Excellent Care For All.

2013/14

Quality Improvement Plan for Ontario Hospitals

(Short Form)

London Health Sciences Centre

March 27, 2013

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.

1. Overview of London Health Sciences Centre's Quality Improvement Plan:

London Health Sciences Centre (LHSC), one of Canada's largest acute-care teaching hospitals, is dedicated to excellence in patient care, teaching and research. Quality Care is deeply engrained in LHSC's culture and vision of *"Exceptional Experiences, Extraordinary People, and Engaging Partnerships*". Building on a legacy of care and innovation, LHSC will be known as an inspiring and leading academic community that is:

- Driven to achieve excellence in patient care, service and safety;
- Dedicated to improving the patient and family experience;
- Transformed by discovery and innovation; and
- Committed to collaborative partnerships

Building on the strength of the Quality Planning process of past years, the Board and Senior Leadership further improved the Quality Framework which guides the development of the Quality Plan. Key characteristics of the improved Quality Framework were summarized as follows:

1) Aligned & Coordinated with the strategic planning and objective setting process, linking all quality activities across the organization and informing project resource allocation and prioritization.

2) Comprehensive & Balanced across the five dimensions of quality (Integrated, Safe, Timely, Effective/Efficient, and Patient Centered) as established by Health Quality Ontario (HQO). Linking these five dimensions creates synergy with the provincial process and allows a simplified model that is clear and memorable to all, especially using the newly adopted pneumonic "I-STEPup" which will be widely rolled across the organization to help staff, physicians and volunteers continuously link their work to the quality mandate.

3) Effective & Sustainable in facilitating multi-year planning of quality targets and associated projects, and enabling regular monitoring of performance and improvement opportunities. The enclosed 2013/14 QIP is in fact part of a three year Quality Plan for the organization containing over 50 indicators that are regularly monitored and evaluated. The multi-year planning enables setting stretch targets for the next three years and having sufficient time to build capacity, prioritize initiatives and resource allocation.

In preparing the hospital's three year plan and subsequent 2013/14 QIP, a thorough review of LHSC's current performance, priorities and challenges were conducted. In addition, QIP reports of peer hospitals and all supportive benchmarking and best practice materials provided by HQO were reviewed.

A comprehensive list of over 50 indicators was compiled to be regularly monitored, and the respective targets are in the process of being established. A short list of six priority 1 indicators and four priority 2 indicators for the 2013/14 QIP were selected based on alignment with strategic priorities, comprehensiveness across the five quality dimensions and active projects already in place or nearing completion expected to deliver benefits during the year. The targets were then determined based on the implementation timeline of each project by December 31st to allow sufficient time to pull the information and report back to HQO by March 31st as legislated.

For subsequent years in the three year plan, the following decision tree was used to establish a target, along with considering baseline performance and the capacity to dedicate both corporate and clinical focus and resources:

1) Theoretical Best (i.e. zero C-difficile rates, 100% hand hygiene compliance…etc)
2) Top quartile performance amongst peer hospitals
3) LHIN & MOH target
4) 10% improvement from last year
5) Maintain performance

2. Focus: London Health Sciences Centre will be focusing on the priority one objectives under the five quality dimensions.

Integrated

Objective: Reduce unnecessary hospital readmission
Measure/Indicator: Percent of readmission's within 30 days for Congestive Heart Failure (CHF) patients
Change Ideas:

- Implement the Guidelines Applied in Practice for Heart Failure (adapted from the University of Ottawa Heart Institute), which includes a pathway for CHF patients along with a pre-printed order form, patient education materials, patient contract and other tools.
- Use the Heart Failure tool kit to standardize physician and nursing assessments, in hospital treatment and discharge planning for all CHF patients.

Safe

Objective: Reduce hospital acquired infection rates
Measure/Indicator: Clostridium Difficile Infection (CDI) - The rate of patients newly diagnosed with hospital-acquired C-diff
Change Ideas:

- Antimicrobial Stewardship Program, part of the Council of Academic Hospitals of Ontario's Adopting Research To Improve Care (ARTIC) Program
- Hand Hygiene Compliance project

Objective: Reduce hospital acquired infection rates
Measure/Indicator: Methicillin-resistant Staphylococcus Aureus (MRSA) - The rate of patients newly diagnosed with hospital-acquired MRSA blood stream infections
Change Ideas:

- MRSA Suppression Protocol
- Antimicrobial Stewardship program
- Central Line Safer Healthcare Now

Timely

Objective: Reduce wait times in the Emergency Department
Measure/Indicator: Length of Stay (in hours) for non-admitted patients in the Emergency Department
Change Ideas:

- Physician Initial Assessment (PIA) Project
- Reducing the pressure in the Emergency Department of admitted patients waiting for a bed though a number of initiatives including: Predictive Care, which improves and streamlines the patient discharge process; Patient Flow Management System, which provides more visibility of the patient's physical journey within the hospital's walls' and Home First, which improves the transition process for patients beyond LHSC and reduces the number of Alternate Level of Care days (ALC).

Effective/Efficient

Objective: Reduce unnecessary deaths in hospitals
Measure/Indicator: Hospital Standardized Mortality Ratio (HSMR) - The ratio of actual number of acute in-hospital deaths to the expected number of in-hospital deaths, for conditions accounting for 80% of inpatient mortality

Change Ideas:

- Sepsis Management Improvement
- Venous Thromboembolism (VTE) Prophylaxis
- Ventilator-Associated Pneumonia Protocol

Patient Centered

Objective: Improve patient satisfaction
Measure/Indicator: Percent of patients that would rate the care and services they received at LHSC as "excellent"
Change Ideas:

- Engage patients as partners in the design of the care journey, through embedding the "Patient Experience Based Design" (EBD) approach in our improvement projects. EBD is defined as using patient experiences (not attitudes or opinions) to gain insights from which opportunities for improvement can be identified, and is based on treating patients and their families as partners.
- Expand the successful "Patient Advisor Role" beyond the three programs which currently utilize it to the wider organization, where patient representatives are actively engaged in program planning and decision making
- Establish Standards and Behaviours for Patient and Customer Service

QIP Plan for: London Health Sciences Centre

AIM		MEASURE					CHANGE			
Quality Dimension	**Objective**	**Measure/Indicator**	**Current Performance**	**Target for 2013/14**	**Target Justification**	**Priority level**	**Initiative Number**	**Planned Improvement Initiative (change ideas)**	**Methods and Process Measures**	**Goal for change ideas (2013/14)**
Integrated	Reduce unnecessary hospital readmission	Congestive Heart Failure (CHF) 30 Day Readmission Rate: The percent of unplanned LHSC readmissions from previous acute care within LHSC for Congestive Heart Failure (CMG 196: Heart Failure without Cardiac Catheterization). Current Performance (April 1, 2012-December 31, 2012), Target Performance (April 1, 2013-December 31, 2013).	21.4	19.3	10% reduction based on a 24 month baseline, to exceed top-quartile.	1	**1**	Implement the GAP-HF (Guidelines Applied in Practice for Heart Failure) adapted from the University of Ottawa Heart Institute. Includes a pathway for CHF patients along with a pre-printed order form, patient education materials, patient contract and other tools.	Heart Failure tool kit is developed, approved and distributed to the appropriate Cardiology and Medicine units.	Heart Failure tool kit is on the appropriate units by Aug. 1, 2013 (cardiology) and 2013 (medicine).
							2	Use the Heart Failure tool kit to standardize physician and nursing assessments, in hospital treatment and discharge planning of all CHF patients.	Measure the use of the Heart Failure tool kit on a quarterly basis by way of chart audits. Measure the degree of standardization of care of CHF patients by way of chart audits.	80% compliance on the use of the new patient contract toolkit and 100% compliance barring documented contraindications.
Safe	Reduce hospital acquired infection rates	Clostridium Difficile Infection (CDI): The rate of patients newly diagnosed with hospital-acquired CDI per 1,000 patient days. Current Performance (April 1, 2012-December 31, 2012), Target Performance (April 1, 2013-December 31, 2013).	0.49	0.44	10% reduction based on new and existing projects and their expected benefits.	1	**1**	Antimicrobial Stewardship	Tracking antimicrobial utilization rates and changes to resistance patterns.	TBD.
							2	Outbreak Management System	Tracking number of alert level 1 incidents and minimizing number of outbreaks called.	Alert level 1 and 2 outbreaks enacted within identified timeframes 100% of the time.
		Methicillin-resistant Staphylococcus Aureus (MRSA): The rate of patients newly diagnosed with hospital-acquired MRSA blood stream infections per 1,000 patient days. Current Performance (April 1, 2012-December 31, 2012), Target Performance (April 1, 2013-December 31, 2013).	0.04	0.03	25% reduction based on new and existing projects and their expected benefits.	1	**1**	MRSA Suppression Protocol	Standardization of bathing protocols at LHSC.	All clinical units aware of optimal suppression protocol based on patient population with > 90% completion.
							2	Hand Hygiene	Monthly hand hygiene audits sustained.	88% for hand hygiene moment 1.
							3	Central Line Infection Reduction	Audits for completion of Central Line insertion checklist.	100% completion the of protocol in the Emergency Departments (except in resuscitation efforts).
Timely	Reduce wait times in the ED	ED Wait Times: 90th Percentile ED length of stay for Non-Admitted Patients, Low Acuity CTAS 4 & 5 (measured from triage to discharge). Current Performance (April 1, 2012-December 31, 2012), Target Performance (April 1, 2013-December 31, 2013).	6	5	Over a 15% reduction for the year, with a goal to achieve top-quartile within 3 years.	1	**1**	Physician Initial Assessment (PIA) Project	Monitor PIA times and follow up on any outliers on a monthly basis.	1 hour improvement in PIA time.
							2	Reducing the pressure in the Emergency Department of admitted patients waiting for a bed though a number of initiatives including, the Predictive Care project which improves and streamlines the patient discharge process, the Patient Flow Management System which provides more visibility of the patient's physical journey within the hospital's walls, and the Home First project which improves the transition process for patients beyond LHSC and reduces the number of Alternate Level of Care days	Measure the reduction in wait time for Admitted Patients and the decrease in ALC days.	Reduction in the Length of Stay of Admitted Patients by 1 hour and reduction of % ALC days by 10%.
Effective / Efficient	Reduce unnecessary deaths in hospitals	Hospital Standardized Mortality Ratio (HSMR): The ratio of actual number of acute in-hospital deaths to the expected number of in-hospital deaths, for conditions accounting for 80% of inpatient mortality. Current Performance (April 1, 2012-December 31, 2012), Target Performance (April 1, 2013-December 31, 2013).	100	93	7% reduction to get statistically better than 100 based on projects and their expected benefits.	1	**1**	Sepsis Management Improvement	Improve the recognition and treatment of Sepsis according to the Sepsis Protocol.	Decrease the HSMR due to Sepsis with unexpected deaths to 32%.
							2	Venous Thromboembolism (VTE) Prophylaxis	Quarterly audits for compliance of ordering VTE Prophylaxis.	100% compliance of ordering VTE Prophylaxis.
							3	Ventilator-Associated Pneumonia (VAP)	Screening patients for VAP and bedside auditing for VAP bundle compliance.	95% compliance to the VAP bundle.
Patient Centered	Improve patient satisfaction	From NRC Picker: "Overall, how would you rate the care and services you received at the hospital?" (percent of those who responded "Excellent"). Current Performance (April 1, 2012-September 30, 2012), Target Performance (April 1, 2013-December 31, 2013).	49	50	2% improvement based on the patient experience strategy continuing to roll out in 2013-2014.	1	**1**	Embed "Patient Experience Based Design" (EBD) approach in Improvement Projects	Assess if EDB approach was used in all new projects and evaluate tools to utilized to capture the patient perspective.	100% of new improvement projects to use Patient Experience Based Design approach (if applicable) or an alternate method to capture patient perspective.
							2	Patient Advisor Role	Percentage of Corporate and Program Committees with active Patient Advisor involvement.	50% of corporate and program based committees to have active participation of Patient Advisors.
							3	Establish Standards and Behaviours for Patient and Customer Service	Development of Standards and Behaviours, and roll-out of training.	Standards/Behaviours developed and corporately adopted, and training modules developed and starting roll-out.

3. Alignment:

The LHSC Quality Improvement Plan was developed based on alignment and coordination with the LHSC Strategic Plan including the Strategy Map, the Enterprise Risk Management Plan and the Key Corporate Annual Priorities. Quality activities and projects across the organization were also linked into the QIP to ensure alignment and better informing project resource allocation and prioritization

For indicators that were also part of the Hospital Services Accountability Agreement (H-SAA) with the Ministry, the planning and target setting processes were synchronized.

4. Integration and continuity of care:

With LHSC's position as a regional resource, integration and care continuity beyond our walls receives significant attention. The organization is actively engaging with regional partners to improve care transitions across the continuum. Furthermore, active discussion and planning is ongoing for more optimal care alignment through commitments to receive referrals and manage repatriation. Additionally, as the organization embarks on regular process improvement projects, more effort will be placed on mapping the patients' journey prior to admission and following discharge from LHSC.

5. Health System Funding Reform (HSFR):

Given the significant transformational change associated with the HSFR, the organization has taken active steps to carefully analyze its data systems to ensure conclusions reached through the benchmarking and funding process are accurate and actionable. More importantly, the Quality Based Procedures (QBP) benchmarking information and practice guidelines provided by the Ministry have been carefully assessed. A team including physicians, clinical leads, data consultants and process analysts for each of the QBPs was formed to carefully review current performance in light of the information provided to identify areas for improvement. To date, several improvements have been identified and benefits realized, with further work underway.

6. Challenges, risks and mitigation strategies:

At a time of increased pressure on health care organizations due to the aging population, limited resources and financial constraints, careful planning and innovation is required to ensure quality and performance levels are continually improving. LHSC recognizes those challenges and appreciates the potential risk of not meeting the set targets if appropriate mitigating measures are not set.

The organization is therefore systematically approaching the challenge by focusing on three key themes which are critical to enabling a successful improvement journey through; 1) dedicating intensive efforts towards cultural transformation and building high performing teams, effective systems, and a culture of empowerment and collaboration; 2) building the skills of staff and physicians and fully embodying a "Learning Organization" philosophy; and 3) ensuring the right structures are in place to monitor progress, ensure accountability and empower change.

To ensure resources and organization focus are appropriately allocated and assigned, a focus on a fewer number of priorities was necessary. While there are many quality initiatives ongoing at LHSC, the QIP is focused on the highest priorities and these in turn have been allocated appropriate resources to enable success. The introduction of the Quality Dashboard in 2013 enables monitoring of a broader list of indicators to ensure that performance levels on other key areas are maintained and potentially enhanced.

7. The link to performance-based compensation:

The compensation plan is aligned to corporate strategies. The six priority 1 indicators are tied to compensation. Up to 10% of the CEO's annual salary and 3% of the remaining executive staff's annual salary will be based on QIP performance.

Compensation will be awarded as follows:

- All quality dimensions carry an equal weight of 20%. For the "Safety" quality dimension, which has two indicators, the 20% is divided evenly across the two indicators.
- There are three levels of achievement for all indicators
  - Missed (<50% of target achieved) – no compensation for the indicator
  - Partial (50-99% of target achieved) – prorated compensation received for the indicator, equal to the percent towards target achieved
  - Met (100% of target achieved) – 100% compensation received for the indicator

Quality Dimension	Measure				Compensation			
	Indicator	Priority	Baseline	Target	Missed (<50%)	Partial (50-99%)	Met (>100%)	Weight
Integrated	CHF 30 Day Readmission Rate (%)	1	21.4%	19.3	>20.4	19.3-20.4	<=19.3	20%
Safe	CDI cases per 1,000 Pt. Days (rate)	1	0.49	0.44	>0.465	0.44-0.465	<=0.44	10%
	MRSA cases per 1,000 Pt. Days (rate)	1	0.04	0.03	>0.035	0.03-0.035	<=0.03	10%
Timely	90% ED LOS for Non-Admit Patients (CTAS 4&5) (hr)	1	6.0 (6.7 UH -5.6 VH)	5.0	>5.5	5.0-5.5	<=5.0	20%
Effective/ Efficient	HSMR (ratio)	1	100	93	>96.5	93-96.5	<=93	20%
Patient Centered	Inpatient Satisfaction - overall rating is excellent (%)	1	49	50	<49.5	49.5-50	>=50	20%

Accountability Sign-off

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

Ms. Ruthe Anne Conyngham	Mr. Tom Gergely	Bonnie Adamson
Board Chair	*Quality Committee Chair*	*Chief Executive Officer*