

Quality Improvement Plans

Excellent Care for All Act (ECFAA)

ECFAA Implementation Working Group

January 26, 2011

Outline

- How we got here
- The contents of the QIP package
- How to fill out the QIP
- Next Steps and resources

Section 1:

HOW WE GOT HERE

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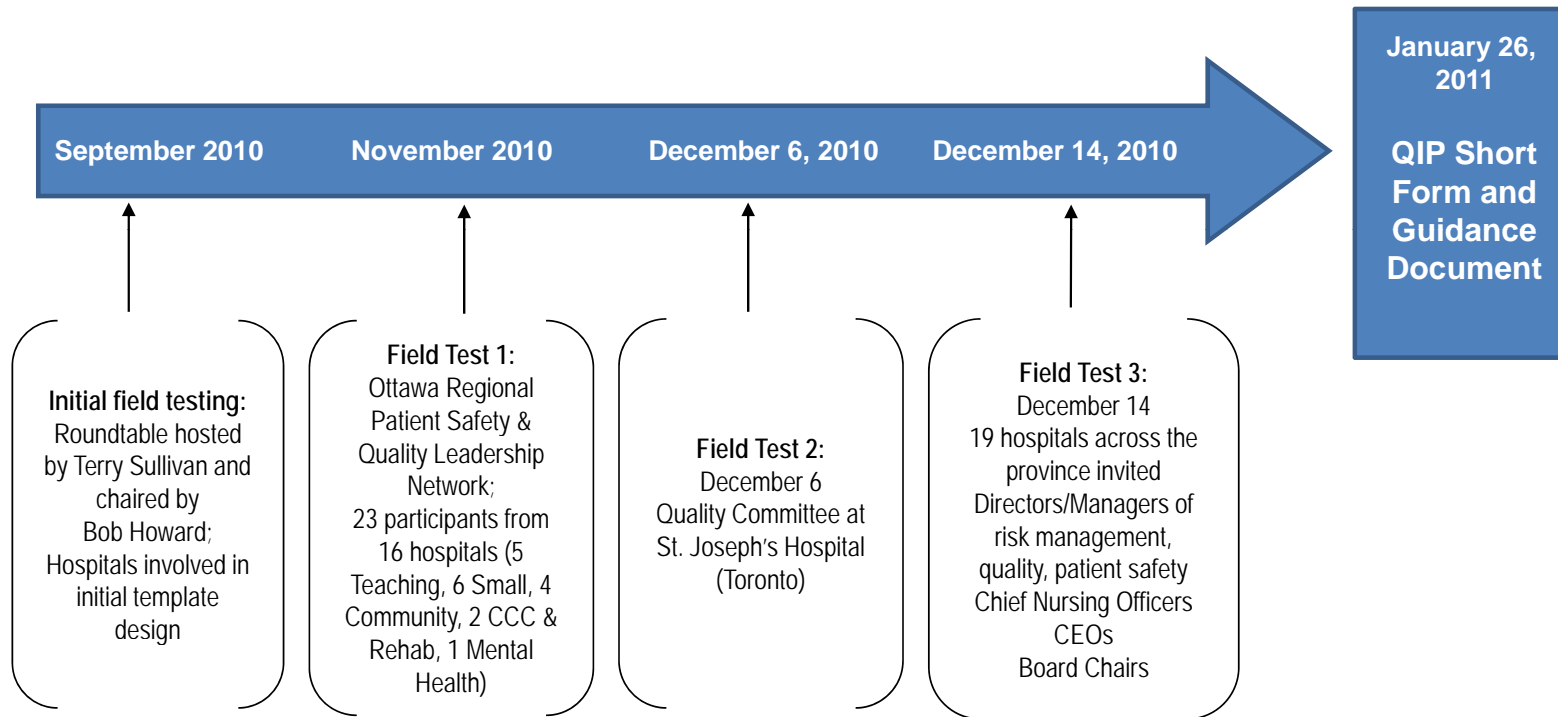
OHQC Ontario Health
Quality Council

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ECFAA Implementation Working Group

- Established to support Ontario hospitals in their efforts to implement ECFAA
- Representatives from OHA, OHQC, LHIN, Hospitals, MOHLTC
- Main goals: **Support, educate and communicate**

QIP Development and Testing Process



The end result of this process is not just a template – it is a meaningful tool created with the input of the sector, designed not just to report on their quality improvement efforts but to provide a structure that will help drive those efforts

Section 2:

CONTENTS OF THE QIP PACKAGE

Your QIP Package

- Includes 3 separate files:
 - QIP Guidance Document
 - QIP “Short Form” Parts A, C & D (Word file)
 - QIP “Short Form” Part B – Targets and Initiatives (Excel file)
- “Short Form” QI Plan:
 - Consists of Parts A to D
 - contains elements necessary for hospitals to meet legislative requirements of ECFAA
 - Called “short form” as many hospitals already have detailed QI plans in place—the “Short Form” is condensed in comparison

Section 3:

HOW TO COMPLETE THE QIP

The “Short-Form” Has Four Parts

- PART A: brief, plain language overview of the plan providing highlights and listing hospital priorities
- PART B: Excel template – *will be reviewed in this deck*
- PART C: Performance based compensation
- PART D: Accountability Sign-off

Part A – Overview

- Provide plain language description of QI plan
- Can be used to share with public, patient advisory groups, or to communicate plan to staff & get them excited about it
- Brief – maximum 1 – 2 pages
- Components:
 - Overview (~100 words)
 - Focus, and how objectives and initiatives will be achieved
 - Aims, change ideas
 - Alignment
 - Challenges, Risks & Mitigating Strategies

Part A - Example

OVERVIEW

Greengarten is committed to a smooth and safe journey for our patients. When this plan is implemented, our patients will have shorter waits in the emergency department. They will get better supportive care and rehabilitation they need to recover in hospital. They will leave hospital with all of information they need and all of their questions answered, and necessary follow-up care arranged. As a result, they will be less likely to have to return to hospital after discharge. Their rates of satisfaction will be among the highest for community hospitals in Ontario.

Example

Aims & Measures:

By March 31, 2012, we will:

- Reduce hospital readmissions by 10% for selected conditions
- Reduce in-patient falls by 30% while making sure patients get up and about when needed
- Reduce emergency department (ED) wait times from 8.5 to 8 hours (as measured by maximum time spent in ED for 9 of 10 patients with complex needs)
- Have 80% of our patients say they would “definitely” recommend our hospital to others, and 40% will say they left hospital with all the information they need (compared to the current 25%)

Example

Ideas for improvement:

From April 2011 to March 2012, we will:

- Do earlier discharge planning and better coordination with home care. Make sure the most frail patients get a day-after-discharge home care visit and family doctor follow-up within a week.
- Eliminate delays in sending out discharge summaries.
- Provide written discharge instructions for all patients at high risk of readmission. Train staff to use the 'teach-back' method to make sure patients understand these instructions.
- Work with our LHIN, CCAC and five nearby Family Health Teams to improve transfer of information at discharge.
- Expand referrals to our chronic disease management outpatient clinic for those at highest risk by 10%

Part B – Improvement Targets and Initiatives

- Part B: Excel spreadsheet
- Focuses on four key quality areas:
 - Safety, Effectiveness, Access and Patient-Centredness
- Includes:
 - core set of indicators to ensure comparability of results across the province
 - space for organizations to add other indicators for local priorities

- Columns 1 & 2 describe: “*what are we trying to accomplish*”
- Safety:
 - Include **at least one** of the following: C difficile, hand-washing, VAP, CLI, falls, pressure ulcers
- Effectiveness
 - Include ALC, readmissions, total margin; HSMR if already large enough for public reporting
- Access
 - Include ED wait times for complex patients
- Patient-Centred
 - Include at least one indicator (your choice)

AIM	
Quality dimension	Objective
Safety	Reduce clostridium difficile associated diseases (CDI)
	Reduce incidence of Ventilator Associated Pneumonia (VAP)
	Improve provider hand hygiene compliance
	Reduce rate of central line blood stream infections
	Avoid new pressure ulcers
	Avoid falls
	<i>Space for additional indicators</i>
Effectiveness	Reduce unnecessary deaths in hospitals
	Reduce unnecessary hospital readmission
	Reduce unnecessary time spent in acute care
	Improve organization financial health
	<i>Space for additional indicators</i>
Access	Reduce wait times in the ER
	<i>Space for additional indicators</i>
Patient-centred	Improve patient satisfaction
	<i>Space for additional indicators</i>

- Columns 3 to 6 describe: *“how we will know if a change is an improvement”*
- In column 3 (shown), a core set of performance measures are pre-populated to ensure comparability of results by the OHQC, as per ECFAA
- Note: the examples at right are not the complete set of indicators

MEASURE
Outcome Measure/Indicator
<p>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</p>
<p>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 - Average for Jan-Dec. 2010, consistent with publicly reportable patient safety data</p>
<p>HSMR: number of observed deaths/number of expected deaths x 100 - FY 2009/10, CIHI</p>
<p>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 - Q2 2010/11, DAD, CIHI</p>
<p>Percentage ALC days: Total number of inpatient days designated as ALC, divided by the total number of inpatient days. Q2 2010/11, DAD, CIHI</p>
<p>ER Wait times: 90th Percentile ER length of stay for Complex conditions. Q3 2010/11, NACRS, CIHI</p>
<p><i>Please choose the question that is relevant to your hospital:</i></p>
<p>NRC Picker / HCAPHS: "Would you recommend this hospital to your friends and family?" (add together percent of those who responded "Definitely Yes")</p>

- Columns 4, 5 and 6 are the “where you are” “where you want to be” and “where this fits into your overall plan”
- This is where you set the performance goals that will drive your quality improvement efforts going forward

Current performance	Performance goal 2011/12	Priority

Performance Goals

- When setting performance goals (targets), consider:
 - Best practice in Ontario or worldwide
 - VAP, CLI rate 0 (Ontario, international examples)
 - C diff. rates of ~ .15 (some hospitals in Ontario)
 - % definitely recommend at 80-90% among leaders in USA
 - Surgical waits: 100% within target for priority (one hospital in Ontario)
 - Ministry or consensus panel-based targets
 - E.g. 8 hours for time spent in ED for complex pts
 - Decreasing gap from current to best by half
 - Pace of improvement seen elsewhere
 - E.g. decrease in HSMR of 5-10 points / yr

Performance Goals

- ALC:
 - Hospitals required to set goals on hospital-based processes that contribute to ALC reduction
 - ideas for consideration:
 - Early home care assessment
 - successful implementation of “Home First”
 - Encouraged to set goal on ALC itself (but not a requirement)

Performance Goals and Time Frames

- Different indicators require different time frames for measuring success
 - E.g. wait times – stable monthly estimates – can set goal for March 2012
 - C diff – high month-to-month variability – set goal for reducing 12-month rolling average
 - Consult guidance document for details

- Columns 7 to 11 complete the model for improvement by describing: *“What changes can we make that will result in improvement”*
- Change plans required for all areas ranked as priority 1
- Change plans strongly recommended for all other priorities but not required; *filling out this section opens opportunities to share and learn among hospitals*

CHANGE				
Improvement initiative	Methods and results tracking	Target for 2011/12	Target justification	Comments
1)				
2)				
... N)				
1)				
2)				
... N)				
1)				
2)				
... N)				
1)				
2)				
... N)				
1)				
2)				

SAMPLE ROW

AIM	MEASURE	CHANGE							
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Objective	Outcome Measure/Indicator	Current performance	Performance goal 2011/12	Priority	High-level improvement plan	Methods and results tracking	Target for 2011/12	Target justification	Comments
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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	65%	80%	1	monthly education and training sessions by program	audit to show 80% of staff trained	80% of hand hygiene champions trained	internal targeting exercise decided to aim for getting half-way towards long-term goal this year and attaining long-term goal in the following year	
					Complete installation of ABHR outside all remaining patient rooms and treatment areas	environmental review to confirm installation			
					Positive deviance training for HH champions	100% attendance at training. 75% self-report using a positive deviance technique.			
					Encourage patients to ask providers if they've washed hands using pamphlets, posters.	Survey patients to ask if they were comfortable doing so; aim for 50%			

Considerations: LHIN Involvement

- Not a requirement, but early LHIN involvement can help with determining targets and strategies to address indicators that are dependent on good coordination of care with external providers (e.g. ALC, ED wait times, readmissions). Addressing questions such as:
 - What is the coordinated strategy across these different providers?
 - If organizations are working in these areas, how will they work with LHIN to plan for success?

Parts C and D

- Part C is where the link between executive compensation and the development of indicator goals is outlined, and Part D is where the Board Chair, CEO and Quality Committee Chair sign off on the plan
- Not all indicators are to be linked to executive compensation—the QIP Guidance Document includes a recommendation that each executive’s compensation should be tied to no more than 6-8 targets maximum
- Hospitals should set stretch targets and it is up to the hospital to determine the extent compensation will be affected and by which indicators
- **A more detailed briefing on this aspect of the QIP is being scheduled for February**

Section 4:

NEXT STEPS AND RESOURCES

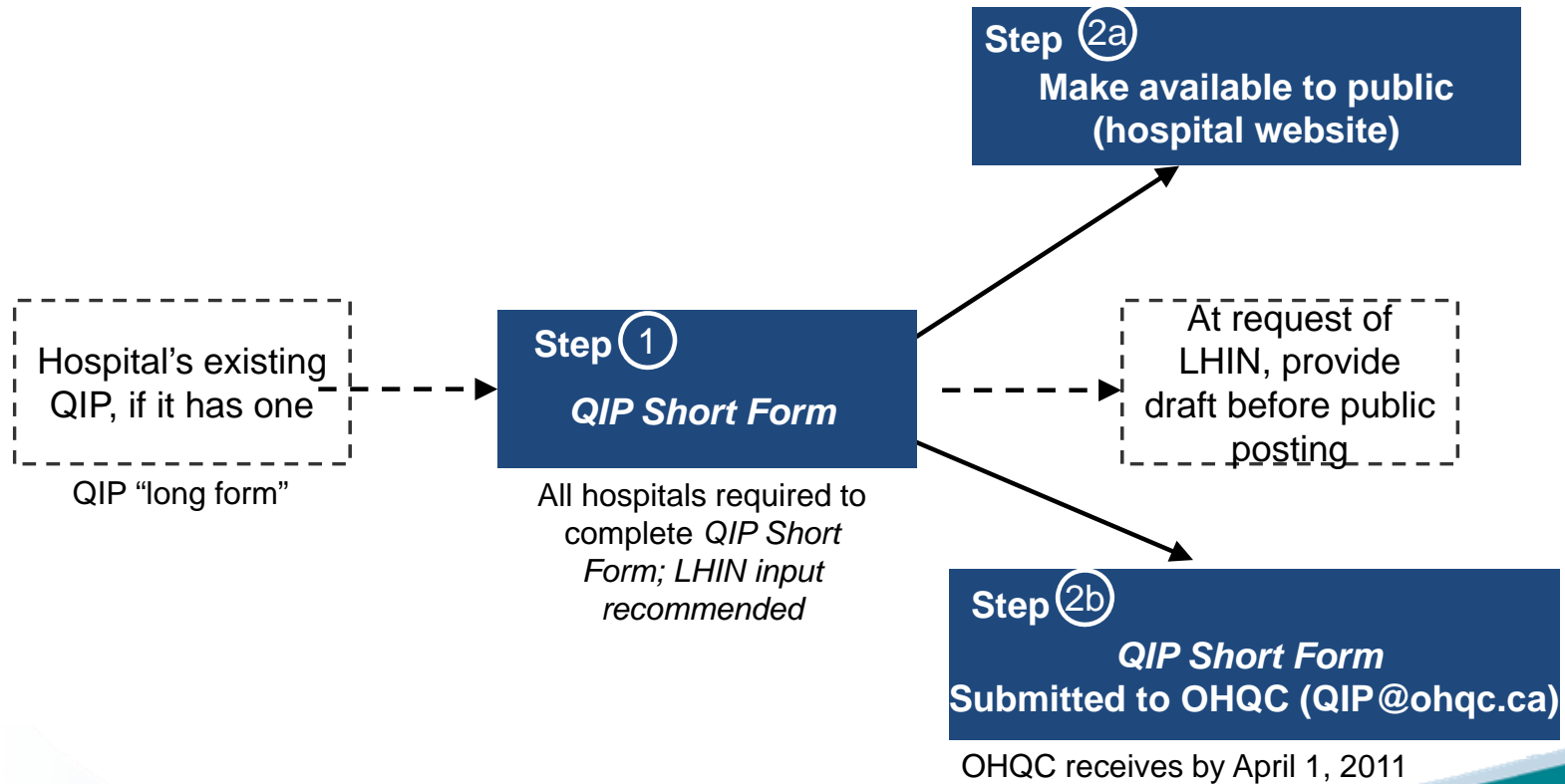
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Steps in Completing Your QIP

*QIP Short Form publicly available
(+ "long form" if hospital chooses)*



Working Together

- Questions from today's session will be incorporated into FAQs and distributed shortly
- Send additional questions via email to: QIP@ohqc.ca
- Under consideration/in development:
 - Additional OHA webcasts to support the field (e.g. on communicating about the QIP)
 - A series of OHQC Quality Congresses across the province to facilitate best practice sharing in the future
 - A library of evidence-based material for all indicators. This resource will include proven protocols for addressing the indicators in the QIP
- **The QIP Short Form is a work in progress—your feedback will help it to evolve and improve over time**