Hospitals

Impressions and Observations
2015/16 Quality Improvement Plans

Let's make our health system healthier

HOSPITALS

Ontario
Health Quality Ontario

About Us

Health Quality Ontario is the provincial advisor on the quality of health care. We are motivated by a single-minded purpose: **Better health for all Ontarians**.

Who We Are.

We are a scientifically rigorous group with diverse areas of expertise. We strive for complete objectivity, and look at things from a vantage point that allows us to see the forest and the trees. We work in partnership with health care providers and organizations across the system, and engage with patients themselves, to help initiate substantial and sustainable change to the province's complex health system.

What We Do.

We define the meaning of quality as it pertains to health care, and provide strategic advice so all the parts of the system can improve. We also analyze virtually all aspects of Ontario's health care. This includes looking at the overall health of Ontarians, how well different areas of the system are working together, and most importantly, patient experience. We then produce comprehensive, objective reports based on data, facts and the voice of patients, caregivers and those who work each day in the health system. As well, we make recommendations on how to improve care using the best evidence. Finally, we support large-scale quality improvements by working with our partners to facilitate ways for health care providers to learn from each other and share innovative approaches.

Why It Matters.

We recognize that, as a system, we have much to be proud of, but also that it often falls short of being the best it can be. Plus certain vulnerable segments of the population are not receiving acceptable levels of attention. Our intent at Health Quality Ontario is to continuously improve the quality of health care in this province regardless of who you are or where you live. We are driven by the desire to make the system better, and by the inarguable fact that better has no limit.

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Executive Summary

There is a clear commitment to improving the care delivered in Ontario hospitals. Hospitals have demonstrated this commitment by articulating improvement goals and targets in their annual Quality Improvement Plan (QIP), sharing it with their community, and submitting it to Health Quality Ontario. The April 1, 2015 submission marks the fifth year of making this formal commitment to quality for all public hospitals in Ontario – more than 140 organizations in total.

The QIPs developed and submitted this year show that hospitals have integrated quality improvement processes into their organizations and are working hard to implement best practices, while building relationships with system partners. Most hospitals (131) improved on at least one of the seven priority indicators, and 55 improved on three or more indicators. Hospitals are expanding their improvement strategies beyond the standard definitions of the indicators, such as extending lessons learned about antimicrobial stewardship into the community, and using "top box" scores to drive improvement on satisfaction.

Hospitals are also taking a more proactive approach to capturing information about patients' experiences by using tools such as patient portals, providing surveys in different languages, and engaging patients and families in advisory councils and quality committees.

At the same time, progress on most of the priority indicators has been slow. This may be because some of the indicators require work outside of organizations and are challenging to improve. The QIPs showed great variability in the indicators across the different hospital types and regions. To understand why some are performing better than others, it is essential to share the lessons from failures as well as from successes.

This report is part of Health Quality Ontario's ongoing *Insights Into Quality Improvement* series. In an effort to continue sharing information about strategies to improve care, it touches on all three components of the QIPs prepared by hospitals and largely concentrates on the lessons learned over the past year.

About This Report

For the past five years, health sectors across Ontario have developed and submitted Quality Improvement Plans (QIPs). A process that began with Ontario's hospitals has now extended to organized primary care organizations, community care access centres (CCACs) and long-term care homes.

The annual submission of QIPs demonstrates the ongoing commitment of more than 1,000 health care organizations to deliver higher quality care in Ontario. These plans allow organizations to articulate their quality objectives, formalize their improvement activities and pinpoint precise ways of achieving those goals.

Each QIP details an organization's work on a set of priority indicators. These indicators align with the Common Quality Agenda, a set of more than 40 indicators developed collaboratively by Health Quality Ontario and other health system partners. The Common Quality Agenda is an effort to focus performance reporting, lend greater transparency and accountability to the health system, and promote integrated, patient-centred care. It forms the foundation of Health Quality Ontario's yearly report on how Ontario's health system is performing, *Measuring Up*. Health care organizations can use the information available in *Measuring Up* and our *Insights Into Quality Improvement* reports to gain a greater understanding of quality improvement from both an organizational and system-wide perspective.

The preparation and detail that go into each QIP typically represent an impressive effort on the part of each health care organization. Health Quality Ontario recognizes this work by carefully reading each QIP to examine and evaluate the data and the change ideas provided. Using QIPs to highlight

progress and identify areas in need of improvement is one way in which Health Quality Ontario works with the 1,076 health care organizations across four sectors to transform the quality of care throughout the health system.

Health Quality Ontario hopes that the findings in this report will help inform decisions about the quality of care delivered in hospitals, encourage further testing of innovations and help to guide planning efforts for the coming year.

This report is part of the ongoing *Insights Into Quality Improvement* series. It touches on all three components of the QIPs (progress report, narrative, and workplan) prepared by hospitals and largely concentrates on the lessons hospitals learned over the past year. Both quantitative and qualitative data are included. The qualitative data are presented as change ideas and organization profiles, pulled from all priority indicators. The quantitative data are drawn only from those hospitals who selected a particular indicator and chose to measure that indicator using Health Quality Ontario's original, technical definition (available in the QIP guidance documents). We use the term "improved" when a hospital's indicator value is better at the end of the year than it was at the beginning of the year. Tests of statistical significance have not been performed on the data and the results should be interpreted with some caution.

Introduction

Last year, Ontario's hospitals provided a wide range of services in both inpatient and outpatient care to support the more than 13.5 million residents of the province. Hospitals work collaboratively with patients, families, and providers across the health care system to deliver acute care and specialized services to patients, with a goal of ensuring patients receive not only high-quality care but also smooth transitions as they move among various services and sectors.

This was the fifth year hospitals developed and submitted QIPs and the first year they not only identified their plan related to specific outcomes and reported on progress related to these outcomes, but also reported on key lessons learned for each change idea they pursued. This has increased the richness and depth about the change initiatives that are working to improve quality of care across the health care sector and also reflects the increasing emphasis on quality improvement across the province.

This report will concentrate on the seven priority indicators identified for Ontario's hospitals:

- Reducing *Clostridium difficile* infection
- Improving medication reconciliation at admission
- Balancing total margin
- Reducing 90th percentile emergency department length of stay for admitted patients
- Reducing percentage of alternate level of care days
- Reducing readmissions within 30 days for selected case mix groups
- Improving patient satisfaction

The priority indicators are selected to bring a common focus to quality across the system and chosen to be complementary to priorities in other sectors as well. As noted in the QIP guidance documents, health care organizations are encouraged to select the priority indicators if their current performance is not at the desired state, particularly where it is lagging behind others in the province.

Improvement Achieved

Hospitals continue to make progress on the provincial priorities, many of which require multi-year strategies to move forward. Throughout this report, graphs show the progress that has been made across the province as the result of improvement efforts by hospitals individually and, in some cases, through collaborations with other organizations. For each indicator, the report provides the percentage of hospitals that have included these metrics in their 2015/16 workplans, along with the direction of their target-setting. We also summarize the improvement initiatives that hospitals told us they are planning to work on and the work they have already done. Key observations round out the high-level summaries for each indicator.

What are the improvement initiatives hospitals are focused on?
The chart shows the percentage of hospitals that selected each of the priority indicators. To reflect the breadth of work going on to improve these indicators, the percentages include the hospitals that used the indicator as defined in the technical specifications, as well as those that used a slightly modified definition.

Priority Indicator	Direction for improvement	Percentage of hospitals
Readmissions within 30 days	⬇	65%
Alternate level of care	⬇	74%
C. difficile infection rate	⬇	65%
ED length of stay for admitted patients	⬇	62%
Medication reconciliation on admission	⬆	78%
Patient satisfaction	⬆	88%
Total margin	Closer to zero	83%

The QIP guidance documents also noted additional indicators that hospitals may include in their QIPs to reflect their specific quality improvement goals and opportunities. Of the additional indicators, hospitals most commonly selected hand hygiene (selected by 46% of hospitals), falls (36%) and medication reconciliation at discharge (34%).

Hospitals are also encouraged to include other indicators that reflect organization-specific quality improvement goals and opportunities, and 98 hospitals did so. These hospitals created custom indicators in the dimensions of (from most common to least) safety, access, effectiveness, patient-centredness, and integration.

Health Quality Ontario's review of the 2015/16 QIPs is outlined as follows:

- Chapter One provides the overarching observations from our analysis

- Chapter Two explores indicators such as *C. difficile* infection or total margin that require improvement work within an individual organization

- Chapter Three addresses other indicators, such as readmissions and emergency department length of stay, that are better improved when sectors collaborate, working together with other organizations and across the care continuum

- Chapter Four focuses on patient-centred care indicators, which have been emphasized recently by the introduction of two new regulations under Ontario's *Excellent Care for All Act*. The new regulations are intended to strengthen patient relations processes and ensure that patients are engaged in the development of QIPs, underscoring the growing role that patient experience and engagement play in quality improvement

- Finally, Chapter Five shares our concluding thoughts on moving forward with the next round of QIPs

We hope the observations included in these chapters will encourage organizations to reflect on their progress and consider new opportunities for collaboration, shared learning, and creative ideas to drive improvement forward.

A closer look at hospital-identified progress:
The number of hospitals that met or exceeded their targets on priority indicators

23 out of 64 **(36%)**
Decreased *C. difficile* infection

39 out of 111 **(35%)**
Improved medication reconciliation at admission

28 out of 100 **(28%)**
Decreased the percentage of alternative level of care days

23 out of 92 **(25%)**
Decreased the 30-day readmission rate to any facility

21 out of 113 **(19%)**
Improved overall patient satisfaction with care

11 out of 79 **(14%)**
Reduced the 90th percentile emergency department length of stay

14 out of 131 **(11%)**
Improved total margin

Chapter One:

Overarching Observations

In addition to reflections on hospitals' progress on the priority indicators, some overarching observations emerged during Health Quality Ontario's analysis of the hospital QIPs.

- **Patient engagement is gaining considerable importance**. Hospitals are working side by side with patients, families and caregivers to actively plan the programs and services they offer and to determine what is most important to patients when they interact with the sector.

  o This year was the first time we have seen a hospital write a QIP narrative specifically for the population it serves. Here are just a few lines from the West Parry Sound Health Centre's narrative: *"…We have written this for the patients and families we are privileged to serve. … Thank you for being a part of this important communication. … You can help us improve by explaining where and how we might have fallen short of your expectation. … Please, respectfully challenge us to be an organization that seeks, finds, and delivers quality improvement."*

- More than two-thirds of hospitals (68%) specifically mentioned the work they are doing to implement **quality-based procedures**, including engaging clinical teams in aligning care to the pathways of the clinical handbooks.

- Hospitals are **partnering** with each other as well as with other sectors. Most hospitals (73%) mentioned working in partnership with home and community care through the CCACs, 56% said they are partnering with primary care and 55% described partnering with other hospitals.

  o Health Links is one of the most commonly cited cross-sector initiatives mentioned in the integration section of the QIPs. Nearly half (46%) of hospitals mentioned being involved with a Health Link. Many of these hospitals are not officially connected to a Health Link but are partnering with them in quality improvement work. However, it is anticipated that many more hospitals are likely working with Health Links – either through a formal or informal partnership – but we have not yet seen this work linked to their QIPs.

- Beyond supporting patients with highly complex needs, we are seeing **more approaches to improving the delivery of integrated care** across sectors and the full continuum of care.

- Hospitals are making efforts to **increase staff engagement in quality improvement** efforts. Many hospitals openly and regularly track their progress on quality indicators among staff through activities such as huddles, and some use quality boards that staff, patients and visitors can view. There is also an increase in data availability, with some organizations using data portals to share quality initiatives with their staff.

  o Sunnybrook Health Sciences Centre uses a data portal for staff to learn more about the QIP indicators, progress in achieving targets, and how staff efforts have an impact on this work. The intent of this initiative is to enable staff to talk about the data and related best practices so that they can support quality improvement at the local level and, ultimately, drive improvements in patient care.

- **A focus on improving surgical quality.** We are pleased to see that more than half of the 16 organizations participating in the Ontario Surgical Quality Improvement Network (ON-SQIN), and have formally signed on to be part of the National Surgical Quality Improvement Program and the Ontario Collaborative (NSQIP-ON), have integrated their surgical program improvement activities into their 2015/16 QIPs. NSQIP, which complements QIP indicators such as readmissions and patient satisfaction, is an internationally recognized program designed to measure and improve the quality of surgical care. The strategies used in this program have been proven to drive improvement in areas such as patient care and outcomes, surgical complications and costs. The ON-SQIN is open to all Ontario hospitals to participate and learn from. This year should bring forward many opportunities for improvement in surgical quality.

- **Using technology as an important enabler of quality and integrated care**. Ontario hospitals are taking advantage of these opportunities in a variety of ways.

  o Several hospitals across Ontario mentioned they are actively measuring their Electronic Medical Record Adoption Model (EMRAM) and Healthcare Information Management Systems Society (HIMSS) scores. EMRAM is a seven-stage model that measures hospital progress toward a paperless environment and allows the organization to track its progress against health care organizations across the country.
  o Technology solutions such as computerized provider order entry are allowing orders for patients to be routed immediately, reducing error and providing shorter turnaround times.
  o Electronic medication administration is allowing the hospital pharmacy and nurses to verify medication as orders are placed. Along with the use of barcode scanning technology, this significantly reduces the risk of patients receiving the wrong medication.
  o Electronic portals allow hospitals to share information with both patients and staff. More and more hospitals are developing common medical record repositories, providing clinicians and community partners with access to real-time patient record information.

- More than three-quarters of hospitals (77%) discussed the implementation of each of their **change ideas** over the past year in their progress reports. While many of them described what change ideas helped lead them to success, few commented on lessons learned over the past year. Full completion of the progress report is important to provide a comprehensive look at what works to move priority areas forward in Ontario.

This report will expand on these and other themes in the analyses of hospitals' initiatives to improve on each of the priority indicators, beginning with the next chapter.

Chapter Two:

Working Within the Sector: Sector-Specific Advances on Priority Indicators

This chapter explores the individual efforts of hospitals to improve on three priority indicators, which require sector-specific improvement activities. These indicators are medication reconciliation at admission, *C. difficile* infection, and total margin (an indicator of fiscal health).

INDICATOR: IMPROVING MEDICATION RECONCILIATION AT ADMISSION

About this indicator: Hospitals evaluate the medication reconciliation process by measuring the total number of patients with medications reconciled as a proportion of the total number of patients admitted to the hospital.

Understanding this indicator: Communicating effectively about medications is a critical component of safe care. In the Canadian Adverse Events Study, medication errors were the second most common type of adverse event.[1] Medication reconciliation is a formal process in which health care providers work together with patients, families and other care providers to ensure accurate and comprehensive medication information is communicated consistently across transitions of care.[2] The first critical step in this process is gathering the best possible medication history (BPMH), an accurate list of the patient's medications before the patient was admitted to hospital.

Analyzing this indicator: For the 2015/16 QIP, hospitals were encouraged to work towards comprehensive implementation of medication reconciliation. Specifically, hospitals that had previously reported medication reconciliation at admission for a unit, service, program or target population in their QIPs were asked to report current performance at the organization level and set targets for the entire hospital. In our review, only 17 hospitals specifically stated the population covered in their measurement (16, entire organization; 1, smaller sample).

Progress

In analyzing the 2015/16 QIPs, 35% of hospitals (39/111) met or exceeded their target set in their 2014/15 QIPs as reflected in their progress report. Fifty-four percent (60/111) improved on their performance, but did not necessarily meet their targets.

Current performance

- Range: 9% to 100% of patients had their medications reconciled upon admission to hospital.

Hospitals that have reached 100% medication reconciliation at admission are strongly encouraged to examine the quality of the reconciliation process and/or move on to the next stage of reconciliation: at transfer or discharge.

2015/16 target setting

The 100 hospitals that included medication reconciliation on admission in their 2015/16 QIPs, using the original definition of this indicator, set the following types of targets:

- Range of targets selected: 9.4% to 100%
- 72% (72/100) set targets to improve
- 17% (17/100) set targets to maintain current performance
- 11% (11/100) set retrograde targets; of these, 7 (64%) explained that their rate varies due to a small number of admissions

About one-fifth of hospitals did not include medication reconciliation at admission as a QIP indicator. They provided the following rationales: they are focusing on another segment of the reconciliation process such as discharge or the quality of the reconciliation, or their goal is to maintain current performance.

Achieving progress on this priority: Reflections on the past year

Here are some examples of innovative ideas that hospitals implemented to improve medication reconciliation at admission, as outlined in their progress reports.

- Securing the commitment of senior leadership and having an organization-wide focus on medication reconciliation.

  o Headwaters Health Care Centre identified that having an organizational focus on medication reconciliation proved invaluable in their ability to make tremendous progress in their completion rate and surpass their stretch target over the past year. Their starting performance was 41.10%, they set a target to reach 70%, and by year end they had achieved 78.44%.
  o Many hospitals identified medication reconciliation as a standing agenda item on several corporate-level committees across the organization, such as medical advisory, nursing advisory, quality and safety, and professional practice committees.

- Focusing on improving the medication reconciliation process.

  o Hospitals employed value stream mapping to identify the gaps in their processes and identify the ideal future state. These hospitals also stated the importance of implementing the process changes sequentially, using Plan-Do-Study-Act cycles.
  o Sunnybrook Health Sciences Centre implemented the electronic documentation of best possible medication histories, integrated with the computerized order entry system, for patients in the preadmissions clinic. The hospital found this change to be a key enabler supporting completion of medication reconciliation across transitions.

- Specifying team roles, responsibilities and accountabilities for each stage of the process: The progress reports conveyed the importance of these steps, as well as the value of involving staff, physicians and patients throughout the initiative.

  o St Joseph's Healthcare Hamilton listed leadership and stakeholder involvement as a key success factor in making progress on medication reconciliation.
  o Sunnybrook Health Sciences Centre found the use of regulated pharmacy technicians, trained to collect high-quality best possible medication histories, can be a significant contributor to increased completion of medication reconciliation on admission.

- Implementing a standardized audit tool: Clinician workflows have not traditionally included making a regular inventory of patient medications. Without a standard tool, variability across an organization creates the potential for error. Lake of the Woods District Hospital uses a standard tool to enable ongoing objective review and evaluation of the medication reconciliation process that can be applied throughout the hospital.

- Ongoing education for staff involved in performing the reconciliation: As part of this education, hospitals conduct regular audits of completion rates and share results with team members to reinforce and celebrate progress; they also provide individual mentoring and follow-up.

    o Lake of the Woods District Hospital found that ongoing education for front-line staff is crucial in maintaining compliance with the medication reconciliation process.
    o North Bay Regional Health Centre stated that frequent reporting and use of a scorecard helped the team focus on the accuracy and completion rate of BPMH for patients being admitted from the emergency department.

Advancing this priority: Plans for the year ahead
Several hospitals mentioned that they are focusing on ensuring the quality of the best possible medication history in 2015/16. Hospitals are looking at ways to integrate this step into existing workflows, and they are focusing on improving the BPMH process for patients admitted through the emergency department.

Enhanced technology can support medication reconciliation by linking to electronic documentation and building this critical activity into everyday processes.[3] For example, 10 regional hospitals in the South West Local Health Integration Network (LHIN) have connected to one information system that they call the HUGO project (Healthcare Undergoing Optimization). It enables all sites to see a patient's medication list and to complete a BPMH at each visit or admission. Medication reconciliation at each transition in care has been recognized as a best practice, and the hospitals in the South West LHIN now have the tools to create safer transitions for patients moving between hospitals in 2015/16.

Hospitals are also beginning to connect with other partners in the health care sector to improve medication reconciliation at discharge. While all hospitals should give patients their medication information at discharge, Wilson Memorial General Hospital has taken this process one step further: not only does the hospital provide the patient with a medication discharge form with all their medication instructions, but the hospital also sends the form directly to the primary care provider and community pharmacist at the time of discharge.

INDICATOR: REDUCING *C. DIFFICILE* INFECTION

About this indicator: This indicator measures the number of patients newly diagnosed with hospital-acquired *C. difficile* infection (CDI), divided by the number of inpatient days in the reporting period, multiplied by 1,000.

Understanding this indicator: *C. difficile*, a bacterium that causes severe diarrhea and other serious intestinal conditions, is the most common cause of infectious diarrhea in hospitals and long-term care facilities in Canada. The illness can be fatal.

C. difficile has been an area of focus for hospital QIPs for many years. Province-wide, the CDI rate decreased between 2011/12 and 2014/15, going from 0.35 cases to 0.26 per 1,000 patient days. This change represents a reduction of more than 800 cases.[4]

Recent research in Ontario indicates that improving CDI may depend more on patient-level factors (older age, non-elective and medical admissions, and specific medical comorbidities) than on the processes hospitals are putting in place to prevent infection. In the largest study to date of CDI prevention in acute care hospitals in this province, prevention strategies were not associated with a statistically significant reduction in patients' risk of infection. However, the authors concluded that, due to the limitations of the study, they would not recommend withdrawing resources from prevention practices.[5]

Analyzing this indicator:

Progress

In analyzing the 2015/16 QIPs, 36% (23/64) met or exceeded their target set in their 2014/15 QIPs as reflected in their progress report. Fifty-two percent (33/64) improved on their performance, but did not necessarily meet their targets.

Current performance
- Provincial average: 0.26 cases of *C. difficile* per 1,000 patient days
- Range: 0 to 0.86 cases of *C. difficile* per 1,000 patient days

2015/16 target setting

The 80 hospitals that selected CDI for their 2015/16 QIPs, using the original definition of this indicator, set the following types of targets:

- Range of targets selected: 0 to 0.5 cases/1,000 patient days
- 44% (35/80) set targets to improve
- 39% (31/80) set targets to maintain current performance
- 18% (14/80) set retrograde targets (worse than 2014/15 performance); six of these 14 hospitals (43%) provided justifications such as their baseline year had zero cases of CDI, so they were allowing for one case in the current year, or performance in 2014/15 was unusual, so they were targeting a reduction from the year prior

More than one-third of hospitals did not select the CDI indicator. They provided the following rationales: performance was consistently at zero; they had achieved the target of their LHIN; and they have processes in place to monitor CDI.

Achieving progress on this priority: Reflections on the past year

Hospitals that are making progress on CDI state that their success is due to a multidisciplinary approach and to the combined implementation of multiple strategies to sustain performance.

Here are some examples of innovative ideas that hospitals implemented to reduce CDI, as outlined in their progress reports.

- Developing a CDI treatment protocol and standardizing cleaning and waste management processes: In reducing *C. difficile*, hospitals identified the necessity of rigorous, ongoing adherence to standardized cleaning practices, isolation precautions, and hand hygiene.

  o Hospitals mentioned the following key success factors for these strategies: clarifying expectations, roles and responsibilities, and measuring performance; ensuring standards are clear, easy to execute, and supported by leaders; and ensuring staff are aware of why equipment is being dedicated to a single patient and what patient safety concerns are behind the decision.
  o Hospitals that made the most progress in reducing CDI over the past year mentioned high hand-hygiene rates as contributing to their success.

- Communication and transparency about the data: Many hospitals feel that open reporting on this indicator is imperative and are employing "audit and feedback" as a strategy for improvement.

  o St. Joseph's Healthcare Hamilton took a unique approach to making CDI performance data meaningful to nursing staff. The hospital's CDI change plan aimed to reduce urinary catheter use in the operating room. This would reduce the risk of urinary tract infections, which require antibiotics that in turn can increase patients' risk for CDI. The hospital found this approach helpful because reducing catheter use is an indicator that is meaningful to the surgical nurses in their work.

- Reducing the use of high-risk antibiotics: Many hospitals continue to develop strategies and initiatives to improve antimicrobial stewardship.

  o Royal Victoria Regional Health Centre described how their Antimicrobial Stewardship Program (ASP) assesses patients for the appropriateness of their prescribed antibiotic(s). *"Recommendations are accepted on average 80% of the time and over half of these recommendations are to stop or narrow the initial antibiotic therapy."* Since the start of program in 2013, *"we have seen a reduction in antibiotic consumption of 125% and a 33% reduction in length of stay in patients with a diagnosis of community-acquired pneumonia. In comparison to the inpatient units who do not have ASP, we have seen a 68% reduction in* Clostridium difficile *infections, translating to 40 fewer cases per year."*

- Testing new approaches in true Plan-Do-Study-Act form.

  o There is conflicting scientific evidence regarding probiotic use as part of order sets for antibiotics. Orillia Soldiers' Memorial Hospital has been testing this further by adding them to order sets. Through small-scale tests of change, the increased use of antibiotics due to post-influenza pneumonia has not shown an increase in *C. difficile*.

★ **Spotlight: Here is one example of an organization describing tests of change that they feel contributed to improvement on this indicator.**

Grand River Hospital
The hospital has not experienced any *C. difficile* outbreaks over the past year and its 2014/15 performance was a very low rate of 0.13. Grand River attributes this to its work on two fronts. First, sustaining infection control practices is key. *"Hand hygiene before patient contact is an indicator on clinical program scorecards. Quarterly, hand-hygiene performance is published in our internal hospital newsletter."* In addition, a hand-hygiene awareness and education program with patients and families has been introduced and will be expanded in 2015/16. Second, *"antimicrobial stewardship continues to be an important initiative within our hospital. Over the last year, a pilot for the use of hygienic bedpans and commodes was conducted. Environmental services staff achieved greater than 95% compliance in microbial simulation assessment audits. These audits are published in our internal hospital newsletter."*

Advancing this priority: Plans for the year ahead
In 2015/16, 14 hospitals will implement a "hub and spoke" model of the ARTIC Community Hospital ICU Local Leadership (CHILL) Project. ARTIC, or Adopting Research to Improve Care, is a program designed to speed up the implementation of research evidence and best practices across Ontario's health system. This initiative aims to establish solid ASPs which optimize the use of antimicrobials in intensive care units, reducing antimicrobial consumption, cost and hospital infections (CDIs).

Peterborough Regional Health Centre (PRHC), one of the spoke sites, mentioned the development of their antimicrobial stewardship program as a key strategy in their QIP workplan. PRHC will work to enhance community partnerships to mitigate the risk for CDI in the community. Specifically, the hospital will organize and offer quarterly education sessions focused on antimicrobial stewardship for community-based prescribers (family health team providers, dentists, pharmacists). These sessions will directly connect community prescribers to the hospital's ASP and infectious diseases expertise to build a community of practice and a common, evidence-informed approach to modifying risk for *C. difficile*.

INDICATOR: BALANCING TOTAL MARGIN

About this indicator: This indicator measures a hospital's fiscal health. This measure examines the percentage by which total corporate (consolidated) revenues exceed or fall short of total corporate (consolidated) expenses in a given year, excluding the amortization costs of their buildings. Each year Ontario hospitals aim to balance their revenues and expenses.

Understanding this indicator: Ontario is currently reforming the way it funds some aspects of the health system, with the goal that payment, policy and planning will follow patients as they make their way through the health system. The total margin indicator is one of the ways organizations can incorporate policies that support health system funding reform into their QIPs.

Analyzing this indicator:

Progress
In analyzing the 2015/16 QIPs, 11% (14/131) met or exceeded their target set in their 2014/15 QIPs as reflected in their progress report. Forty-four percent (58/131) improved on their performance, but did not necessarily meet their targets.

Current performance
• Range: −8.95% to 6.11% margin of revenue over expenses

2015/16 target setting
The 83% (121/146) of hospitals that included total margin in their 2015/16 QIPs, using the original definition of this indicator, set the following types of targets:

• Range of targets selected: −8.37% to 6.60%
• 80% (97/122) set targets to improve
• 10% (12/122) set targets to maintain current performance
• 11% (13/122) set retrograde targets; of these, 6 (46%) provided justifications such as increased patient volume, acuity, numbers of alternate level of care (ALC) patients, or agreement with the LHIN

Hospitals that did not select total margin in their QIPs provided the following rationales: They are maintaining and monitoring current performance, and they are using other indicators to look at the length of stay of quality-based procedures (which has an impact on the hospital's bottom line).

Achieving progress on this priority: Reflections on the past year

The change ideas listed by hospitals to improve total margin are similar to those identified in the past. These include strategies such as maximizing revenue streams (e.g., retail pharmacy, preferred accommodation), focusing on logistics and procurement of supplies, and reducing inventory waste.

Here are some examples of innovative ideas that hospitals implemented to improve their total margins, as outlined in their progress reports.

- Increasing emphasis on implementation of best practices outlined in the quality-based procedures (QBPs).

  o Hospitals are collaborating with other area hospitals and CCACs to develop standardized clinical pathways for transitioning patients.
  o Hospitals are also forming utilization committees to ensure best practices and clinical pathways are being followed. These committees bring together senior leaders and clinicians to review data and reports that have direct and indirect impacts on cost and quality. Examples of the data they consider include conservable days, length of stay for QBPs, cost per day per visit, unnecessary readmissions, alternate level of care days, and emergency department wait times.
  o The Ottawa Hospital focused on identifying and reducing variations for the hip and knee QBPs. The hospital established a multidisciplinary clinical team, supported by administrative departments, to investigate causes of excess spending and implement solutions. Using case-costing data, the team identified opportunities for savings related to reducing blood work, diagnostic imaging and length of stay, with additional savings through a new procurement contract. At the end

of the second quarter, the hospital had achieved a 5% reduction in cost per weighted case for elective hip surgery and a 3% reduction in cost per weighted case for elective knee surgery, while case volumes remained stable compared to prior years. The hospital believes that the savings are likely attributable to decreased length of stay, and the hospital will continue to measure the sustainability of these changes and apply them to other QBPs in the coming year.

- Integrating administrative functions to optimize key processes and focusing on improving the patient experience.

  o In 2014 Headwaters Health Care Centre, William Osler Health System and Central West CCAC committed to an innovative partnership to integrate non-clinical support functions such as administration. The hope is that this new partnership will be a catalyst for collaboration, allowing all three organizations to explore joint investment opportunities and system-level planning. This "back of house" initiative will not only improve their combined ability to meet the needs of the community; ideally, it will also reduce costs in the long run.

Advancing this priority: Plans for the year ahead

With the health system funding reform currently underway in Ontario, hospitals are considering the implications of these changes while still maintaining high levels of patient care. Hospitals are using baseline reports and data to create benchmarks and identify efficiencies. Their 2015/16 workplans indicate that hospitals are increasingly working on reducing average length of stay related to QBPs. They are focusing mainly on stroke and hip fracture quality-based procedures, with the goal of getting patients into rehabilitation programs more quickly. These efforts are aimed at providing higher quality care to reduce costly complications and readmissions.

Chapter Three:

Reaching Out and Working Together: Cross-Sector Improvements on Priority Indicators

This chapter examines three indicators for which performance can improve when organizations collaborate across sectors: length of stay in the emergency department (ED) for admitted patients, percentage of alternate level of care (ALC) days, and readmissions. The chapter reviews how specific organizations are reaching out and working with others to improve care through integrated services.

INDICATOR: REDUCING EMERGENCY DEPARTMENT LENGTH OF STAY FOR ADMITTED PATIENTS

About this indicator: This indicator reports the 90th percentile length of stay (hours) in the ED for patients who are later admitted to the hospital. The 90th percentile length of stay is the time that divides the 10% of patients who stay in the ED the longest from the other 90% of patients who use the ED. In other words, 10% of patients stay in the ED longer than the 90th percentile length of stay. ED length of stay is defined as the time from triage or registration, whichever comes first, to the time the patient leaves the ED. For this indicator, leaving means being admitted to an inpatient bed.

Understanding this indicator: Measuring ED length of stay provides information not only about care within hospitals but also about how well other parts of the health system are working. This indicator only includes data for the approximately 10% of ED patients who need to be admitted to hospital for further care.[6] Some of these patients may spend a long time in the ED because inpatient beds are not available. The lack of available inpatient beds is often a result of other factors in the health system, such as patients not being able to leave the hospital for care in other places.[4]
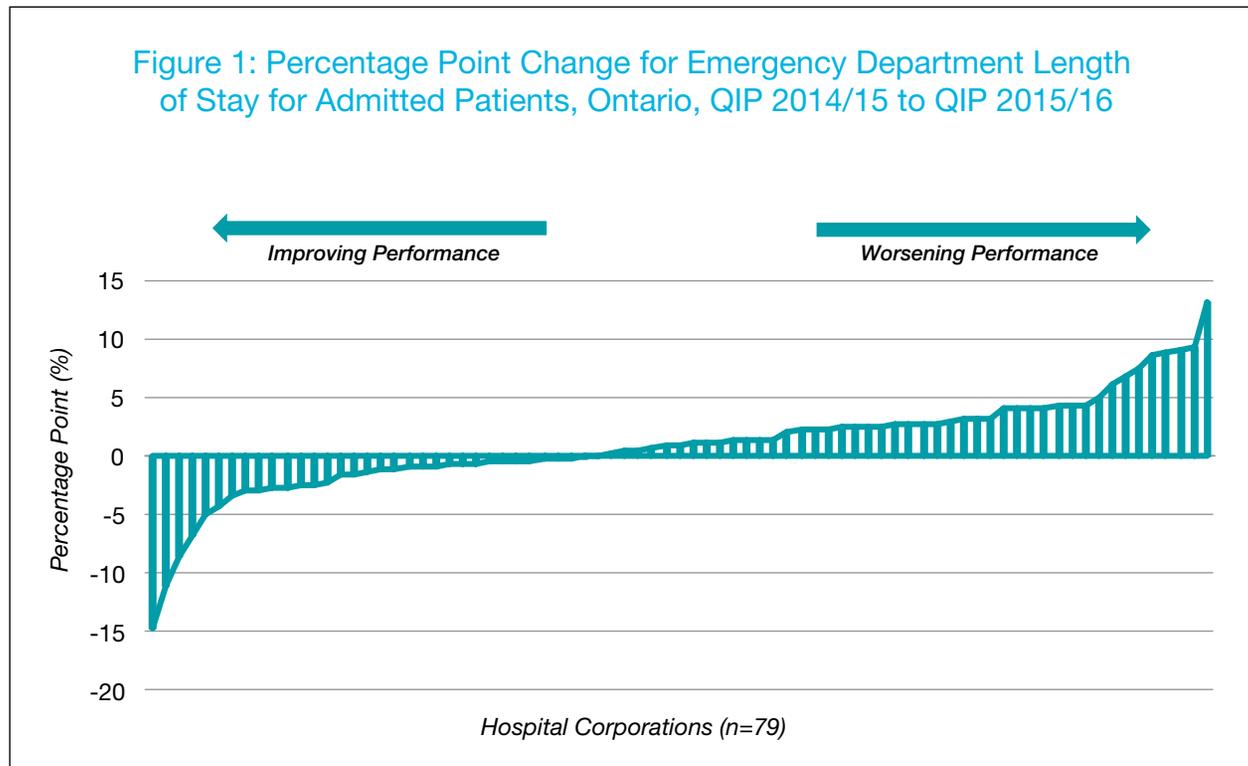
Analyzing this indicator:

Progress

In analyzing the 2015/16 QIPs, 14% (11/79) met or exceeded their target set in their 2014/15 QIPs as reflected in their progress report. Forty-two percent (33/79) improved on their performance, but did not necessarily meet their targets.

Figure 1 provides the absolute percentage point change in hospitals' performance on ED length of stay for admitted patients (as listed in their 2015/16 QIP progress reports) and reflects change in performance from the 2014/15 to 2015/16 QIPs. The bars on the left (below zero) indicate the hospitals that reduced the ED length of stay (n=33), and the bars on the right (above zero) indicate the hospitals where the ED length of stay increased (n=46). Recognizing that small changes in either direction are not conclusive,

the graph generally shows that those achieving success in improvement are fewer than those with worsening results. Despite the five years of focus that ED length of stay has had as a QIP priority indicator, the focus does not appear to be having the desired effect on all hospitals across the province. Hospitals are encouraged to continue to reach out to the other sectors, particularly those that are also developing QIPs, to work collaboratively to reduce the number of avoidable ED visits.

Figure 1: Percentage Point Change for Emergency Department Length of Stay for Admitted Patients, Ontario, QIP 2014/15 to QIP 2015/16

Notes
QIP 2014/15 and QIP 2015/16 represents QIP submission year (to HQO). Percentage point change is calculated based on data from NACRS, CIHI for QIP 2014/15 (Q4 FY 2013/14 to Q3 2014/15) and QIP 2015/16 (Q4 FY 2014/15 to Q3 2015/16).
These data represent 79 Ontario hospital corporations that have selected this indicator in both QIP Years (i.e. QIP 2014/15 and QIP 2015/16).
Analysis excluded 'collecting baseline' and suppressed data.

Sources
National Ambulatory Care Reporting System (NACRS), Canadian Institute for Health Information (CIHI), Quality Improvement Plans (QIPs), Health Quality Ontario

Current performance

- Range, small community hospitals: 1.35 to 54.28 hours was the maximum amount of time nine out of 10 patients spent in the ED before being transferred to an inpatient bed.
- Range, large community hospitals: 4.30 to 63.15 hours
- Range, teaching hospitals: 12.88 to 32.85 hours

Among the hospitals that chose to include ED length of stay in their QIPs, there is great variability in wait times, across all hospital types. In addition, the range of performance among all the hospitals in each LHIN shows some large geographic differences. The variability in current performance is largest in the North East, North West, and Champlain LHINs, and smallest in the Mississauga Halton LHIN (see Appendix, Table 1).

FIGURE 2
Maximum amount of time nine of 10 patients (90th percentile) and five of 10 patients (median) spent in the emergency department for high-acuity conditions, in Ontario, 2009/10 to 2013/14
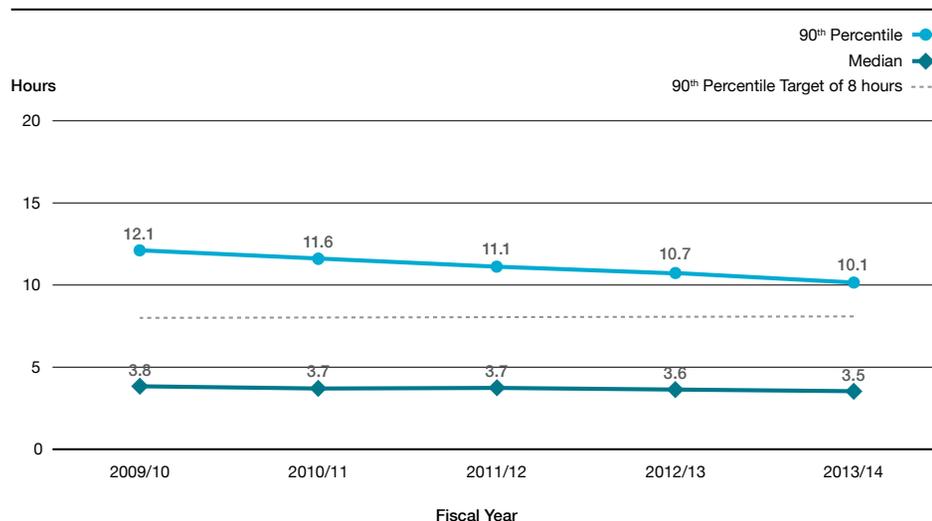
Data source: National Ambulatory Care Reporting System, provided by Cancer Care Ontario.

Looking beyond the QIPs, *Measuring Up* suggests that while ED length of stay has improved since 2009/10, the most recent data suggests that more work needs to be done to reach the provincial target of 8 hours for the 90th percentile (Figure 2).[4]

2015/16 target setting

The 80 hospitals that included ED length of stay in their 2015/16 QIPs, using the original definition of this indicator, set the following types of targets:

- Range of targets selected: 3 to 39 hours
- 86% (69/80) set targets to improve
- 3% (2/80) set targets to maintain current performance
- 11% (9/80) set retrograde targets; three of these 9 (33%) provided a justification, such as the closure of hospital beds

Hospitals that did not include ED length of stay in their QIPs provided the following rationales: they are consistently performing at or below target, or they do not have an ED.

Achieving progress on this priority: Reflections on the past year

Here are some examples of innovative ideas that hospitals implemented to reduce ED length of stay, as outlined in their progress reports.

- Preventing unnecessary ED visits.

  o North Bay Regional Health Centre has a diversion program mainly for older patients who present to the ED but do not need to be admitted. This diversion program is part of how the hospital is using the Priority Assistance to Transition Home (PATH) program, a regional partnership to provide transitional care for seniors.
  o Sault Area Hospital's Mental Health and Addictions Program provides focused resources and support to patients who have four or more mental health-related ED visits, to reduce the need for future ED visits.

- Additional staffing for peak admission times in the ED.

  o Collingwood General and Marine Hospital has a nurse available six hours per day to assist the ED with admissions and discharges. Additionally, the hospital uses an ED transitional team to provide early intervention for patients requiring admission and to begin discharge planning as soon as possible.

- Creating short-stay units.

  o Windsor Regional Hospital created a short-stay medical unit (SSU), a 16-bed unit for unattached family medicine patients whose hospital stay will be less than 72 hours. This approach allows patients to transfer from the ED to the SSU in 90 minutes (from the time the patient is admitted to the time he or she is transferred to the unit). As a result, the hospital has seen a decrease in the ED length of stay for admitted patients, a decline in the number of admitted patients waiting in the ED for an inpatient bed, and improved patient satisfaction.

- Using a hospital-wide approach to improve patient flow: Several hospitals described how they are addressing this indicator more broadly, rather than thinking of it as an ED improvement project.

  o Hawkesbury and District General Hospital uses a patient flow coordinator to focus on the patient and the full episode of care by facilitating movement throughout the hospital. The hospital reports that the introduction of this position has had an impact on patient flow through the ED to the units, helping to reduce ED wait times.

  o Joseph Brant Hospital revised its bed management policy and implemented a "take one patient" strategy into routine operations. The "take one" strategy involves each program in the hospital admitting one patient before 10 a.m. each day. This change had a positive impact not only on patient flow but also on creating a culture of shared accountability for patients admitted from the ED.

★ **Spotlight: Here is one example of an organization describing tests of change that they feel contributed to improvement on this indicator.**

Chatham-Kent Health Alliance
With limited resources and ED physician shortages, the Chatham-Kent Health Alliance has been challenged trying to sustain its ED initiatives under the province's Pay for Results (P4R) program. To mitigate the physician shortages, the hospital implemented a collaborative practice model of care that involves nurse practitioners, physician assistants and physicians. All providers flow among three patient care acuity zones (high, mid and low acuity). In addition, the hospital implemented the Daily Access Report Tool (DART), which provides real-time information on wait times, allowing the hospital to monitor its performance data daily. Through the new model of care, the hospital reduced its ED length of stay for admitted patients from 17.3 hours to 10.6 hours and placed in the top 10% of P4R hospitals in Ontario. The hospital plans to further improve the ED wait time by initiating the role of a multi-function registered practical nurse in the ED; this person will perform such duties as blood draws, electrocardiograms and assistance with medication reconciliation.

Cross-sector conversations: In the spirit of promoting system integration, we provide the following high-level examples to show how organizations are working together across sectors for quality improvement.

- Markham Stouffville Hospital is establishing a multi-disciplinary team that includes representation from family practice and the Central CCAC. This team will review a sample of patients who are admitted to the hospital to determine if there are other types of care or support that could have helped to avoid an inpatient admission, and the hospital and CCAC will work together to implement recommendations arising from the review.

- Connecting frequent ED users with primary care is another cross-sector strategy to reduce the need for hospital-based emergency care. At Sault Area Hospital, a review of patient-level data on ED visits demonstrated that a substantial portion of patients in the high-needs group had no identified

primary care provider. Working with the Superior Family Health Team, the hospital's admission avoidance coordinator and decision support services identified 30 patients for placement with one of the team's physicians. Also, this data has enabled the hospital's admission avoidance coordinator to identify high-needs users of both ED and inpatient services and, in collaboration with the primary care provider and other hospital staff, to create individualized complex care plans which are available electronically.

Advancing this priority: Plans for the year ahead

Working with other sectors to divert potentially avoidable ED visits is a longer-term solution that requires sustained effort over several years. Several hospitals described plans to initiate or advance collaborations with primary care services in their areas, to improve patients' access to care.

- Geraldton District Hospital has signed letters of understanding with the Aroland Health Centre to refer non-emergent patients to the Nakina Medical Clinic for care. The hospital is also building its relationship with the Geraldton Medical Group and Greenstone Family Health Team to refer non-emergent patients to their services. It is anticipated that increased primary care coverage will improve patient access to same-day care and reduce the need to use the ED.

- Follow-up care is often difficult for patients with mental health issues. This year, hospitals such as Arnprior Regional Health will focus on improving access to primary care services for patients who have received mental health treatment in the ED. Through partnerships with other primary care providers, the hospital plans to improve referrals to appropriate services and ensure that "every door will be the right door" for these patients to access the care they need.

INDICATOR: REDUCING PERCENTAGE OF ALTERNATE LEVEL OF CARE DAYS

About this indicator: This indicator measures the percent of inpatient days designated as ALC, which refers to patients who no longer need acute treatment in a hospital but continue to occupy hospital beds as they wait to be discharged or transferred to another care environment.

Understanding this indicator: Patients are not well-served when they are kept in hospital longer than they need to be there. ALC days affect the whole health care system because they strain hospital resources and contribute to congestion at transition points inside and outside the hospital walls. Among other problems, when acute care beds are occupied by ALC patients, those hospitals are losing much-needed capacity to care for acutely ill patients, particularly those admitted through the ED. However, it is recognized that hospitals alone cannot improve this indicator, and they need to involve the community in developing solutions for improvement.

A focus on creating a high-quality, integrated health system is key to ensuring that the right care is delivered in the right place.

Analyzing this indicator: The ALC indicator is challenging to move as it requires multiple partners to effect change; furthermore, the data lag is an ongoing challenge to evaluating progress. As a result, targets on this indicator tend to be modest. In these circumstances, hospitals may benefit from establishing multi-year strategies to address ALC.

Progress

In analyzing the 2015/16 QIPs, 28% (28/100) met or exceeded their target set in their 2014/15 QIPs as reflected in their progress report. Fifty-four percent (54/100) improved on their performance, but did not necessarily meet their targets.

Figure 3 provides the absolute percentage point change in hospitals' performance on ALC days in each hospital (as listed in their 2015/16 QIP progress reports) and reflects change in performance from the 2014/15 to 2015/16 QIPs. The bars on the left (below zero) indicate the hospitals that reduced the percentage of ALC days (n=54), and the bars on the right (above zero) indicate the hospitals where the percentage of ALC days increased (n=46). Recognizing that small changes in either direction are not conclusive, the graph generally indicates slightly more hospitals were trending to achieving improvement than those with worsening results. Despite the focus on ALC days as a QIP priority indicator, this does not appear to have had the desired reduction on percent ALC within all hospitals. HQO is committed to further examining the data to understand how, as a system, we can move this metric forward. At the same time, hospitals are encouraged to continue strengthening the coordination of care with other care providers.
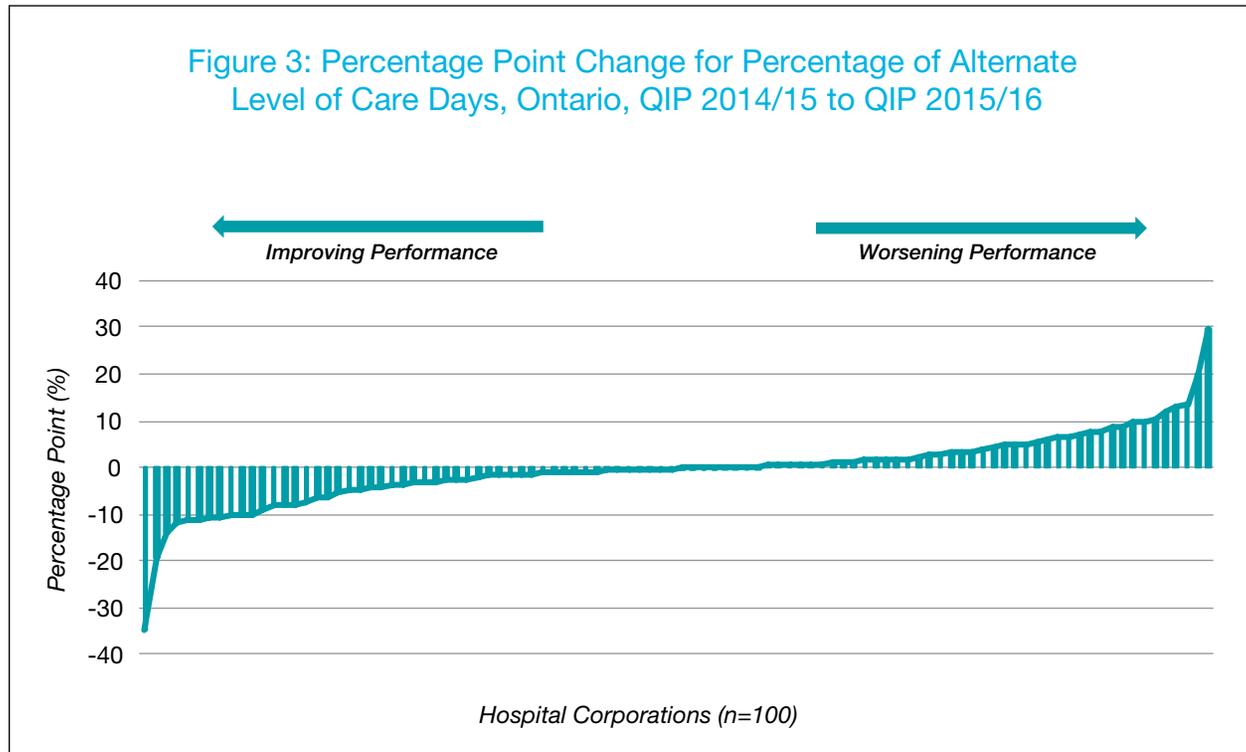
Figure 3: Percentage Point Change for Percentage of Alternate Level of Care Days, Ontario, QIP 2014/15 to QIP 2015/16

Notes

QIP 2014/15 and QIP 2015/16 represents QIP submission year (to HQO). Percentage point change is calculated based on data from NACRS and CIHI for QIP 2014/15 (Q3 FY 2013/14 to Q2 2014/15) and QIP 2015/16 (Q3 FY 2014/15 to Q2 2015/16).

These data represent 100 Ontario hospital corporations that have selected this indicator in both QIP years (i.e. QIP 2014/15 and QIP 2015/16).

Analysis excluded 'collecting baseline' and suppressed data.

Sources

Discharge Abstract Database (DAD), Canadian Institute for Health Information (CIHI)

Quality Improvement Plans (QIPs), Health Quality Ontario

Current performance

- Provincial average: 13.95% of days that patients spent waiting to be discharged or transferred to another care environment.
- Range, small community hospitals: 5.73% to 51.48%
- Range, large community hospitals: 3.23% to 37.99%
- Range, teaching hospitals: 0.51% to 19.51%

Of the hospitals that choose to work on reducing the percentage of inpatient days designated as ALC, there is great variability in wait times for all hospital types. The variability in this indicator is highest in the Champlain LHIN and lowest in the Mississauga Halton LHIN (see Appendix, Table 2).

Looking beyond the QIPs, health system performance data suggests that the percentage of acute care hospital days spent as ALC has been improving, but it is still higher than it was in 2006/07 (Figure 4).[4]

FIGURE 4
Percentage of acute care days spent as alternate level of care, in Ontario, 2006/07 to 2013/14
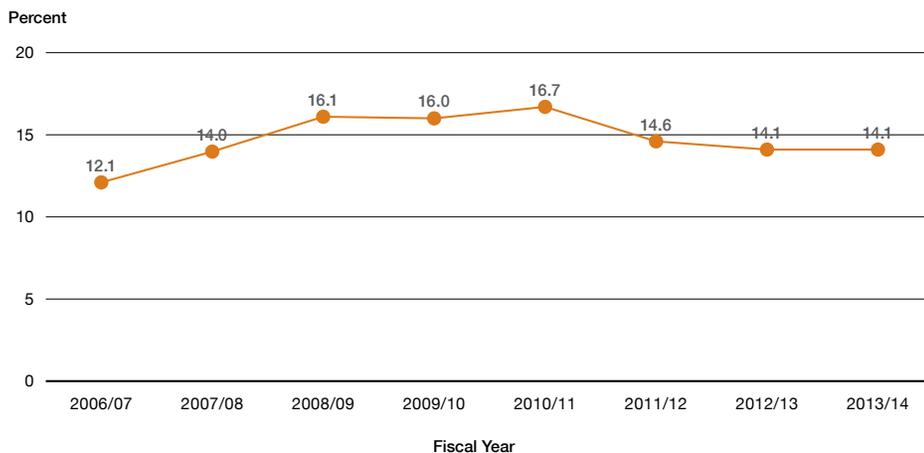
Data source: Discharge Abstract Database, provided by Ministry of Health and Long-Term Care.

2015/16 target setting

The 64% (93/146) of hospitals that included this ALC indicator in their 2015/16 QIPs, using the original definition of this indicator, set the following types of targets:

- Range of targets selected: 0% to 42.76%
- 72% (67/93) set targets to improve
- 6% (6/93) set targets to maintain current performance
- 22% (20/93) set retrograde targets; five of these 20 (25%) provided the justification that the closure of beds for complex continuing care or long-term care would result in an increase in ALC days. As the QIP is an improvement plan, hospitals should consider setting an aspirational target or provide further rationale as to why they expect their performance to worsen.

Hospitals that did not include this ALC indicator provided the following rationales: they had low numbers of ALC days and therefore large variability in their data, or they are not an acute care hospital so they use a different ALC measure.

Achieving progress on this priority: Reflections on the past year

Here are some examples of innovative ideas that hospitals have implemented to reduce their percentage of ALC days, as outlined in their progress reports.

- Following best practice rehabilitation care pathways, especially for hip and knee replacements, hip fractures and stroke.

  o Rouge Valley Health System reorganized its care delivery along patient streams, a best practice outlined in the quality-based procedure handbooks. As part of this process change, the hospital implemented a new bed map that created integrated units designed to reduce the number of patient moves. To measure this process change, the

hospital focused on "ALC throughput," which measures the number of patients not in the optimal bed and reflects the hospital's ability to transition the patient to the optimal bed in a timely manner. Preliminary results show a year-over-year reduction in the number of patients in internal rehabilitation beds who were designated ALC and an overall 5% increase in the percentage of medical patients discharged home. Rouge Valley also saw its overall ALC rate decrease in 2014/15, from 16.25% to 4.38% at the Ajax and Pickering site and from 11.17% to 3.4% at the Centenary site.

- Using prediction models to estimate time of discharge, improving the timing of decision making, and putting services in place to reduce the risk of functional decline that can lead to a patient being designated as ALC.

  o Royal Victoria Regional Health Centre implemented the Triage Risk Screening Tool (TRST) in the ED. The TRST identifies baseline functional impairment in older ED patients and predicts subsequent functional decline after an initial ED visit. This helped the hospital to arrange early deployment of additional support services through the CCAC. ALC days have decreased from 23.19% to 15.34%.
  o Health Sciences North found that 50% of their admitted patients were spending the first 48 hours in the ED before transferring to the unit. To avoid delays in assessing patients' risk for functional decline, this assessment was moved to the ED so that it could occur within the first 48 hours. The hospital found this strategy resulted in a reduction in functional decline in the target population.
  o Complex continuing care and rehabilitation hospitals are using "assess and restore" interventions – short-term treatments to address the loss of functional ability that can occur while patients wait in a hospital

bed and prevent or delay their safe return home. For example, the Sensenbrenner Hospital provides group exercise activities for all patients to promote mobility and maintain strength to return to the community. In 2014/15, the hospital increased the capacity of the exercise program on both the continuing care and the active care units to meet the needs of their patients.

- Optimizing hospital capacity and patient flow. This involves applying best practices in admission avoidance, in discharge planning and in the removal of obstacles to discharge.

  o Winchester District Memorial Hospital has focused on patient flow to reduce ALC through the use of flow coordinators. The flow coordinator and team leader monitor both potential and designated ALC patients daily to remove barriers to discharge. A flow coordinator was also placed in the ED to assist in ensuring safe discharge for those patients who do not require an acute care admission. In 2014/15 the hospital successfully reduced its percentage of ALC days from 7.17 to 3.23.
  o Most hospitals use "huddle boards" to enhance daily team communication to maximize patient flow and care coordination, especially for complex discharges. Bluewater Health, for example, stated that role clarity and feedback to patients are important factors for success in its interprofessional huddles.
  o *"Consistent dedication to discharge planning is a key enabler of success in the reduction of ALC rate,"* Runnymede Healthcare Centre stated in its progress report. Many hospitals have partnered with CCAC discharge planners to provide a seamless transition for patients moving from hospital care back to the community.

- Adapting resources in small rural hospitals where patients in ALC may occupy significant bed capacity. These hospitals have adapted their resources to meet the needs of the population, using the rehabilitative, behavioural, palliative and sometimes restorative capacity available in the hospital.

  o Englehart and District Hospital, located in the North East LHIN, is one such small rural organization. It has designated 14 of its complex continuing care beds (more than 50%) as ALC beds. This process is working well, as the scarcity of community resources means that the needs of some local patients would otherwise would go unmet.
  o Also in the North East, Hôpital de Mattawa Hospital supports patients from ALC beds at North Bay Regional Health Centre when its own census is low to optimize the use of acute care beds at North Bay.

Cross-sector conversations: Hospitals continue to collaborate with the CCACs and LHINs in the implementation of strategies to provide more specialized community supports such as palliative care, mental health care, and senior-friendly services.

- The North East LHIN hospitals have introduced a Priority Assistance to Transition Home (PATH) program to help seniors return home from hospital safely, smoothly and comfortably. To fill the gap between hospital care and the start of home care, personal support workers provided by the CCAC assist patients on the journey home by picking up groceries, prescriptions, or medical equipment and supplies. They can also provide light meals and housekeeping and connect seniors to community services.

- Hospitals and CCACs conduct regular ALC reviews to establish action plans to address barriers to discharge and to facilitate additional options for patients being discharged or transferred.

  o Following the Home First philosophy, Royal Victoria Regional Health Centre and the North Simcoe Muskoka CCAC collaborated to redesign their processes related to transitioning patients back to community care after a hospital stay. The changes include a joint governance structure and have resulted in several positive outcomes: better communication among care providers, patients and families; a new discharge policy that includes an escalation process to raise the wait-list priority for hospital patients being referred to long-term care; extensive education for hospital staff and physicians; and joint metrics to monitor effectiveness.

- Health Links continues to develop across the care continuum to improve the coordination of care for medically complex patients.

Advancing this priority: Plans for the year ahead

The most commonly mentioned change idea for 2015/16 to reduce ALC days recognizes the need for the system to work together: Many hospitals stated plans to further strengthen the coordination of care with other providers, particularly to improve patients' access to long-term care and to community-based home supports. Many hospitals are focusing these efforts on their elderly patients with complex conditions.

Another commonly mentioned strategy was the continued focus on restorative care to reduce hospital-acquired deconditioning. A few hospitals are pursuing the establishment of alternative bed types to help address this issue.

A few hospitals mentioned plans to implement patient flow tracking systems to improve the movement of patients throughout the care continuum. For example, Royal Ottawa Health Care Group has begun to use a LOCUS (Level of Care Utilization System), with organization-wide implementation planned for 2015/16. This system assesses patient needs based on their level of functioning, rather than on a diagnosis and psychiatric risk alone. It is providing valuable information about the level of care being used and the variation of ALC rates across organization.

Similarly, William Osler Health System is continuing to implement its utilization management system (UMS) on medical/surgical units to more easily identify discharge barriers (including community barriers) for ALC and non-ALC patients and to encourage discharges for patients ready to leave the hospital based on predetermined criteria. The UMS also evaluates the level of care requirements for each patient to ensure they are receiving the right care, at the right time and in the right place.

INDICATOR: REDUCING READMISSIONS WITHIN 30 DAYS OF DISCHARGE TO ANY FACILITY

About this indicator: This indicator measures the percentage of acute care inpatients hospitalized for certain conditions (selected case mix groups) who are readmitted to any acute care hospital for non-elective care within 30 days of being discharge from the initial hospitalization.

Understanding this indicator: This indicator is designed to emphasize the importance of appropriate transitions to the next level of care. At times, discharged patients leave the hospital unsure about how to care for themselves at home and unable to follow instructions and get the necessary follow-up care. Preventable readmissions are also an inefficient use of hospital resources. While it is difficult to estimate how many of these readmissions could have been avoided, hospitals can reduce their readmission rates by identifying patients who are likely to return to hospital within a short time and improving discharge processes for these patients. This indicator also has important links to follow up time with primary care post discharge, and timely access to home care services where required.
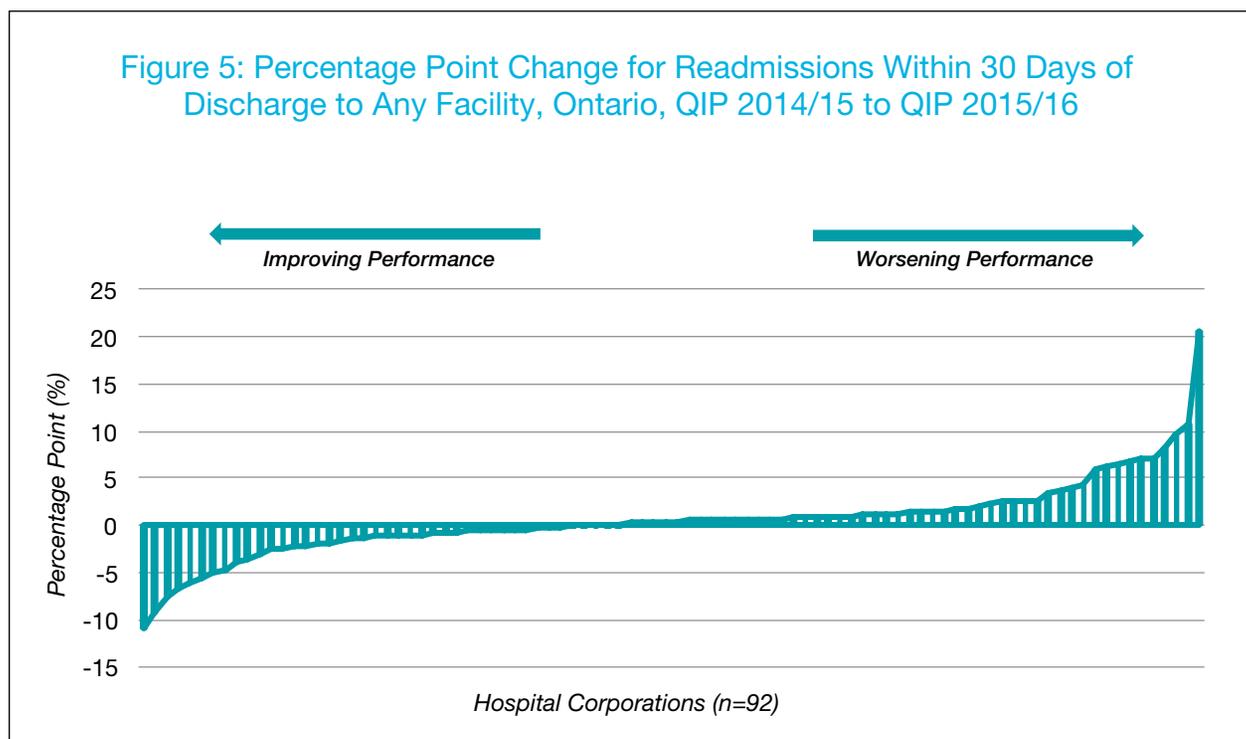
Analyzing this indicator: Data lag is an ongoing challenge to evaluating progress on this indicator, and hospitals have only one quarter to effect change on this metric. This is another area where a multi-year strategy might be the best approach to making progress on this indicator.

Progress

In analyzing the 2015/16 QIPs, 25% (23/92) met or exceeded their target set in their 2014/15 QIPs as reflected in their progress report. Forty-one percent (38/92) improved on their performance, but did not necessarily meet their targets.

Figure 5 provides the absolute percentage point change in hospitals' performance on 30-day readmissions for select case mix groups (as listed in their 2015/16 QIP progress reports) and reflects change in performance from the 2014/15 to 2015/16 QIPs. The bars on the left (below zero) indicate the hospitals that reduced their 30-day readmission rate (n=38), and the bars on the right (above zero) indicate the hospitals where the 30-day readmission rate was increased (n=53). Recognizing that small changes in either direction are not conclusive, the graph generally shows that more hospitals were trending to worsening results than those achieving success in improvement. Readmissions within 30 days has been challenging to improve since the inception of the QIP priority metrics. The readmission rate is a metric that requires a multi-sector approach over several years. Hospitals are encouraged to continue strengthening the discharge process, and sharing information with organizations from other sectors to ensure a smooth transition to the next level of care.

Figure 5: Percentage Point Change for Readmissions Within 30 Days of Discharge to Any Facility, Ontario, QIP 2014/15 to QIP 2015/16

Notes

QIP 2014/15 and QIP 2015/16 represents QIP submission year (to HQO). Percentage point change is calculated based on data from NACRS, CIHI for QIP 2014/15 (Q4 FY 2013/14 to Q3 2014/15) and QIP 2015/16 (Q4 FY 2014/15 to Q3 2015/16).

These data represent 92 Ontario hospital corporations that have selected this indicator in both QIP years (i.e. QIP 2014/15 and QIP 2015/16). Analysis excluded 'collecting baseline' and suppressed data.

Sources

Discharge Abstract Database (DAD), Canadian Institute for Health Information (CIHI) Quality Improvement Plans (QIPs), Health Quality Ontario

Current performance

- Provincial average: 16.77% of patients with certain conditions were readmitted to acute care within 30 days of being discharged from the hospital.
- Range, small community hospitals: 12.21% to 46.94%
- Range, large community hospitals: 12.42% to 26.1%
- Range, teaching hospitals: 14.43% to 19.45%

The highest variability in readmissions for certain conditions appears in the Champlain and North West LHINs and the lowest in the Mississauga and Central West LHINs (see Appendix Table 3).

2015/16 target setting

The 74 hospitals that included 30-day readmissions in their 2015/16 QIPs, using the original definition of this indicator, set the following types of targets:

- Range of targets selected: 0% to 50%
- 80% (59/74) set targets to improve
- 8% (6/74) set targets to maintain current performance
- 12% (9/74) set retrograde targets; these nine hospitals used either their hospital service accountability agreement (HSAA) target or the provincial average as justification for a retrograde target. Hospitals that have achieved their HSAA target or who meet the provincial average for 30-day readmissions are encouraged to consider either setting a more aspirational target (if they feel they can continue to improve on this indicator) or graduating this indicator from the QIP to become an indicator they are monitoring.

Hospitals that did not include this indicator provided the following rationales: they are not an acute care hospital so the indicator does not apply; timely access to data was not available; or they have low patient volumes.

Achieving progress on this priority: Reflections on the past year

Here are some examples of innovative ideas that hospitals implemented to reduce their rates of 30-day readmissions, as outlined in their progress reports.

- Use of care pathways: Several hospitals have order sets (a standardized list of orders for a specific diagnosis) completed on admission for patients who present with chronic obstructive pulmonary disease or congestive heart failure and place these patients on an appropriate care pathway. Care pathways reduce variability in clinical practice and have been shown to improve outcomes, leading to fewer readmissions.[7]

    o At Groves Memorial Community Hospital, order sets and care pathways for patients with chronic obstructive pulmonary disease or congestive heart failure have been updated to reflect the guidelines for quality-based procedures, including automatic referral to follow-up clinics at a family health team. The CCAC outreach nurse sees discharged patients within two weeks to improve continuity of care, ensure good communication and prevent readmissions.

- Use of a standardized client assessment tool to detect risk of readmission.

    o Campbellford Memorial Hospital uses the Barthel index to assess each patient on admission and discharge to identify and document functional improvement or decline.
    o Muskoka Algonquin Healthcare uses the LACE index to prospectively identify patients who might benefit from post-discharge care and then optimizes discharge practices for these patients, who are at high risk for readmission.

- Implementation of the Senior-Friendly Hospital initiatives to prevent hospital-acquired delirium and functional decline.

    o Campbellford Memorial Hospital implemented a multidisciplinary restorative care program to provide services that not only prevent deconditioning but also strengthen patients' physical and cognitive functioning so they are at reduced risk of readmission.

- Integrating the transfer of care to smooth transitions for discharged patients.

  o Several hospitals identified improved communication with primary care physicians as key to reducing readmissions. Specific strategies for patients at high risk of readmission include having a follow-up appointment confirmed with their most responsible care provider within seven days of discharge and notifying the physician when their patient has been discharged.
  o For patients with substance abuse and/or mental health issues, part of the discharge process at Riverside Health Care is to refer them to the necessary counselling services and follow-up support.
  o The Ottawa Hospital has partnered with Bruyère Continuing Care to introduce transition navigators who help patients with complex medical needs find the follow-up services they require as they move from one health care provider to another.

- Strengthening Health Links: As noted earlier, many hospitals are using the Health Links program to focus on transitions across the continuum of care for patients with complex conditions.

  o Hospitals are implementing standardized, patient-focused care pathways to guide care from admission in the ED to discharge and beyond. These care pathways are focused on populations with frequent ED use and high rates of readmissions.

- Working in partnership with the CCACs to prevent readmissions.

  o Many hospitals access the CCAC rapid response teams to support patients in the transition from hospital to home. These nurses connect with patients within the first 24 hours of discharge and ensure they have an appointment with a physician or nurse practitioner within the next seven days. They also work with CCAC care coordinators, other health care professionals and community agencies to help patients with more complex needs avoid unnecessary ED visits and readmissions.
  o Other ongoing improvements in communication and data-sharing agreements to coordinate care include, for example, more timely discharge summaries and triggers to alert the CCAC when one of their patients visits the ED.
  o Collaboration with the CCAC can also ensure that community nursing support is available for patients after discharge from acute care. Several hospitals that did not see progress on this indicator listed the lack of community support services as the key contributing factor.

- Preventing medication-related readmissions: A high proportion of adverse events are drug-related.[1] Medication reconciliation at discharge can help bring these numbers down.

  o In the transition from inpatient to outpatient, Waypoint Centre for Mental Health Care provides each patient with a compliance card outlining the specific days and times they should take each of their medications.
  o St. Joseph's General Hospital – Elliot Lake successfully implemented a medication reconciliation program that includes informing the patient's pharmacist and family health team on discharge.

⭐ **Spotlight: Here is one example of an organization describing tests of change that they feel contributed to improvement on this indicator.**

Rouge Valley Health System
The Care After The Care in Hospital (CATCH) program is reducing readmissions at Rouge Valley's Centenary site and its Ajax and Pickering site by surrounding patients with complex needs and circumstances with the support services they need for a safe transition back home. In its first eight months, the program served more than 400 patients and none had been readmitted at least three months post-discharge. In contrast, similar populations of Rouge Valley patients not in the program had 30-, 60- and 90-day readmission rates of 15.5%, 20.6% and 25.26%, respectively.

The CATCH program connects patients with an interdisciplinary team that helps them better manage their health at home and access the right support services in the community. A general internist addresses medical concerns that arise once the patient is discharged; a nurse assesses the patient for risk factors such as falls, medications, cognition, nutrition, incontinence and pain; a physiotherapist prescribes an individualized reconditioning program that patients carry out in small groups with help from a therapy assistant.[8]

Cross-sector conversations:
- A clinical pathway specifying local practice guidelines and discharge criteria can reduce the risk of readmission to hospital.[9] In a concerted effort to strengthen care transitions for patients in the Waterloo Wellington LHIN, the hospitals and CCAC are working together to implement best practices for several patient populations. Through their CEO Network, these organizations have developed a Clinical Program Integrated Accountability Framework, and staff and physicians are participating in clinical councils and committees to support and promote the delivery of integrated care in a wide range of specific clinical areas such as stroke and mental health and addictions.

- Hospitals are partnering with local pharmacists to ensure that community medication reconciliation supports efforts to reduce adverse events that can lead to readmissions. Health Sciences North has teamed up with local pharmacists to assist with evaluating all medications a patient is prescribed in hospital and at discharge and comparing them to existing medications to minimize the risk of medication errors. *"With this partnership, we can ensure the transition from hospital to home is as seamless as possible and make the care for our patients better and safer."*

Advancing this priority: Plans for the year ahead
In 2015/16, small, rural hospitals in the North West LHIN are working together to improve their discharge planning processes. All rural hospitals in the North West LHIN have adopted a screening tool to identify patients at high risk of readmission and have implemented a common discharge plan template for high-risk patients. This joint initiative is called Better Admissions and Transitions in Ontario's Northwest (BATON).

In addition, rehabilitation specialists in the region have created community transition teams to follow clients as they transition from a hospital stay to ensure they are managing well in their home environment. The transition teams will work with clients for up to two weeks after discharge and support the transfer of care to the North West CCAC.

Chapter Four:

Listening to Patients: Patient Satisfaction and Engagement

Patients and caregivers are an important source of insight and ideas for quality improvement. One way that hospitals gather feedback to inform their improvement efforts is by measuring their satisfaction with the care and services they receive, and this chapter summarizes what hospitals are doing with respect to the final priority indicator: patient satisfaction. While this indicator currently focuses on patient satisfaction, it is worth noting that hospitals are examining a move from satisfaction to an indicator focused on patient experience.

To truly understand the patient experience and make the best use of patient and caregiver input, however, hospitals must go beyond satisfaction surveys and actively involve patients and caregivers in the development, maintenance and improvement of the care and services provided. More organizations are engaging with and listening to patients in order to strengthen the delivery of care. New regulations are providing an impetus for engaging patients as organizations develop their QIPs. This chapter will also summarize how hospitals are beginning to engage patients in the design of improvement initiatives and use patient councils or advisory groups to drive improvement activities.

INDICATOR: IMPROVING PATIENT SATISFACTION

About this indicator: This indicator measures the percentage of survey respondents who answered positively to one of the following questions (respondents are people who received care in the ED or as inpatients):

- "Would you recommend this hospital to your friends and family?"
- "Overall, how would you rate the care and services you received at the hospital?"

Understanding this indicator: The overall objective of patient satisfaction monitoring and reporting is to identify areas where hospitals can drive targeted improvements in the patient's experience. Research shows that when health care organizations integrate the perspectives of patients, family members and caregivers into their improvement activities, this can result in higher-quality care, lower costs, increased satisfaction among health care providers and better experiences for patients.[10]

Analyzing this indicator:

Progress

In analyzing the 2015/16 QIPs, 42% (48/113) met or exceeded their target set in their 2014/15 QIPs as reflected in their progress report. Sixty-one percent (69/113) improved on their performance, but did not necessarily meet their targets.

Current performance

- "Would you recommend …?"

  o ED range: 41.0% to 100% of patients would recommend the hospital.
  o Inpatient, range: 53.5% to 100%

- "Overall, how would you rate …?"

  o ED range: 47.0% to 100% of patients rated their overall care received at the hospital as positive.
  o Inpatient, range: 68.7% to 100%

Of the hospitals that included patient satisfaction in their QIPs, there is great variability in the satisfaction rates. Hospitals that have reached 100% patient satisfaction utilizing percent positive scoring ("good", "very good", and "excellent" responses) are encouraged to examine the indicator using "top box" scoring (just "excellent" responses) for this indicator.

2015/16 target setting

Of the 146 hospitals that developed and submitted a QIP, 128 hospitals included one of the two questions that make up the priority indicator on patient satisfaction. While not every hospital set a target for improvement, hospitals with retrograde targets provided the following rationales: low survey volumes leading to large variability in their rates, current performance above the 90th percentile, and a goal to sustain the 90th percentile rate (please see Appendix,

Tables 4 and 5, for province-wide hospital results on patient experience surveys, by percentile). Hospitals that did not include this priority indicator explained that they are measuring patient satisfaction using a different survey question.

Achieving progress on this priority: Reflections on the past year

Hospitals are taking a more proactive and timely approach to capturing information about patients' experiences. The traditional follow-up strategy – mailing surveys to patients after discharge – has been helpful, but it does not always generate a significant sample size and is primarily retrospective in nature. Here are some examples of innovative ideas that hospitals implemented to get better information and improve patient satisfaction and experience, as outlined in their progress reports.

- Hospitals are looking at a variety of approaches, particularly addressing some of the linguistic and other barriers that exist for patients to provide feedback on experience, to improve response rates and to improve the timeliness of patient satisfaction or experience data.

  o Weeneebayko Area Health Authority (WAHA) has focused on increasing response rates by making the process of providing feedback more accessible, for example by removing linguistic barriers. A Cree language version of the patient satisfaction survey has improved the response rates. Patients are also able to report their levels of satisfaction electronically: they can access the patient satisfaction survey on the WAHA website, and they can provide feedback by writing to the patient satisfaction e-mail address, also introduced on the health authority's website. The WAHA also has a patient navigator who visits patients on a regular basis and asks about their satisfaction with the treatments they have received and about their perceptions of WAHA staff and services overall. If needed, the navigator also assists patients in completing the survey. All of these activities have resulted in a higher response rate.

- Shifting to a sustainable patient-centred care model using technology: Some hospitals are using videoconferencing and data-sharing to remotely diagnose and treat patients where and when they need it.

  o To reduce the need for patients to be transferred for care out of their rural communities, Health Sciences North (HSN) has partnered with 16 hospitals across northeastern Ontario to create virtual critical care units that care for patients where their families and support systems are located. Using videoconferencing and electronic medical records, HSN connects with critical care units and ED at the other hospitals to enhance their ability to diagnose and treat critically ill patients locally. This reduces the costs and burden of travel for patients' families and increases patient access to health care services, resulting in greater satisfaction with the health system.

> Improving access to French language services for patients and their families in Francophone communities helps to improve patient satisfaction overall as well as address other important dimension of quality such as equitable access, patient centredness and effectiveness.
>
> - The Timmins and District Hospital has partnered with the Réseau du mieux-être francophone du Nord de l'Ontario to provide staff training on actively offering French language services.
>
> - In 2015/16, Hotel Dieu Hospital in Kingston will be undertaking a number of initiatives to improve French language services. The hospital will be offering language training for interested staff, will boost bilingual signage to help Francophones know which departments have French-speaking staff, and will launch French language functionality on the hospital website. The hospital also plans to develop linguistic profiles for key clinical positions and will begin to recruit bilingual staff for these positions as they open up.

Advancing this priority: Plans for the year ahead

Continuing the trend from last year, several hospitals are focusing on their "top box" scores of "excellent" to drive improvement on patient satisfaction. In addition, hospitals are currently examining a shift from patient satisfaction to measuring patient experience.

ENGAGING PATIENTS IN QUALITY IMPROVEMENT

This year, the QIP narrative section also asked hospitals how they engaged patients and how this input informed the development of their plan. Nearly all hospitals (142 of 146) mentioned specific change initiatives aimed at improving patient and caregiver engagement over the next year. Here are some highlights of the change ideas and key take-aways from these narratives to inspire organizations as they engage their patients and families:

- Engage with patients to meet their unique needs.

  o Georgian Bay General Hospital has created an aboriginal patient navigator position, a unique role — funded entirely through a partnership with a First Nations women's organization — to assist the organization in improving experiences for its indigenous patients. A cultural awareness program supports this work, so that all staff *"have a foundational understanding of the unique views and beliefs on health and health care delivery of our First Nation, Métis and Inuit community … Expanding this cultural awareness training to our board members illustrates our commitment to the aboriginal communities that we serve and our level of engagement and commitment to ensure that the patient experience is one that meets their needs and facilitates unique partnerships and robust collaboration."*

- Use technology to connect with patients and families and gather feedback.

  o Starting in 2014, Holland Bloorview Kids Rehabilitation Hospital partnered with Canada Health Infoway to develop an external portal, called connect2care, for families with children receiving care at the hospital. *"This was a strategic and purposeful effort to empower families with the information they need to make informed decisions and better communicate with their child's provider. The online client and family portal allows families to access their child's Holland Bloorview healthcare record, view appointments and connect with members of their healthcare team in just a few clicks."* The portal also gives patients and families a quick link to the hospital's client and family relations service to suggest other improvements. More than 180 families enrolled in the first few months of the portal's launch.

- Co-design hospital programs and services with patients and families.

  o This year, Bridgepoint Active Healthcare (Sinai Health System) adopted the Experience Based Co-Design methodology, from the UK National Health Service, that brings patients, families and staff together to re-design services and improve the patient experience of care. *"Patient and family experience in these projects was captured to identify change opportunities and some patients and families were recruited as advisors on the redesign teams. This year at the Bridgepoint site, six patient and family advisors who participated in the hospital's co-design quality improvement work were recruited to review the Quality Improvement Plan 2015/16,"* particularly the change ideas for patient satisfaction and to take *"the opportunity to provide insight into how to best engage future patients and families in other priority areas."*

- Publicly launch the QIP.

  o Like all Ontario hospitals, St. Michael's Hospital publicly posted its full QIP on the hospital website on April 1, 2015. Going a step further, the hospital also created an easy-to-read, one-page infographic describing their 2015/16 quality and safety priorities, available here on the hospital's website. It includes a contact email for any questions or feedback about quality improvement activities at St. Michael's, and was included in the hospital's media release on the launch of the QIP.

- Work with patient and family advisory councils.

  o In the third phase of its implementation plan for enhancing the patient and family experience, St. Joseph's Health Care London actively sought out the involvement of its family and patient councils in the hospital's overall Quality Council to identify barriers for patients and find solutions to address them.
  o Norfolk General Hospital developed a patient and family advisory council in 2014/15 and a placed a patient/family advisor on the accreditation team.

- Inform policymakers and administrators on the importance and value of partnerships with patients and families.

  o St. Marys Memorial Hospital developed a Patient Experience Framework approved by the Quality Committee of the Board. This framework identifies targets and a process for following-up on patient complaints in a timely manner; it is also the foundation of the hospital's plan to engage a patient or family representative in every quality improvement initiative.

Chapter Five:

Moving Forward

This report takes a close look at the priority indicators identified for Ontario hospitals and reflects back to the field the work that hospitals are doing to improve the quality of health care for Ontarians. Increasingly, hospitals are emphasizing quality as core to strategy, and aligning the strategic plan and QIP to be mutually reinforcing. The change ideas and "spotlights" profiled throughout the report demonstrate the hospitals' commitment to delivering higher-quality care. This commitment is particularly evident in the ways that hospitals are collaborating across sectors to effect large-scale, system-level change and create a smoother health care journey for patients. We offer these concluding reflections for hospitals to consider as they continue to move forward.

Overall, the 2015/16 QIPs demonstrate some progress, but we should aim for more. While the hospital sector has greatly improved in the collection and analysis of data and in the creation of structural supports for quality improvement, these advances have not necessarily translated into broad gains across the sector. For many indicators, such as readmissions and ED length of stay for admitted patients, we have not seen substantial progress or progress has been inconsistent across organizations. Where possible, large-scale efforts designed to improve quality, such as care for patients with complex needs and circumstances through Health Links or implementation of the recommendations in the QBP clinical handbooks, should be strongly leveraged to support improvements. It may take a tremendous effort to push forward, and

as we move ahead, it will be important for hospitals, Health Quality Ontario, and the broader health care system to reflect on what is working well and why, and what can be done to reduce barriers to improvement.

A recent report authored by Dr. Ross Baker, examining the trends in patient safety in Canada 10 years following the publication of the Canadian Adverse Events Study makes this point: improving quality is challenging work and is taking time. Based on this experience, the report includes a series of recommendations for organizations to consider as they continue to build capacity for quality improvement and foster a culture of quality across the organization. Some of these recommendations are echoed in Health Quality Ontario's Quality Matters framework, particularly the important foundations for organizations and the health system to have in our sights and actively develop as we look to make improvement.

It is positive to see the emphasis on challenging indicators of integrated care, and it will be important to sustain these efforts to achieve improvement. Some of the priority indicators are challenging to improve, involve interdependencies with other sectors, and will take time to improve. This is especially true of the indicators covered in Chapter Three: readmissions, ALC days, and ED length of stay for admitted patients. In isolation, the impact of any one hospital or program to advance this indicator will be limited. Cross-sector collaboration and multi-year strategies are essential to making progress.

As this report shows, hospitals are laying the groundwork to improve on these indicators. They are implementing proactive programs, such as Health Links, that focus on providing care appropriate to complex needs and circumstances of a population of patients that tend to use more health care resources, providing care coordination outside of the hospital environment, and building interdisciplinary programs with system partners to safely transition patients back home after discharge.

Failure and success are equally important teachers. Whether it is a cross-sector collaboration or a purely internal change, every improvement initiative holds useful lessons. Sharing those lessons is a key goal of the QIP progress reports, along with celebrating successes. Health Quality Ontario encourages hospitals to use these progress reports more fully, including their lessons learned so that we all can benefit from others' experiences. Comments aimed at performance improvement will deepen our understanding of what works and what does not, avoid repeated mistakes, and ultimately lead to more successful improvement projects and better experiences and outcomes for Ontario patients.

To improve patient experience, continue to remove barriers for patients to provide feedback, and engage directly with patients to inform improvements. While hospitals are seeking to make their care more patient-centred, many organizations are trying to understand what patient-centred care truly means and what it really looks like. Is a rating that combines "good," "very good" and "excellent" responses on patient satisfaction surveys a good enough measure of success? A substantial portion of Ontario hospitals think not and are shifting their survey measures to focus on the "top box" scores (that is, only the "excellent" responses). In addition, ensuring patient feedback is representative of the entire hospital population is imperative. Ontario hospitals are encouraged to consider ways to remove barriers for their patients and families to provide their feedback such as addressing linguistic issues.

On a related note, Health Quality Ontario is supporting these efforts through the development of resources designed to help all sectors engage patients in the care they deliver. New regulations released this year will help us better articulate how health care organizations can achieve their patient engagement goals. We are working in collaboration with the Ontario Hospital Association to assist hospitals and other sectors in engaging patients in the development of their QIPs and their quality improvement activities more broadly. For most hospitals, this has been a baseline year in terms of bringing patients into the QIP process. We look forward to working with hospitals and learning from their experiences in this important initiative in patient-centred care.

This report has attempted to capture the creativity and innovation conveyed through the commitment to quality demonstrated in the QIPs. It is clear that hospitals understand the value of these annual plans, beyond merely reporting progress, and are actively integrating them with their strategic plans. We hope the examples included throughout this report will serve as inspiration to others to reflect upon their current initiatives and consider the full scope of opportunities available to help move quality improvement efforts forward. Along with the public posting of their QIPs, this report offers hospitals and other sectors an opportunity to learn from each other and apply this learning to their own practices.

By reflecting on our measured progress and a relentless commitment to improvement, we can ensure that the excellent health care delivered today is even better tomorrow.

Appendix:

Data Ranges for Selected Priority Indicators

Table 1. 90th percentile emergency department length of stay for admitted patients
Data ranges for current performance and targets, by LHIN, based on hospitals that included this indicator in their 2015/16 QIP workplans.

Reporting period: January 2014 – December 2014

LHIN	Minimum current performance, hours	Maximum current performance, hours	Minimum target performance, hours	Maximum target performance, hours
Erie St. Clair	10.55	28.63	10.90	20.90
South West	1.35	31.90	3.00	28.62
Waterloo Wellington	7.45	18.88	8.00	16.00
Hamilton Niagara Haldimand Brant	9.72	63.15	9.72	39.00
Central West	10.85	36.10	9.70	33.30
Mississauga Halton	34.15	35.50	28.00	39.00
Toronto Central	12.88	36.82	12.80	30.00
Central	10.38	48.43	10.00	35.00
Central East	18.90	52.02	15.00	34.08
South East	4.30	32.42	4.30	29.00
Champlain	10.28	38.90	9.00	30.00
North Simcoe Muskoka	23.28	32.35	21.30	27.5
North East	7.98	54.28	7.50	30.00
North West	3.70	32.85	5.00	32.60

Table 2. Percentage of alternate level of care days

Data ranges for current performance and targets, by LHIN, based on hospitals that included this indicator in their 2015/16 QIP workplans.

Reporting period: October 2013 – September 2014

LHIN	Minimum current performance, %	Maximum current performance, %	Minimum target performance, %	Maximum target performance, %
Erie St. Clair	8.20	22.07	8.50	15.30
South West	3.88	35.64	5.20	32.10
Waterloo Wellington	11.63	15.80	9.50	12.00
Hamilton Niagara Haldimand Brant	9.52	23.12	9.52	17.00
Central West	4.15	7.63	4.15	9.50
Mississauga Halton	9.36	12.50	8.00	10.00
Toronto Central	0.51	18.25	0.51	16.00
Central	10.59	16.56	10.50	16.50
Central East	3.40	24.72	7.10	24.00
South East	7.74	28.13	7.00	22.00
Champlain	1.14	49.29	0.81	35.00
North Simcoe Muskoka	15.34	26.41	17.10	24.23
North East	18.34	47.51	0	42.76
North West	6.34	51.48	7.90	26.10

Table 3. 30-day readmission rate for select case mix groups
Data ranges for current performance and targets, by LHIN, based on hospitals that included this indicator in their 2015/16 QIP workplans.

Reporting period: July 2013 – June 2014

LHIN	Minimum current performance, %	Maximum current performance, %	Minimum target performance, %	Maximum target performance, %
Erie St. Clair	15.55	15.60	12.80	14.80
South West	12.74	19.69	10.00	18.00
Waterloo Wellington	12.94	16.41	14.00	18.92
Hamilton Niagara Haldimand Brant	12.21	18.84	8.00	16.45
Central West	15.77	16.34	15.49	15.77
Mississauga Halton	16.28	16.28	13.50	13.50
Toronto Central	18.73	19.45	16.70	18.80
Central	13.93	17.25	13.50	16.00
Central East	16.07	17.51	12.50	15.50
South East	13.66	17.16	12.00	16.25
Champlain	13.73	26.42	0	20.30
North Simcoe Muskoka	14.84	17.38	13.00	17.10
North East	13.16	46.94	14.15	40.00
North West	12.42	27.91	12.42	50.00

Table 4. Patient satisfaction: acute care inpatient experience survey results

Ratings of overall care and likelihood to recommend, by percentile, for all Ontario hospitals reporting, April 2013 – March 2014

	Overall care, % positive	Would recommend, % positive
Top performer	100.0	97.2
90th percentile	98.1	87.0
75th percentile	96.6	81.7
50th percentile (median)	94.2	75.2
25th percentile	92.3	66.8
Lowest performer	81.0	48.8

Source: National Research Corporation of Canada. (2015). *Patient experience percentile report: Results of patient experience surveys from April 2013 to March 2014*. Markham, ON: National Research Corporation Canada.

Table 5. Patient satisfaction: emergency department experience survey results

Ratings of overall care and likelihood to recommend, by percentile, for all Ontario hospitals reporting, April 2013 – 2014

	Overall care, % positive	Would recommend, % positive
Top performer	98.3	85.9
90th percentile	95.3	78.7
75th percentile	92.3	72.0
50th percentile (median)	88.9	60.7
25th percentile	83.5	53.6
Lowest performer	68.4	38.8

Source: National Research Corporation of Canada. (2015). *Patient experience percentile report: Results of patient experience surveys from April 2013 to March 2014*. Markham, ON: National Research Corporation Canada.

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Committed to Quality Improvement

We promote ongoing quality improvement aimed at substantial and sustainable positive change in health care, fully leveraging emerging evidence and public reporting to help identify improvement opportunities. We then help build the health system's capacity for quality improvement by supporting the collection and use of data for improvement, sharing insights into innovations that are working to make improvement and promoting skills development in quality improvement. We actively support the development of a culture of quality and connect the quality improvement community to learn from each other.

Quality Matters

Quality Matters is an effort at Health Quality Ontario designed to bring everyone in the health system to a shared understanding of quality health care and a shared commitment to act on common goals.

Quality Matters takes a two-pronged approach. One involves a patient engagement process, called *Quality Is…* that allows patients, caregivers, and the public to provide their insights on what quality is from their perspective. A second involves a deep dive by an expert panel into understanding health quality, delivering system-wide quality, and developing a culture of quality. The panel's first report, *Realizing Excellent Care For All*, provides a provincial quality framework and lays out key factors to consider. Our hope is that it will serve as a touch stone for organizations as they undertake quality improvement efforts, such as those identified in their QIPs, and support an ever improving health system.

This is just the start. In the months ahead, we will continue to engage with patients, experts, and those across the system. *Quality Matters* will result in a road map, informed by patients and the public, to help policy makers, clinicians, and health system leaders build a quality-first health system in Ontario.

Learn more about *Quality Matters* by visiting www.hqontario.ca

The Common Quality Agenda

The Common Quality Agenda is the name for a set of measures or indicators selected by Health Quality Ontario in collaboration with health system partners to focus performance reporting. Health Quality Ontario uses the Common Quality Agenda to focus improvement efforts and to track long-term progress in meeting health system goals to make the health system more transparent and accountable. The indicators promote integrated, patient-centred care and form the foundation of our yearly report, *Measuring Up*. As we grow our public reporting on health system performance, the Common Quality Agenda will evolve and serve as a cornerstone for all of our public reporting products. Health Quality Ontario is the operational name for the Ontario Health Quality Council, an agency of the Ministry of Health and Long-Term Care.

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