Excellent Care For All.

2011-12

Quality Improvement Plan

(Short Form)

Cornwall Community Hospital
Hôpital communautaire de Cornwall

March 31, 2011

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 the OHQC in the format described herein.

Part A:

Overview of Our Hospital's Quality Improvement Plan

Purpose of this section: Quality Improvement Plans (QIPs) are, as the name suggests, all about improvement. They are an opportunity for organizations to focus on how and what to improve, in the name of better patient-focused care. As such, they will be unique documents, designed by, and for, each individual organization. Overall, a QIP should be seen as a tool, providing a structured format and common language that focuses an organization on change. The QIP will drive change by formalizing a plan and facilitating shared dialogue to support continuous quality improvement processes. This introductory section should highlight the main points of your hospital's plan and describe how it aligns overall with other planning processes within your organization. In addition, this section provides you with an opportunity to describe your priorities and change plan for the next year.

*Please refer to **Appendix D** in the QIP Guidance Document for more information on completing this section.*

1. Overview of our quality improvement plan for 2011-12

[A general statement (100 words maximum) that is inspiring and situates the objectives within the Vision, Mission and Values of your organization

- The CCH vision, mission, values and strategic directions have provided a guiding framework for not only the development of a Patient Declaration of Values, but also for the selection of QIP performance indicators, goals/targets and weighting.
- It is anticipated that the QIP will be a roadmap, translating our vision, mission, values and strategic directions, and drive the results expected by CCH's key internal and external stakeholders.

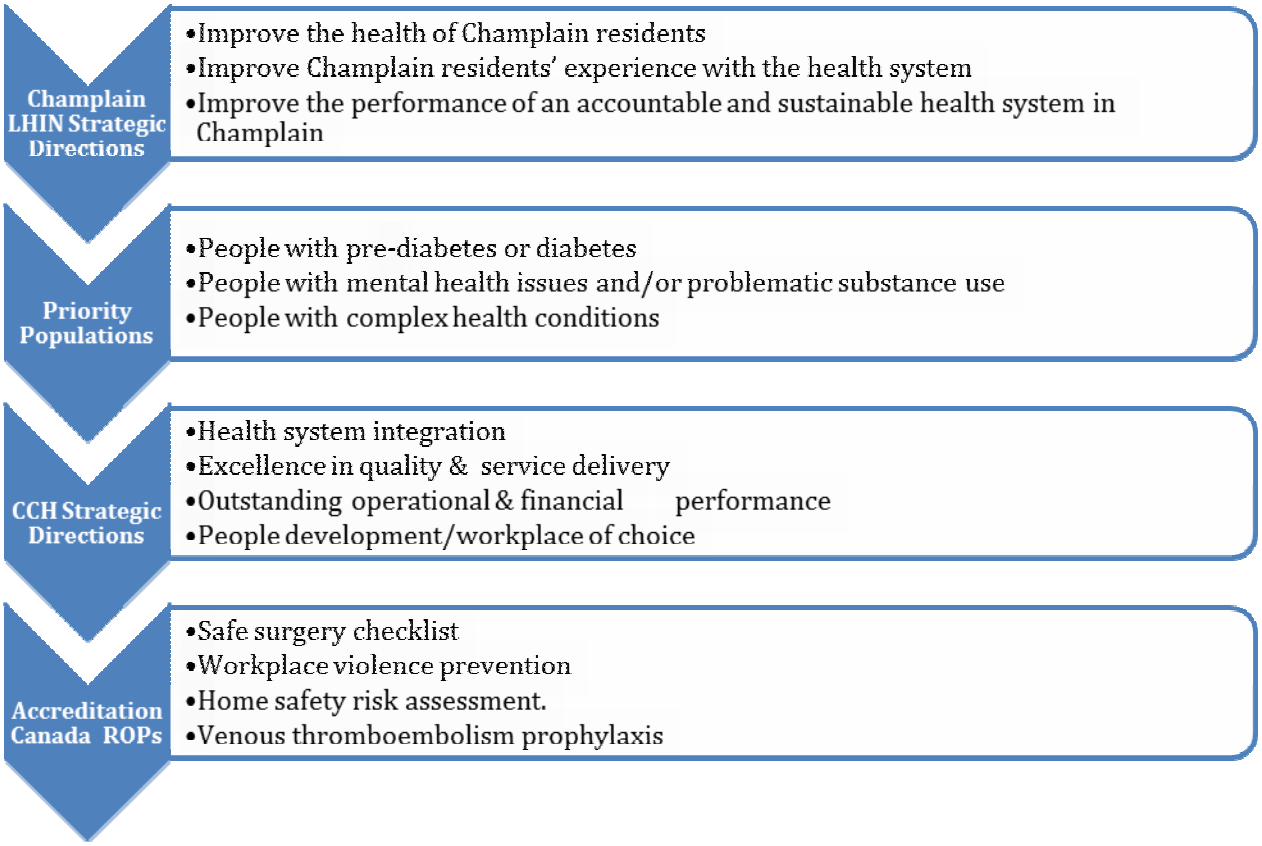
2. What we will be focusing on and how these objectives will be achieved

[A description of the objectives that have been identified to improve quality of services and care in your hospital. This section describes the specific aims, measures and change ideas that form the core of the plan. You should also indicate how resources will be used to ensure that the correct financial levers are in place to execute the activities listed in your QIP]

- The primary focus of the 2011/12 CCH QIP is establishing demand management and patient inflow/outflow processes which optimizes utilization available resources, a major corporate undertaking is enrollment in the ED-PIP Full Program Wave IV, notice of application acceptance received 14-Mar-2011.
- Other priorities reflected within the QIP is an emphasis on patient safety, quality of care and establishing the necessary infrastructure, safeguards and evidence-based, best practices to produce the best possible outcomes for the patient populations served.

3. How the plan aligns with the other planning processes

[An explanation of how this document links to the other planning documents developed by your organization (such as H-SAA) and key external partners such as the LHIN and CCACs.]



4. Challenges, risks and mitigation strategies

[This section describes the relative risks that may inhibit the accomplishment of the objectives and the mitigating strategies that have been identified to lower those risks.]

Environmental Scan[1] [2]

- Eastern Counties and Renfrew County are tied for lowest university graduation rate, with 12.5% of 25 to 64 year olds having completed a bachelor's degree or higher (vs. 19.1% to 46.3%).
- Eastern Counties is the most Francophone Community of Care. Forty two percent of residents have French as a mother tongue (vs. 5.6% to 33.1%). French mother tongue is especially common in Casselman (84.4%), Alfred-Plantagenet (80.3%) and Hawkesbury (79.7%).
- Including Akwesasne, Eastern Counties has proportionately more Aboriginal people (6.5%) than other parts of Champlain (1.5% to 5.6%). In fact, Eastern Counties is home 40% of all Aboriginal people in Champlain.
- At 81.5, life expectancy for women in Eastern Counties is 2.1 to 3.4 years lower than in Ottawa. From men, life expectancy is 75.8, 0.7 to 2.1 years lower than Ottawa.
- Compared with Champlain overall, Eastern Counties has higher mortality rates from chronic lower respiratory disease (+30%), ischemic heart disease (+26%) and lung cancer (+23%). Mortality related to dementia and Alzheimer's was 36% lower.

[1] Champlain LHIN Profile of the Champlain Communities of Care: Focus on Eastern Counties (June 2008 Version 1).
[2] Cornwall Community Hospital Operational, Clinical and IM/IT 5-Year Strategic Planning, Steering Committee – Current State (April 6, 2010 Deloitte).

- Hospitalization rates for asthma, chronic obstructive pulmonary disease (COPD) and ischemic heart disease were all higher than for Champlain overall (+95%, +70% and +57%).
- Compared with Champlain overall, lung cancer rates were higher in Eastern Counties among both women (+19%) and men (+24%).
- The daily smoking rate in Eastern Counties was nearly double the Ottawa rate (23% vs. 13%, ages 12+).
- 19% of Eastern Counties' residents are obese compared with only 12% in Ottawa. Nearly six in 10 (57%) are either overweight or obese.
- The proportion of Eastern Counties' residents reporting contact with a medical doctor in the previous 12 months (75.2%) was low compared to Ottawa (82.1%). Contact with dental professionals is also lower (56.7% vs. 74.1%) as is contact with alternative health providers (8.5% vs. 13.4%).

Emergency Department

- The ED visit rate for Eastern Counties' residents was more than double the rate for Ottawa residents.
- Among the ED visits at CCH, a significant portion of patients seeking care are non-urgent cases (e.g. return visits for IV therapy, follow up visits after treatment, dressings/wound care and receive test results).
- 46% of ED visits at CCH are CTAS 4-5 patients, who expected long wait times to receive care.
- Contributing to this is the fact that 19% of CCH patients receiving care within the ED do not have a family physician; this rate is highest among the four Eastern Counties hospitals.
- CCH has the highest volume of ED visits and largest referring population in the Eastern Counties. It is the only hospital in the Eastern Counties that can provide ICU services with ventilation support.
- The relative distribution of patients across four hospitals in the Eastern Counties is projected to remain consistent (CCH, Glengarry, Winchester, Hawkesbury) with CCH capturing 40% of the service.

Medicine Department

- CCH currently has an exceptionally high volume of ALC patients, especially with the senior patients (65+).
- The leading inpatient admissions include COPD, pneumonia, CHF, MI and arrhythmia which represents 55% of all acute separations and 59% of LOS at CCH.
- Inadequate long term care, family practice capacity, and aging population contribute to output issues at CCH, increased ALC volumes and inefficient use of resources (i.e. ED RNs are caring for medicine patients).
- Cornwall and surrounding communities have significant cancer prevalence; however, currently the active provision of oncology related services is not part of CCH's current core service complement.

Surgery Department

- Compared to Ontario and Champlain LHIN hospitals, on average, patients awaiting general surgery at CCH are experiencing longer wait times.
- CCH is the leading surgical service provider among the Eastern Counties hospitals with over 75% of total hospital inpatient days in the Eastern Counties.
- Emergency surgery volume is significantly high, which causes disruption the scheduled surgeries.
- Some surgical specialties (i.e. OB/GYN) are facing challenges in their ability to refer patients to tertiary centres in Ottawa (e.g. access; long wait times).

Mental Health & Addiction

- CCH is the only facility with designated schedule 1 beds in the Eastern Counties.
- Aging population will lead to increased need for already sparse geriatric psychiatry service in the region.
- Geriatric population has been identified as an area that is underserved as well as children and youth.

Part B:
Our Improvement Targets and Initiatives

Please complete the "Improvement Targets and Initiatives – Part B" spreadsheet (Excel file). Please remember to include the spreadsheet (Excel file) as part of the QIP Short Form package for submission to the OHQC (QIP@ohqc.ca), and to include a link to this material on your hospital's website.

[Please see the QIP Guidance Document for more information on completing this section.]

PART B: Improvement Targets and Initiatives

Cornwall Community Hospital | Cornwall, ON

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

AIM		MEASURE				CHANGE				
Quality Dimension	**Objective**	**Outcome Measure/Indicator**	**Current Performance**	**Performance Goal 2011/12**	**Priority**	**Improvement initiative**	**Methods and results tracking**	**Target for 2011/12**	**Target justification**	**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. 2010, consistent with publicly reportable patient safety data	**0.52**	**0.0**	**2**	Not Required.	Not Required.	Not Required.	Not Required.	Results Oct-Dec 2010 = 0.75, this rate is above the 80th percentile among hospital group. From Jan-Nov 2010 9/11 months above provincial average. Infection prevention and control added measures introduced Jun-10 with positive results observed.
	Reduce incidence of Ventilator Associated Pneumonia (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. 2010, consistent with publicly reportable patient safety data	**2.975**	**0.0**	**2**	Not Required.	Not Required.	Not Required.	Not Required.	Results observed: 1 Case Jan-Mar 2010, 0 Cases Apr-Dec 2010.
	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	**MCC Ste = 73%, 2nd St Ste = 69.6%**	**80%**	**2**	Not Required.	Not Required.	Not Required.	Not Required.	Hand hygiene program has been developed and launched with dedicated ICP RN attached, however critical mass of CCH physicians and front-line nursing/other clinical staff will not have completed the mandatory inservices until Jul-Aug, 2011. To have priority 1 ranking Apr/12-Mar/13.
	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. 2010, consistent with publicly reportable patient safety data	**0.0**	**0.0**	**2**	Not Required.	Not Required.	Not Required.	Not Required.	Results Oct-Dec 2010 = 0.00.
	Avoid new pressure ulcers	**Pressure Ulcers**: Percent of complex continuing care residents with new pressure ulcer in the last three months (stage 2 or higher) 2009/10, CCRS	**9.5**	**Perf goal not established Apr/11-Mar/12**	**2**	Not Required.	Not Required.	Not Required.	Not Required.	Rate below median value reported by 18 peer community hospitals (9.5 vs. 12.7).
	Avoid falls	**Falls**: Percent of complex continuing care residents who do not have a recent prior history of falling, but fell in the last 90 days 2009/10, CCRS	**Data Incomplete**	**Perf goal not established Apr/11-Mar/12**	**2**	Not Required.	Not Required.	Not Required.	Not Required.	CCRS data entry commenced Dec 2010. Standardized assessment tool currently being evaluated.
	Avoid adverse events	**ER Left Without Being Seen (LWBS) Rate:** Reduce by 10% compared to baseline performance Q3 2010/11.	**8.6**	**7.7**	**1**	Refer to indicators below: ER Wait times.	Refer to indicators below: ER Wait times.	Q3 = Less than/equal to 7.7%	Significant risk exposure and patient safety/quality improvement opportunity, intervention aligns with MoHLTC, Champlain LHIN and CCH strategic directions and priorities.	Periodic updates to be provided.
	Avoid adverse events	**Accreditation Canada ROPs (2011):** Safe surgery checklist; Workplace violence prevention; and, Venous thromboembolism prophylaxis. Target = 100% policy/procedure/staff training complete.	**30%**	**100%**	**1**	1) Multidisciplinary teams established to develop, implement and evaluate ROPs.	Designated ROP Champion assumes this accountability.	Q4 = 100%	Critical patient safety initiatives, Accreditation Canada survey 2012.	Periodic updates to be provided.
Effectiveness	Reduce unnecessary deaths in hospitals	**HSMR:** number of observed deaths/number of expected deaths x 100 2009/10, CIHI.	**83**	**Perf goal not established Apr/11-Mar/12**	**2**	Not Required.	Not Required.	Not Required.	Fiscal Year: 2009-2010, CCH Cumulative HSMR Year-to-Date: HSMR = 83, LCI = 71, UCI = 97. HSMR values greater than 100 mean that the hospital had more deaths among applicable inpatient cases then would be expected, given the characteristics of the hospital's patient population.	Periodic updates to be provided.
	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 2010/11, DAD, CIHI	**COPD = 16.3% Heart Failure = 16.1%**	**Perf goal not established Apr/11-Mar/12**	**2**	Not Required.	Not Required.	Not Required.	Not Required.	Rate above median value reported by 18 peer community hospitals for the following selected CMGs: COPD; Heart Failure. Indicator substituted for ALOS of 3 orthopaedic procedures in accordance with CCH and Champlain LHIN identified regional priorities (see ALOS Performance).
	Reduce unnecessary 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 2010/11, DAD, CIHI	**37%**	**Perf goal not established Apr/11-Mar/12**	**2**	Not Required.	Not Required.	Not Required.	34-bed ALC/LTC beds being transferred to a community-based operator (July, 2011) which also coincides with the start date of an additional hospitalist. Despite the current high rate of ALC days, the above initiatives are expected to substantially remedy this major operational challenge/priority.	Periodic updates to be provided.
	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 2010/11, OHRS	**0**	**0-5%**	**1**	1) HCM functional centre benchmarking 2) Lean workflow/process improvements 3) Staffing model reviews 4) Over-time reduction/attendance management.	Monthly Variance Reports.	Q4 = Greater than/equal to 0%	This indicator is a measure of financial viability. A positive value indicates total expenses are less than total revenues (a surplus). A hospital is demonstrating good financial management if Total Margin is between 0 to 5%.	Periodic updates to be provided.
	Improve resource utilization	**ED Worked Hours/Equiv. Visit.** Reduce by 10% compared to baseline performance. 2009/10.	**2.18**	**1.96**	**1**	Refer to indicators below: ER Wait times.	Refer to indicators below: ER Wait times.	Q4 Target = Less than/equal to 1.96	HCM functional centre benchmarking reports indicate significant reductions are achievable when current performance is compared to peers.	Periodic updates to be provided.
	Reduce avoidable hospital patient days	**ALOS Performance** (Main Performance): a) Hip Replacement - excluding revisions and resurfacing; b) Knee Replacement - excluding revisions; c) Hip Fractures with Fixation of Hip Joint or Fixation Femur. Reduce by 5% at Q4 2011/12 compared to baseline performance.	**Acute ALOS = a) 7.5 b) 5.8 c) 10.8**	**Q4 Target = Less than/equal to a) 7.1 b) 5.5 c) 10.3**	**1**	1) Multidisciplinary team established to develop, implement and evaluate CPs specific to each procedures/interventions.	Designated CP Champion assumes this accountability.	Q4 Target = Less than/equal to a) 7.1 b) 5.5 c) 10.3	Development and implementation of clinical pathways specific to the 3 procedures are expected to measurably reduce ALOS, intervention consistent with Champlain LHIN orthopaedic procedure improvement aims.	Periodic updates to be provided.
Access	Reduce wait times in the ED	**ER Wait times:** 90th Percentile ER length of stay for Admitted patients. Q3 2010/11, NACRS, CIHI.	**50.7**	**Perf goal not established Apr/11-Mar/12**	**2**	Not Required.	Not Required.	Not Required.	Not Required.	Indicators substituted for mandatory indicators within ED PIP Wave IV Full Program (2011/12).
	Reduce wait times in the ED	**ER Wait times:** 90th percentile ER Length of Stay for Complex conditions. Q3 2010/11, NACRS, CIHI.	**17.9**	**Perf goal not established Apr/11-Mar/12**	**2**	Not Required.	Not Required.	Not Required.	Not Required.	
	Reduce wait times in the ED	**ER Wait time:** 90th Percentile ER length of stay for Admitted patients. Q1-3 2010/11. Reduce by 10% length of stay of Admitted patients.	**72.9**	**65.6**	**1**	CCH is a successful applicant to the Emergency Department Process Improvement Program (ED PIP) Wave IV Full Program (2011/12). ED PIP provides hospitals with an intensive structured approach and resources to improve patient flow from the point patients arrive in the ED through to discharge from inpatient units.	Mandatory performance metrics and additional indicators will be tracked and regularly reported to the ED-PIP Steering Committee, ED and Inpatient Teams by the designated Data Lead and Daily Access Reporting Tool (DART) Lead.	Q4 Target = Less than/equal to 65.6	CCH current performance not achieving provincial targets (90th percentile): Admitted patients; Non-admitted, high acuity; Non-admitted, low acuity. Performance expectation: If site's LOS is above provincial target, improve by 10%. PIA Performance expectation: 10% improvement from baseline, if not achieved in 10/11.	Periodic updates to be provided.
	Reduce wait times in the ED	**ER Wait times:** 90th Percentile ER length of stay for Non-Admitted, high acuity patients. Q1-3 2010/11. Reduce by 10% length of stay of Non-Admitted, high acuity patients.	**10.1**	**9.1**	**1**			Q4 Target = Less than/equal to 9.1		
	Reduce wait times in the ED	**ER Wait times:** 90th Percentile ER length of stay for Non-Admitted, low acuity patients. Q1-3 2010/11. Reduce by 10% length of stay of Non-Admitted, low acuity patients.	**5.1**	**4.6**	**1**			Q4 Target = Less than/equal to 4.6		
	Reduce wait times in the ED	**ER Wait times:** 90th Percentile PIALOS (Earlier of triage/registration date/time to Physician Initial Assessment date/time). Q1-3 2010/11. Reduce by 10% PIALOS.	**3.7**	**3.3**	**1**			Q3 Target = Less than/equal to 3.3		
Patient-centred	Improve patient satisfaction	*Please choose the question that is relevant to your hospital:*				Not Required.	Not Required.	Not Required.	Not Required.	NRC+Picker engaged to conduct patient experience surveys, currently limited to CCH ED.
		NRC Picker / HCAPHS: "Would you recommend this hospital to your friends and family?" (add together percent of those who responded "Definitely Yes")	**53**	**Perf goal not established Apr/11-Mar/12**	**2**					"Would you recommend this hospital to your friends and family?" vs. "Overall, how would you rate the care you received in the Emergency Department?" Project team concerned that this 'recommend' indicator may be prone to misinterpretation, whereas the 'overall' indicator would provide a better global indicator of the patient care experience within the ED, the only CCH clinical area surveyed by NRC+Picker.
		In-house survey (if available): provide the percent response to a summary question such as the "Willingness of patients to recommend the hospital to friends or family" (Please list the question and the range of possible responses when you return the QIP)	**N/A**	**N/A**	**N/A**					
	Improve patient satisfaction	**NRC+Picker Canada survey question:** "Overall, how would you rate the care you received in the Emergency Department?" Q1-3 2010/11. Increase by 10% compared to baseline performance.	**82**	**90**	**1**	Project team developing and implementing interventions targeting the ED patient experience.	NRC+Picker quarterly results monitoring and trending.	Q3 Target = Less than/equal to 90	From Apr-Dec, 2010 positive scores ranged 72.5 to 89.74, average = 82.03. Year-to-date a negative linear trendline is evident.	Periodic updates to be provided.

Part C:
The Link to Performance-based Compensation of Our Executives

Purpose of Performance-based compensation:

1. *To drive performance and improve quality care*
2. *To establish clear performance expectations*
3. *To create clarity about expected outcomes*
4. *To ensure consistency in application of the performance incentive*
5. *To drive transparency in the performance incentive process*
6. *To drive accountability of the team to deliver on the Quality Improvement Plan*
7. *To enable team work and a shared purpose*

Please refer to Appendix E in the QIP Guidance Document for more information on completing this section of the QIP Short Form.

Manner in and extent to which compensation of our executives is tied to achievement of targets

[Compensation should be linked to targets for those members of the senior management group who report directly to the CEO, including the chief of staff (where there is one) and the chief nursing executive. Please refer to the regulation (Ontario Regulation 444/10)]

Our executives' compensation is linked to performance in the following way:

CEO/Executive Team Compensation At-Risk (%) **2%**

Quality Dimension	Objective	Outcome Measure/Indicator	Priority	Indicator Weight
Safety	Avoid adverse events	ER Left Without Being Seen (LWBS) Rate: Reduce by 10% compared to baseline performance. Q3 FY 2010/11.	1	15%
Safety	Avoid adverse events	Accreditation Canada ROPs (2011): Safe surgery checklist; Workplace violence prevention; and, Venous thromboembolism prophylaxis. Target = 100% policy/procedure/staff training complete.	1	10%
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 2010/11, OHRS.	1	10%
Effectiveness	Improve resource utilization	ED Worked Hours/Equiv. Visit. Reduce by 10% compared to baseline performance. 2009/10.	1	5%

CEO/Executive Team Compensation At-Risk (%) 2%

Quality Dimension	Objective	Outcome Measure/Indicator	Priority	Indicator Weight
Effectiveness	Reduce avoidable hospital patient days	ALOS Performance (Main Performance): a) Hip Replacement - excluding revisions and resurfacing; b) Knee Replacement - excluding revisions; c) Hip Fractures with Fixation of Hip Joint or Fixation Femur. Reduce by 5% at Q4 2011/12 compared to baseline performance.	1	10%

CEO/Executive Team Compensation At-Risk (%) 2%

Quality Dimension	Objective	Outcome Measure/Indicator	Priority	Indicator Weight
Access	Reduce wait times in the ED	ER Wait time: 90th Percentile ER length of stay for Admitted patients. Q3 2010/11, NACRS, CIHI. Reduce by 10% length of stay of admitted patients.	1	10%
Access	Reduce wait times in the ED	ER Wait times: 90th Percentile ER length of stay for Non-Admitted, high acuity patients. Q3 2010/11, NACRS, CIHI. Reduce by 10% length of stay of Non-Admitted, high acuity patients.	1	10%
Access	Reduce wait times in the ED	ER Wait times: 90th Percentile ER length of stay for Non-Admitted, low acuity patients. Q3 2010/11, NACRS, CIHI. Reduce by 10% length of stay of Non-Admitted, low acuity patients.	1	10%
Access	Reduce wait times in the ED	ER Wait times: 90th Percentile PIALOS (Earlier of triage/registration date/time to Physician Initial Assessment date/time). Q1-3 2010/11. Reduce by 10% PIALOS.	1	10%
Patient-centred	Improve patient satisfaction	NRC+Picker Canada survey question, "Overall, how would you rate the care you received in the Emergency Department?". Q1-3 2010/11. Increase by 10% compared to baseline performance .	1	10%

Part D:
Accountability Sign-off

[Please see the QIP Guidance Document for more information on completing this section.]

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

1. Was developed with consideration of data from the patient relations process, patient and employee/provider surveys, aggregated critical incident data, and patient safety indicators;
2. Contains annual performance improvement targets, and justification for these targets;
3. Describes the manner in and extent to which, executive compensation is tied to achievement of QIP targets; and
4. Was reviewed as part of the planning submission process and is aligned with the organization's operational planning.

Fernand Hamelin *Board Chair*	Michael E. Turcotte *Quality Committee Chair*	Jeanette Despatie *Chief Executive Officer*