Let's Make Healthy Change Happen.

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

3/31/2015

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

Ontario

Overview

Quality of care and optimal organizational performance occupy a prominent place in the mission and 2013-2016 strategic plan and operational initiative of our organization. We are aligned with a broader Ontario wide strategy that aims to provide the right evidence-informed health care at the right time and in the right place by producing system-level solutions and results.

The Excellent Care for All Act (ECFAA) received royal assent in June 2010. ECFAA is a key component of the broad strategy. Participation in the South West LHIN transformation agenda and fulfilling the hospital accountability agreement reflects our commitment to the delivery of high quality care. Accreditation Canada's standards for excellence, quality, safety and patient experience are also used to drive our performance.

To this end, our priority Indicators for 2014-15 QIP focus on readmission, emergency department visits, patient experience, medication management, receiving care in the right setting, hospital acquired infections, and the financial health of the organization. Further, the targets set for the defined indicators communicate the expected performance level for the organization, and focus the organization on improvement.

Integration & Continuity of Care

The South West LHIN is key partner for SBGHC in transforming the health system to better meet the needs of our communities and to ensure a healthier tomorrow. Transformation means collaborating with health service providers – long-term care homes, community support services and hospitals – in redesigning effective approaches in the delivery of health services and to integrate services for more seamless care.

To provide for a seamless continuum, our strategy sets out to promote partnership, engagement and connectedness with other Hospitals, Family Health Teams, Public Health, Community Care Access Centre, community support agencies (e.g., Community Mental Health Association), Emergency Medical Services, Gateway Rural Research, and local communities as the way to improve integration and continuity of care for the people we service.

To strengthen our commitment towards the delivery of high quality care, SBGHC's planned improvement initiatives for 2014-15 align with Ontario's health plan to deliver comprehensive, integrated system solutions to ensuring patients receive high quality, accessible, coordinated care. Examples of SBGHC improvement initiatives to improve access to care include coordinating primary care service alignment with our Family Health Teams, and participating in Home First implementation.

Challenges, Risks & Mitigation Strategies

The challenges in the execution of the QIP are as follows:

• Implementing system level initiatives involves partnering with other hospital and services in our network; this presents a challenge to manage within existing resources. Aligning QIP priority indicators with internal quality and performance indicators the organization uses to monitor strategic objectives needs to be established (e.g., quality of employee and physician work life; maternal child outcomes). Effective communication strategies will need to be developed to help

link the corporate and QIP goals to increase stakeholder awareness and improve performance transparency.

• The uncertain funding environment makes budget assumptions and business planning difficult.

• Implementing an automated collection of information process for priority indicator "medication reconciliation at admission". A custom application will need to be designed to support the automation of collecting and reporting of this measure across all levels of the organization.

Information Management

SBGHC allocates significant resources to analyze and understand the patient experience and clinical outcomes, the efficiency and effectiveness of internal processes, and patterns of patient utilization, including the acuity of cases. All services/departments at SBGHC are subject to reviews using clinical, administrative and financial data with a goal to improving overall performance. This information is shared at the department, senior management and board level for openness and transparency. When trends are identified an in-depth analysis is initiated to determine options to improve patient care. Data from the SBGHC patient safety incident management system is particularly helpful to quickly react to problems in patient care that may arise. SBGHC produces daily, weekly, monthly, and quarterly reports on utilization, acuity, infection control, incidents, and on specific service/department or corporate quality initiatives all with the goal of improving care.

Engagement of Clinicians & Leadership

The SBGHC leadership team works with clinicians as partners to address emerging priorities and achieve results. Key participants in the development of the QIP include the board, management team, and physician leadership (MAC). The Board Quality Committee and Board of Directors oversee development and implementation of the QIP. Service/department Quality and Performance Teams (with physician leads) reinforce priorities and monitor progress towards achievement of targets on scorecards. The employee performance management system is designed to support goals aligned with strategic objectives and scorecard indicators.

Patient/Resident/Client Engagement

The QIP was informed by the following:
- Patient Experience Surveys
- Patient Feedback System (compliment/complaint management)
- Patient representation on some service-level Quality Performance Committees (expanding to more in future)
- Patient Family Meetings

Accountability Management

The Excellent Care for All Act (ECFAA) makes it a legislated requirement of Hospital Corporations to tie Executive Level Compensation to the achievement of a Corporation's quality goals. The purpose of the performance-based compensation according to the legislation is to drive accountability for the delivery of key quality initiative that improves patient care. At SBGHC the Board takes this requirement and responsibility seriously. The Quality Improvement Committee receives progress reports at every meeting and provides a report and recommendations to the Board of Directors.

Performance Based Compensation [As part of Accountability Management]

The Chief Executive Officer, Chief Nurse Executive, Chief of Staff, Vice President of Finance and Corporate Services, and the Vice President of Human Resources and Support Services will have a portion of their salary held back (5%) pending the achievement of these goals (with the exception of Total Margin) due to ongoing budget negotiations with the SWLHIN and MOHLTC) which will be evaluated and awarded at the end of the 2014/15 fiscal year by the Board.

Health System Funding Reform (HSFR)

The introduction of Health System Funding Reform (HSFR) by the MOHLTC as a funding model for hospitals has influenced SBGHC to become efficient in the management of certain patient conditions. HSFR and Quality Based Procedures have established benchmarks for care that hospitals must recognize because of the financial impact it creates. For example, patient with chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF), and stroke now have funding ceilings for patient care. In the future, SBGHC will also be subject to surgical procedures that will have funding ceilings. Therefore, SBGHC is introducing health system best practice methods to improve quality of care and obtain greater efficiency in the management of patient care at SBGHC.

Other

None

Sign-off

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

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

Board Chair
Quality Committee Chair
Chief Executive Officer
CEO/Executive Director/Admin. Lead _____ (signature)
Other leadership as appropriate _____ (signature)

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

South Bruce Grey Health Centre 21 McGivern Street Box 1300

AIM		Measure							Change				
Quality dimension	Objective	Measure/Indicator	Unit / Population	Source / Period	Organization Id	Current performance	Target	Target justification	Planned improvement initiatives (Change Ideas)	Methods	Process measures	Goal for change ideas	Comments
Access	**Reduce wait times in the ED**	ED Wait times: 90th percentile ED length of stay for Admitted patients.	Hours / ED patients	CCO iPort Access / Jan 1, 2014 - Dec 31, 2014	946*	6.8	7	H-SAA<7.0 hours	1)• Coordinate Primary Care Service Alignment with our Family Health Teams • Adopt ED best practices related to improvement in	Review and analysis of implementation on a project progress report	% of initiatives implemented; monitored quarterly by Senior Management , Quality Performance Teams, MAC, and externally through the CCAC	100% compliance by end of fiscal year	
Effectiveness	**Improve organizational financial health**	Total Margin (consolidated): % by which total corporate (consolidated) revenues exceed or	% / N/a	OHRS, MOH / Q3 FY 2014/15 (cumulative from April 1, 2014 to December 31,	946*	-1.18	0	H-SAA requirement	1)Maintain performance	Not Applicable	Not Applicable	Not Applicable	
Integrated	**Reduce unnecessary time spent in acute care**	Percentage ALC days: Total number of acute inpatient days designated as ALC, divided by the total	% / All acute patients	Ministry of Health Portal / Oct 1, 2013 - Sept 30, 2014	946*	13.58	10.95	H-SAA	1)• Access to Care - participate in Home First implementation • Higher utilization of Assisted Living, Supportive Housing and	Review and analysis of implementation of initiatives using a project progress report	% of initiatives implemented; monitored quarterly by Senior Management , Quality Performance Teams, and MAC	100% compliance by end of fiscal year	
	Reduce unnecessary hospital readmission	Readmission within 30 days for Selected Case Mix Groups	% / All acute patients	DAD, CIHI / July 1, 2013 - Jun 30, 2014	946*	16.09	17.5	Prior year 18%	1)• Implement evidence base practices for targeted quality based procedures (QBPs) (Clinical Handbook for Chronic Obstructive	Review and analysis of implementation of initiatives using a Project Progress Report	% of initiatives implemented; monitored quarterly by Senior Management , Quality Performance Teams, MAC, and externally by Health Links Network (once established)	100% compliance by end of fiscal year	
Patient-centred	**Improve patient satisfaction**	From NRC Canada: "Would you recommend this hospital (inpatient care) to your friends	% / All patients	NRC Picker / October 2013 - September 2014	946*	95	90	Awaiting new tool to determine baseline and targets	1)NA	NA	NA	NA	To be developed once tool determined.
		Percentage of those who responded excellent, very good and good.	% / All acute patients	In-house survey / To Be Determined	946*	95	90	Awaiting new tool to determine baseline and target	1)To Be Determined	To Be Determined	To Be Determined	To Be Determined	To Be Determined
	Improve patient satisfaction ED	Percentage of those who responded excellent, very good and good.	% / ED patients	In-house survey / To Be Determined	946*	95.3	90	Awaiting new tool to determine baseline and target.	1)To Be Determined	To Be Determined	To Be Determined	To Be Determined	To Be Determined
Safety	**Increase proportion of patients receiving medication reconciliation upon admission**	Medication reconciliation at admission: The total number of patients with medications	% / All patients	Hospital collected data / most recent quarter available	946*	87	90	Performance below target in 2014-15.	1)Compliance with the medication reconciliation process is monitored and improvements are made when required	Review and analysis of implementation using data collected on an Excel spreadsheet	Medication reconciliation rate; monitored quarterly by Senior Management , Quality Performance Teams, and MAC	Rate of 90% or greater at all sites by end of fiscal year	