Excellent Care For All.

# 2012/13 Quality Improvement Plan

(Short Form)

ATIKOKAN GENERAL HOSPITAL

**April 18, 2012**

This document is intended to provide public hospitals with guidance as to how they can satisfy the requirements related to quality improvement plans in the *Excellent Care for All Act, 2010* (ECFAA). While much effort and care has gone into preparing this document, this document should not be relied on as legal advice and hospitals should consult with their legal, governance and other relevant advisors as appropriate in preparing their quality improvement plans. Furthermore, hospitals are free to design their own public quality improvement plans using alternative formats and contents, provided that they comply with the relevant requirements in ECFAA, and provided that they submit a version of their quality improvement plan to HQO in the format described herein.

# Part A:
# Overview of Our Hospital's Quality Improvement Plan

## 1. Overview of our quality improvement plan for 2012-13

In 2012 Atikokan General Hospital will commence our new five (5) year Strategic plan. There are four (4) key directions in our plan, namely: Quality Care, Workplace Excellence, Planning for the Future, and Health Care Integration with other community health care providers. Atikokan General Hospital's mission is to provide excellent quality, compassionate and supportive healthcare for those we serve. It is the goal of our Hospital's quality improvement plan to identify opportunities for quality improvement in our delivery of services that focus on the key concepts of patient safety and positive patient experiences and outcomes.

Adopting and implementing the Hospital's annual quality improvement plan will align all members of our team in the common purpose of becoming the leading edge community health center to which we aspire to be. Participating in the process of implementing this plan will keep patient safety and quality of care central to the hospital's staff and governance team's activities throughout the year.

Communication of our successes in this endeavor will assure the members of the community that those entrusted with their care are working diligently to provide services at the highest level of excellence.

## 2. What we will be focusing on and how these objectives will be achieved

The 2012-13 QIP will focus on the suggested key indicators (as listed in part B) that are applicable to the hospital. We have several priorities under the subject areas of: Safety, Effectiveness, Access, Patient Satisfaction, and Integration.

Investments have been made in several projects associated with these initiatives designed to improve several areas of concern. The focus for 2012-13 will be continuing to resource these initiatives, see them through to maturity and identify further measures needed to meet the identified goals on an ongoing basis.

In safety we will focus on controlling infection risks by ensuring hand washing occurs. We practice good wound care to reduce the incidence of new pressure ulcers, and we will educate staff to ensure good standards in reducing the risks of falls.

We will monitor our income and expenses so that we manage our funds effectively and do not incur a deficit.

We will collaborate with the Family Health Team to offer non-urgent care at the clinic and thus reduce wait times in our emergency department.

We will listen to our patients' comments in surveys and feedback statements and address all issues so that we maintain a high level of satisfaction.

Finally, we will work to improve the integration of services by collaborating with the Community Care Access Center during our discharge planning process with the aim of reducing unnecessary time spent in acute care beds.

Further, in this second year of this process, our experience in this plan will serve to fine tune the organizational restructuring that has been undertaken in our development of an Integrated Quality Program. This program is currently being formalized and includes the development of a clearly defined Integrated Quality Program including a redesign of our current Quality Council and reporting processes through to the Board of Directors and public. The focus of the redesign is to provide clear accountabilities for activity and reporting related to quality issues from the front line worker through to the Board of Directors.

The priority 1 objectives as identified have been resourced and work has begun in these areas. The support given includes staffing, education and materials. Our activities over this year will see the organization develop a more robust system for Quality Improvement, results reporting and planning that will move the organization forward in a manner that is in keeping with our strategic plan, goals and objectives.

## 3. How the plan aligns with the other planning processes

Quality is one of the top priorities for the Atikokan General Hospital. We recognize that quality improvement and patient safety must be central to all activities and planning. The QIP was reviewed by the Board of Directors to ensure that they consider the five (5) key areas of: safety, effectiveness, access, patient centered care and integration. These five (5) focuses are integrated with the Atikokan general Hospital Strategic plan. They are also supported by our mission, goals and values.

This plan will be monitored by the Quality Council who reports to the Quality Committee of the Board. The AGH Quality Council has the role of coordination and monitoring all the quality initiatives and activities within the hospital. As part of the council's work it will provide advice and input into the development of future QIPs by identifying opportunities for improvement or bringing forward emerging best practices or indicators that will assist the organization in improving patient care or organizational effectiveness.

The QIP will include indicators that are integrated into the Hospital Services Accountability Agreement (H-SAA) document. Inclusion of these indicators will facilitate regular review of performance by the Board of Directors and public reporting.

The QIP acknowledges and incorporates improvement targets and initiatives that complement the Northwest Local Health Integration Network's Integrated Health services plan in the areas of Optimizing health (population health), optimizing care (patient Satisfaction) and optimizing resources (per capita health).

This plan aligns with the Community Care Access Centre (CCAC) goals of effective use of Long Term Care (LTC) beds and reduction in Alternative Level of Care (ALC) days.

Finally, these Quality goals directly align with Ontario's Ministry of Health and Long Term Care's Action Plan for Health Care. The three (3) key goals of this plan are Better Access, Better Quality and Better Value.

## 4. Challenges, risks and mitigation strategies

One of the challenges in managing our Quality goals is the description of the statistical outcomes. When an organization such as ours is experiencing small numbers of occurrences or event opportunities, a shift of small numbers can have a large effect statistically. Our small size and low volumes potentially makes statistical comparison unreliable and subject to wide swings in reported values. Another significant risk to the organization in not being able to reach the stated QIP goals is events that are external to the organization. Our community has the potential to see sudden, rapid and unpredictable population growth due to proposed industrial projects. This population growth will impact on overall activity and demand for services that could far exceed the current expectations, budgeting and resources. In addition uncertainty as to the level of funding and subsequent impact of resource availability has the potential to negatively impact certain indicators included in the plan.
To mitigate these risks and challenges, the hospital will necessarily need to incorporate qualifiers into our performance targets. Goals and targets will need to be carefully selected to allow for the wide statistical variations that a small number of clients may create.

# Part B:
# Our Improvement Targets and Initiatives

*Purpose of this section: Please complete the "Part B - Improvement Targets and Initiatives" spreadsheet (Excel file). Please remember to include the spreadsheet (Excel file) as part of the QIP Short Form package for submission to HQO (QIP@HQOntario.ca), and to include a link to this material on your hospital's website.*

[Please see the QIP Guidance Document for more information on completing this section.]

See Attached Spreadsheet

# Part C:
# The Link to Performance-based Compensation of Our Executives

*The purpose of performance-based compensation related to ECFAA is to drive accountability for the delivery of quality improvement plans (QIPs). By linking achievement of targets to compensation, organizations can increase the motivation to achieve both long and short term goals. Performance-based compensation will enable organizations to ensure consistency in the application of performance incentives and drive transparency in the performance incentive process.*

*Please refer to Appendix E in the QIP Guidance Document for more information on completing this section of the QIP Short Form. The guidance provided for executive compensation is also available on the ministry website.*

## Manner in and extent to which compensation of our executives is tied to achievement of targets

[Compensation should be linked to targets for the CEO and those members of the senior management group who report directly to the CEO, including the chief of staff (where there is one) and the chief nursing executive. Members of the senior management team who do not fall under the definition of "executive" as listed in the regulations (i.e. those not reporting directly to the CEO) may also be included in performance-based compensation, at the discretion of the organization. Please refer to the regulation (Ontario Regulation 444/10) and the guidance on executive compensation available from the ministry's website.]

Our executives' compensation is linked to performance in the following way:

| **Individuals included in the performance-based compensation plan:** |
|---|
| Chief Executive Officer |
| Chief of Staff |
| Chief Nursing Officer |
| Chief Finance Officer |

**Performance Based Pay: 10% of CEO annual salary and 5% of annual salary applied equally to other 3 Senior Management positions.**

**Timing of Payouts: Targets will be monitored quarterly but performance based pay adjusted annually.**

**Targets were chosen based on previous performance and previous years' provincial averages.**

*** See attached indicator worksheet – Part C***

## Part D:
## Accountability Sign-off

[Please see the QIP Guidance Document for more information on completing this section.]

I have reviewed and approved our hospital's Quality Improvement Plan and attest that our organization fulfills the requirements of the *Excellent Care for All Act*. In particular, our hospital's Quality Improvement Plan:

1. Was developed with consideration of data from the patient relations process, patient and employee/service provider surveys, and aggregated critical incident data
2. Contains annual performance improvement targets, and justification for these targets;
3. Describes the manner in and extent to which, executive compensation is tied to achievement of QIP targets; and
4. Was reviewed as part of the planning submission process and is aligned with the organization's operational planning processes and considers other organizational and provincial priorities *(refer to the guidance document for more information)*.

| Vic Prokopchuk | Laura Homer | Doug Moynihan |
|---|---|---|
| *Board Chair* | *Quality Committee Chair* | *Chief Executive Officer* |



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**PART B: Improvement Targets and Initiatives**

# 2012/13

**Atikokan General Hospital 120 Dorothy Street, Atikokan, Ontario P0T 1C0**

| AIM | | MEASURE | | | | | CHANGE | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **Quality dimension** | **Objective** | **Measure/Indicator** | **Current performance** | **Target for 2012/13** | **Target justification** | **Priority level** | **Planned improvement initiatives (Change Ideas)** | **Methods and process measures** | **Goal for change ideas (2012/13)** | |
| **Safety** | Reduce clostridium difficile associated diseases (CDI) | **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. 2011, consistent with publicly reportable patient safety data | 0 cases/1000 Patient days | 0 cases of nosocomial transmission of CDAD within the facility | The target will measure the effectiveness of infection control practices. The occurrence of CDAD is expected in relation to certain conditions and treatments. Measuring the effectiveness of containment measures demonstrates performance. | 3 | 1)Continued monitoring and utilization of infection control protocols | | | |
| | Improve provider hand hygiene compliance | **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 - Jan-Dec. 2011, consistent with publicly reportable patient safety data | 2011 Annual Audit 74% | 80% | This target will ensure that continued emphasis is placed on improving compliance with this indicator and further reduce risk to patients. The target exceeds previous years performance and provincial average. | 1 | Annual education on infection control and hand washing to be reviewed and revised if needed. | 1)Compliance audits conducted and results reported.<br>2)Review and renew annual learning package and monitoring staff completion of annual training | To increase knowledge and improve compliance with best practices. The participation of staff in educational programs and the frequency of educational offerings will be monitored reported. | |

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|---|---|---|---|---|---|---|---|---|---|---|
| | Reduce incidence of new pressure ulcers | **Pressure Ulcers**: Percent of complex continuing care residents with new pressure ulcer in the last three months (stage 2 or higher) - FY Q3 2011/12, CCRS | 0 Cases | 0 Cases | Current performance is at optimal level. Ongoing monitoring is required. Cases in which there are risk factors that cannot be mitigated will not be considered | 1 | 1) Wound Care best practices will be followed and supported through continuing education and the development of best practice champions. 2) Capital resources will be directed to the purchase of speciality pressure relief and wound treatment surfaces. | Hospital staff will participate in education that targets wound prevention and care. Policy and procedure will be reviewed and renewed. The hospital will track the frequency of educational programming and staff participation | The goal is that 100% of LTC staff will have completed education related to prevention and treatment of pressure ulcers. | |
| | Avoid patient falls | **Falls:** Reduce the incidents of patient falls in all patient care units. Measured in number of patient falls/1000 patient days. | Q1-3 2011 8.71 falls/1000 pt days | 2012 target 6.968 This represents a 20% reduction in falls across all patient care areas | Falls have been identified as the most common avoidable risk to patients and residents. Reduction in the frequency of falls will represent a reduction of risk to patients. | 1 | 1) Staff education to increase staff awareness of and compliance with best practices for fall prevention. 2) 3 additional beds equipped with exit alarms will be purchased | 1) All incidents of falls will be reported and tracked through the Patient Incident Reporting System. | To increase knowledge and improve compliance with best practices. The participation of staff in educational programs and the frequency of educational offerings will be monitored reported. | |
| **Effectiveness** | Improve organizational financial health | **Total Margin (consolidated):** Percent 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. Q3 2011/12, OHRS | 0.78% | 0.0% or greater | Maintaining a positive Total Margin represents the performance of the organization | 1 | 1) The organization will participate in the Regional Supply Chain Initiative | Assuming 0% revenue increases, expenses will be reduced in non-patient care. | Purchase 80% of supplies through Group Purchasing Organizations. | |
| | | | | | | | 2) The total inventory will be reduced by 5% | The pharmacy will establish minimum stock levels for all formulary medications. | The minimum stock levels will be established by Q3 2012. A quarterly review of the inventory program will determine progress. | |
| **Access** | Reduce wait times in the ED | **ER Wait times:** 90th Percentile ER length of stay for <u>Admitted</u> patients. Q3 2011/12, NACRS, CIHI | Q 2 - 2012 4.8 hours | 4.5 hours | A reduction in LOS in the E.R. for admitted patients will indicate improved efficiency and patient flow. | 3 | | | | |

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| | Reduce number of CTAS V patients admitted to the ED | Number of CTAS V patients admitted to the ED | Q 1-3 2012 CTAS V visits were 27.36% of total ED visits | The % of CTAS V cases will be reduced by 5% as a percentage of total cases. | Reduction in % of CTAS V as a total % of total cases demonstrates movement of patients to the appropriate provider site. | 1 | Changes to physician utilization that remove the case-load of non-urgent patients, have been implemented. | The goal is to change community utilization of the ED for accessing non-emergent care. | To reduce crowding and improve patient flow in the ED. | |
| **Patient Centred** | Survey of patient satisfaction | **From NRC Picker:** "Overall, how would you rate the care and services you received at the hospital?" | Q1-3 2011 Acute 98.41% ED 95.45 | Positive scores will remain within +/- 2% | High performance area that requires ongoing monitoring | 3 | | | | |
| **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. Q2 2011/12, DAD, CIHI | Jan 1 - Dec 31 2011 - 11% | Performance target will remain less that NWLHIN average of 21.64% | Comparison with NWLHIN hospitals is best reflection of regional bed utilization patterns. | 1 | Discharge and planning coordination with CCAC and community providers through discharge planning group will ensure timely transition to appropriate location/service | ALC days and ALOS will be monitored monthly. | The discharge planning process will reduce ALC days and LOS. | |

# PERFORMANCE BASED COMPENSATION PLAN 2012-2013

**Part C**

| **Individuals included in the performance-based compensation plan:** | |
|---|---|
| Chief Executive Officer | 10% |
| Chief of Staff | 5% |
| Chief Nursing Officer | 5% |
| Chief Financial Officer | 5% |

**Performance based pay : 10% of CEO annual salary and 5% of annual salary applied equally to other 3 Senior Management positions.**

**Timing of Payouts: Targets will be monitored quarterly but performance based pay adjusted annually.**

**Targets were chosen based on previous performance and previous years provincial averages.**

| | | | | | | % of available incentive | | |
|---|---|---|---|---|---|---|---|---|
| **Quality dimension** | **Objective** | **Outcome measure/indicator** | **Current performance** | **Target** | **Weighting** | **100%** | **50%** | 0% |
| Safety | Improve provider hand hygiene compliance | **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 - Jan -Dec 2011, consistent with publicly reportable patient safety data. | 2011 Annual Audit 74% | 80% | 16.66% | performance at or above 75% | performance at or above 70% | Performance below 70% |
| | Avoid new pressure ulcers | **Pressure Ulcers:** Percentage of complex continuing care residents with new pressure ulcers in the last 3 months (stage 2 or higher) - FY Q3 2011/12 CCRS | 0 cases 2011 | 0 cases | 16.66% | 10 or less cases | 11-19 case | 20 or more cases |
| Effectiveness | Improve organizational financial health | Total Margin: Percent by which total corporate revenues exceed or fall short of total corporate expense, excluding the impact of facility amortization, in a given year. Q3 2011/12 OHRS | 0.78% | 0% or greater | 16.66% | equal to or less than minus 3% | greater than minus 3% but less than minus 5% | greater than minus 5% |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Access | Reduce the percentage of CTAS V patients registered in the Emergency Department | Number of CTAS V patients registered to the ED as a percentage of total registrations. Baseline Q3 cumulative 2011 | 37.3% | 25% | 16.66% | reduce 1% or greater | No change | increase in CTAS V |
| Patient-Centred | Improve patient satisfaction | Positive responses to the question "Overall, how would you rate the care and services you received at the hospital?" | Q1 -3 2011 Acute 98.41% ED 95.45% | positive scores will remain within 2% +/- | 16.66% | greater than 89% | greater than 84% but less than 90% | less than 85% |
| Integrated | Reduce unnecessary time spent in acute care | Percentage of ALC days: Total number of inpatient days designated as ALC, divided by the total number of inpatient days. 2011/12, DAD, CIHI | Jan - Dec 2011 11% | Performance target will remain less than 20% | 16.66% | less than 25% ALC days | 25% to 29% ALC days | 30% or greater ALC days |
| | | | | | **100%** | | | |