Excellent Care
For All.

2011-12

Quality Improvement Plan

(Short Form)

ATIKOKAN
GENERAL HOSPITAL

March 24, 2011

Atikokan General Hospital
120 Dorothy Street
Atikokan, Ontario
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Ontario

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

Purpose of this section: Quality Improvement Plans (QIPs) are, as the name suggests, all about improvement. They are an opportunity for organizations to focus on how and what to improve, in the name of better patient-focused care. As such, they will be unique documents, designed by, and for, each individual organization. Overall, a QIP should be seen as a tool, providing a structured format and common language that focuses an organization on change. The QIP will drive change by formalizing a plan and facilitating shared dialogue to support continuous quality improvement processes. .

1. Overview of our quality improvement plan for 2011-12

The Atikokan General Hospital is dedicated to excellence in compassionate and supportive healthcare for those we are committed to 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 2011-12 QIP will focus on the suggested key indicators (as listed in part B) that are applicable to the hospital.

Investments have been made in several projects associated with initiatives designed to improve several areas of concern. The focus for 2011-12 will be to continuing to resource these initiatives, see them through to maturity and identify further measures needed to meet the identified goals on an ongoing basis.

Further, in this inaugural 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 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. It is known that the projects will continue into the future and require ongoing support and resources. 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

The Atikokan General Hospital recognizes that quality improvement and patient safety must be central to all activities and planning. As such, the QIP will be reviewed by the Board of Directors at the annual planning retreat to ensure that they consider the four key areas of safety, effectiveness, access and patient centered care and provide strategic direction on an ongoing basis and that the strategic plan, mission, goals and values align with quality improvement efforts in these areas.

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 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 Networks 2010-2013 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 CCAC goals of effective use of LTC beds and reduction in ALC days.

4. Challenges, risks and mitigation strategies

The most significant risks and challenges the organization faces in relation to not being able to reach the stated QIP goals 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. Another challenge is that our small size and low volumes potentially makes statistical comparison unreliable and subject to wide swings in reported values.

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

See Attached Spreadsheet

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

Purpose of Performance-based compensation:

1. *To drive performance and improve quality care*
2. *To establish clear performance expectations*
3. *To create clarity about expected outcomes*
4. *To ensure consistency in application of the performance incentive*
5. *To drive transparency in the performance incentive process*
6. *To drive accountability of the team to deliver on the Quality Improvement Plan*
7. *To enable team work and a shared purpose*

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

[Compensation should be linked to targets for 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. Please refer to the regulation (Ontario Regulation 444/10)]

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
Assistant Executive Director - Patient Care Services
Assistant Executive Director - Finance

Pay at Risk : 5% of annual salary applied equally to all 4 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 – entitled Performance Based Compensation Plan***

Part D:
Accountability Sign-off

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/provider surveys, aggregated critical incident data, and patient safety indicators;
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.

Vic Prokopchuk	Joan T McIntosh	Robert G Wilson
Board Chair	*Quality Committee Chair*	*Chief Executive Officer*

PART B: Improvement Targets and Initiatives

ATIKOKAN GENERAL HOSPITAL

Atikokan General Hospital

AIM		MEASURE				CHANGE				
Quality dimension	Objective	Outcome Measure/Indicator	Current performance	Performance goal 2011/12	Priority	Improvement initiative	Methods and results tracking	Target for 2011/12	Target justification	Comments
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. 2010, consistent with publicly reportable patient safety data	Jan-Dec 2010 0.233 cases/1000 patient days	no cases of nosocomial transmission of CDAD	3	1) Continued monitoring and utilization of infection control protocols	Continued public reporting of CDAD cases as per MOHLTC guidelines.	0 cases of nosocomial transmission within the facility	CDAD is a known complication of certain treatments and conditions. As the occurrence of CDAD is expected in certain cases a more meaningful measure is the tracking and reporting of nosocomial cases. The goal for this measure is that the hospital will through early detection and intervention prevent the nosocomial spread of this disease.	Very low patient volume makes statistical reporting using the case per 1,000 patient days unreliable as an indicator. A more relevant measure is the incidence of nosocomial infections.
	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 - 2009/10, consistent with publicly reportable patient safety data	2009 - 28% 2010 - 54% 2011 - 74%	To show continuous annual improvement of 10% year over year from the initial reporting until the hospital performance meets or exceeds the provincial average for our comparator group.	1	1) Ongoing education for staff. Annual mandatory education on hand hygiene	annual audits and public reporting	maintain performance at or above provincial average of 68%	Performance over last two years has increased to levels that meet the 2010 provincial average for performance. The hospital will continue to meet or exceed the provincial average	
	Avoid 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 2009/10, CCRS	Total % of CCC patients with new pressure ulcers 0%	0 cases of stage 2 pressure ulcers in patients with less than 2 risk factors	3	1) Hospital staff participate in regional wound care initiative and a wound care champion acts as liaison with regional wound care specialists and advocates best practice adoption and acts as advisor to the medical and nursing staff.	The data is gathered in the RUGS-MDS assessments. Results to be reported quarterly to the BOD in the patient safety report	There will be no new stage 2 pressures ulcers in CCC patients that do not have multiple and/or uncorrectable risk factors.	CCC patients often receive palliative care and end of life care. These cases will include multiple and profound risk factors that may make the development of pressure ulcers unavoidable therefore a goal of no new pressure ulcers is not attainable in this population.	based on FY 09/10 & 09/11 inpatient statisitics 1 case = 5.5% of CCC admissions.
	Avoid falls	**Falls:** Percent of complex continuing care residents who do not have a recent prior history of falling, but fell in the last 90 days - FY 2009/10, CCRS	0% of CCC patients	100% of CCC patients will have fall risk identified and preventative measures in place within 24 hours of admission.	1	1) The hospital has a falls prevention team and has developed a process for identifying fall risk in patients. This initiative will examine the effectiveness of this process by determining the percentage of new patients that are assessed for fall risk at admission and have preventative measure in place within 24 hours of admission.	All falls are reported to the falls team and risk management team for evaluation and recommendation. This data is compiled quarterly and reported to the Board of Directors and part of the patient safety report.	100% of patients will be assessed for fall risk. There will be a fall prevention plan in place prior to any new falls.	Patient falls are not 100% avoidable in our patient population due to high incident of cognitive impairment and minimal restraint policy as per best practice guidelines. Therefore the goal is to ensure that the hospital reconsidered risk and took all appropriate measures to mitigate risk of fall and injury.	Due to very low number of admissions the CCRS data is not reliable as a performance indicator, therefore the hospital will monitor our fall prevention strategy as it relates to falls in CCC patients.

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Quality dimension	Objective	Outcome Measure/Indicator	Current performance	Performance goal 2011/12	Priority	Improvement initiative	Methods and results tracking	Target for 2011/12	Target justification	Comments
Effectiveness	Reduce unnecessary hospital readmission	**Readmission within 30 days for selected CMGs to any facility:** The number of patients with specified CMGs readmitted to any facility for non-elective inpatient care within 30 days of discharge, compared to the number of expected non-elective readmissions - Q1 2010/11, DAD, CIHI	18.5%	no increase in percentage.	1	1) The hospital has initiated a partnership with the local CCAC case coordinator and Family Health Team staff to improve the discharge planning process and provide every discharged patient with follow up contact in the community.	Data gathered through DAD on readdmission rates.	To keep the percentage under 20%	due to small volumes this indicator is subject to wide fluctuations.	
	Reduce unecessary 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 2010/11, DAD, CIHI	2008/09 18.6% 2009/10 25.3%	The hospital will reduce the number of acute care ALC days to 20%	3	1) The hospital has initiated a partnership with the local CCAC case coordinator and Family Health Team staff to improve the discharge planning process.	Data gathered through DAD on ALC days.			The CCC bed utilization patterns for small and rural hospitals are that these beds are often utilized as LTC interim beds and typically have a very high percentage of ALC occupancy. Acute care utilization patterns demonstrate that bed availability and ALC utilization does not negatively impact our ability to provide service or increase ED wait times.
	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 2010/11, OHRS	-0.04%	< 0% deficit	1	AGH is reducing expenses by partnering with the region on supply chain management.	OHRS Quarterly reports 2011/12.	< 2% deficit	The GAPS exercise shows a a deficit increase of approx 2%	At this time increases in base funding for 11/12 is uncertain.
Access	Reduce wait times in the ED	**ER Wait times:** 90th Percentile ER length of stay for Admitted patients. Q3 2010/11, NACRS, CIHI	unknown	95% of patients will be admitted within 8 hours	3	1)				
Patient-centred	Improve patient satisfaction	NRC Picker / HCAPHS: "Would you recommend this hospital to your friends and family?" (add together percent of those who responded "Definitely Yes")	Would you recommend this hospital (definitely yes) E.R. 78.31%	to exceed the small hospital average of 70.1%	3	1)				

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PERFORMANCE BASED COMPENSATION PLAN 2011-2012

Individuals included in the performance-based compensation plan:

Chief Executive Officer
Chief of Staff
Assistant Executive Director - Patient Care Services
Assistant Executive Director - Finance

ATIKOKAN GENERAL HOSPITAL

Pay at Risk : 5% of annual salary applied equally to all 4 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 for 2011/12**	**Weighting**	**100%**	**75%**	**0%**
Safety	Reduce clostridium difficile associated diseases (CDI)	**CDI rate per 1000 patient days:** Number of patients newly diagnosed with hospital-acquired CDI, divided by the number of patient days in that month, multiplied by 1000 - average for Jan-Dec 2010 consistent with publicly reportable patient safety data.	less than 1 case per 1000 pt days Feb 10 - Jan 11	0 cases of nosocomial **transmission** within the facility	0.75%	0 cases	< or = to 1 case	>1 case
	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 - 2009/10, consistent with publicly reportable patient safety data.	2009 - 28% 2010 - 54% 2011 - 74%	maintain performance at or above the 2010 provincial average of 68%	0.75%	performance at or above the 2010 provincial average of 68%	0 -10% below provincial average	>10% below the provincial average

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Safety	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 2009/10 CCRS	0 % of CCC patients with new pressure ulcers.	There will be no new Stage 2 pressure ulcers in CCC patients that do not have multiple and/or uncorrectable risk factors.	0.75%	= to or <6% this equals 1 case avg 18 admission/yr	>6% but <12% = 2 cases	> 12% = 3 cases
	Avoid Falls	Percentage of complex continuing care residents who do not have a recent prior history of falling, but fell in the last 90 days - FY 2009/10 CCRS	0% of CCC residents	100% of patients will be assessed for fall risk and there will be a fall prevention plan in place prior to any new falls.	0.75%	1 fall in which an assessment has not occurred	2 falls in which an assessment has not occurred	3 or more falls in which an assessment has not occurred.
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 2010/11 OHRS	-0.04%	<2% deficit	1%	equal to or <-2% deficit	> -2% to <4% deficit	Greater than 4% deficit
Patient-Centred	Improve patient satisfaction	**NRC Picker** - "Would you recommend this hospital to your friends and family? 2010 Q3 &Q4	ER 78.31%	to exceed the small hospital ER average of 70.1%	1%	meet or exceed the small hospital average	10% below the small hospital average	25% below the small hospital average
					5%			

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