### PART B: Improvement Targets and Initiatives

**Hamilton Health Sciences | Hamilton, ON**

**2012/13**

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

<table>
<thead>
<tr>
<th>Quality dimension</th>
<th>Objective</th>
<th>Measure/Indicator</th>
<th>Current performance</th>
<th>Target for 2012/13</th>
<th>Target justification</th>
<th>Priority level</th>
<th>Planned improvement initiatives (Change Ideas)</th>
<th>Methods and process measures</th>
<th>Goal for change ideas (2012/13)</th>
<th>Comments</th>
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</thead>
<tbody>
<tr>
<td>Safety</td>
<td>Reduce clostridium difficile associated diseases (CDI)</td>
<td>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</td>
<td>0.41</td>
<td>0.4 cases per 1000 patient days</td>
<td>Regional benchmark</td>
<td>2</td>
<td>Establish a multidisciplinary hospital-wide “Falls Prevention and Reduction” Steering Team to support the identification, implementation, evaluation and sustainment of evidence informed best practices.</td>
<td>100% of identified programs/Departments participate in the hospital-wide Steering Team and/or related subcommittees.</td>
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<td>Reduce incidence of Ventilator Associated Pneumonia (VAP)</td>
<td>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</td>
<td>2.42</td>
<td>2.25 cases per 1000 ventilator days</td>
<td>Return performance to last year’s target</td>
<td>2</td>
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<td></td>
<td>Improve provider hand hygiene compliance</td>
<td>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</td>
<td>72.2%</td>
<td>85%</td>
<td>Made significant improvement; continue towards stretch target</td>
<td>2</td>
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<td>Reduce rate of central line blood stream infections</td>
<td>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</td>
<td>1.09</td>
<td>0.50 cases per 1000 central line days</td>
<td>Stretch target to improve performance by 50%</td>
<td>2</td>
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<td>Reduce incidence of new pressure ulcers</td>
<td>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</td>
<td>5%</td>
<td>4.75%</td>
<td>Continuous improvement year over year</td>
<td>3</td>
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<td></td>
<td>Avoid patient falls</td>
<td>Falls: Percent of complex continuing care residents who fell in the last 30 days - FY Q3 2011/12, CCRS</td>
<td>10%</td>
<td>6.9%</td>
<td>Return performance to last year’s target</td>
<td>2</td>
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<td>Reduce rates of deaths and complications associated with surgical care</td>
<td>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</td>
<td>97.4%</td>
<td>100%</td>
<td>Continue towards stretch target</td>
<td>2</td>
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The initiatives described below have been selected purposefully in order to have the greatest impact on falls prevention and injury reduction among acute care patients. An overall sustained 5% reduction in falls occurrences in acute care is the main measure of outcome. The Registered Nurses’ Association of Ontario Best Practice Guideline on falls prevention has been in the organization since 2008 however widespread uptake across interdisciplinary team members beyond nursing and hospital support services has not been methodically approached for greater impacts. This plan escalates the involvement of the organization to contribute impacts that support the work at the clinical unit level and drives increased accountability and focus on performance outcomes at all levels in the organization.

(1) Each hospital department/program contracts to provide a meaningful role to Falls Prevention and Reduction. Establish a multidisciplinary hospital-wide Falls Prevention and Reduction Steering Team to support the identification, implementation, evaluation and sustainment of evidence informed best practices. 100% of identified programs/Departments participate in the hospital-wide Steering Team and/or related subcommittees.
### AIM
Avoid patient falls

Acute Inpatient Falls per 1000 acute inpatient days: Number of acute inpatient falls divided by the number of acute inpatient days multiplied by 1000 - January to December 2011. (Inpatient falls at HGH, JHCC, MUMC excluding Rehab. Acute-inpatient days exclude Villa).

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<tr>
<th>Measure</th>
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<tr>
<td>2.44</td>
<td>2.32 acute IP falls per 1000 acute IP days</td>
<td>(2) Establish standardized Program and Unit level falls monitoring and communication processes.</td>
<td>1% improvement would be a stretch improvement from historical performance</td>
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1. Falls data to be included on inpatient unit Program Dashboards.
2. Quality Council, Practice Council and Unit Council/Staff meeting Agenda’s to include focused discussions regarding Falls Prevention and Reduction.
3. Health Outcomes for Better Information and Care (HOBIC) data to be reported regularly to provide trends in functional status.
4. Transfer of accountability (TOA) reporting practices will be reinforced for sustainability to ensure falls risk assessments and care plan interventions are consistently relayed for follow through.
5. Falls data is updated daily and is visible on the identified clinical units complemented with approaches that engage discussion of team members regarding improvement tactics.

### CHANCE

1. 100% of all identified Programs include Falls Rate on Program Dashboards.
2. 100% of identified units post monthly Falls data and have approaches to ensure daily falls tracking visible on the unit.
3. 100% of identified units post and review HOBIC data.
4. 100% of all identified Programs include “Falls Prevention and Reduction” on Quality Council and Unit specific Agenda’s.
5. 100% inclusion of Falls Risk Assessment and Care Plan in TOA on identified units.

### 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

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<tr>
<td>99</td>
<td>95</td>
<td>Continue to have less deaths than predicted</td>
<td></td>
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1. Establish standardized “Patient Rounding” process on identified clinical units.
2. Introduce the “Healthy Elders Program” (HELP) in identified high risk units to enhance patient mobilization and reduce risks of deconditioning.
3. Participate in the Council of Academic Hospitals (CAHO) “MOVE ON” research project focused on early mobility for seniors.

### CHANCE

1. Standardized and consistent process for regular Patient Rounding in place on 100% of identified clinical units.
2. Expansion of HELP to identified high risk units completed.
3. “MOVE ON” pilot initiated in identified units.

### Effectiveness
Reduce injuries to workforce

Lost Time Frequency Rate: the number of lost time injuries per 100 insured workers - January to December 2011

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<td>1.56</td>
<td>1.4</td>
<td>10% improvement over 2011 and 19% over 2010</td>
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The initiatives described below have been selected purposefully in order to have the greatest impact on an admitted patient’s Emergency Department (ED) length of stay. The patient’s journey from time of arrival in the Emergency Room to transfer to an inpatient bed has been measured and the longest wait period for patients is from the time of the decision to admit to the time a patient is transferred to an inpatient bed. As such, the opportunities below are aimed at: 1) ensuring available alternatives to admission are considered; 2) and opportunities to improve flow through inpatient beds are optimized.

### CHANCE

1. Development of Reporting Tools completed.
2. Dissemination and Feedback Process developed and implemented.
3. One GIM and one ED Physician improvement opportunity implemented.
4. September, 2012
5. November, 2012

This intervention will provide GIM and ED physicians with a regular data report regarding admission and referral patterns and support the identification of improvement opportunities.

### Effectiveness
Improve organizational financial health

Total Margin (consolidated): Percent by which total corporate (consolidated) revenues exceed or fall short of total corporate (consolidated) expense, excluding the impact of facility amortization, in a given year. Q3 2011/12, OHRS

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<tr>
<td>+1.86%</td>
<td>0%</td>
<td>Continue to meet budget</td>
<td></td>
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<tr>
<td>(2) Maximize referrals to the General Internal Medicine Rapid Access Outpatient Clinic (GIMRAOC) by providing quarterly data to General Internal Medicine (GIM) and Emergency Department (ED) physicians regarding their referral rate to the GIMRAOC.</td>
<td>Percentage increase in the number of new visits to GIMRAOC over 2011/12.</td>
<td>0% improvement over 2011-12. This intervention is aimed at reducing unnecessary admissions to hospital by ensuring eligible patients are identified and referred to the GIMRAOC.</td>
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<td>(3) Partnership with community long-term care homes to determine opportunities to enhance support for residents and prevent unnecessary emergency department visits and hospital admissions.</td>
<td>1. Physician led retrospective review of hospital admissions and visits from community long-term care homes completed. 2. Retrospective review of long-term care home transfers to hospitals completed. 3. Two improvement opportunities implemented.</td>
<td>1. September, 2012 2. September, 2012 3. December, 2012 This intervention is aimed at improving partnerships and communications with long-term care home facilities and ensuring opportunities to support residents care needs are identified and addressed.</td>
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<td>(4) Improve access to the right beds at the right time through a simulation-informed bed map.</td>
<td>1. Application of surgical predictive bed model. 2. Development of medical predictive bed model.</td>
<td>1. Surgical Predictive Model: application complete at identified HHS sites by October, 2012. 2. Medical Predictive Model: pilot model developed April, 2013. This intervention is aimed at matching bed demand to supply through the introduction and application of analytical modeling.</td>
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<td>(5) Introduction of predictive screening tool (LACE – Length of Stay, Acuity, Co-morbidity and Emergency Room visits) to support successful/earlier patient discharges and reduce readmissions.</td>
<td>1. Education and Training completed. 2. Tool implementation.</td>
<td>1. September, 2012 2. April, 2013 This intervention is aimed at matching bed demand to supply through the introduction and application of analytical modeling.</td>
</tr>
<tr>
<td>(6) Improve acute inpatient length of stay and discharge patterns through optimization of site-based patient flow initiatives.</td>
<td>Percentage of Medicine patients discharged on weekends.</td>
<td>12% increase over 2011-12. This intervention is aimed at ensuring barriers (e.g. access to Allied Health professionals, access to laboratory or diagnostic tests) to weekend discharges are eliminated.</td>
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**Patient-centered**

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<thead>
<tr>
<th>Access</th>
<th>Reduce wait times in the ED</th>
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<tr>
<td><strong>ER Wait times:</strong> 90th Percentile ER length of stay for <strong>Admitted</strong> patients. Q3 2011/12 (October-December 2011), NACRS, CIHI</td>
<td>27.9 hours</td>
</tr>
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</table>

**From NRC Picker:**

“Overall, how would you rate the care and services you received at the hospital?” - October 2010 to September 2011 for both Emergency Department (ED) and...
### Aim: Prevent transitions to ALC LTC through the implementation of best practice care strategies for seniors including continence maintenance protocols and sit to stand programs.

1. Two pilot initiatives completed in 2011/2012 sustained and spread to identified acute care units.

This strategy is aimed at ensuring seniors maintain continence and mobility during hospitalization.

### Aim: “Home First” strategies maintained in collaboration with patients, families, community partners and agencies.

1. Intensive Case Management Review (ICMR) process completed in collaboration with CCAC and patients/families to ensure barriers to discharge home are identified and addressed.
2. Introduction of joint meetings between CCAC and HHS social workers.
3. Development of tools to assist staff in understanding roles and timelines of ICMR processes.

1. ICMR process completed on 100% of identified patients.

This strategy is aimed at ensuring that barriers and challenges to discharges are addressed and patients are supported to return to their homes following hospitalization.

### Aim: Improve care for palliative patients through:

1. Participation in ICCP (Integrated Client Care Project) Palliative Care Strategy to reduce admissions and visits to emergency department for palliative patients in community.
2. Exploration of opportunities to collaborate with hospice sector in order to better identify hospice level patients, improve transfer process and reduce waits for hospice beds.

1. Decrease in the number of palliative patients that present to the emergency department.
2. Reduction in ALC-palliative care days.

1. 5% improvement over 2011/2012.
2. 5% reduction from 2011/2012.

These initiatives are aimed at supporting palliative care in the community and reducing the length of time patients wait in hospital for a bed in palliative care programs.

### Aim: Focussed examination of Rehab referral process/practices in order to identify opportunities to reduce TBD-Rehab days.

1. Two strategies to improve ALC Rehab designation process implemented.
2. Reduction in TBD-Rehab days.

2. 5% improvement over 2011/2012.

This intervention is aimed at improving the accuracy of rehab referrals and reducing waits for rehab beds.