad) to increase efficiency and timeliness of feedback on hand hygiene audit data for staff	Number of audits; percentage of patient units receiving audit data within seven working days	50% of patient care units receive audit data	Brant Community Healthcare System (large community)
Processes	Ensure dispenser always full	Installation of red "empty" flags on all hand sanitizer dispensers in targeted non-clinical areas to ensure quick identification of empty dispensers, including "if empty, call" stickers	Install red "empty" flags on all hand sanitizer dispensers; percentage of hand sanitizer dispensers with red "empty" flags	80% of hand sanitizer dispensers with red flags installed by time of audit in December 2012	Halton Healthcare Services (large community)
	Transfer of accountability	Hand hygiene will be incorporated into the roll-out of a transfer of accountability checklist. This will occur with each RN transfer and in front of each patient, where possible.	Percentage of checklists completed for hand hygiene	At least six units will have implemented a transfer of accountability checklist that includes hand hygiene	St. Michael's Hospital (acute teaching)

TABLE 16: CHANGE IDEAS TO IMPROVE HAND HYGIENE (CONTINUED)

Change Concept	Change Sub-Category	Change Idea	Process Measure	Process Target	Hospital (Type)
Patient Engagement	Encourage patients to ask	Develop an “It’s OK to Ask” campaign in collaboration with the Children’s Council and Families as Partners in Patient Safety	Percentage of high-priority units (high-risk, chronic populations) with program implemented	80%	The Hospital for Sick Children (acute teaching)
	Educate patients/community on hand hygiene	Educate patients about hand hygiene via informational placemats that are placed on all patient trays (at least one meal per day/week)	Number of meal tray placements distributed	3,900/year	South Bruce Grey Health Centre (small community)
		Dissemination of Krames hand hygiene brochure, with education for families and patients on the importance of personal hand hygiene in and outside of the hospital	Number of units that implement patient hand hygiene education (via Krames brochure) as part of their admission materials Electronic version of patient brochure would also be posted on the Intranet for front-line staff to print/refer to, to help with their education	At least three units to include hand hygiene education materials upon patient admission	St. Michael’s Hospital (acute teaching)
Skills Development and Verification	Staff training	Focused and regular staff rounding, internal coaching, education and accountability systems to monitor improvement efforts	Computer monitors are linked to display compliance monthly, organizational and individual unit audit compliance rate. Unit-specific results will be posted on all units’ performance boards	None listed	Stevenson Memorial Hospital (small community)
		Electronic learning and face-to-face training sessions demonstrating hand hygiene core competencies required for nursing recertification every two years	Completion rate of the e-learning module and of individual program-based training	All nursing staff recertified every two years	Sunnybrook Health Sciences Centre (acute teaching)
	Verify hand-washing skills	Posting of a hand hygiene quiz on the Intranet for healthcare providers (physicians, nursing, health disciplines, clinical assistants, etc.) to complete	The quiz will prompt respondents to enter their discipline (competition between the disciplines). Special recognition/prize for the discipline with the most respondents	500 respondents	St. Michael’s Hospital (acute teaching)

TABLE 16: CHANGE IDEAS TO IMPROVE HAND HYGIENE (CONTINUED)

Change Concept	Change Sub-Category	Change Idea	Process Measure	Process Target	Hospital (Type)
Skills Development and Verification (continued)		Implement clinician hand hygiene travelling road shows to bring the black light, blood agar before/after, question period, etc., to units one on one	Take road show to 30 units once per year	100%	North Bay Regional Health Centre (large community)
	Decision Supports	A system should be implemented to indicate which patients need assistance with hand hygiene before meals, with an indicator placed at the patient's door to alert staff		Accumulate a minimum of 100 hand hygiene observations per site per quarter	Providence Care (CCC & rehab)
Resources	Redeploy staff on modified work	Utilizing modified workers to speak with staff, reminding individuals to wash before and after patient contact	Hand hygiene audits continue to be performed by infection prevention control	Achieve single target for corporation of 75% before patient contact	William Osler Health System (large community)
	Optimize location of hand hygiene stations	Complete an assessment of sanitizer availability/placement so sanitizer is part of the workflow area	Percentage of units with assessment completed	100%	North Bay Regional health Centre (large community)
Incentives	Leadership attention/walkabouts	Employ leadership walkabouts to encourage dialogue and awareness and demonstrate leadership commitment to hand hygiene	Walkabouts to encourage dialogue and awareness	Monthly reports on hand hygiene compliance will be provided, analyzed and used to identify improvement opportunities	Hotel Dieu Hospital (acute teaching)
	Recognition	Send letters of appreciation to staff who are 100% compliant with hand hygiene practices prior to patient contact	Number of letters sent to staff annually	None listed	Chapleau Health Services (large community)

TABLE 16: CHANGE IDEAS TO IMPROVE HAND HYGIENE (CONTINUED)

Change Concept	Change Sub-Category	Change Idea	Process Measure	Process Target	Hospital (Type)
Incentives (continued)	Recognition (continued)	Spontaneous coffee voucher giveaway for staff showing excellent compliance with the Four Moments and/or supporting hand hygiene initiatives	Number of coffee vouchers distributed	Four each month	North Bay Regional health Centre (large community)
		Poster campaign congratulating units that met or surpassed goal, and encouraging those who didn't, to strive for improvement. Introduction of a friendly competition between units to improve Moment 1 hand hygiene	Variety of eye-catching, informative posters with different titles related to hand hygiene will be displayed appropriately throughout the organization	Posters will be distributed to units at least quarterly	Bruyère Continuing Care (CCC & rehab)
	Competition	Maintain frequency of quarterly hand hygiene audits; introduction of an integrated quarterly contest, which rewards high-performing units/departments	Proactive scheduling; number of quarterly audits; units will be rewarded for hand hygiene compliance and contest quiz answer submissions; participation rate	25% increase in willingness to use hand sanitizer	Runnymede Healthcare Centre (CCC & rehab)
	Use of champions	Identification and public posting of hand hygiene champion posters	Hand hygiene champion posters will be hung in three public space locations	A minimum of four champions will be identified in each stream. 100% of posters mounted	Bluewater Health (large community)

TABLE 16: CHANGE IDEAS TO IMPROVE HAND HYGIENE (CONTINUED)

Change Concept	Change Sub-Category	Change Idea	Process Measure	Process Target	Hospital (Type)
Incentives (continued)	Use of champions (continued)	Recognize top performers and consider use of incentives to rewarded excellent performance. Identify and engage unit and medical staff champions to model excellent hand hygiene behaviours	Weekly audits completed by various members of all departments. Sharing in auditing heightens the importance and accountability of hand hygiene compliance. Timely feedback loop and education to address poor performers	1) Monthly reporting to leaders and board to continue heightened awareness of hand hygiene rates 2) Increase auditing to bi-weekly 3) Achievement of 75% compliance would place SHHA as one of the highest performers in Ontario	South Huron Hospital (small community)
	Positive deviance	Implement strategy of “positive deviance” led by organizational hand hygiene champion. This strategy recognizes those with compliant practice as positive deviants: They use various methods of modelling behaviour, sharing knowledge and exploring barriers to raise compliant practice of peers (including physicians), who in turn are recognized as positive deviants when their compliance increases	None listed	None listed	Cambridge Memorial Hospital (large community)

Safety: Central Line Associated Blood Stream Infection (CLI)

One hospital chose CLI as Priority 1 and 38 hospitals chose it as any priority.

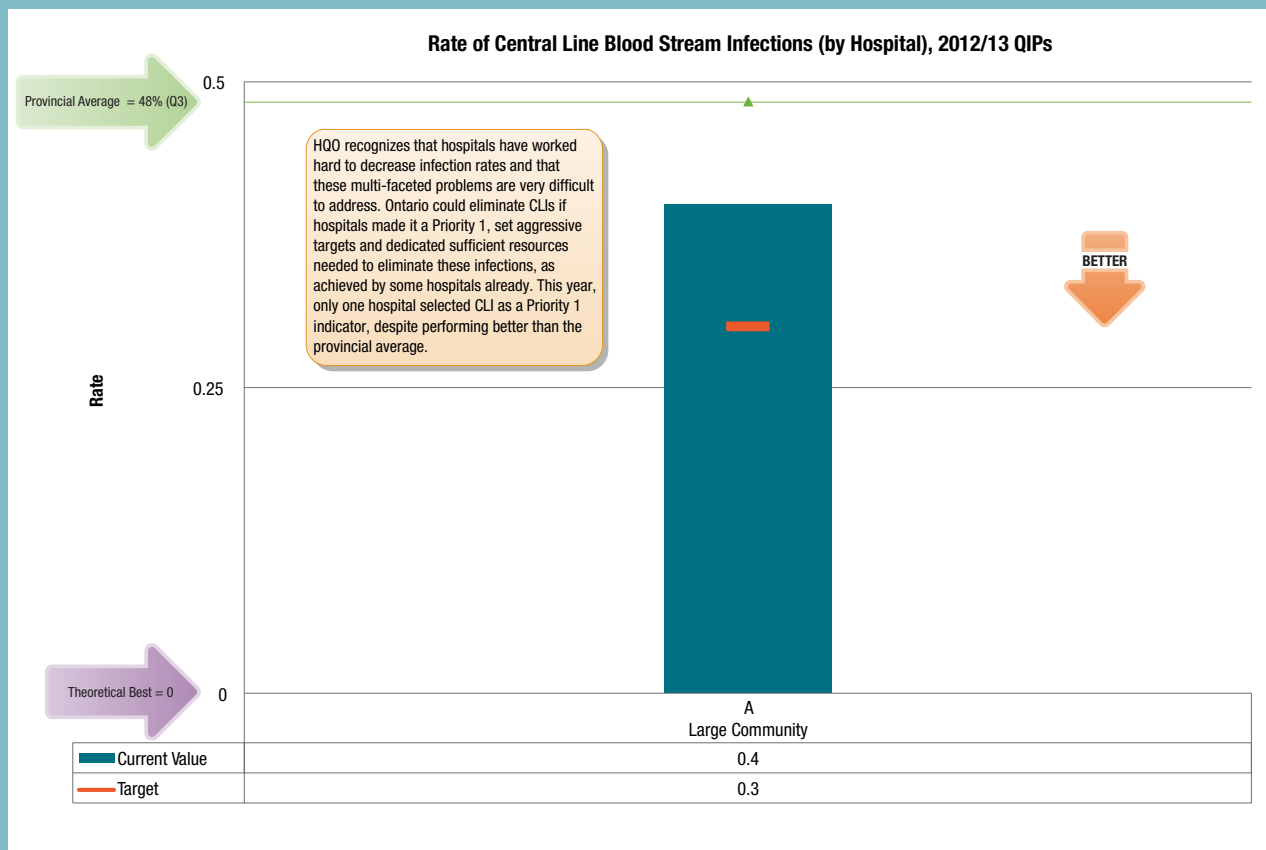
Definition

The CLI rate is defined as the 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.

TABLE 17: CLI TARGET SETTING, 2012/13 QIPS

Best Achieved to Date in Ontario	Theoretical Best	Provincial Average	Relative Improvement Targets by Hospitals That Selected as Priority 1		
			Average Target	Lowest Target	Highest Target
Zero for teaching, large, and small hospitals; not applicable for CCC & rehab, and mental health	Zero	0.48 (Q3 2011/12)	25%	25%	25%

FIGURE 5: CLI — CURRENT PERFORMANCE AND TARGETS WITHIN 2012/13 QIPS



Safety: Pressure Ulcers

Ten hospitals chose pressure ulcers as Priority 1 and 44 hospitals chose it as any priority. This indicator was most selected by CCC and rehab hospitals.

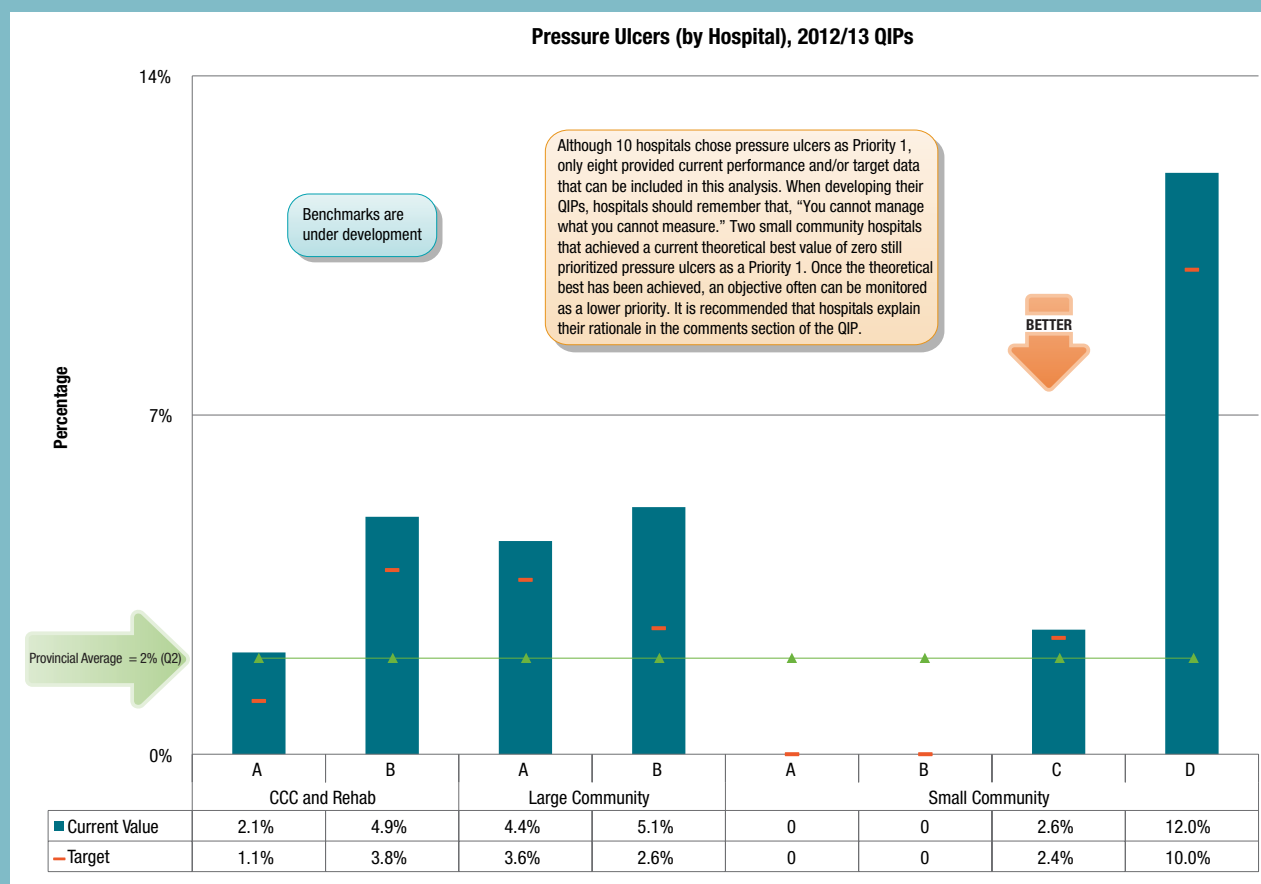
Definition

The pressure ulcer rate is defined as the percentage of complex continuing care residents with a new pressure ulcer in the last three months (stage 2 or higher).

TABLE 18: PRESSURE ULCERS TARGET SETTING, 2012/13 QIPS

Best Achieved to Date in Ontario	Theoretical Best	Provincial Average	Relative Improvement Targets by Hospitals That Selected as Priority 1		
			Average Target	Lowest Target	Highest Target
Benchmarks under development		2.0% (Q2 2011/12)	20%	0%	49%

FIGURE 6: PRESSURE ULCERS — CURRENT PERFORMANCE AND TARGETS WITHIN 2012/13 QIPS



Safety: Falls

Twelve hospitals chose falls as Priority 1 and 40 hospitals chose it as any priority. This indicator was most selected by CCC and rehab hospitals.

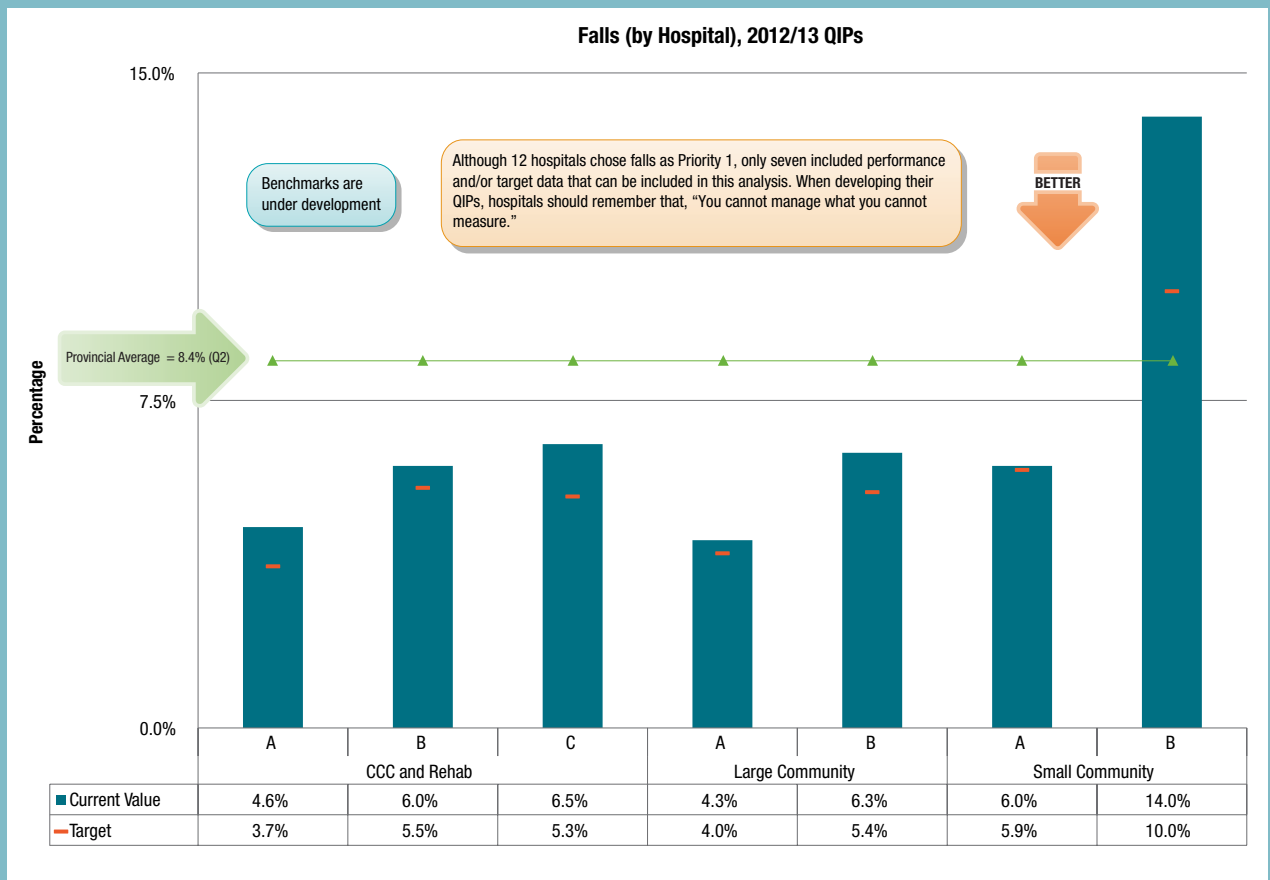
Definition

The falls rate is defined as the percentage of complex continuing care residents who fell in the last 30 days.

TABLE 19: FALLS TARGET SETTING, 2012/13 QIPS

Best Achieved to Date in Ontario	Theoretical Best	Provincial Average	Relative Improvement Targets by Hospitals That Selected as Priority 1		
			Average Target	Lowest Target	Highest Target
Benchmarks under development		8.4% (Q2, 2011/12)	14%	2%	29%

FIGURE 7: FALLS — CURRENT PERFORMANCE AND TARGETS WITHIN 2012/13 QIPS



Safety: Surgical Safety Checklist

Eight hospitals chose surgical safety checklist as Priority 1 and 60 hospitals chose it as any priority.

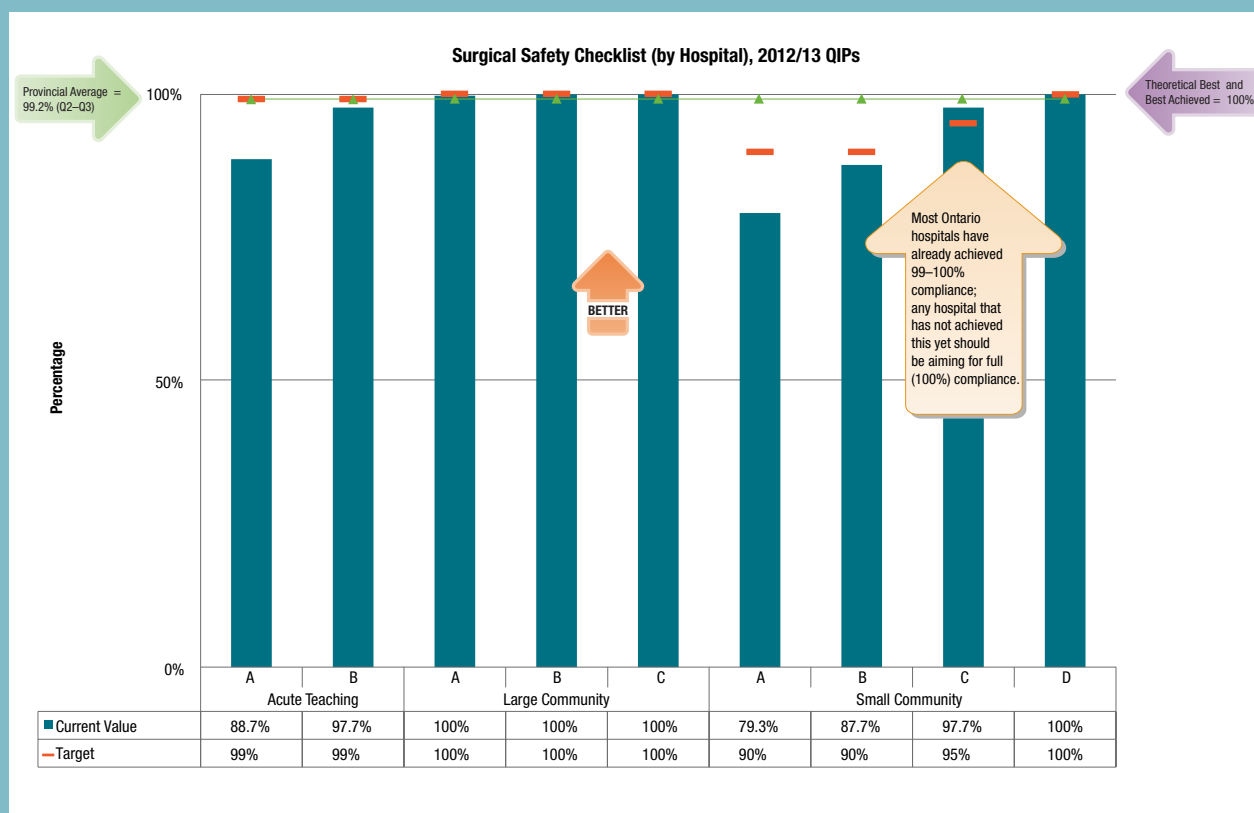
Definition

The surgical safety checklist rate is defined as the number of times all three phases of the surgical safety checklist were 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.

TABLE 20: SURGICAL SAFETY CHECKLIST TARGET SETTING, 2012/13 QIPS

Best Achieved to Date in Ontario	Theoretical Best	Provincial Average	Relative Improvement Targets by Hospitals That Selected as Priority 1		
			Average Target	Lowest Target	Highest Target
100%	100%	99.2% (Q2 to Q3 2011/12)	5%	0%	13%

FIGURE 8: SURGICAL SAFETY CHECKLIST — CURRENT PERFORMANCE AND TARGETS WITHIN 2012/13 QIPS



Safety: Physical Restraints

Eight hospitals chose physical restraints as a Priority 1 and 30 hospitals chose it as any priority. This indicator was most selected by mental health hospitals.

Definition

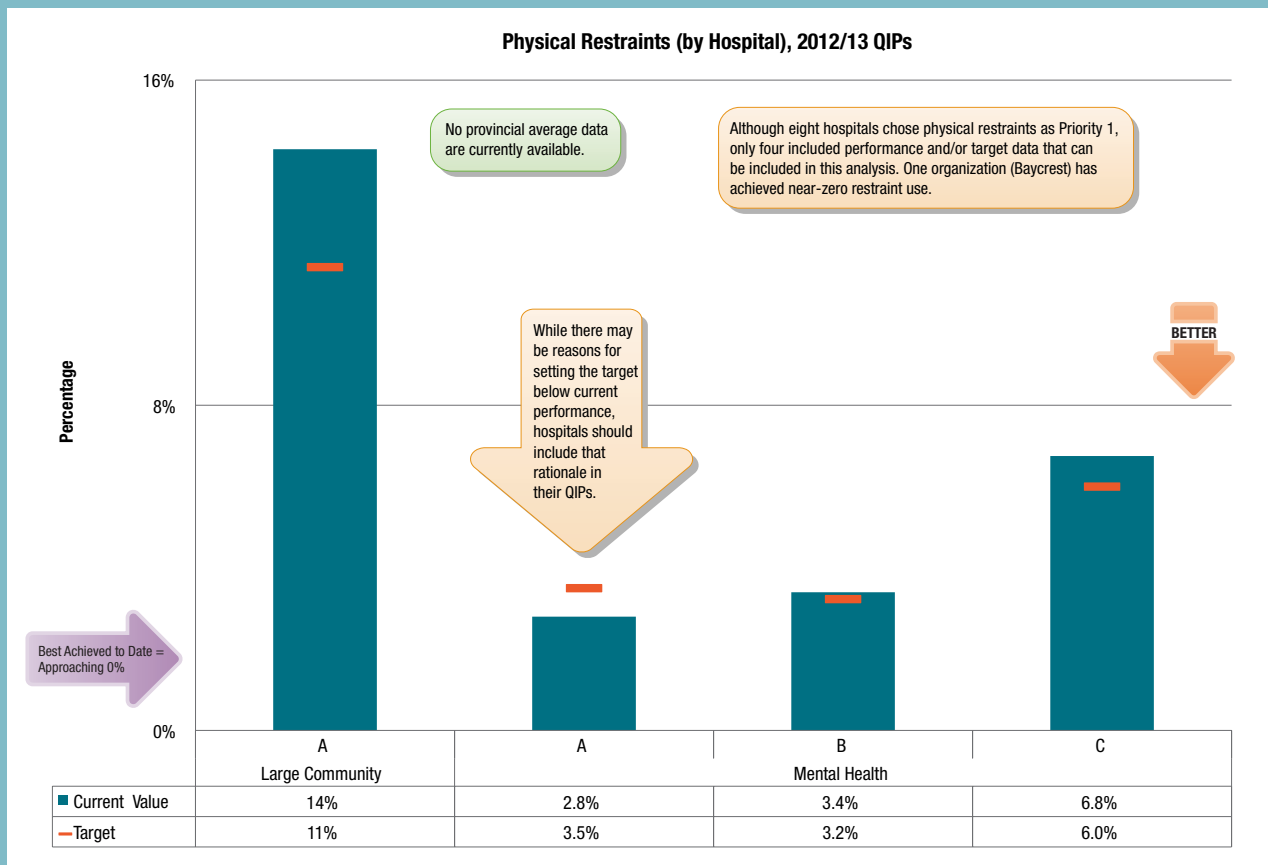
The physical restraints rate is defined as the number of patients who are physically restrained at least once in the three days prior to a full admission, divided by all cases with a full admission assessment.

TABLE 21: PHYSICAL RESTRAINTS TARGET SETTING, 2012/13 QIPS

Best Achieved to Date in Ontario	Theoretical Best	Provincial Average	Relative Improvement Targets by Hospitals That Selected as Priority 1		
			Average Target	Lowest Target	Highest Target
Approaching zero		No data available	3%	-25%*	20%

*Negative values reflect the fact that some hospitals set targets that were lower than baseline performance.

FIGURE 9: PHYSICAL RESTRAINTS — CURRENT PERFORMANCE AND TARGETS WITHIN 2012/13 QIPS



Effectiveness: Hospital Standardized Mortality Ratio (HSMR)

Six hospitals chose HSMR as Priority 1 and 41 hospitals chose it as any priority.

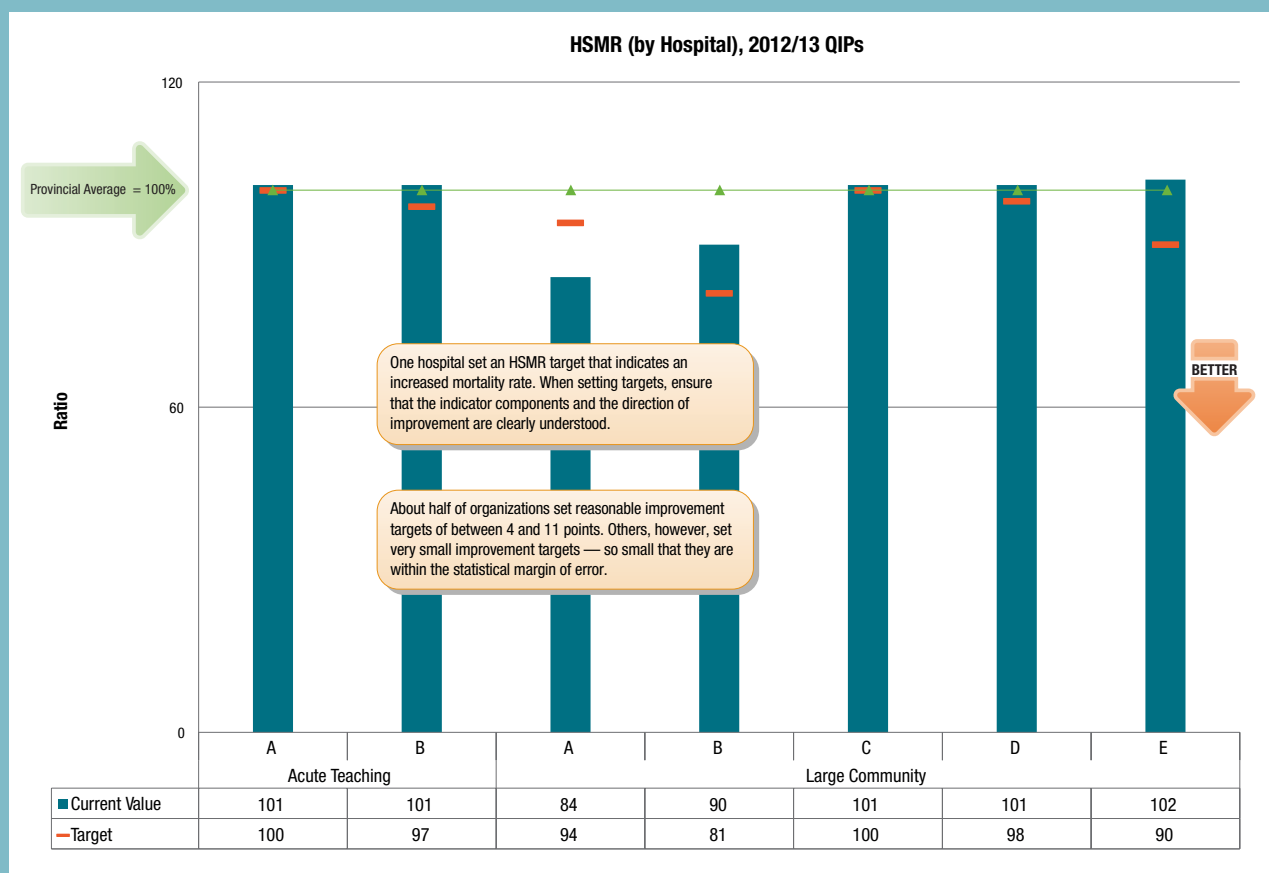
Definition

The HSMR is defined as the number of observed deaths/number of expected deaths, multiplied by 100.

TABLE 22: HSMR TARGET SETTING, 2012/13 QIPS

Best Achieved to Date in Ontario	Theoretical Best	Provincial Average	Relative Improvement Targets by Hospitals That Selected as Priority 1		
			Average Target	Lowest Target	Highest Target
n/a	n/a	100% (this is baseline)	5%	1%	12%

FIGURE 10: HSMR — CURRENT PERFORMANCE AND TARGETS WITHIN 2012/13 QIPS



Effectiveness: Hospital — Total Margin (OHRS)

Sixty-two hospitals chose total margin as Priority 1 and 121 hospitals chose it as any priority.

Definition

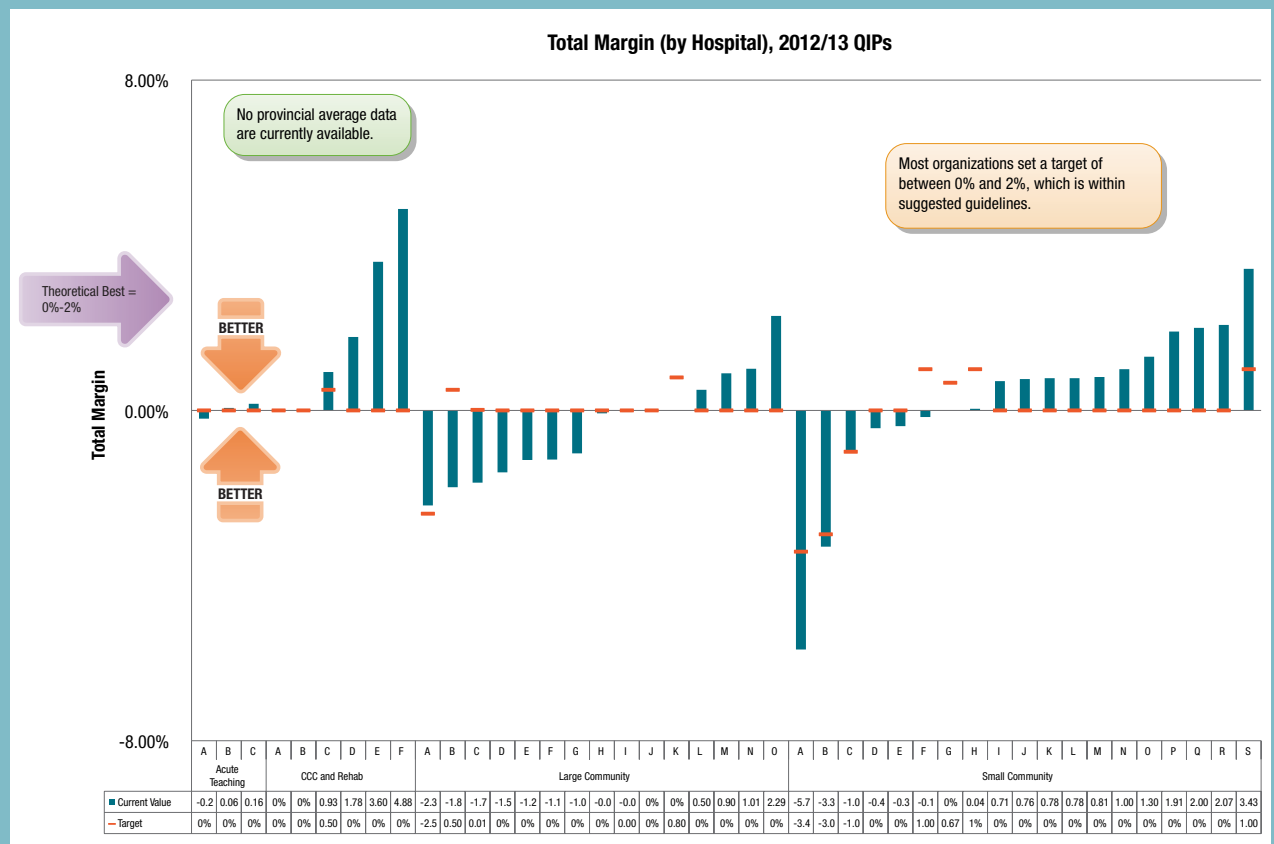
The total margin is defined as the percentage by which total corporate (consolidated) revenues exceed or fall short of total corporate (consolidated) expenses, excluding the impact of facility amortization, in a given year.

TABLE 23: TOTAL MARGIN TARGET SETTING, 2012/13 QIPS

Best Achieved to Date in Ontario	Theoretical Best	Provincial Average	Relative Improvement Targets by Hospitals That Selected as Priority 1		
			Average Target	Lowest Target	Highest Target
0.7%–1.7% for teaching; 0.1%–1.6% for CCC; 0%–1.6% for large; 0%–1.8% for small; 1.9% for mental	0%–2%	Data not available*	n/a	n/a	n/a

*Data available on MOHLTC website; HQO cannot access this data, however.

FIGURE 11: TOTAL MARGIN — CURRENT PERFORMANCE AND TARGETS WITHIN 2012/13 QIPS



Access: 90th Percentile ED Length of Stay for Admitted Patients

Fifty-four hospitals chose 90th percentile ED length of stay for admitted patients as Priority 1 and 94 hospitals chose it as any priority.

Definition

The ED length of stay for admitted patients is defined as the time from triage or registration, whichever comes first, to the time the patient leaves the ED.

TABLE 24: 90TH PERCENTILE ED LENGTH OF STAY FOR ADMITTED PATIENTS TARGET SETTING, 2012/13 QIPS

Best Achieved to Date in Ontario	Theoretical Best	Provincial Average	Relative Improvement Targets by Hospitals That Selected as Priority 1		
			Average Target	Lowest Target	Highest Target
Data not available	Approaching zero	11.5 hours (FY 2010/11)	11%	-117%*	68%

*Negative values reflect the fact that some hospitals set targets that were lower than baseline performance.

FIGURE 12: 90TH PERCENTILE LENGTH OF STAY FOR ADMITTED PATIENTS – CURRENT PERFORMANCE AND TARGETS WITHIN 2012/13 QIPS

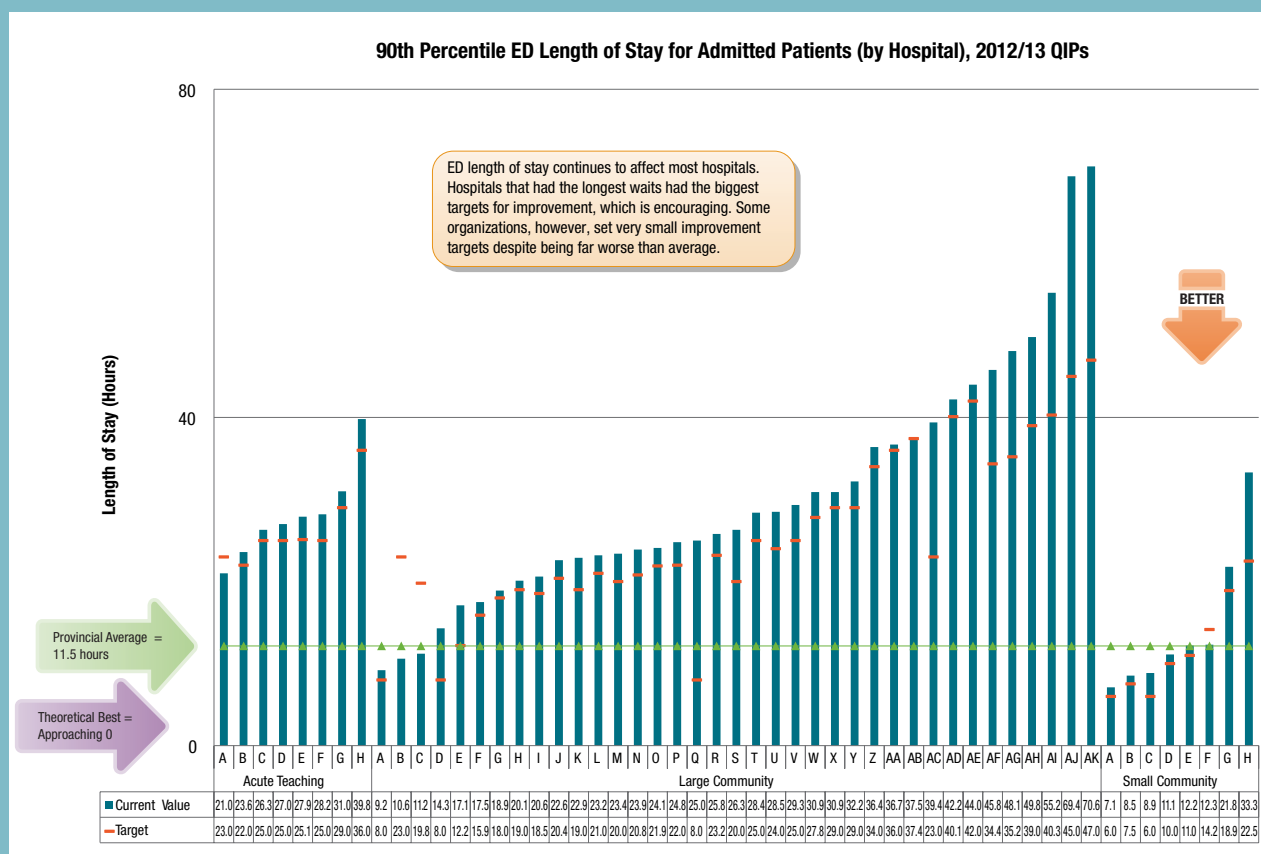


TABLE 25: CHANGE IDEAS TO IMPROVE ED WAIT TIMES FOR ADMITTED PATIENTS

Change Concept	Change Sub-Category	Change Idea	Process Measure	Process Target	Hospital (Type)
Monitoring and Feedback	Electronic dashboard	Implement real-time monitoring of length of stay in the emergency department with an electronic dashboard	Percentage of inpatient managers' meetings where ED bed wait times is on the agenda	100%	The Hospital For Sick Children (acute teaching)
		A new electronic messaging system in the ED to alert attending physicians to the availability of results of diagnostic tests	System implementation; system operation; measurement of response times	Reduction in wait times for all ED patients, including those who are eventually admitted	Sunnybrook Health Sciences Centre (acute teaching)
	Inpatient bed tracking system	Continue to keep bed wait times visible and accessible through hospital-wide reporting, access to data via Intranet (daily dashboard, DART, reports), profile at daily bed management meetings, daily email to leaders, etc. Implement an electronic bed management system to allow tracking and improvements in wait time for available beds	Percentage of inpatient managers' meetings where ED bed wait times is on the agenda Director, Critical Care Services, provides oversight and ongoing monitoring of intervention compliance and impact	100% Implemented process measures expected to provide timely notice of intervention effectiveness or if a recovery plan required at the operational, executive and governance levels	The Hospital For Sick Children (acute teaching) Cornwall Community Hospital (large community)

TABLE 25: CHANGE IDEAS TO IMPROVE ED WAIT TIMES FOR ADMITTED PATIENTS (CONTINUED)

Change Concept	Change Sub-Category	Change Idea	Process Measure	Process Target	Hospital (Type)
Processes	Match staffing levels to handle demand surges	We will review the scheduling of physicians in the ED and make changes to align physician resources with patient needs	Data on patient arrivals indicate that there are periods of high demand that do not have optimal physician staffing for non-urgent cases. During these periods there are longer waits	To provide additional physician coverage for 90% of the high-demand periods in the ED	St. Joseph's Healthcare Hamilton (acute teaching)
		Evaluate having a "float" Environmental Service Worker position during peak admission period to reduce time waiting for a room to be cleaned and prepared for admission	None listed	Implemented process measures expected to provide timely notice of intervention effectiveness or if a recovery plan required at the operational, executive and governance levels	Cornwall Community Hospital (large community)
		Load leveling or coordinating staff schedules to correspond with demand	Report quarterly to the Quality and Patient Care Committee of the board, Emergency Clinical Team and Medical Advisory Committee	Goal has been set to internally manage patient flow by fiscal year	Brockville General Hospital (large community)
	Spread elective surgeries evenly	Spread elective surgery cases more evenly throughout the week to allow more flexibility to accept surgical cases from the ED as they arise	Report quarterly to the Quality and Patient Care Committee of the board, Emergency Clinical Team and Medical Advisory Committee	Goal has been set to internally manage patient flow by fiscal year	Brockville General Hospital (large community)

TABLE 25: CHANGE IDEAS TO IMPROVE ED WAIT TIMES FOR ADMITTED PATIENTS (CONTINUED)

Change Concept	Change Sub-Category	Change Idea	Process Measure	Process Target	Hospital (Type)
Processes (continued)	Create specialized zones (e.g., rapid assessment areas)	Implementation of a rapid assessment room for CTAS IV-V patients	None listed	5% improvement in wait times	Campbellford Memorial Hospital (acute teaching)
	Design ED layout for efficient flow	Storage of materials near their point of use	Report quarterly to the Quality and Patient Care Committee of the board, Emergency Clinical Team and Medical Advisory Committee	Goal has been set to internally manage patient flow by fiscal year	Brockville General Hospital (large community)
		Conduct an ED process review using principles of Lean, to find further opportunities for reducing wait time in ED			Cambridge Memorial Hospital (large community)
	Improve discharge process to prevent returns to ED	Discharge communication sent to community care provider within 72 hours of patient discharge	None listed	Implemented process measures expected to provide timely notice of intervention effectiveness or if a recovery plan required at the operational, executive and governance levels	Cornwall Community Hospital (large community)

TABLE 25: CHANGE IDEAS TO IMPROVE ED WAIT TIMES FOR ADMITTED PATIENTS (CONTINUED)

Change Concept	Change Sub-Category	Change Idea	Process Measure	Process Target	Hospital (Type)
Processes (continued)	Improve discharge process to prevent returns to ED (continued)	Discharged patients to be contacted within 24–72 hours of discharge	None listed	Implemented process measures expected to provide timely notice of intervention effectiveness or if a recovery plan required at the operational, executive and governance levels	Cornwall Community Hospital (large community)
	Improve access to community services to prevent returns to ED	Maximize referrals to the General Internal Medicine Rapid Access Outpatient Clinic (GIMRAOC) by providing quarterly data to GIM and ED physicians regarding their referral rate to the GIMRAOC	Percentage increase in the number of new visits to GIMRAOC over 2011/12	5% improvement over 2011/12	Hamilton Health Sciences (acute teaching)
	Inpatient bed management strategies	Building on the success of the Rapid Referral Clinic for assessment and management of medical patients to avoid inpatient admissions, a feasibility study will be initiated for additional clinics for cancer and cardiac patients Medical patient journey; identify key barriers to patient flow; align bed management processes to best practice and patient outcomes; release/protect capacity and resource demands (balance demand with capacity)	Tracking the number of General Medicine admissions averted by the Rapid Referral Clinic	Completion of feasibility study	Sunnybrook Health Sciences Centre (acute teaching)
				ELOS vs. ALOS variance % <8 hours	Hotel-Dieu Grace Hospital (large community)

TABLE 25: CHANGE IDEAS TO IMPROVE ED WAIT TIMES FOR ADMITTED PATIENTS (CONTINUED)

Change Concept	Change Sub-Category	Change Idea	Process Measure	Process Target	Hospital (Type)
Processes (continued)		Improve access to the right beds at the right time through a simulation-informed bed map	1. Application of Surgical Predictive Bed Model 2. Development of Medical Predictive Bed Model	1. Surgical Predictive Model: application complete at identified HHS sites by October 2012 2. Medical Predictive Model: pilot model developed April 2013	Hamilton Health Sciences (Acute Teaching)
		Ensure physician rounds in acute care are complete in order to ensure patient discharge from unit before 11:00 hours	Report quarterly to the Quality and Patient Care Committee of the board, Emergency Clinical Team and Medical Advisory Committee	Goal has been set to internally manage patient flow by fiscal year	Brockville General Hospital (large community)
	Improve handoffs from ED to inpatient ward	Implementation of a multidisciplinary admission team in the ED to coordinate the care of patients awaiting transfer to an inpatient bed	Reduction in ALOS for patients admitted through ED and cared for by the admission team	Decrease the average acute length of stay for patients admitted through ED from 5.9 days (2011/12 YTD Q3) by 10%, to 5.3 days	Markham Stouffville Hospital (large community)
		Transition team in place and testing started on improving the process of transitioning the patient from the ED to IPU in a more timely and safe manner, which should reduce IP length of stay. Improve transition process to inpatient unit, reduce time to inpatient unit	Bed ready for patient in 30 minutes, volume of admitted patients seen by transition team	Percentage meeting 30-minute target	Hotel Dieu Grace Hospital (large community)

TABLE 25: CHANGE IDEAS TO IMPROVE ED WAIT TIMES FOR ADMITTED PATIENTS (CONTINUED)

Change Concept	Change Sub-Category	Change Idea	Process Measure	Process Target	Hospital (Type)
Decision Supports	Patient order sets	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	Percentage of patients admitted with a completed admission order set on chart	Low acuity: 4; high acuity: 8	Joseph Brant Memorial Hospital (large community)
	Patient Engagement	Inform patients about wait times Be transparent with current wait times. Use technology to let the public know what the wait time is	None listed	Low acuity: 4; high acuity: 8	Brockville General Hospital (large community)
	Inform patients about their care	Utilize whiteboards in each patients room; identify discharge planning for families and patients to view	Random audits performed to ensure that staff update whiteboards on daily basis to reflect plan of care and discharge plan developed in collaboration with physicians	100% compliance with whiteboard utilization	Stevenson Memorial (small community)
Resources	Dedicated staff to manage ED flow	Use a Patient Flow Coordinator position to guide process improvements in the ED for CTAS 1-3 patients. The Coordinator will help the ED team to use ED beds more efficiently so that they can reduce the wait time for patients	Use ED tracking board data to map the flow of patients through the ED, and use this data to examine and improve bed utilization	None listed	St Joseph's Health Centre—Hamilton (acute teaching)

TABLE 25: CHANGE IDEAS TO IMPROVE ED WAIT TIMES FOR ADMITTED PATIENTS (CONTINUED)

Change Concept	Change Sub-Category	Change Idea	Process Measure	Process Target	Hospital (Type)
Resources (continued)		Pilot and evaluate Bed Coordinator role to support bed management best practices, e.g., predictive discharge process, bed management meetings twice daily at change of shift to optimize bed utilization, early-morning patient transfers from ED-IP services, 10 am discharge, etc.	Quarterly QIP2 scorecard presented to senior leadership team, Medical Quality Committee and Quality and Performance Monitoring Committee	None listed	Cornwall Community Hospital (large community)
	Redeploy resources to bottlenecks	Continue with “hot spot” strategies, e.g., nurse practitioner in fast-track area, flow coaches and admission/discharge unit	None listed	None listed	Cambridge Memorial Hospital (large community)
Staff Skills	Staff training	Communication tools: introduce “teach back” training, health literacy awareness and communication training to all front-line HCP	Percentage trained	90% of frontline HCP (excluding MD are trained in teach back (FT and PT)	Red Lake Margaret Cochenour Memorial Hospital (small community)

Patient-Centred: Patient Satisfaction

Fifty-nine hospitals chose patient satisfaction as Priority 1 and 129 hospitals chose it as any priority.

Definition

Improving patient satisfaction involves asking patients questions about the care and services they have received at a hospital, and/or whether they would recommend the hospital to others. Most hospitals use NRC Picker Canada questions for both hospital in-patients and ED patients, but an in-house survey may also be administered.

TABLE 26: PATIENT SATISFACTION TARGET SETTING, 2012/13 QIPS

Indicator	Best Achieved to Date in Ontario	Theoretical Best	Provincial Average	Relative Improvement Targets by Hospitals That Selected as Priority 1		
				Average Target	Lowest Target	Highest Target
Percentage who would definitely recommend to others – inpatients	Benchmarks under development	Approaching 100%	73.1% FY 2010	3%	-20%*	23.0%
Percentage who would definitely recommend to others – EDs	Benchmarks under development	Approaching 100%	58.2% FY 2010	11%	2%	20%
Percentage who rate the care they received as excellent, very good or good – inpatients	Benchmarks under development	Approaching 100%	93.2% FY 2010	2%	-15%*	15%*
Percentage who rate the care they received as excellent, very good or good – EDs	Benchmarks under development	Approaching 100%	85.1% FY 2010	2%	0%	5%

*Negative values reflect the fact that some hospitals set targets that were lower than baseline performance.

FIGURE 13: PATIENT SATISFACTION — CURRENT PERFORMANCE AND TARGETS WITHIN 2012/13 QIPS

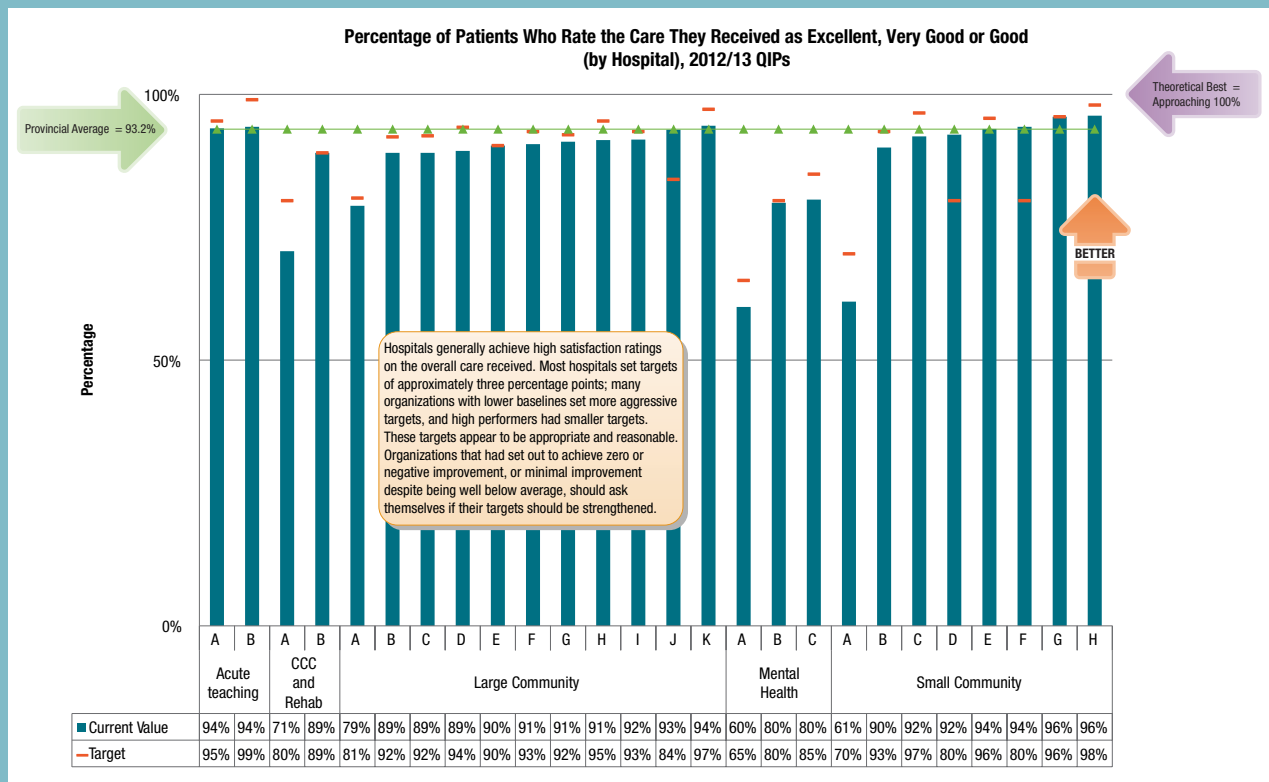
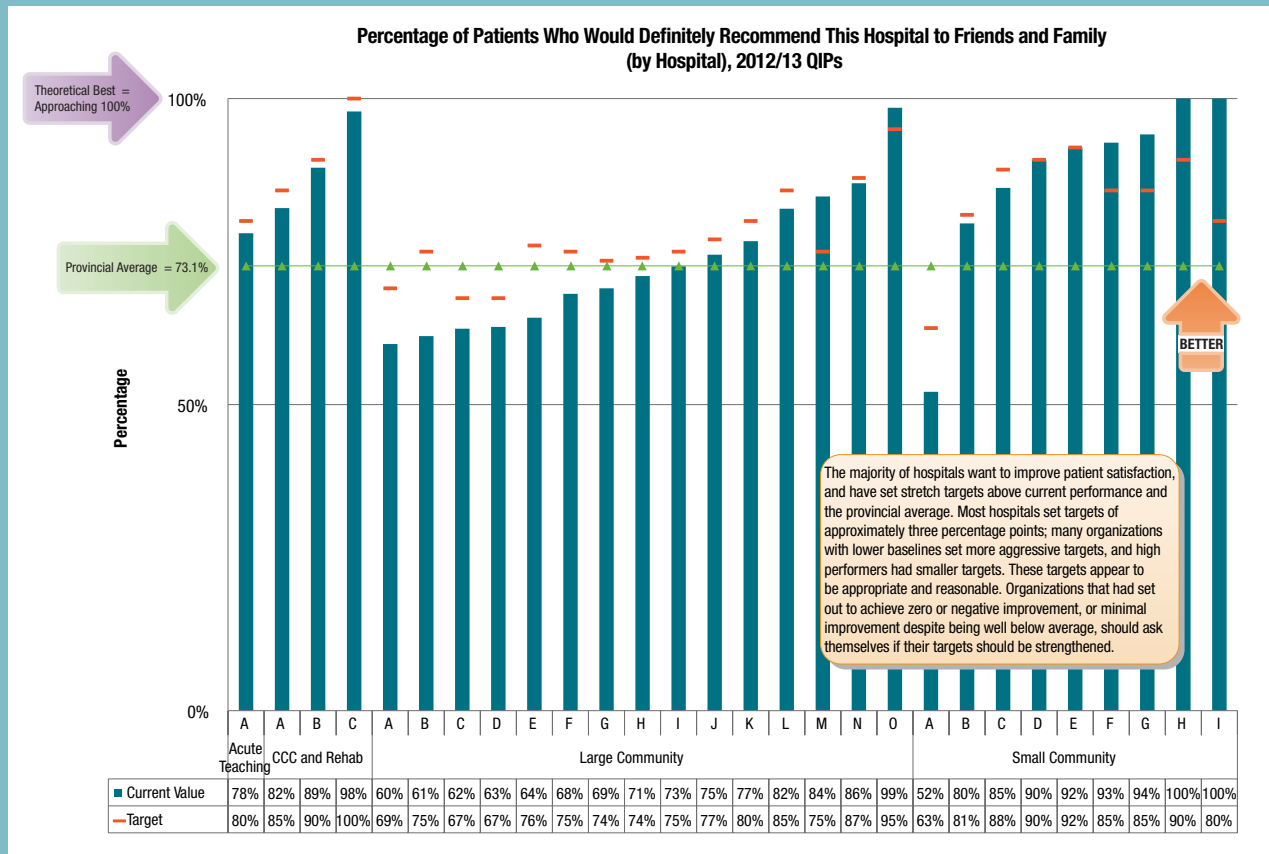


FIGURE 13: PATIENT SATISFACTION – CURRENT PERFORMANCE AND TARGETS WITHIN 2012/13 QIPS
(CONTINUED)

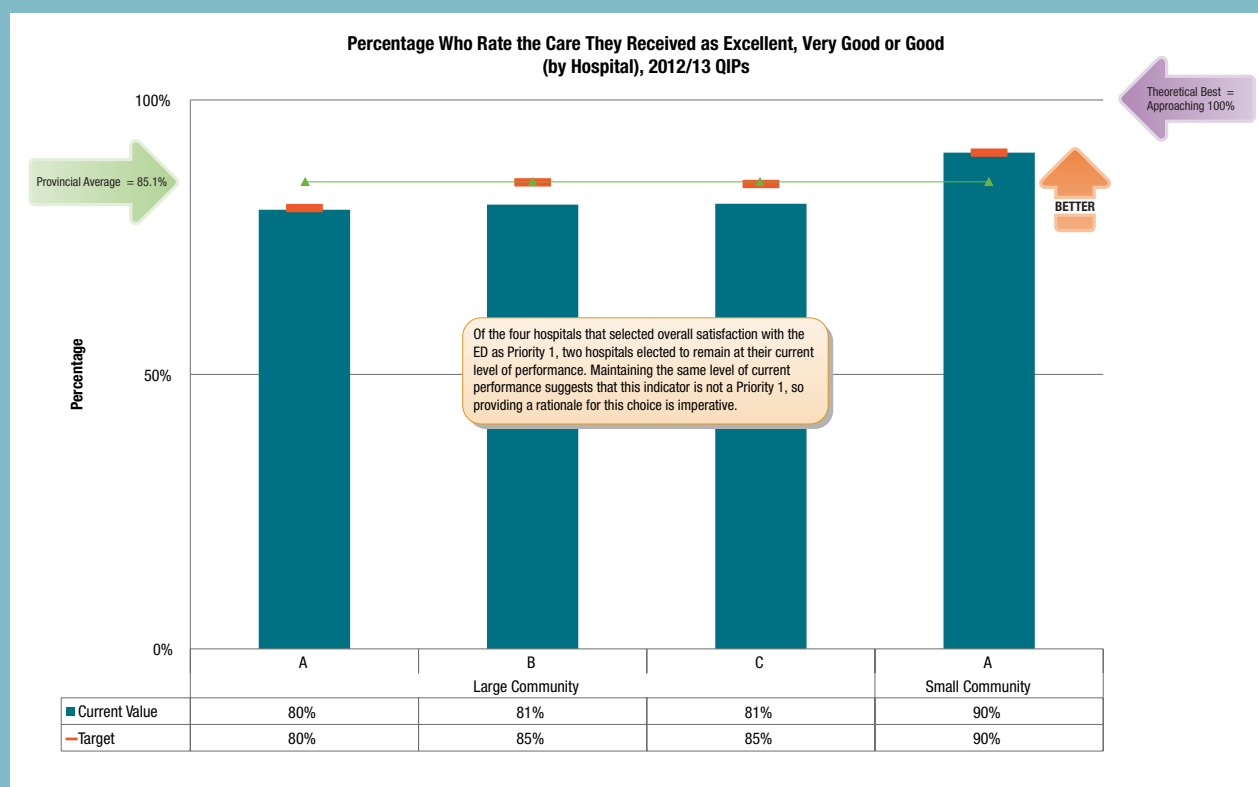
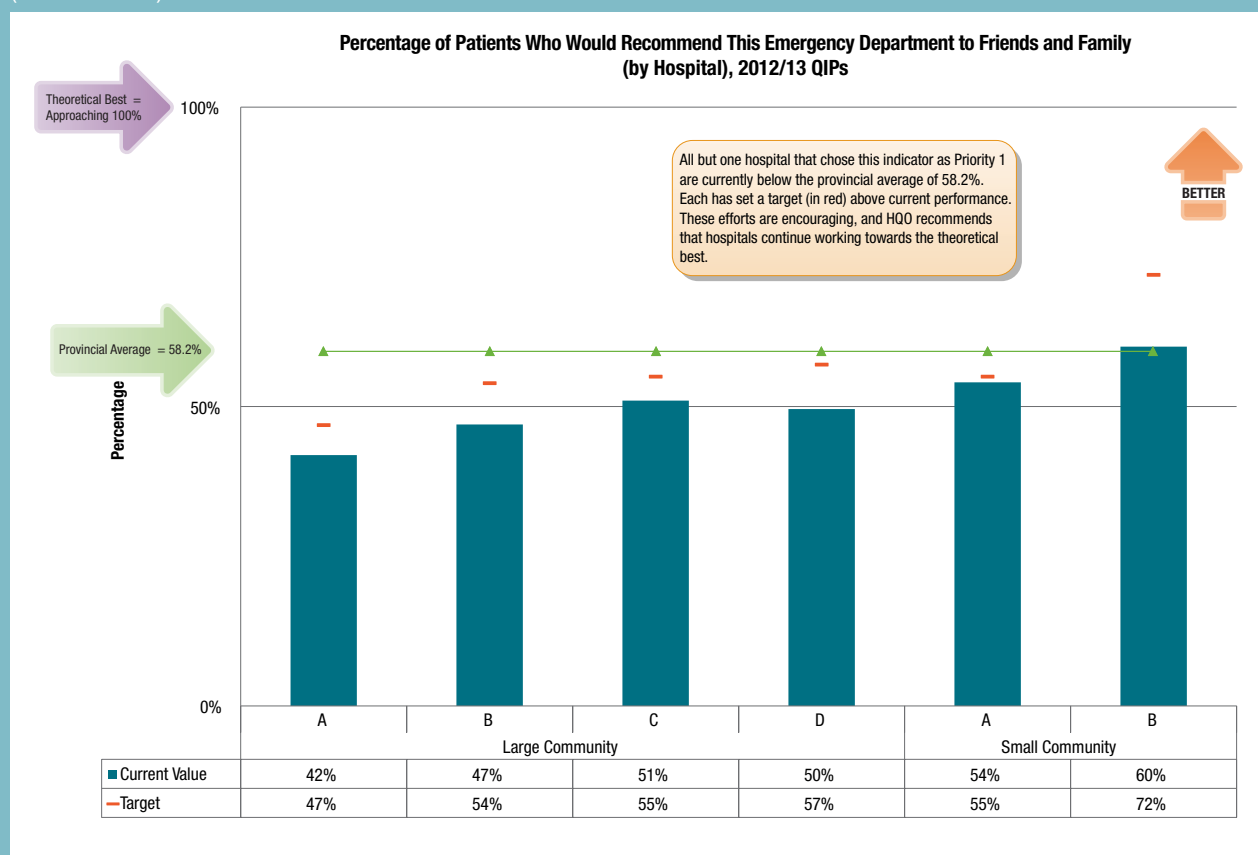


TABLE 27: CHANGE IDEAS TO IMPROVE PATIENT SATISFACTION

Change Concept	Change Sub-Category	Change Idea	Process Measure	Process Target	Hospital (Type)
Measurement and Feedback	Feedback to individual units	Highlight positive scores received from survey results to staff	Analyze survey results from January 2012 survey and develop quality improvement initiatives as required	None provided	Royal Ottawa Health Care Group (mental health)
	Monitor patient feedback and complaints	i) Rollout of client and family feedback application ii) Monitor Centralized Client and Family Feedback (compliments, suggestions and complaints) System	Compliments, suggestions and complaints are received from many sources and findings will be trended and shared with managers	None provided	Royal Ottawa Health Care Group (mental health)
	Frequent mini-surveys	No hospitals mentioned mini-surveys specifically, but this best practice should be considered by organizational leaders to help them gain timely and valuable insights into the delivery of healthcare services that patients receive, in order to better meet their needs and expectations. For more information on positive patient experience and on mini-surveys, please go to the HQO Quality Improvement Map Positive Patient Experience section (http://www.hqontario.ca/en/imap/positive.html). The tools area lists, among other material, an OHA guidance document on developing surveys.			
Processes	Teach back	Utilize a teach-back method to ensure patients understand what has been explained to them	Report to the Quality Patient Committee and Emergency Clinical Team	Goal is to improve access in the ED by fiscal year-end	Brockville General Hospital (large community)
	Written discharge instructions	Provide clear, written discharge instructions to patients regarding medication, aftercare instructions at home and follow-up plans	Report to the Quality Patient Committee and Emergency Clinical Team	1) Reduce complaints 2) Improve NRC Picker evaluations 3) Increase response to NRC Picker Satisfaction Questionnaires	Brockville General Hospital (large community)
	Whiteboards	Whiteboards for communication to patient and family of the names of care providers, expected discharge date, needs, etc.	Number of times patients found this helpful (from the patient rounds question)	100%	The Royal Ottawa Health Care Group (mental health)

TABLE 27: CHANGE IDEAS TO IMPROVE PATIENT SATISFACTION (CONTINUED)

Change Concept	Change Sub-Category	Change Idea	Process Measure	Process Target	Hospital (Type)
Processes (continued)	Daily rounding with patients	Implement clinical tactics for service excellence across all inpatient units. Tactics include: hourly rounding, bedside shift reporting, care boards and patient rounding by leaders. The introduction of these best practices will ensure patients are well informed and engaged in their care process	Adoption of the clinical tactics will be measured quarterly; compliance with hourly rounding will be monitored using bedside rounding logs daily for first three months and then quarterly by audit	100% adoption by March 2013	The Ottawa Hospital (acute teaching)
	Patient Engagement	Patient and family advisory councils Patient Advisory Council Patient Feedback Monitoring System renewal Patient Experience Task Force Implementation of family-centred care	1) Measurement and evaluation of patient complaints and compliments 2) New role in place and education to staff on patient- and family-centred care 3) Data utilization with enhanced system to monitor complaints and compliments 4) Creation of targeted strategies to address themes identified	For enhanced provision of family-centred care and a model that is proactive in anticipating and responding to patient and family needs	London Health Sciences Centre (acute teaching)
Focus groups		Conducting focus groups of ED users to identify recommendations from the patients' perspective; involve the patient/family/friend, and respect patient preferences	Report to the Quality Patient Committee and Emergency Clinical Team	1) Our goal is to reduce complaints 2) Improve NRC Picker evaluations 3) Increase response to NRC Picker Satisfaction Questionnaires	Brockville General Hospital (large community)

TABLE 27: CHANGE IDEAS TO IMPROVE PATIENT SATISFACTION (CONTINUED)

Change Concept	Change Sub-Category	Change Idea	Process Measure	Process Target	Hospital (Type)
Skills Development and Verification	Customer service training	Education of leaders on use of data management system for patient feedback	1) Measurement and evaluation of patient complaints and compliments	For enhanced provision of family-centred care and a model that is proactive in anticipating and responding to patient and family needs; decrease number of complaints related to communication and courtesy	London Health Sciences Centre (acute teaching)
		Customer service training to ED clerks as pilot for service delivery	2) New role in place and education to staff on patient- and family-centred care		
Resources	Designated staff for patient experience	Patient-experience "20-Minute Workout" coaching sessions	3) Data utilization with enhanced system to monitor complaints and compliments	Sunnybrook Health Sciences Centre (acute teaching)	
			4) Creation of targeted strategies to address themes identified		
Incentives	Leadership attention/ walkabouts	Implement Patient Advocate role to establish Patient- and Family-Centred Care Steering Committee; creation of Office of Patient Experience; new Patient Experience Senior Consultant role	Develop first 20-minute Workout session (mini-coaching forums to be conducted on the patient care units with staff) on conflict management	Data review included in 100% of monthly steering committee meetings	Bluewater Health (large community)
			Conduct a minimum of two walkabouts per month		
Incentives	Leadership attention/ walkabouts	Continue with patient safety leadership walkabouts	Conduct a minimum of two walkabouts per month	Demonstrated leadership support to improve quality of care and patient safety and identify areas to improve safety and quality of care	Royal Ottawa Health Care Group (mental health)
			Conduct a minimum of two walkabouts per month		

TABLE 27: CHANGE IDEAS TO IMPROVE PATIENT SATISFACTION (CONTINUED)

Change Concept	Change Sub-Category	Change Idea	Process Measure	Process Target	Hospital (Type)
Incentives (continued)	Tie to executive compensation	Many hospitals chose to tie patient satisfaction to executive compensation and referred to pay for performance			
	Assessment tools	Develop and implement ED nursing assessment tool to include patient education and assessment triggers; include accreditation guidelines for ED	Chart audit of ED patients	100% of ED charts with completed nursing assessment tool	Red Lake Margaret Cochenour Memorial Hospital (small community)
Decision supports	Checklist/ reminders	Redesign ED outpatient form to include documentation of discharge teaching and follow-up and who to call	Chart audits on documentation of instructions and follow-up calls for high-risk patients	75% of all charts will have discharge teaching instructions noted and follow-up plan	Dryden Regional Health Centre (small community)

Integrated: 30-Day Readmission Rate to Any Facility (Specific Case Mix Groups)

Eighteen hospitals chose 30-day readmission rate to any facility (specific case-mix groups) as Priority 1 and 74 hospitals chose it as any priority.

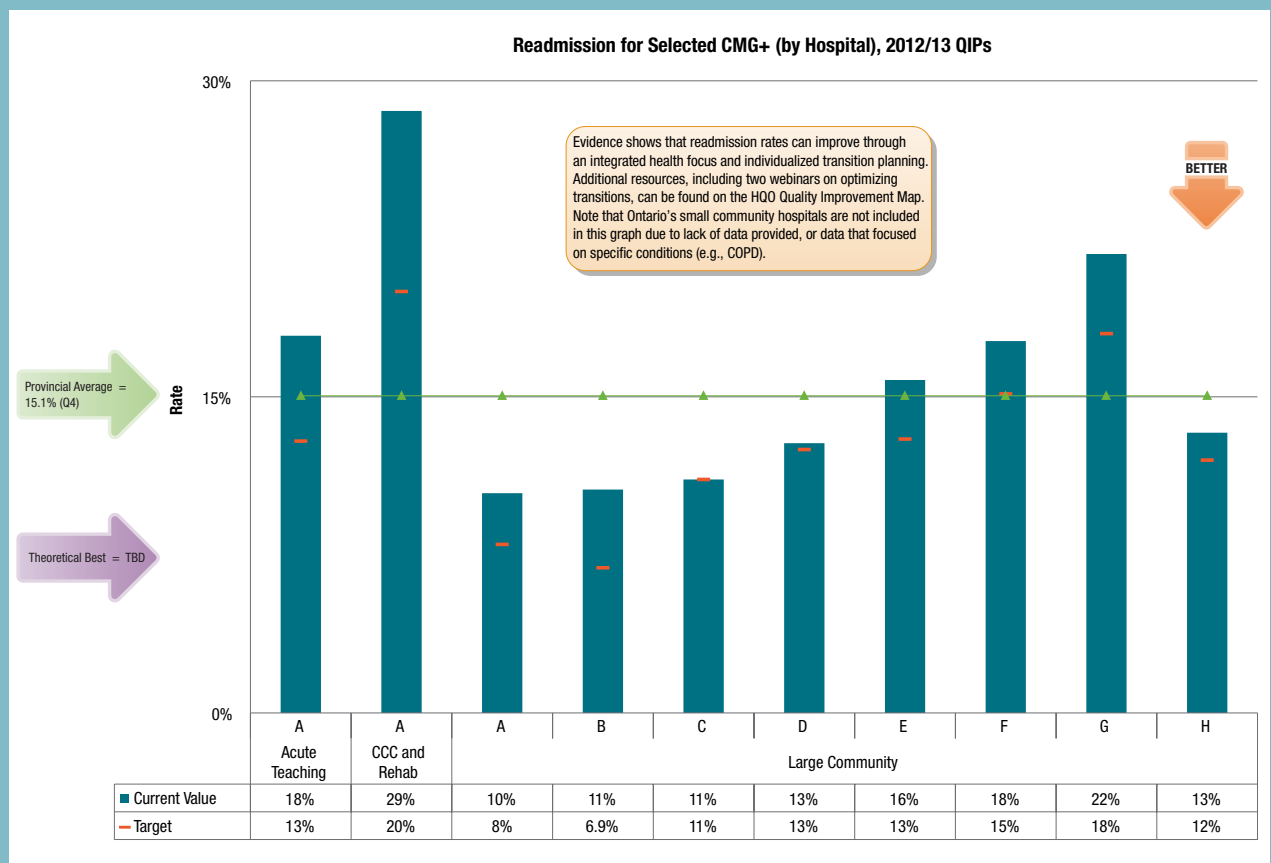
Definition

The 30-day readmission rate to any facility (specific case mix groups) is defined as readmission within 30 days for selected CMGs to any facility.

TABLE 28: 30-DAY READMISSION RATE TO ANY FACILITY TARGET SETTING, 2012/13 QIPS

Best Achieved to Date in Ontario	Theoretical Best	Provincial Average	Relative Improvement Targets by Hospitals That Selected as Priority 1		
			Average Target	Lowest Target	Highest Target
TBD		15.1% (Q4 2010/11)	18%	0%	35%

FIGURE 14: 30-DAY READMISSION RATE TO ANY FACILITY — CURRENT PERFORMANCE AND TARGETS WITHIN 2012/13 QIPS



Integrated: Percentage of Alternative Level of Care (ALC) Days

Thirty-six hospitals chose percentage of ALC days as Priority 1 and 103 hospitals chose it as any priority.

Definition

The percentage of ALC days is defined as the total number of inpatient days designated as ALC, divided by the total number of inpatient days.

TABLE 29: PERCENTAGE OF ALC DAYS TARGET SETTING, 2012/13 QIPS

Best Achieved to Date in Ontario	Theoretical Best	Provincial Average	Relative Improvement Targets by Hospitals That Selected as Priority 1		
			Average Target	Lowest Target	Highest Target
0% for acute teaching, large community, small community and mental health; 2% for CCC (<5)	Zero	17% FY 2010	10%	-97%*	64%

*Negative values reflect the fact that some hospitals set targets that were lower than baseline performance.

FIGURE 15: PERCENTAGE OF ALC DAYS — CURRENT PERFORMANCE AND TARGETS WITHIN 2012/13 QIPS

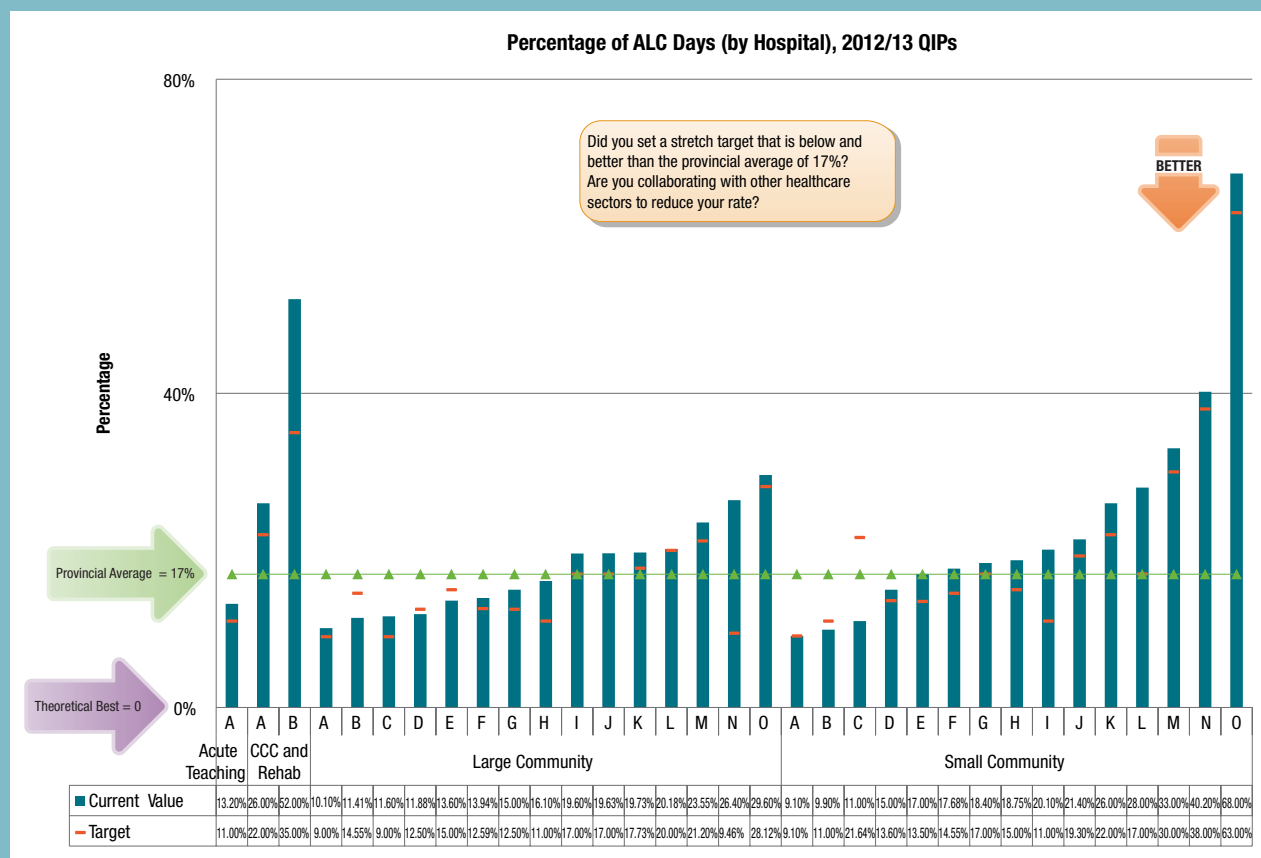


TABLE 30: CHANGE IDEAS TO IMPROVE PERCENTAGE OF ALC DAYS

Change Concept	Change Sub-Category	Change Idea	Process Measure	Process Target	Hospital (Type)
Measurement and Feedback	Feedback ALC, other data to providers	Monitor the use of the DASH tool implementation, ensuring patients are placed in the right level of care	Percentage of people placed into an LTC home who do not have high or very high needs for LTC services as measured using the MAPLe scores	Baseline: 31% (2009/10)	North Bay Regional Health Centre (large community)
Processes	Home First (aim to discharge to home, make decision on LTC from home, avoid discharging directly to LTC)	Discharges to LTC must be reviewed by the interprofessional Discharge Review Team, which includes senior management, CCAC Manager of Client Services and the discharge planner	95% of clinical staff who work on the inpatient units are educated on the Discharge Review Committee	Within 90 days	Glengarry Memorial Hospital (small community)
	Risk assessment	Work with family doctors and FHTs to complete risk assessments on their patients for early detection and intervention	Quarterly audits	Have the right patient receiving the right care in the right place, which contributes to the effectiveness and efficiency of the healthcare system as a whole	Manitoulin Health Centre (small community)
	Intensive case management	1) Intensive case management review (ICMR) process completed in collaboration with CCAC and patients/families to ensure barriers to discharge home are identified and addressed 2) Introduction of joint meetings between CCAC and HHS social workers 3) Development of tools to assist staff in understanding roles and timelines of ICMR processes	None listed	1. ICMR process completed on 100% of identified patients 2. Three joint meetings in 2012/2013 3. Tools completed July 2012	Hamilton Health Sciences (acute teaching)

TABLE 30: CHANGE IDEAS TO IMPROVE PERCENTAGE OF ALC DAYS (CONTINUED)

Change Concept	Change Sub-Category	Change Idea	Process Measure	Process Target	Hospital (Type)
Processes (continued)	Rehabilitation/ deconditioning programs	Improvement in patients' functional status and quality of life through the use of Assess/Restore Beds. This will prepare patients to recover strength, endurance and functioning for discharge home or another appropriate residential setting	As per the assess and restore initiative	None listed	Timmins and District Hospital (large community)
		Optimize utilization of rehab services and beds to prevent patient decomposition following admission to hospital	Review of program parameters, physical space, resource requirements	Assess and restore program plan will be developed by May 1, 2012	West Parry Sound Health Centre (small community)
	Access to community services	Work with community agencies to expedite access to home care, assisted living in the home through VON, LTC	Quarterly audits	Have the right patient receiving the right care in the right place, which contributes to the effectiveness and efficiency of the healthcare system as a whole	Manitoulin Health Centre (small community)
		1) Explore cluster-care model 2) Conduct community inventory 3) Identify gaps 4) Confirm community priorities with community support organizations 5) Development of care continuum with all local care providers 6) Utilize and monitor Home First model	Reported quarterly to board and clinical team	• Complete inventory of community support services • Community strategy to address gaps • Process for individuals to navigate the community system • Continuation of Home First process	Winchester District Memorial Hospital (small community)

TABLE 30: CHANGE IDEAS TO IMPROVE PERCENTAGE OF ALC DAYS (CONTINUED)

Change Concept	Change Sub-Category	Change Idea	Process Measure	Process Target	Hospital (Type)
Processes (continued)		Implement a Behavioural Support Ontario Program to be more responsive to the behaviours of the elderly in order to keep them in the right place	As per the Behavioural Support Ontario initiative		Timmins and District Hospital (large community)
	Improve access to community services to prevent returns to ED	Maximize referrals to the General Internal Medicine Rapid Access Outpatient Clinic (GIMRAOC) by providing quarterly data to GIM and ED physicians regarding their referral rate to the GIMRAOC.	Percentage increase in the number of new visits to GIMRAOC over 2011/12	5% improvement over 2011/12	Hamilton Health Sciences Centre (acute teaching)
		Building on the success of the Rapid Referral Clinic for assessment and management of medical patients to avoid inpatient admissions, a feasibility study will be initiated for additional clinics for cancer and cardiac patients	Tracking the number of General Medicine admissions averted by the Rapid Referral Clinic	Completion of feasibility study	Sunnybrook Health Sciences Centre (acute teaching)

TABLE 30: CHANGE IDEAS TO IMPROVE PERCENTAGE OF ALC DAYS (CONTINUED)

Change Concept	Change Sub-Category	Change Idea	Process Measure	Process Target	Hospital (Type)
Processes (continued)	Integrated discharge planning	Work with the CSS System Navigator to liaise with assisted living providers, CSS, CCAC and mental health and additions providers to coordinate assessments/re-assessments to support integrated discharge planning in line with the Home First philosophy	As per the Home First and Integrated Discharge Planning work	None listed	Timmins and District Hospital (large community)
		Discharge planning: Assistance of Aging at Home Coordinator and Aboriginal Navigator in discharge planning	Weekly meetings	None listed	Hôpital Notre-Dame Hospital (small community)
		Falls prevention in community	Partner with and target retirement home and LTC facilities with falls prevention practices/tools to address the results of a review of ED admits from LTC/retirement homes primarily due to falls	100% of toolkits distributed	North Bay Regional Health Centre (large community)
Skills	Staff training	Educate all nurses that 100% of patients who are ALC must be referred to the CCAC for consult	Percentage of ALC patients referred to CCAC	100%	Glengarry Memorial Hospital (small community)
		Educate all staff on flow processes, Medworxx and expectations	Train all nursing staff in the standard work process and behavioural expectation associated with transfer or care	90% of nursing staff trained in standard work processes, flow goals and expectation by Q3 2012/13. 100% of new nursing staff oriented at “new hire” orientation	Leamington District Memorial Hospital (small community)

TABLE 30: CHANGE IDEAS TO IMPROVE PERCENTAGE OF ALC DAYS (CONTINUED)

Change Concept	Change Sub-Category	Change Idea	Process Measure	Process Target	Hospital (Type)
Resources	Plan for community geriatric services	Use secured funding and consultant to prepare a district specialized geriatric services plan to identify system funding gaps and opportunities	Complete by April 2012 and submit to the LHIN	100% complete	North Bay Regional Health Centre (large community)
	Supportive housing/safe housing	We will continue to work with physicians and community partners to ensure all supports are available to be utilized to the fullest extent to encourage safe and timely discharge from hospital. This includes timely implementation of discharge planning processes and application for LTC placement if appropriate or assistance to find suitable social housing as required. Our success is highly correlated to the availability of community care services and supports, availability of appropriate placement of individuals into LTC homes, suitable geared-to-income social housing, safe housing for those with mobility impairments and cooperation with the entire continuum of care	Weekly monitoring of ALC bed utilization reported to LHIN, monitoring of LTC wait lists, weekly review of all ALC patients during multidisciplinary meetings with physicians and care team; sharing of data with MAC	ALC rates will continue to be higher as there are many mitigating factors: limited appropriate housing, 0% vacancy in all LTC homes with waiting lists, insufficient primary care physicians in the community and use of locum hospitalists in the hospital, gaps in services for mental health and addictions care, as well as limited availability of home care supports	Kirkland District Hospital (small community)
Patient Engagement	Assist family caregivers (help them continue to support patient in community)	Training sessions for family members and caregivers who assist seniors in the community	Sessions for 25 participants	None listed	Hôpital Notre-Dame Hospital (small community)

North Bay Regional Health Centre produced an excellent change plan in support of ALC reduction (see Table 31).

TABLE 31: NORTH BAY REGIONAL HEALTH CENTRE'S CHANGE PLAN FOR ALC REDUCTION

Aim		Measure			
Quality Dimension	Objective	Measure/Indicator	Current Performance	Target for 2012/13	Target Justification Level
Integrated	Reduce unnecessary time spent in acute care	Percentage ALC days: Total number of inpatient days designated as ALC, divided by the total number of inpatient days	23.55% average, Jan.-Dec. 2011, North East Local Health Integration Network (North East LHIN)	21.2% average, Jan.-Dec. 2012, North East LHIN	10% average reduction towards meeting the North East LHIN target of 17%
Change Plan					
Planned Improvement Initiatives (Change Ideas)		Methods and Process Measures	Goal for Change Ideas (2012/13)	Comments	
Continue to expand the HELP program through volunteer recruitment		Number of new volunteers participating in HELP program	14+ volunteers to allow for ongoing recruitment due to turnover	The ALC initiatives are linked to the 2012-13 Senior Friendly Hospital Action and Implementation Planning Process through the North East LHIN	
Improve awareness of the Geriatric Day Program available in OP Rehab to stakeholders, physicians' offices and community Fall Prevention Program ("Stay on Your Feet") by providing scheduled information sessions for them		Average number of monthly referrals received	Five referrals per month		
Develop and implement a Patient Flow Coordinator position		Implement by June 2012	100% complete		
Evaluate, assess and restore and use lessons learned to drive improvement		Percentage of patients discharged home within 90 days	60%		
Complete value stream mapping of the hospital discharge planning process including utilization, community partners and discharge planners, and use to drive process improvement		Complete by June 2012	100% complete		
Develop a hospital-wide process for integrated discharge planning/ALC designation so all processes are aligned post-amalgamation		Complete by June 2012	100% complete		
Develop an online hospital discharge summary for use in the ED, CCAC and physician's offices, including the discharge plan		Complete by January 2013	100% complete		

TABLE 31: NORTH BAY REGIONAL HEALTH CENTRE'S CHANGE PLAN FOR ALC REDUCTION (CONTINUED)

Change Plan (continued)			
Planned Improvement Initiatives (Change Ideas)	Methods and Process Measures	Goal for Change Ideas (2012/13)	Comments
Integrate discharge planning with CCAC	Complete by June 2012	100% complete	
Develop and implement a Behavioural Response Team to address screening, team/family training and patient discharge to home and/or community	Complete by June 2012	100% complete	We are partnering with NE Behavioural Support Ontario to develop baseline and performance measures to evaluate effectiveness of behavioural response team
Continue to expand and build upon ISAR	Number of patients >69 years old seen by the Social Worker/Discharge Planner in ED		
Implement Seniors' Mental Health Integrated Services to expedite patients through transition/placement to community	Complete by June 2012	100% complete	At this time we have partnered with similar services in Southern Ontario to find a tool that measures the effectiveness of the service and all are struggling. Ongoing work to collect measures as per our Medical Director with ongoing monitoring
Use secured funding and consultant to prepare a district specialized geriatric services plan to identify system funding gaps and opportunities	Complete by April 2012 and submit to the LHIN	100% complete	
Continue to expand general practitioner (GP) recruitment strategies	Number of new GPs recruited	Minimum number = 4	

TABLE 31: NORTH BAY REGIONAL HEALTH CENTRE'S CHANGE PLAN FOR ALC REDUCTION (CONTINUED)

Change Plan (continued)			
Planned Improvement Initiatives (Change Ideas)	Methods and Process Measures	Goal for Change Ideas (2012/13)	Comments
Monitor the use of the DASH tool implementation, ensuring patients are placed in the right level of care	Percentage of people placed into a LTC home who do not have high or very high needs for LTC services as measured using the MAPLe scores	Baseline: 31% (2009/10)	
Develop a LHIN-wide policy for consistency of LTC placement and access to beds across LHIN if beds are available elsewhere	Complete by March 2013	100% complete	
Develop an expedited process that is built on predetermined indicators to enable a community response to hospital over-capacity to enact the C1A designation	Complete by March 2013	100% complete	
Partner and target retirement home and LTC facilities with falls prevention practices/tools to address the results of a review of ED admits from LTC/retirement homes primarily due to falls	Percentage of identified facilities to which toolkits/practices distributed	100% of toolkits distributed	
Continue to participate on LHIN and community committees, e.g., Interim Strategies, to facilitate patient flow/patient strategies	Percentage of NBRHC represented on Interim Strategies Committee	75% attendance	

Conclusion

This *Analysis for Improvement* highlighted many of the successes achieved across quality improvement domains over 2011/12 and the excellent work that hospitals put into creating their quality improvement plans for 2012/13, as required under ECFAA. Many hospitals developed effective QIPs that identified clear aims aligned with strategic priorities, included measures and motivational targets, and provided change plans that lead towards improvement.

Although a number of hospitals identified bold aims and innovative ideas for change, others did not set clear priorities or goals, achievable stretch targets or comprehensive change ideas. This analysis of the QIPs is a learning tool that will help all Ontario hospitals going forward — to share innovative change ideas, effective strategies and success stories, to communicate progress achieved and to highlight continued areas for improvement.

Moving forward, we hope to see greater improvements in hospitals' QIPs, which will result in continued improvement and success for hospitals: Patients will experience and receive better care and better outcomes, and hospitals will achieve success by providing the right care in the right place at the right time. In the future, more detailed change plans, stretch targets and better data quality will enable HQO to evaluate progress, broker improvement and catalyze spread.

HQO expects that hospitals will continue to use their QIPs to drive performance improvement, and to ensure that they are focusing on key priority areas.

Congratulations to all Ontario hospitals for their continued efforts this year. Their hard work and commitment to developing effective QIPs are laying the groundwork for improved quality across the Ontario healthcare system.

Appendix A: Suite of Capacity-Building Supports

ECFAA (<i>Excellent Care for All Act</i>)	
HQO Strategic Roles • Focus system on common agenda • Build evidence of knowledge • Broker improvement • Catalyze spread • Evaluate progress	HQO Functional Roles for Capacity Building • Facilitate • Dissemination of change ideas, effective strategies and QI success stories through using the resources below

RESOURCES FOR CAPACITY BUILDING

HQO Quality Improvement Map: An online tool created to help hospitals develop their quality improvement plans. The Quality Improvement Map is a source for best practice change ideas and provides links to recommended resources. See <http://www.hqontario.ca/en/ecfaa.html>.

2012/13 Quality Improvement Plans: An Analysis for Improvement: This report communicates progress achieved and highlights continued areas for improvement for hospital QIPs.

HQO QIP Specialists: The QIP Specialist works with partners and hospitals to support the development of QIPs. To connect with a QIP specialist, send an email to QIP@hqontario.ca.

HQO's live web-based learning opportunities: These sessions are facilitated on a variety of improvement topics. We encourage you to suggest topics of interest for the future. You can join our email list and receive notification of upcoming events by sending an email to QIP@hqontario.ca.

Peer-to-Peer QIP feedback: The proposed Plan–Do–Study–Act cycle is set to begin in fall 2012. HQO is working with partners to identify opportunities to facilitate regional peer-to-peer QIP feedback sessions.

Institute for Healthcare Improvement (IHI) Open School: The school offers a vast array of QI supports through its website, www.IHI.org. HQO is providing an opportunity to enroll two employees from each hospital in IHI Open School improvement courses for health professionals, designed for the next generation of leaders. To enroll, contact us at QIP@hqontario.ca.

Mentorship Program: The Ontario Hospital Association (OHA) and the Canadian Health Care Risk Management Network (CHRMN) are offering individuals an opportunity to participate in a Patient Safety, Quality and Risk Management Mentorship Program. See www.oha.com/SERVICES/PATIENTSAFETY/Pages/QualityandPatientSafetyMentorshipProgram.aspx.

HQO Capacity-Building Linkages

- **HQO Integrated Program Delivery Branch**
 - **Access and Chronic Disease:** As part of its work to foster quality improvement capacity in Ontario's healthcare system, HQO offers improvement initiatives in Advanced Access, Efficiency and Chronic Disease Management in Primary Care. See www.hqontario.ca/en/supporting_qi_pc.html.
 - **bestPATH:** Quality improvement coaches facilitate health system integration for participating communities. bestPATH products include evidence-informed best practices for transitions in care targeted to reduce avoidable rehospitalizations.
 - **Long-Term Care:** Residents First is a provincial quality improvement initiative that supports all Ontario long-term care homes in providing safe, effective and responsive care to their residents. See www.hqontario.ca/en/supporting_qi.html.
- **HQO Evidence Development and Standards Branch:** HQO's Evidence Development and Standards (EDS) team works with clinical experts, scientific collaborators and field evaluation partners to conduct evidence-based analyses to evaluate the effectiveness and cost-effectiveness of health technologies and services in Ontario. Based on the results of EDS's evidence-based analyses, the Ontario Health Technology Advisory Committee (OHTAC) — a standing advisory sub-committee of the HQO Board — makes recommendations about the uptake, diffusion, distribution or removal of health interventions to Ontario's Ministry of Health and Long-Term Care, clinicians, health system leaders and policy-makers. See www.hqontario.ca/en/mas/mas.html.
- **HQO Health System Performance Branch:** As part of HQO's mandate, the health system performance (HSP) team monitors and reports to the people of Ontario on access to publicly funded health services, health human resources in publicly funded health services, consumer and population health status and health system outcomes. The primary vehicles for evaluating progress are the *Quality Monitor* and the comprehensive suite of public reporting websites. HSP is also active with other projects related to primary care performance measurement, benchmarking of key quality indicators, and the development and alignment of indicators for monitoring and reporting on the quality improvement initiatives supported by HQO. See www.hqontario.ca/en/framework.html.

Other Support Organizations

- **Local Health Integration Networks (LHINs)** plan, fund and integrate health service locally and develop LHIN-specific Integrated Health Service Plans (IHSPs). Consequently, the LHIN IHSPs differ from one LHIN to the next, since each is tailored to local health services needs and priorities. See www.lhins.on.ca.
- **Professional organizations**, including the Ontario Hospital Association, Association of Family Health Teams Ontario, etc.
- **The Quality Healthcare Network** is a community-based, not-for-profit organization with a mission to elevate system performance through collaborative and innovation means. See www.QHN.ca.
- **Accreditation Canada** provides program-specific standards, tools and processes. See www.accreditation.ca.
- **The Canadian Patient Safety Institute** is a national not-for-profit organization that raises awareness and facilitates implementation of ideas and best practices to achieve a transformation in patient safety. See www.patientsafetyinstitute.ca/English/Pages/default.aspx.
- **The Institute for Safe Medication Practices Canada** is an independent, national not-for-profit organization committed to the advancement of medication safety in all healthcare settings. See www.ismp-canada.org.

Appendix B: Technical Report

INTRODUCTION

The purpose of the Technical Report is to provide public access to details of the process used to generate indicator results. This information will be useful to others interested in replicating the indicators presented. Further details on the process and methods used to select the indicators on the Health Quality Ontario (HQO) website can be obtained from HQO.

DATA SOURCES

The indicator results presented were provided to HQO by several sources, including the Canadian Institute for Health Information (CIHI), the Ontario Hospital Association (OHA) and the Ministry of Health and Long-Term Care (MOHLTC).

Discharge Abstract Databases (DAD)

DAD is a data collection tool used by CIHI to collect information on patients treated in acute care facilities. DAD contains administrative, clinical and demographic data. CIHI receives data directly from acute care facilities or from their respective health/regional authority or ministry/department of health.

Ontario Mental Health Reporting System (OMHRS)

OMHRS data are sourced from the Resident Assessment Instrument-Mental Health (RAI-MH), a unique standardized data collection system for mental health. OMHRS contains data about individuals admitted to adult mental health beds in Ontario. The data are collected at admission, discharge and every three months for patients with extended stays.

National Ambulatory Care Reporting System (NACRS)

NACRS is a data collection tool developed by CIHI to capture information on patient visits to hospital- and community-based ambulatory care facilities. NACRS data used in this report are collected on a routine basis by all emergency departments (EDs) in Ontario.

Continuing Care Reporting System (CCRS)

CCRS is a data collection tool developed by CIHI to capture demographic, clinical, functional and resource utilization information on individuals receiving continuing care services in hospitals or residential care facilities in Canada. Participating organizations also provide information on facility characteristics to support comparative reporting and benchmarking.

Critical Care Information System (CCIS)

CCIS is a data collection tool developed by MOHLTC to collect information on admitted ICU patients, interventions performed to address care needs and the utilization of critical care response teams.

Web-Enabled Reporting System (WERS)

WERS is an easy-to-use online tool developed by MOHLTC for the complete preparation and tracking of reports prepared by hospitals and other institutional users.

Ontario Hospital Reporting System (OHRS)

OHRS databases developed by MOHLTC provide the only integrated source of data on the actual financial and operational activities of hospitals in the province.

NRC Picker/Hospital Consumer Assessment of Healthcare Providers and Systems (HCAPHS)

NRC Picker/HCAPHS uses standardized surveys to capture patients' perspectives on the hospital care. This provides the public with comparable information on hospital quality.

OHA CLASSIFICATIONS

The following are brief descriptions of the five hospital types used in the current QIP report.

1. Acute Teaching Hospitals

Acute teaching hospitals are defined as those acute and pediatric hospitals that are members of the Council of Academic Hospitals of Ontario (CAHO). Member hospitals provide highly complex patient care, are affiliated with a medical or health sciences school and have significant research activity and postgraduate training. (Source: www.hospitalreport.ca/downloads/2007/AC/acute_report_2007.pdf.)

2. Large Community Hospitals

Large community hospitals encompass those hospitals not defined as small or teaching. (Source: www.hospitalreport.ca/downloads/2007/AC/acute_report_2007.pdf.)

3. Small Community Hospitals

Small community hospitals are defined according to the guidelines set by the former Joint Policy and Planning Committee (JPPC). In general, these hospitals are a single community provider and the total inpatient acute, CCC and day surgery-weighted cases are under 2,700, based on 2005/06 data. (Source: www.hospitalreport.ca/downloads/2007/AC/acute_report_2007.pdf.)

4. Complex Continuing Care Hospitals and Rehabilitation Hospitals

Complex continuing care (CCC) hospitals generally meet the following criteria: (a) do not have acute care patients; (b) report statistical, clinical and financial data separately (from other hospitals or facilities) to MOHLTC; (c) have their own chief executive officer (CEO) and board; and (d) are physically separate buildings. (Source: www.hospitalreport.ca/downloads/2007/CCC/ccr_report_2007.pdf.)

Rehabilitation hospitals provide rehabilitation in publicly funded designated adult rehabilitation beds, either in free-standing specialty inpatient rehabilitation hospitals or in beds or units designated for rehabilitation purposes that are part of a general hospital. This type of hospital does not include rehabilitation in acute care, outpatient settings or home-based settings. The facilities or units care for clients with a primary health condition that is physical in nature — e.g., stroke, orthopedic conditions, brain dysfunction, spinal cord dysfunction or amputation. (Source: www.hospitalreport.ca/downloads/2007/rehab/rehab_report_2007.pdf.)

5. Mental Health Hospitals

Mental health hospitals serve individuals with more complex treatment and behavioural-management needs, who typically require a longer length of stay. Specialty hospitals include both dedicated mental health hospitals and mixed-service hospitals (which also provide acute care for mental health and other conditions). Many specialty facilities are former provincial psychiatric hospitals. (Source: www.hospitalreport.ca/downloads/2007/MH/2007_MH_techman.pdf.)

FIGURE 1. NUMBER OF HOSPITALS BY OHA CLASSIFICATION (TOTAL = 145)

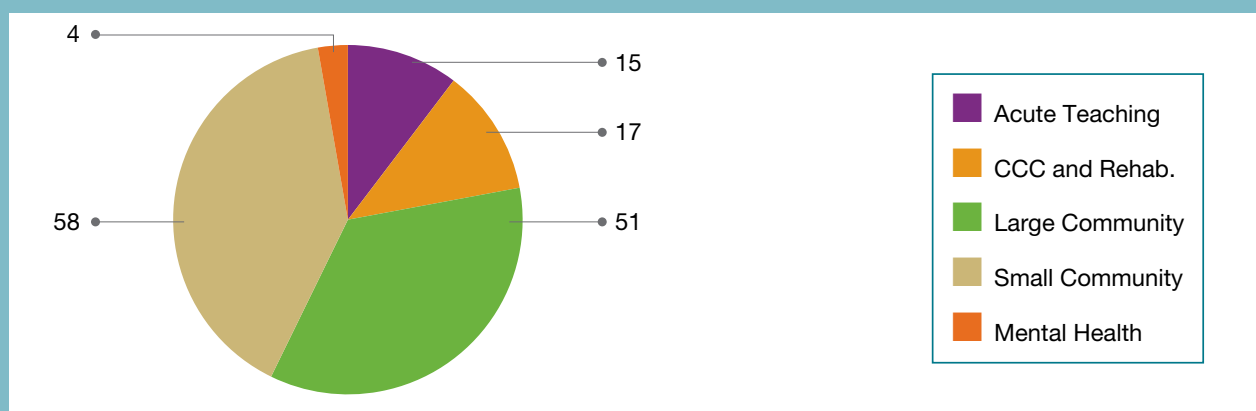


TABLE 1: TECHNICAL INFORMATION ON INDICATOR DEFINITIONS

Attribute	Indicator	Numerator	Denominator	Data Source
Safety	<i>C. difficile</i> infection (CDI) rate per 1,000 patient days	Inclusion: The CDI count is the number of new nosocomial cases of CDI by month	Inclusion: The denominator, patient days data, should be sourced from the hospital's daily bed census data	MOHLTC
	Overall			
	Acute teaching	Exclusion: children under one year of age	Exclusion: children under one year of age	
	Large community			
	Small community			
	Chronic/rehabilitation			
	Mental health			
Safety	Ventilator-associated pneumonia (VAP) rate per 1,000 ventilator days	Inclusion: The total number of newly diagnosed VAP cases in the ICU after at least 48 hours of mechanical ventilation	Inclusion: The number of ventilator days in that month	MOHLTC
	Overall		Ventilator days are the number of days spent on a ventilator for all patients in the ICU	
	Acute teaching	Exclusion: Any patient with a recorded incident of VAP within the first two calendar days of admission will be excluded	18 years and older	
	Large community			
	Small community			
	Chronic/rehabilitation			
	Mental health			
Safety	Hand hygiene compliance before patient contact	Number of times hand hygiene performed before initial patient/patient environment	Number of observed hand hygiene indications before initial patient/patient environment	MOHLTC
	Overall	contact by hospital type	contact by hospital type	
	Acute teaching			
	Large community			
	Small community			
	Chronic/rehabilitation			
	Mental health			
Safety	Rate of central line associated blood stream infections (CLI) per 1,000 central line days	Inclusion: Total number of newly diagnosed CLI cases in the ICU after at least 48 hours of receiving a central line	The number of central line days in that month, multiplied by 1,000	MOHLTC
	Overall		Central line days are the total number of days a central line was used in ICU patients 18 years and older	
	Acute teaching	Exclusion: Any patient admitted to the unit with an existing CLI		
	Large community			
	Small community			
	Chronic/rehabilitation			
	Mental health			

TABLE 1: TECHNICAL INFORMATION ON INDICATOR DEFINITIONS (CONTINUED)

Attribute	Indicator	Numerator	Denominator	Data Source
Safety	Percentage of CCC residents with new pressure ulcer in the last three months (stage 2 or higher)	Inclusion: If any of the following apply: • M1b>0 on the target assessment • M1c>0 on the target assessment • M1d>0 on the target assessment	Inclusion: All assessments for chronic patients in fiscal 2011/12 that meet general inclusion/exclusion criteria for incidence indicators Exclusion: If any of the following apply: M1b>0 on prior assessment M1c>0 on prior assessment M1d>0 on prior assessment M1b, M1c or M1d is missing on the prior assessment M1b, M1c or M1d is missing on the target assessment	CCRS, CIHI
	Overall			
	Acute teaching			
	Large community			
	Small community			
	Chronic/rehabilitation			
	Mental health			
Safety	Percentage of CC residents who fell in the last 30 days	Inclusion: If J4a=1 (fell in past 30 days) on the target assessment	Inclusion: All assessments for chronic patients in FY 2011/12 that meet general inclusion/exclusion criteria Exclusion: J4a is missing on the target assessment	CCRS, CIHI
	Overall			
	Acute teaching			
	Large community			
	Small community			
	Chronic/rehabilitation			
	Mental health			
Safety	Surgical safety checklist compliance	Number of times all three phases of the surgical safety checklist were performed	Total number of surgeries	MOHLTC
	Overall			
	Acute teaching			
	Large community			
	Small community			
	Chronic/rehabilitation			
	Mental health			

TABLE 1: TECHNICAL INFORMATION ON INDICATOR DEFINITIONS (CONTINUED)

Attribute	Indicator	Numerator	Denominator	Data Source
Safety	Physical restraints in mental health	Number of patients who are physically restrained at least one of the three days prior to a full admission	Total number of cases with a full admission assessment	OMHRS, CIHI
Effectiveness	Hospital standardized mortality ratio (HSMR) Overall Acute teaching Large community Small community Chronic/rehabilitation Mental health	Observed deaths or actual number of in-hospital deaths that occurred	Expected deaths or number of deaths that would have occurred in a hospital had the mortality of these patients been the same as the mortality of similar patients across the country, based on the reference year Inclusion: 1. Discharge between April 1 of a given year and March 31 of the following year 2. Admission to an acute care institution 3. Discharge with diagnosis group of interest (i.e., one of the diagnosis groups that account for approximately 80% of in-hospital deaths) 4. Age at admission between 0 and 120 years 5. Sex recorded as male or female 6. Length of stay up to 365 consecutive days 7. Admission category is elective or emergent/urgent 8. Canadian resident	DAD, CIHI

TABLE 1: TECHNICAL INFORMATION ON INDICATOR DEFINITIONS (CONTINUED)

Attribute	Indicator	Numerator	Denominator	Data Source
Effectiveness	Hospital standardized mortality ratio (HSMR)		Exclusion:	
	Overall		1. Cadavers	
	Acute teaching		2. Stillborns	
	Large community		3. Sign-outs (that is, discharged against medical advice)	
	Small community		4. Neonates (age of admission less than or equal to 28 days)	
	Chronic/rehabilitation		5. Records with brain death as most responsible diagnosis code	
	Mental health (continued)		6. Records with palliative care as most responsible diagnosis code	
Effectiveness	Total margin (consolidated)	Percentage by which total corporate (consolidated) revenues exceed or fall short of total corporate (consolidated) expenses, excluding the impact of facility amortization, in a given year		OHRS, MOHLTC
	Overall			
	Acute teaching			
	Large community			
	Small community			
	Chronic/rehabilitation			
	Mental health			
Access	ER wait times: 90th percentile ED length of stay for admitted patients	90th percentile ED length of stay for admitted patients.		NACRS, CIHI
	Overall	ED length of stay is defined as the time from triage to registration, whichever comes first, to the time the patient leaves the ED		
	Acute teaching			
	Large community			
	Small community			
	Chronic/rehabilitation			
	Mental health			

TABLE 1: TECHNICAL INFORMATION ON INDICATOR DEFINITIONS (CONTINUED)

Attribute	Indicator	Numerator	Denominator	Data Source
Patient-Centred	Would you recommend this hospital to your friends and family?	Number of respondents who responded “Yes, definitely” (NRC Picker) or “Definitely yes” (HCAHPS) to the question	Number of respondents who registered any response to this question (exclude non-respondents)	NRC Picker/ HCAPHS
	Overall, how would you rate the care and services you received at the hospital?	Number of respondents who responded “Excellent, very good and good” (NRC Picker)	Number of respondents who registered any response to this question (exclude non-respondents)	
	Overall			
	Acute teaching			
	Large community			
	Small community			
	Chronic/rehabilitation			
	Mental health			
Integrated	Readmission within 30 days for selected CMGs to any facility	The sum of readmissions for all index cases	Inclusion: Select all discharges among the selected CMGs with discharge dates for period in question and age restrictions as described in Inclusions section. Include only typical and outlier cases (based on DAD RIW exclusion indicator) among the index cases Acute inpatients in the specified CMGs, age restrictions are cohort specific The readmission hospitalization is deemed non-elective or unplanned if: a) the admission date is within 30 days of the index case discharge date	DAD, CIHI
	Overall			
	Acute teaching			
	Large community			
	Small community			
	Chronic/rehabilitation			
	Mental health			

TABLE 1: TECHNICAL INFORMATION ON INDICATOR DEFINITIONS (CONTINUED)

Attribute	Indicator	Numerator	Denominator	Data Source
Integrated	Readmission within 30 days for selected CMGs to any facility		b) the DAD field “admission category” is urgent	
	Overall		Exclusion: Deaths, transfers, patient sign-outs against medical advice, records with missing valid data on discharge/admission date, health number, age, gender	
	Acute teaching			
	Large community			
	Small community			
	Chronic/rehabilitation			
	Mental health			
	(continued)			
Integrated	Percentage of alternate level of care (ALC) days	Total bed days designated as ALC	Inclusion: Total inpatient days in the year	DAD, CIHI
	Overall		Exclusion: Invalid or missing discharge date from hospital, newborns, stillborns	
	Acute teaching			
	Large community			
	Small community			
	Chronic/rehabilitation			
	Mental health			

TABLE 2: FREQUENCY WITH WHICH A TOPIC WAS CHOSEN AS PRIORITY 1, FOR DIFFERENT TYPES OF HOSPITALS

Priority 1	Acute Teaching	CCC and Rehab	Large Community	Small Community	Mental Health	Province
CDI rate per 1,000 patient days	4	3	15	8	0	30
ED wait times for admitted patients	0	0	1	0	0	1
Falls	0	0	1	0	0	1
Hand hygiene compliance before patient contact	0	2	3	5	0	10
HSMR	0	3	3	6	0	12
NRC Picker/HCAPHS or in-house survey (if available)	2	0	2	4	0	8
Percentage ALC days	0	2	1	2	3	8
Pressure ulcers	2	0	4	0	0	6
Rate of central line blood stream infections per 1,000 central line days	5	8	24	24	1	62
Readmission within 30 days for selected CMGs to any facility	7	0	37	10	0	54
Total margin (consolidated)	0	0	1	0	0	1
VAP rate per 1,000 ventilator days	4	6	25	21	3	59

TABLE 3: FREQUENCY WITH WHICH A TOPIC WAS CHOSEN AS ANY PRIORITY (1, 2 OR 3) FOR DIFFERENT TYPES OF HOSPITALS

Any Priority	Acute Teaching	CCC and Rehab	Large Community	Small Community	Mental Health	Province
CDI rate per 1,000 patient days	11	12	34	34	0	91
ED wait times for admitted patients	7	0	25	6	0	38
Falls	8	0	24	6	0	38
Hand hygiene compliance before patient contact	2	8	15	19	0	44
HSMR	1	7	14	18	0	40
NRC Picker/HCAPHS or in-house survey (if available)	10	0	28	22	0	60
Percentage ALC days	1	4	16	5	4	30
Pressure ulcers	8	0	30	3	0	41
Rate of central line blood stream infections per 1,000 central line days	13	15	37	52	4	121
Readmission within 30 days for selected CMGs to any facility	10	0	50	36	1	97
Total margin (consolidated)	10	0	48	35	1	94
VAP rate per 1,000 ventilator days	0	0	2	1	0	3

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