Excellent Care For All.

2012/13 Quality Improvement Plan

(Short Form)

Cornwall Community Hospital
Hôpital communautaire de Cornwall

April 2, 2012

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 HQO in the format described herein.

Ontario

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 hospitals 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 hospital. 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 hospital and even more broadly with other initiatives underway in your hospital and across the province. In addition, this section provides you with an opportunity to describe your priorities and change plan for the next year.

Please refer to the QIP Guidance Document for more information on completing this section.

[In completing this overview section of your hospital's QIP, you may wish to consider including the following information:

- Provide a brief *overview* of your hospital's QIP.
- Describe the *objectives* of your hospital's QIP and how they will improve the quality of services and care in your hospital.
- Describe how your plan *aligns* with other planning processes in your organization.
- Describe how your plan takes into consideration *integration and continuity of care.*
- Describe any *challenges and risks* that your hospital has identified in the development of their plan.]

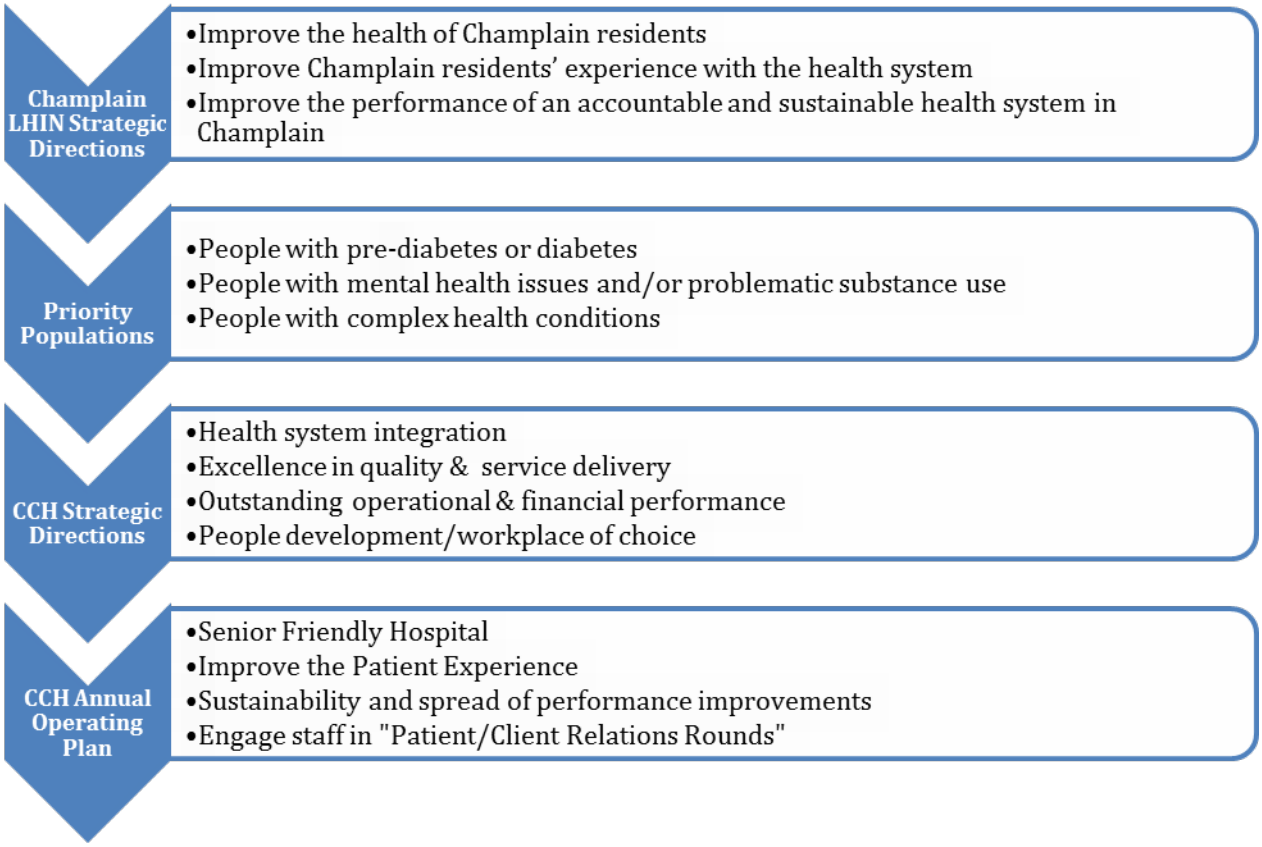
1. Overview of our quality improvement plan for 2012-13

- 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

- The primary focus of the 2012/13 CCH QIP is improving the patient experience which encompasses both patient safety, and the strengthening of internal and external health service linkages which affect the care experience.
- It is recognized that this priority can only be achieved through an engaged, patient-centred workforce.

3. How the plan aligns with the other planning processes



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.
- 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 to receive test results).
- Contributing to this is the fact that 19% of CCH patients receiving care within the ED do not have a family physician; CCH's rate is the highest of 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 the four hospitals (Cornwall, Glengarry, Winchester, Hawkesbury) in the Eastern Counties is projected to remain consistent with CCH providing 40% of the service.

[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).

Medicine Department

- CCH currently has a high occupancy rate of ALC patients, especially with the senior patients (65+).

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.
- Significantly high emergency surgery volume, combined with limited surgical bed availability, contributes to surgical procedure rescheduling and cancellations.
- 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.
- Children and youth have also been identified as underserved subpopulations.

Part B:
Our Improvement Targets and Initiatives

Purpose of this section: Please complete the "Part B - Improvement Targets and Initiatives" spreadsheet (Excel file). Please remember to include the spreadsheet (Excel file) as part of the QIP Short Form package for submission to HQO (QIP@HQOntario.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.]

1 CCH QIP2 2012/13 Part B: Improvement Targets and Initiatives

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.	**0.19** (Q3,2011)	**Range 0.00/Ont. Rate**	**CCH = 0.00, Ont. Rate = 0.36** (Dec - 2011)	**2**				
	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. 2011, consistent with publicly reportable patient safety data.	**0.00** (Q3, 2011)	**Range 0.00/Ont. Rate**	**CCH = 0.00, Ont. Rate = 1.26** (Q3, 2011)	**2**				
	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.	**MC Site = 59% SS Site = 82%** (Apr-11)	**80%**	**Large Community Hospitals Best Performers = 92%**	**1**	**a)** Recognize top performers and evaluate use of incentives and rewards for consistent excellence. **b)** Establish annual mandatory hand hygiene reviews/refreshers. **c)** Complete quarterly hand hygiene audits and provide immediate feedback to staff on performance. **d)** Ongoing audits and reporting of hand hygiene compliance to all managers. **e)** Unit specific hand hygiene results posted on patient care units. **f)** Incorporate hand hygiene compliance rates as a performance goal for all managers and leaders. **g)** Patient care areas that do not meet 70% compliance will be required to submit an action plan to IPAC Committee. **h)** Develop and roll out an e-learning module for staff. **i)** Incorporate IPAC/Hand Hygiene component within Patient Safety Leadership Walkarounds.	**a)** Monthly progress reviews conducted by Director Q/R. **b)** Quarterly QIP2 Scorecard presented to Senior Leadership Team, Medical Quality Committee and Quality and Performance Monitoring Committee. **c)** IPAC provides oversight and ongoing monitoring of intervention compliance and impact IPAC provides intervention oversight Indicator	Implemented process measures expected to provide timely notice of intervention effectiveness or if a recovery plan required at the operational, executive and governance levels.	**None**
	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	**0.00** (Q3, 2011)	**Range 0.00/Ont. Rate**	**CCH = 0.00, Ont. Rate = 0.48** (Q3, 2011)	**2**				
	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 Q3 2011/12, CCRS	**N/A**	**N/A**	**N/A**	**N/A**				

2 CCH QIP2 2012/13 Part B: Improvement Targets and Initiatives

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
	Avoid patient falls	**ADDED: Falls**: Acute inpatient units (2011, Q3 = 73 patient falls RL Solutions/1,730 cases)	**73 Falls 4.2%** (Q3, 2011)	**69 Falls 4.0%** (5% Reduction)	**Fall Prevention Program essential to Senior Friendly Hospitals**	**1**	**a)** Participate in LHIN Ontario-wide Falls Prevention Program. **b)** Daily Morse Fall Risk Assessment for all inpatients. **c)** Monitor compliance with fall risk assessment. **d)** Investigate all falls, conduct root cause analysis, and communicate findings and contributing factors, implement recommendations. **e)** Phased implementation of comprehensive falls prevention protocol, engage physicians in development process. **f)** Review data captured within RL Solutions ensuring relevant data elements captured, i.e., new or repeated falls, etc. **g)** Develop an algorithm guiding interdisciplinary interventions for at-risk patients, i.e., elderly. **h)** Review best practice guidelines from RNAO and incorporate strategies within assessment and intervention components of protocol. **i)** Introduce mandatory clinical staff training and assess competencies in performing protocol, include wheelchair skills and safety program. **j)** 4P rounding: personal needs, pain and proximity to personal items – initiate comfort rounds.	**a)** Monthly progress reviews conducted by Director Q/R. **b)** Quarterly QIP2 Scorecard presented to Senior Leadership Team, Medical Quality Committee and Quality and Performance Monitoring Committee. **c)** Patient Safety Coordinator provides oversight and ongoing monitoring of intervention compliance and impact.	Implemented process measures expected to provide timely notice of intervention effectiveness or if a recovery plan required at the operational, executive and governance levels.	**None**
	Avoid patient falls	**Falls**: Percent of complex continuing care residents who fell in the last 30 days - FY Q3 2011/12, CCRS	**N/A**	**N/A**	**N/A**	**N/A**				
	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	**99.7%** Data from SETP, includes IP & OP cases	**Range 100%/Ont. Rate**	**CCH = 99.44, Ont. Rate = 99.19%** (Q2+Q3, 2011)	**2**				
	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	**4.9%** (Q2, 2011)	**4.66%** (5% Reduction)	**Peer hospitals = 5.1%**	**2**				
	Avoid patient harm related to premature departure from ER	**ADDED: Left Without Being Seen Rate:** Percentage of total unscheduled visits to ER that left without being seen by a physician.	**2.9%** (Q3, 2011)	**2.76%** (5% Reduction)	**Sustain/build on gains achieved via ED-PIP**	**1**	**a)** Complete LWBS patient profile analysis, follow-up patient surveys to identify factors contributing to premature departure. **b)** Provide patient information and education related to triage and other processes within ER. **c)** Implementation of ER manager daily patient rounding. **d)** Evaluate feasibility of incorporating an, "enhancing the patient experience" component within general and department specific orientation which includes patient	**a)** Monthly progress reviews conducted by Director Q/R. **b)** Quarterly QIP2 Scorecard presented to Senior Leadership Team, Medical Quality Committee and Quality and Performance Monitoring Committee. **c)** Director, Critical Care	Implemented process measures expected to provide timely notice of intervention effectiveness or if a recovery plan required at the	**None**

3 CCH QIP2 2012/13 Part B: Improvement Targets and Initiatives

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
							declaration of values, communications skill building. **e)** Monitor/review ER physician scheduling and sub-service assignments alignment with volumes, acuity and demand variance. **f)** Monitor/review Diagnostics/ER process improvement options continue to be investigated. **g)** Monitor/review response times by CCH specialists, medical departments analyzed, benchmarks reviewed, with recommendations to be implemented. **h)** Pilot and evaluate Bed Coordinator role to support bed management best practices, i.e., predictive discharge process, bed management meetings twice daily at change of shift to optimize bed utilization, 10:00am discharge. **i)** Continuous monitoring of PIA and other emerging flow bottlenecks, develop strategies which result in timely response/resolution.	Services, provides oversight and ongoing monitoring of intervention compliance and impact.	operational, executive and governance levels.	
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	**63** Data Available Q2, 2011	**CCH HSMR less than 100**	**Less than 100 indicates mortality rate lower than national experience**	**2**				
	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	**0.195%** (Q3, 2011)	**0.0 - 5.0%**	**Optimal Range**	**2**				
	Reduce avoidable surgical cancellations	**ADDED: Surgical Cancellation Rate:** inpatient/outpatient same day cancellations and cancellations due to hospital resources, i.e., no beds	**1.28%** (Q2 + Q3, 2011)	**1.21%** (5% Reduction)	**1.1% (Juravinski Hospital)**	**1**	**a)** Establish surge capacity to accommodate excess demand for acute care. **b)** Pilot and evaluate Bed Coordinator role to support bed management best practices, i.e., predictive discharge process, bed management meetings twice daily at change of shift to optimize bed utilization, 10:00am discharge. **c)** Optimize discharge planning processes to ensure safe and effective transitions to community-based health services. **d)** Develop and implement electronic bed management system to allow tracking wait times for available beds. **e)** Develop and promote the use of diagnosis-specific admission Order Sets. **f)** Implement and monitor compliance with the approved Care Maps/Pathways.	**a)** Monthly progress reviews conducted by Director Q/R. **b)** Quarterly QIP2 Scorecard presented to Senior Leadership Team, Medical Quality Committee and Quality and Performance Monitoring Committee. **c)** Director, Surgical Services, provides oversight and ongoing monitoring of intervention compliance and impact.	Implemented process measures expected to provide timely notice of intervention effectiveness or if a recovery plan required at the operational, executive and governance levels.	**None**
Access	**Reduce wait times in the ER**	**ER Wait times:** 90th Percentile ER length of stay for Admitted patients. Q3 2011/12, NACRS, CIHI	**42.2** (Q3, 2011) ERNI	**40.09** (5% Reduction)	**Large Community Hospitals Best Performers = 4.5**	**1**	**a)** Establish surge capacity to accommodate excess demand for acute care. **b)** Pilot and evaluate Bed Coordinator role to support bed management best practices, i.e., predictive discharge	**a)** Monthly progress reviews conducted by Director Q/R. **b)** Quarterly QIP2 Scorecard presented to Senior	Implemented process measures expected to provide timely	**None**

4 CCH QIP2 2012/13 Part B: Improvement Targets and Initiatives

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
							process, bed management meetings twice daily at change of shift to optimize bed utilization, early am patient transfers from ER-IP services, 10:00am discharge. **c)** Implement an electronic bed management system to allow tracking and improvements in wait time for available beds. **d)** Monitor/review response times by CCH specialists, medical departments analyzed, benchmarks reviewed, with recommendations to be implemented. **e)** Optimize discharge planning processes to ensure safe and effective transitions to community-based health services. **f)** Develop and promote the use of diagnosis specific admission Order Sets. **g)** Implement and manage compliance with the approved Care Maps/Pathways. **h)** Increase access to diagnostic services for ER patients (e.g. 24 hrs. CT). **i)** Discharged patients to be contacted within 24-72 hours of discharge. **j)** Discharge communication sent to community care provider within 72 hours of patient discharge. **k)** Evaluate having a "float" environmental service worker position during peak admission period to reduce time waiting for a room to be cleaned and prepared for admission.	**c)** Leadership Team, Medical Quality Committee and Quality and Performance Monitoring Committee. Director, Critical Care Services, provides oversight and ongoing monitoring of intervention compliance and impact.	notice of intervention effectiveness or if a recovery plan required at the operational, executive and governance levels.	
		ADDED: Physician Initial Assessment (PIA): 90th percentile time to Physician Initial Assessment (within ER)	**2.4** (Q3, 2011) ERNI	**2.28** (5% Reduction)	**Sustain/build on gains achieved via ED-PIP**	**1**	**a)** Establish surge capacity to accommodate excess demand for acute care. **b)** Pilot and evaluate Bed Coordinator role to support bed management best practices, i.e., predictive discharge process, bed management meetings twice daily at change of shift to optimize bed utilization, early am patient transfers from ER-IP services, 10:00am discharge. **c)** Monitor/review response times by CCH specialists, medical departments analyzed, benchmarks reviewed, with recommendations to be implemented. **d)** Provide printed discharge instructions to patients. **e)** Develop and promote the use of diagnosis specific admission Order Sets. **f)** Implement and manage compliance with the approved Care Maps/Pathways. **g)** Increase access to diagnostic services for ER patients (e.g. 24 hrs. CT). **h)** Discharged patients to be contacted within 24-72 hours of discharge. **i)** Discharge communication sent to community care provider within 72 hours of patient discharge. **j)** Continuous monitoring of PIA and other emerging flow bottlenecks, develop strategies which result in timely response/resolution.	**a)** Monthly progress reviews conducted by Director Q/R. **b)** Quarterly QIP2 Scorecard presented to Senior Leadership Team, Medical Quality Committee and Quality and Performance Monitoring Committee. **c)** Director, Critical Care Services, provides oversight and ongoing monitoring of intervention compliance and impact.	Implemented process measures expected to provide timely notice of intervention effectiveness or if a recovery plan required at the operational, executive and governance levels.	**None**

5 CCH QIP2 2012/13 Part B: Improvement Targets and Initiatives

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
Patient-centred	**Improve patient satisfaction**	**From NRC Picker / HCAPHS:** "Would you recommend this hospital to your friends and family?"	**ED = 51.63%, IP = 66.67%** (Jan - Dec, 2011)	**ED = 54.21%, IP = 70.00%** (NRCP, 5% Improvement)	**Achievable incremental gain in improving patient experience**	**2**				
		From NRC Picker: "Overall, how would you rate the care and services you received at the hospital?" (ED)	**ED = 80.93%** 430 Returns (Jan - Dec, 2011	**ED = 85.0%** (NRCP, 5% Improvement)	**Achievable incremental gain in improving patient experience**	**1**	**a)** Implement improved pre-admission and pre-discharge patient education and communication processes within inpatient services. **b)** Provide patient information and education related to triage and other processes within ER. **c)** Full implementation of inpatient unit manager daily patient rounding. **d)** Review hallway and mixed gender room assignment policy and performance. **e)** Evaluate feasibility of unrestricted (open) hours for patient visiting. **f)** Strengthen family engagement in in-hospital and post hospital care planning, as appropriate. **g)** Strengthen discharge preparedness/information provided to patients and family members to assist with care transition. **h)** Evaluate feasibility of incorporating an, “enhancing the patient experience” component within general and department specific orientation which includes patient declaration of values, communications skill building. **i)** Evaluate feasibility of implementing Patient and Family Advisory Council. **j)** Evaluate organizational strengths and improvement opportunities identified with Worklife Pulse Surveys. **k)** Evaluate feasibility of unrestricted (open) hours for patient visiting. **l)** Implement best practices associated with Senior Friendly Hospitals. **m)** Implement Patient Relations monthly leadership walkabouts to engage patients/family members regarding their care experience. **n)** Strengthen quality of care and patient handoffs including follow-up appointments with physician post discharge and calls after surgery. **j)** NRC Picker patient experience surveys reports at the departmental level to be posted quarterly with services required to identify and implement a minimum of 3 strategies to improve the patient experience. **o)** Evaluate and revise patient relations process/framework and post on corporate website.	**a)** Monthly progress reviews conducted by Director Q/R. **b)** Quarterly QIP2 Scorecard presented to Senior Leadership Team, Medical Quality Committee and Quality and Performance Monitoring Committee. **c)** Director, Q/R and Patient Safety Coordinator, provide oversight and ongoing monitoring of intervention compliance and impact.	Implemented process measures expected to provide timely notice of intervention effectiveness or if a recovery plan required at the operational, executive and governance levels.	**None**
		From NRC Picker: "Overall, how would you rate the care and services you received at the hospital?" (IP)	**IP = 89.36%** 357 Returns (Jan - Dec, 2011)	**ED = 93.8%** (NRCP, 5% Improvement)	**Achievable incremental gain in improving patient experience**	**1**				
		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**	**N/A**				

6 CCH QIP2 2012/13 Part B: Improvement Targets and Initiatives

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
		ADDED: **Performance Appraisal Completion Rate:** percentage of employees having received a performance appraisal within the last 12 months	**61%** (Q3, 2011)	**75%**	**Increase recognition of patient-centred behaviours, and alignment with PDoV**	**1**	**a)** Incorporate performance appraisal compliance rates as a performance goal for all managers and leaders. **b)** Ensure that performance appraisals incorporate evidence of and/or goals for the coming year: incorporating PDoV within practice; improving the patient experience; and, contributions to improving patient safety.	**a)** Monthly progress reviews conducted by Director Q/R. **b)** Quarterly QIP2 Scorecard presented to Senior Leadership Team, Medical Quality Committee and Quality and Performance Monitoring Committee. **c)** Director, Q/R, provide oversight and ongoing monitoring of intervention compliance and impact.	Implemented process measures expected to provide timely notice of intervention effectiveness or if a recovery plan required at the operational, executive and governance levels.	**None**
Integrated	**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 2011/12, DAD, CIHI	**25.78%** (Q4, 2010) MOHLTC FIM	**24.49%** (5% Improvement)	**Achievable incremental gain in improving service integration**	**2**				
	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	**18%** (Q4 2010) MOHLTC FIM	**17.10%** (5% Improvement)	**Achievable incremental gain in improving service integration**	**2**				
	Reduce avoidable ER visits	ADDED: **ER mental health/substance abuse visits:** Percent of repeat emergency visits following a visit for a mental health or substance abuse condition. A visit is counted as a repeat visit if it is for either a mental health or substance abuse condition, and occurs within 30 days of an index visit for a mental health or substance abuse condition. This indicator is presented as a proportion of all mental health emergency visits.	**14.0%** (Q1-4 2011)	**13.3%** (5% Improvement)	Since Sept, 2010, all LHINs in Ontario have been required to report on and respond to data related to this indicator of System Integration.	**1**	**a)** Monitor the use of care maps/pathways to assess whether or not they decrease ER visits through use of evidence-based practice. **b)** Review ER visit cases for patterns and trends, contributing factors, undertake a chart audit and interview ER visit patients to identify trends and/or illnesses regarding repeat visits. **c)** Collaborate with Family Health Teams and Community Health Centre and primary care providers on consistent strategy for referrals and follow-up. **d)** Improve linkages between the ER and community-based mental health programs (CCH Mental Health Programs, and Canadian Mental Health Association). **e)** Improve linkages between the ER and community-based addiction services (e.g., Addiction Services of Eastern Ontario and Withdrawal Management Services (WMS). **f)** Increase the presence of ASEO staff at CCH WMS (ASEO staff will be present a minimum of three times per week at CCH WMS). **g)** Reduce the wait time for services at ASEO. **h)** Strengthen linkages and improve access of clients with long-term substance misuse disorders with ASEO's Supportive Housing Program. **i)** Work towards the development of a community/day withdrawal management service; include within the staffing model an addictions therapist rapidly accessible	**a)** Monthly progress reviews conducted by Director Q/R. **b)** Quarterly QIP2 Scorecard presented to Senior Leadership Team, Medical Quality Committee and Quality and Performance Monitoring Committee. **c)** Director, Director, Community Mental Health Programs, provides oversight and ongoing monitoring of intervention compliance and impact.	Implemented process measures expected to provide timely notice of intervention effectiveness or if a recovery plan required at the operational, executive and governance levels.	**None**

7 CCH QIP2 2012/13 Part B: Improvement Targets and Initiatives

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
							to ER staff and physicians. **j)** Increase ER and family physician awareness of community-based resources and treatment options for those clients with concurrent and/or mental health/addictions issues. **k)** Continue to work towards a full integration between ASEO and CCH. **l)** Increase MH Crisis Team presence in the community versus the ER (ER diversion). **m)** Strengthen linkages between MH and addiction services and Cornwall Community Police.			

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

The purpose of performance-based compensation related to ECFAA is to drive accountability for the delivery of quality improvement plans (QIPs). By linking achievement of targets to compensation, organizations can increase the motivation to achieve both long and short term goals. Performance-based compensation will enable organizations to ensure consistency in the application of performance incentives and drive transparency in the performance incentive process.

Please refer to Appendix E in the QIP Guidance Document for more information on completing this section of the QIP Short Form. The guidance provided for executive compensation is also available on the ministry website.

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

[Compensation should be linked to targets for the CEO and 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. Members of the senior management team who do not fall under the definition of "executive" as listed in the regulations (i.e. those not reporting directly to the CEO) may also be included in performance-based compensation, at the discretion of the organization. Please refer to the regulation (Ontario Regulation 444/10) and the guidance on executive compensation available from the ministry's website.]

QIP2 Executive Performance Compensation (2% At-Risk[3])

Quality Dimension	Outcome Measure/ Indicator	Priority	Indicator Weight
Safety	Hand hygiene compliance: Before patient contact.	1	10%
	Falls: Acute inpatient units.	1	10%
	Left without being seen rate.	1	10%
Effectiveness	Surgical cancellation rate.	1	5%

[3] The CCH Board reserves the right to adjust this percentage based on in-year financial situation and legislative/regulatory changes which would permit a greater investment in the CCH executive incentive compensation program.

Quality Dimension	Outcome Measure/ Indicator	Priority	Indicator Weight
Access	ER wait times: Admitted patients.	1	15%
	ER Physician: Initial assessment.	1	10%
Patient-centred	From NRC Picker: "Overall, how would you rate the care and services you received at the hospital?" (ER)	1	10%
	From NRC Picker: "Overall, how would you rate the care and services you received at the hospital?" (IP)	1	10%
	Performance appraisal completion rate.	1	15%
Integrated	ER mental health/substance abuse visits.	1	5%

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/service provider surveys, and aggregated critical incident data
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 processes and considers other organizational and provincial priorities *(refer to the guidance document for more information)*.

Helene Periard *Board Chair*	Lydia Johnson *Quality and Performance Monitoring Committee Chair*	Jeanette Despatie *Chief Executive Officer*