Excellent Care For All.

Quality Improvement Plan (QIP) Narrative for Health Care Organizations in Ontario

MIDDLESEX HOSPITAL ALLIANCE

Middlesex Hospital Alliance

April 1, 2015

Strathroy Middlesex General Hospital
395 Carrie Street
Strathroy ON N7G 3J4

Four Counties Health Services
1824 Concession Drive
Newbury ON N0L 1Z0

The Middlesex Hospital Alliance (MHA) is comprised of Strathroy Middlesex General Hospital (SMGH) and Four Counties Health Services (FCHS). The two community hospitals are located in the Southwest Local Health Integration Network. The MHA Board and Quality Committee have been engaged throughout the current fiscal year with supporting the improvement plan efforts of leadership and health care providers. The committee monitors the progress quarterly, provides guidance, and requests detailed information of change ideas, challenges and plans moving forward to address priority indicator opportunities for improvement.

2014-15 Achievements include:

- Achievement of C.Difficile target of zero cases at FCHS, near target achievement SMGH
- Breast Assessment Program development completes final requirement for submission March 2015
- Greater than 90% compliance of hand washing maintained both before and after patient contact.
- Achievement of a balanced or better total margin
- ED Knowledge Transfer project implementation of equipment, tools and resources
- Improved ED admitted Length of Stay
- Quality Workplace Award- Silver Award
- MORE OB Program completion of Module 2
- Home First Program Implementation
- HUGO Electronic Provider Order Entry Launch February 2014
- Dissemination of HSFR and QBP funding understanding and impacts following thorough review of MOHLTC Clinical Guidelines, clinical review of case volumes, outcomes, costs and readmissions.
- SWLHIN Regional working group collaborating on quality outcomes achievement of provincial Total Joint Replacement indicators, Regional Information Decision Support(RIDS)

The MHA is well positioned to succeed in quality improvement changes and processes with its current status. The Quality committee of the Board is a highly engaged group providing insightful guidance and support. Lean process improvement practices are evident in all areas of the hospital providing a common and inclusive platform for day to day operations, departmental goals and addressing barriers and challenges.

The objectives of the MHA Quality Improvement Plan include the identification of targets and initiatives for all applicable provincial priority indicators of:

- Clostridium Difficile: To sustain or reduce existing low incidence of hospital acquired C.Difficile. To be achieved through continued surveillance, hand hygiene before and after patient contact and implementation of antibiogram and antibiotic stewardship processes. These efforts are successful through collaboration with many care providers; Pharmacy and Therapeutics Committee members, infection control practitioner, housekeeping staff and adherence to provincial cleaning standards, investigation of new and emerging cleaning products, and physician adoption of antibiotic stewardship.

- Medication Reconciliation: To complete a Best Possible Medication History and Medication Reconciliation for greater than 90% of all admitted patients. The medications are assessed to determine whether they need to be continued, adjusted or discontinued with respect the patient health status, to reduce medication errors in the transition to hospital. This is consistent with Required Organizational Practices and Qmentum Accreditation. The MHA medication reconciliation process has recently become electronic through Care Provider Order Entry. Early vigilance and reporting of performance is expected.

- Readmission following hospitalization: To understand the rate and reasons for unplanned readmission to any hospital within thirty days following discharge for selected Case Mix Groups. An examination of previous performance of early readmission rates to any hospital continues. Knowledge gained from the review is helping to inform practice of all health care providers regarding clinical practices, medications, patient education and timely follow-up. Though this indicator will be tracked at both hospitals, the Four Counties site demonstrates low volumes of both readmissions and patient volumes, which are insufficient for public reporting.

- To maintain a balanced budget within the shifting and limited funding corridors. To sustain institutional financial health requires a continued understanding and application of principles relative to HBAM and Quality Based Procedure funding models and Hospital Service Accountability Agreement (HSAA) targets.

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- ED Wait Times Admitted Patient Length of Stay reduction to ten hours or less for 90 percent of patients. This work plan builds upon the SWLHIN ED- Strathroy site Knowledge Transfer Project objectives and implementation of associated actions plans. The plans address several key intervals of care which impact upon the total time elements from triage or registration to admission to an inpatient bed. With continued dissemination of new process improvements, the decision to admit time to admit to inpatient bed algorithm, reinforcement of clinical expectations, the abilities of the team and celebration of performance achievements, this aggressive improvement target of will be achieved. Though this indicator is tracked at both hospitals, the Four Counties site is not a Wait Time Information Strategy (WTIS) reporting hospital and not required to publicly report wait times. Of note, the length of stay admission wait times at Four Counties are routinely very good, related to patient volumes and bed availability.

- Achieve Patient Satisfaction of Overall Quality of Care positive results in greater than 93% responses received through survey respondents. The MHA hospital sites monitor several dimensions and avenues for obtaining information regarding patient satisfaction with their hospital experience. The SMGH is focused on ' Overall Care' satisfaction results for the entire organization for this QIP patient centered quality dimension; FCHS surveys only the ED specific 'overall care' indicator related to low inpatient volumes.

- Reduce the number of Alternate level of Care patient days in acute care beds by 10%. This integration quality dimension requires the collaborative efforts of all care providers, community supports and physicians. Early identification of patient risk and discharge planning are vital to this achievement.

The 2015-16 hospital wide focus on improvement is on the two major categories of Emergency Department and Alternate Level of Care and in doing so, addresses several Quality Dimensions of Accessibility, Safety, Integration, Patient Centeredness, and Effectiveness.

The Quality Improvement Plan aligns with several current and anticipated planning processes and initiatives:

Having completed the Qmentum Accreditation Survey in 2013 with exemplary status, the organization has been working on completing the required organizational practice of medication reconciliation. This coupled with the very use of electronic Care Provider Order Entry will enhance the completion of medication reconciliation through mandatory computer entry fields and monitor the percentage of achievement of this indicator. The quality of the BMPH is also being tracked to ensure its accuracy with new strategies and resources to support.

The Strategic Plan of the hospital, is under redevelopment by the Board and newly formed leadership with the intent to maintain a patient and family focus at the community hospital level and identify new areas of development. This process, in conjunction with the 2015-16 Quality Improvement Plan, will necessitate a redesign of current corporate dashboard reports.

The Quality Improvement Plan aligns closely with performance targets of SWLHIN Hospital Accountability Agreements and Wait Time Information Strategy.

The operating plan is maturing every year as a more robust and informed plan in collaboration with senior leadership, finance, individual department managers and a hospital wide focus on understanding case costs and pressures. Monthly budget line variances reports are identifying the impact of over and under budget realities. The areas of focus are guided by high cost patients and procedures and by HBAM and QBP funding adjustments. Positive total margin achievement is challenged significantly, year over year with required balance budgets and zero funding growth.

Integration and continuity of care

The MHA works closely with system partners to develop and execute quality improvements for patient benefits.

The MHA participates closely with the SWLHIN in several initiatives, most recently through an ED knowledge transfer project. The SWLHIN supported the initiative through sharing of expertise, LEAN process improvements and change ideas among regional and community hospitals to evaluate current process flow, areas of improvement, including equipment and supplies. The established goals for improvement negotiated with the LHIN continue to align well with the provincial priority indicator of ED Admitted length of stay.

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Community Care Access Centre has launched its Home First Program in our hospitals in early 2014, with implementation continuing through the current fiscal year. CCAC has been included in the development of the Alternate Level of Care plan through the objectives of this initiative. The HOME First Implementation is co- chaired by a hospital unit manager, project lead and CCAC and several other members, including case managers and data resources are active participants. The hospital is looking forward to facilitating the supported transition of many of its patients, back to their homes with early patient risk identification and discharge planning. The MHA has established and sustained daily bullet rounds on the inpatient units which are attended by nurses, allied health and CCAC case managers. Another collaborative enhancement to reducing Alternate Level of Care days and accessibility is the MHA access to complex continuing care and rehabilitation beds in surrounding regional community hospitals.

The Regional Chief Nursing Executives and SW CCAC have collaborated on the creation of LHIN wide policies and procedures and supporting documents. The objective is to provide greater consistency of care practices and patient communications among hospitals from admission to discharge. Some current initiatives at this time include ED knowledge transfer and Home First implementation, as well as Wound Care assessment, including documentation, metrics and standardization of products. These initiatives will enhance the standard of care for patients, optimize their length of stay and enhance their transition from hospital to home. This will impact the patient outcomes positively as well as several of the provincial priority indicators of wait time outcomes for ED, ALC days, patient satisfaction and readmission rates.

Challenges, risks and mitigation strategies

Maintaining a balanced budget in the current unstable environment of fiscal constraints: Challenges include understanding and applying the shift in funding from volumes and dollars to efficiency and best practices. Particular challenges include the need to grow or develop new and existing programs with the risk of being unable to meet the needs of individual patients. As an example, a closer examination of incidence of congestive heart failure and chronic obstructive disease readmission rates indicates these as areas of high readmission rates to our facilities. Best practice evidence supports the need for specific patient education of triggers for assessment, regular and predictable intervals of follow-up and availability of urgent ambulatory clinics with this population, to avoid hospital readmission. The hospital will continue to examine admission and readmission rates carefully and continue to address case cost pressures to ensure delivery of quality care and efficient use of existing financial and clinic resources.

Hospital Physician recruitment for such specialty areas of intensive care and ED to support the expansion of surgical specialities and ED is a challenge. It also includes challenges of Family Physician recruitment to both of our communities, but especially in the rural setting of Four Counties Health Services. Community hospitals depend greatly on family physician presence for ED, inpatient, obstetrics and hospitalist roles to provide round the clock coverage of patient accessibility to services. ED length of stay is impacted by the single physician coverage of the ED at both community hospitals. This creates its own challenges for recruitment in ED with wide ranges in CTAS values and daily visit volumes. The MHA actively engages in recruitment activities with some success and significant efforts.

The role of our community hospitals has capacity for a wide range of elective and urgent ambulatory care and surgical interventions, excluding cardiac, neurology and multiple trauma patients. A wide range of patient service availability remains. Our community hospitals are frequently restricted to life and limb only access to tertiary level care, despite all the current repatriation and patient flow processes in place. Mitigating strategies should include movement of elective and urgent surgical procedures which community hospitals are readily able to complete, allowing the tertiary hospitals to focus on those in need of high intensity specialized services.

Limited accessibility to long term care homes and community care access care in the home. Evident at both sites of the MHA, but certainly magnified in the rural setting of Four Counties Health Services. This impacts the number and length of stay of alternate level of care patients greatly at our facilities. The MHA is actively engaged with CCAC and Home First implementation to address ALC options following the acute episode of care and hope to realize significant improvements.

Information management:

The MHA readily utilizes available national, provincial, regional, SWLHIN and internal electronic resources to inform long term and immediate information and wait time information needs to support clinical and administrative decisions.

The MHA implemented Care Provider Order Entry and closed loop medication administration in February 2014 in its participation with an electronic medical record implementation with the Thames Valley Hospitals Planning Partnership. This represents one of several steps in the progression to a complete electronic patient record. The current step

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enhances the standardization of physician order entries, electronically communicates all orders to the associated department, tap in and out access and supports safe medication administration practices.

The MHA participates with the SWLHIN in its utilization of regional Integrated Decision Support (IDS) system. The early use of the IDS system demonstrates utilization of the health care system by patients at many levels including inpatient and outpatient hospitals visits and CCACs.

The MHA is moving to eresources for its numerous resource requirements through collaboration with surrounding hospitals in the Western Ontario Health Knowledge Network. This network provides 24 hours access to electronic journals and skills resources for all health care providers.

The MHA began receiving 'Active CCAC Client status enotification in fall of 2014 for any patient presenting to registration /triage in ED or admitted to an inpatient area. And conversely, the CCAC receives notification of the patient ED visit and/or admission to hospital. Patient presenting to the ED are also escreened for likely risk of discharge home without support. This will enhance early understanding of existing patient supports and the potential for return to home earlier with increase in services or early review of care needs.

The resulting information is used to inform a board range of service provision from patient population program development to the individual patient care coordination and optimization of health. The specific provincial priority indicators and corporate dashboard indicators are monitored and reported quarterly to the Quality Board Committee and MHA Board

Engagement of clinicians and leadership:

The MHA engages its clinical staff and broader leadership at many levels. Unit specific goals are increasing being developed to support strategic goals and quality improvement plans. The most responsible departments or services develop the work plan and performance targets for their areas. These are presented for consideration and recommendations to the senior leadership, the Quality committee of the board and the MHA Board.

The MHA strives to include its frontline staff and physician at every opportunity. Monthly coffee with the CEO, monthly staff meetings following monthly Board meetings, regular discussion with medical staff, and recently cost saving suggestions from any and all staff members are just a few examples of staff and physician engagement.

The MHA Senior leadership and clinical managers are present and engaging patients and staff in all patient care and support areas on a daily basis.

Accountability Management:

Under the ECFAA legislation, hospital organizations are required to link Senior Executive compensation to the achievement of performance improvement targets. The Senior Executive of the MHA is held accountable for achieving targets which are laid out in the MHA's Quality Improvement Plan (QIP). The percentage of salary at risk for each individual executive has been set at 2% of the base salary. This compensation formula applies to the following individuals: President & CEO, Chief Operating Officer, Chief Financial Officer and Chief of Staff. The achievement of provincial priority improvement targets will result in 100% payout. Partial achievement of targets will result in partial payout. The Board of Directors has the discretion to modify the amount of the performance-based compensation (subject to the 2% maximum) following assessment of the MHA's performance related to the QIP, in the event that there has been significant achievement of the objectives specified but the targets set out in the QIP have not been achieved.

Health System Funding Reform:

The MHA continues to develop its understanding, knowledge and application to the Health System Funding Reform. Information has been shared through all levels of organization, including Physician and staff health care providers, professional practice committee incorporating care pathway development and best practices, finance, health records and decision support. The MHA has initiated a Funding Transformation Steering Team. This leadership team is under development with the intent to support and act as the steward of the implementations of QBP's across the organization. The Funding Transformation Team will focus primarily on the QBP's in an effort to leverage and optimize quality and efficiency within the new funding model. The team will review provincial handbooks, admission and readmission volumes, current and recommended practice variations, staff and patient education, electronic CPOE and pathway development, costs.

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Accountability Sign-off

I have reviewed and approved our organization's 2015-16 Quality Improvement Plan and attest that Strathroy Middlesex General Hospital fulfills the requirements of the *Excellent Care for All Act*.

Ken Williams	Neil MacLean	Todd Stepanuik
Board Chair	*Quality Committee Chair*	*Chief Executive Officer*

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