PART B: Improvement Targets and Initatives 2012-13

Four Counties Health Services

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**
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	1 case-0.28 rate	0.28-0.40 (Ontario averages)	Improve or maintain current rate	2	Continue to monitor this year . Observe results for trending . Identify previous C Diff cases on admission.	Chart review , lab value reports, symptom and antibiotic use surveillance.
	Improve provider hand hygiene compliance	**Hand hygiene compliance before and after 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	88%	90%	Hand hygiene continues to a priority indicator for all areas. Increased frequency and volumes of hand	1	1) Reassess sufficient point -of care placement and location of hand hygiene product	Product placement on overbed tables in all in-patient rooms.
							2)Improve the auditing ,reporting process and visibility of compliance.	New on-line program purchased (mAiRiner)to make auditing and reporting easier for auditors.
								Compliance numbers will be supplied by the auditors and infection control to all the requesting departments and disciplines
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	3.63	Greater than or equal to 0	Sustain current total margin at greater than or equal to 0	1	1) Currently achieving performance goal and will continue to monitor through Board Finance Committee. Sustaining Total Margin at zero or better balance of institutional financial health requiring rapid internal learning curve relative to new Quality Based Funding model and Hospital Service Accountability Agreement(HSAA)	Monthly financial tracking and reporting. Enrollment in HBAM and QBP HSFR education sessions and review of resources provided. Develop template for monitoring and costing of QBP procedures, following review of monthly and forecasted volumes.
Access	Urgent Hip Fracture Referral to Surgical Site	**Hip Fracture Repair** :Time to Hip Fracture repair surgery within 48 hours of diagnostic X-ray for medically stable patients.	Historically less than 90% completion of surgery within 48 hours of patient registration.	90 % completion of hip fracture repair surgery within 48 hours of diagnostic X-ray	Consistent with provincial BJHN recommended clinical guidelines.	2	1) Hip Fracture Pathway Implementation 2) Urgent Hip Fracture Regional Orthopedic On Call Project	Early patient identification, early assessment of medical complications and their treatment to be able to proceed with surgery within appropriate timelines, consultation and timely transfer to ortho centre, documentation of patient on tracking form.
	CT Wait Times	**90th Percentile CT Wait Time in Days.**	12	11	Consistant with HSAA target of alliance hospital.	2	Monitor wait time targets and wait days monthly.	CT volumes and wait times tracked quarterly .
	Diabetes Education Centre (DEC)	**Average Wait Time Days for DEC patients for initial appointment.**	Unknown	30 days	New target, unknown current wait time, highly variable.	2	Assess current performance and establish target to improve.	Tracking of number of wait days to initial appointment for diabetes management.
Patient Centered	Patient Satisfaction	**From NRC Picker:** "Overall, how would you rate the care and services you received at the hospital?"	90%	93%	Sustain and improve current performance	2	1) Tracking and Communication of Quarterly Departmental Results	Quarterly results retrieved by department managers, shared with staff and posted within department. Establish departmental targets for achievement.
		From NRC Picker / HCAPHS: "Would you recommend this hospital to your friends and family?"	76.86	80%	Continue current improvement trend .	2	1) Tracking and Communication of Quarterly Departmental Results	Quarterly results retrieved by department managers, shared with staff and posted within department. Establish departmental targets for achievement.

							2) Quarterly Analysis of documented complaints and NRC Picker detail question.	Analyze specific questions to identify specific areas of strength and improvement . Eg Courtesy of ED nurse, call bell response time, care coordination, education etc.
		Patient Complaints: Percentage of patient complaints initial respond within 2 business day of receipt of complaint.	Unknown, variable	85% Initial response to complaints within 2 business days.	Actual performance is unknown, however variable.	1	Reporting and Tracking of Complaints response times.	Documentation of current expectations to respond to patient complaints within 2 business days.
Integrated	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 2011/12, DAD, CIHI	9.29 (Annual performance Q3 2010-Q2 2011 17.68)	Less than or equal to 14.55	Annual performance Q3 2010-Q2 2011 17.68. Target established to reflect target for alliance hospitals and based on quarters identified.	1	1) Early identification of discharge plan	Nursing admission history inclusion of discharge destination assessment. Inclusion of CCAC and Support services referral orders in Patient Order Sets . Review roles and responsiblities of CCAC case manager of patient case reviews.
							2) Monitoring of ALC days and patient types	WTIS ALC- regional gateway report through EPR documentation.

Goal for change ideas (2012/13)	Comments
Early identification of possible, recurrent or actual C. diff.	Limited trending to consider given single case over two consecutive years.
100% of all patient care areas and overbed tables.	Product will be available for patients to use prior to eating or during the day and be more readily for staff
Minimally, quarterly reports provided to all areas and disciplines for display in departments.	The MHA purchased a web based hand auditing program that has greatly improved the numbers of audits being completed and has allowed many more reports to be circulated to the units and disciplines.
Minimally quarterly reporting to all areas and disciplines	
	This is a priority item because it is tied to HSAA funding and unknown impact related to new HBAM and Quality Activity Funding 2012-13. LEAN initiatives related to improved patient care , education, access, but also costing underway.
Reach 90% patient hip fracture repair within 48 hours of patient registration.	FCHS refers ortho to SMGH first or other ortho centres , both tertiary and hospitals in SW LHIN Urgent Hip Fracture initiative to optimize orthopedic hip fracture coverage. Patients who exceed the 48 target hours will be reviewed to determine nature of the delay and may be excluded relative to availability of required internal medical consult, medical condition preventing proceeding with surgery until stable, or external factors beyond our control.
Track departmentally on quarterly basis and post on departmental indicators.	Wide age, population and culture variance. Aiming to enhance consistency of time to initial appointment following physician or patient self referral.
Establish departmental targets for achievement.	
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	Improved performance this year over 2010-11. Continued trend with professional development, unit specific goals and performance targets.
85%	Patient complaints and compliments tracked within electronic occurrence reporting system. Policy and procedure established to support and decscribe documentation of first followup .
Earlier and Improved discharge planning of all patients, reducing number of ALC patients and length of ALC stay for ALC appropriate patients.	Factors for success include collaboraton with CCAC external provider, consistent use of ALC definition, timely transfers to ALC facilities.