PART B: Improvement Targets and Initiatives

2012/13

St. Joseph's Healthcare Hamilton

St. Joseph's Healthcare Hamilton | 50 Charlton Ave. E., Hamilton, Ontario L8N 4A6

Please do not edit or modify provided text in Columns A, B & C

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**	**Goal for change ideas (2012/13)**	**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. 2011, consistent with publicly reportable patient safety data	0.56	0.39	SJHH Internal Target of 40% improvement	1	1) Reduce our CDI Rate through a continued focus on the 25 Recommendations made by the ICRT Team in their external review. (See Website http://www.stjoes.ca/media/ICRTExternalReviewRecommendationsMarch2012.pdf)	The outcome indicator is 'CDI rate' and our target is a 30% improvement.	0.39	
							2)			
							... N)			
	Reduce incidence of Ventilator Associated Pnemonia (VAP)	**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. 2011, consistent with publicly reportable patient safety data	1.47	0	HQO Benchmark for Best Performers	2	1)			
							2)			
							... N)			
	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 - Jan-Dec. 2011, consistent with publicly reportable patient safety data	83%	92%	HQO Benchmark for Best Performers	2	1)			
							2)			
							... N)			
	Reduce rate of central line blood stream infections	**Rate of central line blood stream infections per 1,000 central line days**: total number of newly diagnosed CLI cases in the ICU after at least 48 hours of being placed on a central line, divided by the number of central line days in that reporting period, multiplied by 1,000 - Average for Jan-Dec. 2011, consistent with publicly reportable patient safety data	0.62	0	HQO Benchmark for Best Performers	2	1)			
							2)			
							... N)			
	Reduce incidence of 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 2010/11, CCRS	Not Selected				1)			
							2)			
							... N)			
	Avoid patient falls	**Falls**: Percent of complex continuing care residents who fell in the last 30 days - FY 2010/11, CCRS	Not Selected				1)			
							2)			
							... N)			
	Reduce rates of deaths and complications associated with surgical care	**Surgical Safety Checklist:** number of times all three phases of the surgical safety checklist was performed ('briefing', 'time out' and 'debriefing') divided by the total number of surgeries performed, multiplied by 100 - Jan-Dec. 2011, consistent with publicly reportable patient safety data	98%	100%	HQO Theoretical Best Compliance	3	1)			
							2)			
							... N)			
	Reduce use of physical restraints	**Physical Restraints:** The number of patients who are physically restrained at least once in the 3 days prior to initial assessment divided by all cases with a full admission assessment - Q4 FY 2009/10 - Q3 FY 2010/11, OMHRS	Charlton Campus 0.012 West 5th Campus 0.036	0.01	SJHH Internal Target	2	1)			
							2)			
							... N)			
	Reduce seclusions in mental health	**Seclusions:** Annual number of mental health inpatients who are placed in a secure secluded environment in response to a crisis during their care. Reported incidents 2011.	249*	200	SJHH Internal Target	2	1)			
							2)			
							... N)			
	Space for additional indicators									

AIM		MEASURE					CHANGE			
Effectiveness	Reduce unnecessary deaths in hospitals	**HSMR:** number of observed deaths/number of expected deaths x 100 - FY 2010/11, as of December 2011, CIHI	81	79	Top Quartile Performance for HSMR 2010/11	3	1)			
							2)			
							… N)			
	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	0.16%	0%	Ontario H-SAA Funding Agreement Target 2011/12	1	1) Implement an integrated care model with St. Joseph's Home Care for three patient groups, in partnership with the Ministry of Health, our LHIN, and our CCAC. The project will be evaluated by a McMaster University affiliated research team.	The primary measure will be % implementation Other metrics will likely include: cost and readmission rates, as determined by the evaluation team.	100% implementation and Interim evaluation complete.	This is an ECFAA Project.
							2) Become a leader in pay for performance funding models that link hospital funding to the number of patients served and the quality of care delivered.	Implement at least one patient based and/or quality based funding model in partnership with the MOHLTC & LHIN	50% Implementation	
							3) Expand and develop waste reduction strategies that will include: sick time, overtime, agency staffing, observational care, drug utilization and operating room expenses.	Achieve at least $500,000 in savings from waste reduction strategies	$500,000	
	Space for additional indicators									
Access	Reduce wait times in the ED	**ER Wait times:** 90th Percentile ER length of stay for <u>Admitted</u> patients. Q3 2011/12, NACRS, CIHI	28.2	25	LHIN Target	2	1)			
							2)			
							… N)			
		ER Wait times: 90th Percentile ER length of stay for <u>Non-Admitted</u> patients. Q3 2011/12, NACRS, CIHI	8.1 hours CTAS 1-3	7.3 hours CTAS 1-3	LHIN Target	1	1) We will use a Patient Flow Coordinator position to guide process improvements in the ED for CTAS 1-3 patients. The Flow Coordinator will help the ED Team to use ED beds more efficiently so that they can reduce the wait time for patients.	We will use ED Tracking Board data to map the flow of patients through the ED, and use this data to examine and improve bed utilization.	A 10% improvement in the time from Triage to Patient Ready to be seen by Physician	
							2) We will review the scheduling of physicians in the ED and make changes to align physician resources with patient needs.	Data on patient arrivals indicates that that there are periods of high demand that do not have optimal physician staffing for non-urgent cases. During these periods there are longer waits.	To provide additional physician coverage for 90% of the high demand periods in the ED.	
							… N)			

AIM		MEASURE					CHANGE			
Patient-centred	Improve patient satisfaction	*Please choose the question that is relevant to your hospital:*					... N)			
		From NRC Picker / HCAPHS: "Would you recommend this hospital to your friends and family?" (add together percent of those who responded "Definitely Yes")	Not Selected				1)			
		From NRC Picker: "Overall, how would you rate the care and services you received at the hospital?" (add together percent of those who responded "Excellent, Very Good and Good")	Not Selected				2)			
		In-house survey (if available): The question is Overall Satisfaction, and is a composite of other questions on the survey. The scale is Strongly Disagree to Strongly Agree in a 5 point scale, with only the most positive 2 scale points counted in the result. Q3 2011/12.	92.4%	95%	SJHH Internal Target that reflects a significant improvement	2	... N)			
	Increase the Patient Voice and Level of Engagement	**Patient Voice and Engagement:** This indicator represents a continuation of our work to include patients and family as members of our Clinical Program Quality Councils, our Patient and Family Advisory Council, and in quality improvement projects. These are now well established at SJHH. New this year is a trial of patient membership on our Board Quality and Mission Committee as recommended by Reinertsen and Orlikoff at the IHI National Forum 2011. Fiscal Year 2011/12.	20 Projects	20 New Projects	SJHH Internal Target and IHI Model	1	1) We will start 20 new quality improvement projects involving patients and/or family as members of the project team or quality council.	Survey of new projects.	20 new projects	
							2) We will conduct a trial of patient and family membership of the Quality and Mission Committee of the Board.	Minutes of Quality and Mission Committee of the Board	Trial completed	
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	12.30%	11%	LHIN Target	3	1)			
							2)			
							... N)			
	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 2011/12, DAD, CIHI	16.4% (104 cases)	14.76	SJHH Internal Target of 10% Improvement	2	1)			
							2)			
							... N)			
	Space for additional indicators									

Seclusions data under review with new electronic point of care data collection