Let's Make Healthy Change Happen.

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

Cornwall Community Hospital
Hôpital communautaire de Cornwall

**03/06/2014**

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

## Overview

The CCH quality indicators selected to be a priority focus for the 2014/2015 QIP represent key indicators associated with patient safety, quality[1] and flow. Particular emphasis has been placed on obstetrical performance. The rationale underlying this emphasis is the Canadian Institute for Health Information (CIHI) Canadian Hospital Reporting Project (CHRP) results (2011-12) and more recent Ontario hospital peer benchmarking which has identified several obstetrical indicators where CCH's performance fell short of expectations. Further, the Better Outcomes Registry and Network (BORN) Ontario Maternal Newborn Dashboard has mirrored these findings.

| QIP 4 (2014/2015) Performance Indicators | Priority Level |
|---|---|
| a. Clostridium Difficile Infection Rate | MOHLTC Priority |
| b. Hospital Total Margin | MOHLTC Priority |
| c. ED LOS for Admitted Patients (90$^{th}$ percentile) | MOHLTC Priority |
| d. 30-Day Readmission Rate to Any Facility | MOHLTC Priority |
| e. 5-Day In-Hospital Mortality Following Major Surgery | MOHLTC Additional |
| f. Caesarean Section Rate | OBGYN/WCHP PIP |
| g. Vaginal Birth After Caesarean Section Rate | OBGYN/WCHP PIP |
| h. Episiotomy Rate | OBGYN/WCHP PIP |
| i. Patients Breastfeeding at Discharge Rate | OBGYN/WCHP PIP |
| j. WCHP Patient Satisfaction[2] | OBGYN/WCHP PIP |

## Integration & Continuity of Care

It is anticipated that the following indicators will act as proxy for the effectiveness of CCH's and our partners' initiatives promoting integration and continuity of care. For example:

a. building capacity and ensuring timely access to hospital-based clinics and community primary care services providing chronic disease management, targeting those patients who have experienced multiple acute exacerbations leading to hospitalization; and,
b. CCH and Public Health Unit joint venture to deliver pre-natal programming in combination with the launch of CCH Baby-Friendly Hospital Initiative (BFHI), including but limited to, ensuring full compliance with standards for maternity services to protect, promote and support breastfeeding.

| QIP 4 (2014/2015) Performance Indicators | Priority Level |
|---|---|
| a. 30-Day Readmission Rate to Any Facility | MOHLTC Priority |
| b. Caesarean Section Rate | OBGYN/WCHP PIP |
| c. Patients Breastfeeding at Discharge Rate | OBGYN/WCHP PIP |
| d. WCHP Patient Satisfaction | OBGYN/WCHP PIP |

[1] In addition to the Excellent Care for All Act, 2010 definition of a high quality health care system, CCH has adopted the National Health Service (NHS) definition of quality: care that is effective, safe and provides as positive an experience as possible" (Quality in the New Health System, 2013, p. 4).

[2] Currently evaluating several survey instruments, including the MOREOB Patient Satisfaction Survey and Birth Satisfaction Scale - Revised (BSS-R), target start date = March, 2014.

## Challenges, Risks & Mitigation Strategies

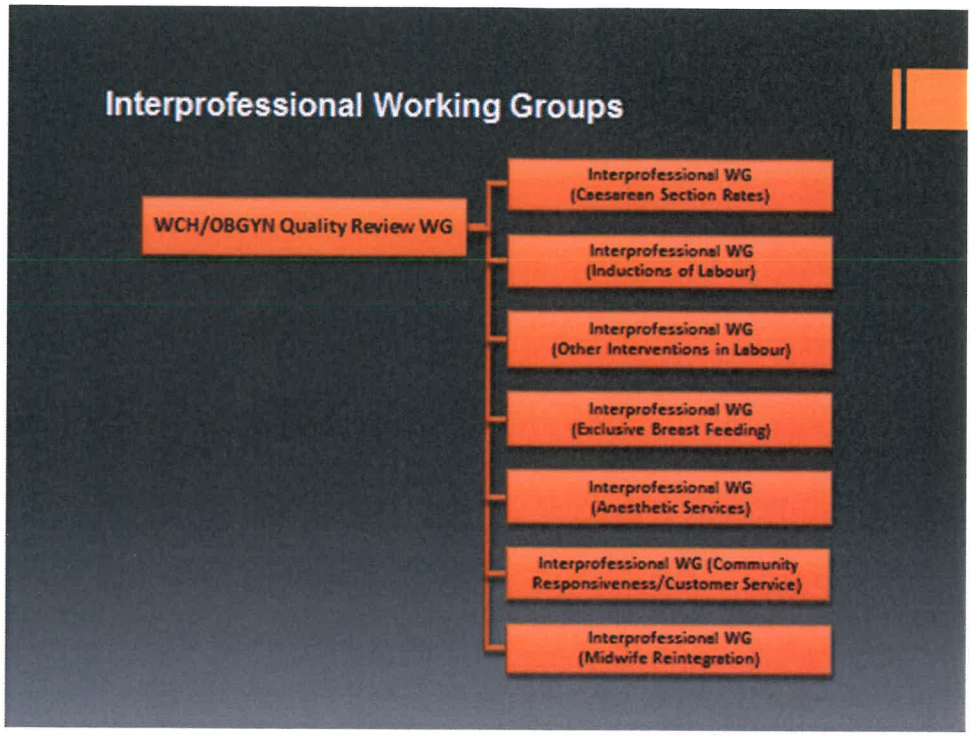
- In undertaking our transformational strategy to become the birthplace of choice for our community, CCH has analyzed the profiles of expectant women served and their families, to ensure that the OBGYN/WCHP bundle of services available provides the capacity to ensure individualized care and a superior patient experience.
- From April 1, 2012 – September 30, 3013, 788 infants were born at CCH. 11.9% of the mothers were between 14-19 years of age; 77.9% of the mothers were between 20-34 years of age; 10.1% of the mothers were 35 years or older. During this time frame 99.1% of the mothers were English whereas only 1.8% were French. With reference to Pre-Natal Classes: 11.7% had pre-natal classes, 61.2% did not. During this same period 76.5% of women indicated their intention to breastfeed.
- 95.8% of the mothers did not experience post-partum complications; highest rate was late post-partum hemorrhage at 1.8%. Maternal smoking at time of newborns birth was highly prevalent: 68.6% of the women were non-smokers; 6.8% smoked less than 10 cigarettes per day; 17.8% smoked 10-20 cigarettes per day. Medication exposure during pregnancy was also highly prevalent: 43.6% none; 5% anti-emetics; 3.1% narcotics; 2.6% over the counter medications; 8.6% other prescriptions, 46.7% vitamins. Drug and substance exposure: 90.8 % no exposure; 3.5% marijuana; 1% methadone; 1.2% narcotics. Alcohol exposure: 95.4 % no exposure; 0.5 % less than 1 drink per month; 0.3% 1 drink per month; 0.4% more than one drink per week. Infection in pregnancy: 71.8% none; 19% group B streptococcus; 0.8% HPV; 0.5% chlamydia. Hypertension Disorder in pregnancy: 96.3 % none; 44.6% gestational hypertension; 0.9% pre-eclampsia; 0.5% pre-existing hypertension with super imposed pre-eclampsia.
- Complications of Pregnancy: gestational diabetes 5.8%. Maternal Mental Health Concerns: 73.5% none; 11% anxiety; 11.8% depression; 3.5% history of postpartum depression; 2.8% addictions.

## Information Management Systems

- CCH has made substantial and continues invest in information systems/infrastructure to support, promote and sustain quality improvement initiatives, e.g., ED and inpatient flows, patient profiles, incident reporting, management and trending, etc.

## Engagement of Clinical Staff & Broader Leadership

- CCH continues to invest in executive, mid-level managers and front-line practitioners in professional development/training with a focus on continuous improvement and lean methodologies and techniques, i.e., 99% of Directors/Managers have been trained at the yellow-belt level or above, whereas 41% of front-line practitioners have been trained at the white-belt level or above.
- In undertaking our transformational strategy to become the birthplace of choice for our community, mid-level managers and front-line practitioners have been also engaged to participate within seven interprofessional working groups to develop interventions to close identified performance gaps and ensure full compliance with evidence-informed best practice guidelines.




## Accountability Management

Cornwall Community Hospital did not have any performance pay during the last performance cycle ending before the "effective date" of March 31, 2012 (2010/2011 performance pay cycle). As stipulated by the BPSAA, executives within our organization do not have any pay-for-performance tied to the achievement of targets in our 2014/2015 QIP.

# 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

Michael E. Turcotte
Board Chair

Naresh Bhargava
Quality and Performance Monitoring Committee Chair

Jeanette Despatie
Chief Executive Officer

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

**High Priority Indicators =** **HPI**

| Quality Dimension | Objective | Measure/Indicator | Unit/ Population | Source/ Period | Org Id | Current performance | Target | Target justification | Priority Level | 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 / Q4 2012/13 - Q3 2013/14 | 967* | 32.7 | 30 | Target based on HSAA commitment | Improve | • Optimize bed management, bed assignment and overcapacity protocols to improve earlier discharges, decrease bed turnaround times and improve compliance with 11:00 discharge time.<br>• Optimize use of Bedside Boards, pathways and discharge tools to ensure patient ready for discharge.<br>• Optimize use of predictive discharge tools (Currently traffic light system / review other models), as well as bullet rounds.<br>• Physician Roles: Ensure daily rounding, as well as provide clear indication of planned discharge date, including writing Rx and CCAC referrals the day before discharge.<br>• Ensure real time admissions vs batching of admissions, to support flow 24/7. | • QIP4 BSC will be developed to capture progress of change ideas & process measures as well as trending towards target performance.<br>• Performance to-date will be reviewed monthly by the Director, Q/R & quarterly by the Senior Leadership Team & Quality, Monitoring and Performance Committee of the Board. | • Time to inpatient bed (department specific and overall).<br>• % of discharges by 11:00 (department specific and overall).<br>• Compliance with use and completeness of Bed Side Boards (Unit specific and overall). | • ≥ 35% discharge time = 11:00. | Nil |
| Effectiveness | Improve organizational financial health | Total Margin (consolidated): % by which total corporate (consolidated) revenues exceed or fall short of total corporate (consolidated) expense, excluding the impact of facility amortization, in a given year. | %/ Not applicable | OHRS, MOH / Q3 2013/14 | 967* | 7.3 | 0 | Target based on HSAA commitment | Improve | • Review nursing and allied health staffing model, applying lean techniques to ensure that providers are working to full scope of practice.<br>• Review inventory management processes, applying lean techniques to minimize waste.<br>• Review integration opportunities, applying lean techniques to ensure that patients receive care within the most appropriate and least resource intensive setting(s). | • QIP4 BSC will be developed to capture progress of change ideas & process measures as well as trending towards target performance.<br>• Performance to-date will be reviewed monthly by the Director, Q/R & quarterly by the Senior Leadership Team & Quality, Monitoring and Performance Committee of the Board. | • % of CCH executive, mid-level managers & front-line practitioners having received formal training in lean methodologies and techniques. | • A minimum of two waste and/or cost reduction opportunities have been identified by each CCH department with related projects initiated within Q2, 2014/15. | Nil |
| | Reduce unnecessary deaths in hospitals | HSMR: Number of observed deaths/number of expected deaths x 100. | Ratio (No unit) /All patients | DAD, CIHI / 2012/13 | 967* | 97 | 97 | 75th percentile peer group performance (105) | Maintain | | | | | HSMR Results: 2013 Q2 = 72 (25thPercentile) 2013 Total: Q1+Q2 = 77 |
| Integrated | Reduce unnecessary time spent in acute care | Percentage ALC days: Total number of acute inpatient days designated as ALC, divided by the total number of acute inpatient days. | % /All acute patients | MOHLTC Portal / Q3 2012/13 – Q2 2013/14 | 4451 | 14.18 | 14.18 | HSAA commitment (16) | Maintain | | | | | |
| | Reduce unnecessary hospital readmission | Medication reconciliation at admission | % /All acute patients | Internal Audit | 967* | 100 | 100 | Accreditation ROP | Maintain | | | | | Medication reconciliation on admission is in place across the organization (Accreditation Report, 2012). |
| | Reduce unnecessary hospital readmission | Readmission to any facility within 30 days for selected CMGs for any cause: The rate of non-elective readmissions to any facility within 30 days of discharge following an admission for select CMG's. | % /All acute patients | DAD, CIHI / Q2 2012/13- Q1 2013/14 | 967* | 18.77 | 16.19 | CCH peer hospital performance Q4 2012/13 | Improve | • Implement HARP (Hospital Admission Risk Prediction) Tool or similar tool by end of 2014/15 Q2.<br>• Optimize use of clinical pathways, discharge tools and written discharge instructions for patients/families (including booked follow-up appointment for COPD patients – IDEAS project). | • QIP4 BSC will be developed to capture progress of change ideas & process measures as well as trending towards target performance.<br>• Performance to-date will be reviewed monthly by the Director, Q/R & | • Pathway utilization rates.<br>• % of COPD patients with documented Primary Care follow-up appointments on discharge.<br>• Discharge Tool utilization rates 2014/15, Q3-Q4.<br>• % of discharge follow-up phone calls to at-risk patients completed within target timeframe. | • Minimize incidents of patients identified as at-risk for rehospitalisation are readmitted due to provider aftercare and/or medication management related factors within Q2, 2014/15. | Nil |

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|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | • Conduct medication reconciliation on discharge for targeted subpopulation (COPD, CHF, Stroke, etc.).<br>• Discharge follow-up phone calls by discharge planning 8-10 days post discharge for high risk patients.<br>• Optimize weekly interagency Joint Discharge Reviews to plan for patients at risk for readmission for non-acute care reasons.<br>• Implement weekly reviews between psychogeriatrics team and GEM, DP and Social Work. | quarterly by the Senior Leadership Team & Quality, Monitoring & Performance Committee of the Board. | | | |
| | Increase Breastfeeding Rates | Rate of formula supplementation at discharge in term infants whose mothers intended to breastfeed | % /OB delivered | BORN / Q1 & Q2 2013/14 | 967* | 40.3 | 20 | BORN target | Improve | • As an Ontario community hospital with 501 - 1000 birth volume, designated Level 1b obstetrical care & Level 1 neonatal care:<br>• Achieve full compliance SOGC, MOREOB & other best practice guidelines appropriate to this setting.<br>• Achieve full compliance with external quality review recommendations.<br>• Engage RN with Lactation Consultant Certification (IBCLC).<br>• Engage NP to lead CCH Baby-Friendly Hospital Initiative (BFHI). | • QIP4 BSC will be developed to capture progress of change ideas & process measures as well as trending towards target performance.<br>• Performance to-date will be reviewed monthly by the Director, Q/R & quarterly by the Senior Leadership Team & Quality, Monitoring & Performance Committee of the Board. | • % of guidelines, risk mitigation strategies & external quality review recommendations which have been evaluated by interprofessional working group.<br>• % of endorsed guidelines, risk mitigation strategies & external quality review recommendations which have been implemented. | • Full compliance with best practices appropriate to a community hospital setting which promote and support breastfeeding within Q2, 2014/15. | Nil |
| Patient-centred | Improve patient satisfaction | From NRC Picker: "Would you recommend this hospital (inpatient care) to your friends and family?" (Add together % of those who responded "Definitely Yes" or "Yes, definitely"). | % /All patients | NRC / Oct 2012-Sept 2013 | 967* | 64.37 | NA[1] | NA | NA | | | | | |
| | | From NRC Picker: "Overall, how would you rate the care and services you received at the hospital (inpatient care)?" (Add together % of those who responded "Excellent, Very Good and Good"). | % /All patients | NRC Picker / Oct 2012-Sept 2013 | 967* | 92.54 | NA | NA | NA | | | | | |
| | | From NRC Picker: Would you recommend this ED to your friends and family?" (add together % of those who responded "Definitely Yes" or "Yes, definitely") | % /ED patients | NRC Picker / 2013 | 967* | 60.2 | NA | NA | NA | | | | | |
| | | From NRC Picker: "Overall, how would you rate the care and services you received at the ED?" (Add together % of those who responded "Excellent, Very Good and Good"). | % /ED patients | NRC Picker / 2013 | 967* | 86.14 | NA | NA | NA | | | | | |

[1] Not Applicable

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|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | WCHP Patient Satisfaction (Survey Tool Selection and Distribution Process In-Progress)<br><br>✱ Due to concerns regarding timing of performance results being available and therefore, inability to initiate timely corrective action(s), CCH is shifting from NRC to an alternative instrument with in-house distribution process to be established (Target: March/14). | % /WCHP patients | Internal / Q1 2014/15 | 967* | Not Available | ↑10% | Target increase over base-line measure | Improve | • Redesign of patient & family complaints management process to ensure clear role accountabilities & timeframes for initial response, investigation and closing complaint.<br>• Consult with patients & families to involve them in health care redesign and quality improvement & regularly engage with them to keep them informed.<br>• Bring patient stories to the Board/ leadership team.<br>• Regularly measure satisfaction within clinical services, provide timely feedback to enable rapid resolution of concerns at point of care. | • QIP4 BSC will be developed to capture progress of change ideas & process measures as well as trending towards target performance.<br>• Performance to-date will be reviewed monthly by the Director, Q/R & quarterly by the Senior Leadership Team & Quality, Monitoring & Performance Committee of the Board. | • % of CCH mid-level managers and front-line practitioners having received formal training in redesigned complaints management process.<br>• % active complaints by department which have breached target timeframe for closure.<br>• Survey participation rates.<br>• % of patients/family members involved in care planning. | • 100% of CCH mid-level managers and front-line practitioners having received formal training in redesigned complaints management process within Q2, 2014/15. | Nil |
| Safety | Reduce hospital acquired infection rates | CDI rate per 1,000 patient days: Number of patients newly diagnosed with hospital-acquired CDI, divided by the number of patient days in that month, multiplied by 1,000 - Average for Jan-Dec. 2013, consistent with publicly reportable patient safety data. | Rate per 1,000 patient days / All patients | Publicly Reported, MOHLTC / 2013 | 967* | 0.09 | 0.00 | 10th percentile teaching, large, community hospitals 101 - 300 beds (0.18). | Improve | • Implementation of prevention & control measures identified by the Provincial Infectious Diseases Advisory Committee (PIDAC). | • QIP4 BSC will be developed to capture progress of change ideas & process measures as well as trending towards target performance.<br>• Performance to-date will be reviewed monthly by the Director, Q/R & quarterly by the Senior Leadership Team & Quality, Monitoring & Performance Committee of the Board. | • % of patients with hospital-acquired CDI associated disease.<br>• Time between hospital-acquired cases of CDI.<br>• Hand hygiene compliance (%). | • 100% compliance with recommended prevention & control measures identified by PIDAC within Q2, 2014/15. | Nil |
| | | Hand hygiene compliance before patient contact: The number of times that hand hygiene was performed before initial patient contact divided by the number of observed hand hygiene indications for before initial patient contact multiplied by 100 - consistent with publicly reportable patient safety data. | %/Health providers in the entire facility | Publicly Reported, MOHLTC/ 2013 | 967* | 71.9 | 77 | ↑7% | Improve | | | | | |
| | | VAP rate per 1,000 ventilator days: the total number of newly diagnosed VAP cases in the ICU after at least 48 hours of mechanical ventilation, divided by the number of ventilator days in that reporting period, multiplied by 1,000 - consistent with publicly reportable patient safety data. | Rate per 1,000 ventilator days/ ICU patients | Publicly Reported, MOHLTC/ 2013 | 967* | 0 | 0 | Target based on HSAA obligation | Maintain | | | | | |
| | | Rate of central line blood stream infections per 1,000 central line days: total number of newly diagnosed CLI cases in the ICU after at least 48 hours of being placed on a central line, divided by the number of central line days in that reporting period, multiplied by 1,000 - consistent with publicly reportable patient safety data. | Rate per 1,000 central line days/ ICU patients | Publicly Reported, MOHLTC/ 2013 | 967* | 0 | 0 | Target based on HSAA obligation | Maintain | | | | | |

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|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Reduce rates of deaths and complications associated with surgical care | Rate of 5-day in-hospital mortality following major surgery: The rate of in-hospital deaths due to all causes occurring within five days of major surgery. | Rate per 1,000 major surgical cases/ All patients with major surgery | CIHI eReporting Tool / 2012/13 | 967* | 0 | 8.55 | Target based on CHRP peer group performance Internal performance reflects non-adjusted rates (currently, CHRP data not available for 2013/14 Q2) | Maintain | • Use the Surgical Safety Checklist to reduce complications & mortality associated with a variety of surgical procedures.<br>• Evaluate patient profiles, diagnostic groups and surgical procedures which are at higher risk for morbidity/mortality.<br>• Evaluate & communicate evidence informed mitigation strategies which have been demonstrated to reduce above risks. | • QIP4 BSC will be developed to capture progress of change ideas and process measures as well as trending towards target performance.<br>• Performance to-date will be reviewed monthly by the Director, Q/R and quarterly by the Senior Leadership Team and Quality, Monitoring and Performance Committee of the Board. | • Surgical Safety Checklist (SSC) compliance rates.<br>• % of initiative completion: evaluation at-risk patient profiles, diagnostic groups & surgical procedures & mitigation strategies & report to Medical Quality Committee. | • 100% compliance with Surgical Safety Checklist within Q1, 2014/15.<br>• Complete evaluation of at-risk patient profiles, diagnostic groups & surgical procedures & mitigation strategies with report submitted to Medical Quality Committee within Q3, 2014/15. | Nil |
| | | Surgical Safety Checklist: number of times all three phases of the surgical safety checklist was performed ('briefing', 'time out' and 'debriefing') divided by the total number of surgeries performed, multiplied by 100 - consistent with publicly reportable patient safety data. | %/All surgical procedures | Publicly Reported, MOHLTC / 2013 | 967* | 99.5 | 100 | performance based on Q2 2013/14 | Maintain | | | | | |
| | Reduce use of physical restraints | Physical Restraints: The number of patients who are physically restrained at least once in the 3 days prior to a full admission divided by all cases with a full admission assessment. | %/ Mental health/ addiction patients | OMHRS, CIHI / Q4 2010/12 - Q3 2012/13 | 967* | 3.3 | 4.6 | Target based on 5% reduction of benchmark hospital performance. Internal performance for Q1 2013/14 | Maintain | | | | | |
| | Caesarean Section Rate | Total Caesarean section rate. | % /OB delivered | BORN / Q1 & Q2 2013/14 | 967* | 37.4 | 27.4 | Ontario Hospital Peer Average | Improve | • For an Ontario community hospital with 501 - 1000 birth volume, designated Level 1b obstetrical care & Level 1 neonatal care:<br>• Achieve full compliance SOGC, MOREOB & other best practice guidelines appropriate to this setting.<br>• Achieve full compliance HIROC risk mitigation strategies appropriate to this setting.<br>• Achieve full compliance with external quality review recommendations. | • QIP4 BSC will be developed to capture progress of change ideas & process measures as well as trending towards target performance.<br>• Performance to-date will be reviewed monthly by the Director, Q/R & quarterly by the Senior Leadership Team & Quality, Monitoring & Performance Committee of the Board. | • % of guidelines, risk mitigation strategies & external quality review recommendations which have been evaluated by interprofessional working group.<br>• % of endorsed guidelines, risk mitigation strategies & external quality review recommendations which have been implemented. | • 100% of guidelines, risk mitigation strategies & external quality review recommendations have been evaluated by interprofessional working group within Q1, 2014/15.<br>• 90% of endorsed guidelines, risk mitigation strategies & external quality review recommendations have been implemented within Q3, 2014/15. | Nil |
| | Episiotomy Rate | Episiotomy Rate. | % /OB delivered | BORN / Q1 & Q2 2013/14 | 967* | 16.8 | 13 | BORN target | Improve | | | | | |
| | VBAC rate | Vaginal birth after Caesarean section rate | %/ OB delivered | BORN / Q2 2013/14 | 967* | 5.9 | 15.9 | Ontario Hospital Peer Average | Improve | | | | | |