PART B: Improvement Targets and Initiatives

Hôpital Montfort 713 chemin Montréal, Ottawa, ON K1K 0T2

AIM		MEASURE				CHANGE				
Quality dimension	Objective	Outcome Measure/Indicator	Current performance cum. at Q3	Performance goal 2011/12	Priority	Improvement initiative	Methods and results tracking	Target for 2011/12	Target justification	Comments
Safety	Reduce clostridium difficile associated diseases (CDI)	**CDI rate per 1,000 patient days**: Number of patients newly diagnosed with hospital-acquired CDI, divided by the number of patient days in that month, multiplied by 1,000 - Average for Jan-Dec. 2010, consistent with publicly reportable patient safety data	*0.35*	*≤ provincial average (cum. Q3) of 0.28*	*2*	*1) Judicious use of antibiotics* *2) Screen any patient with a new diarrhoea for c-dif cytotoxine without delay* *3) Reduce the risk of environmental contamination linked to the use and cleaning of bedpans and commode chairs*	*Cumulative average for last 12 months*	*0.28*	*100% reduction of the gap between actual performance and the provincial average (cum. Q3).*	*Provincial average for January 2011 is 0.34*
	Reduce incidence of Ventilator Associated Pneumonia (VAP)	**VAP rate per 1,000 ventilator days**: the total number of newly diagnosed VAP cases in the ICU after at least 48 hours of mechanical ventilation, divided by the number of ventilator days in that reporting period, multiplied by 1,000 - Average for Jan-Dec. 2010, consistent with publicly reportable patient safety data	*3.5*	*≤ provincial average of 2.2*	*2*	*1) Comply with best practices*	*Cumulative average for last 12 months*	*≤ 2.75*	*First 12 months : 50% reduction of the gap between actual performance and the provincial average; 12 to 24 months : achieve provincial average.*	
	Improve provider hand hygiene compliance	**Hand hygiene compliance before patient contact:** The number of times that hand hygiene was performed before initial patient contact divided by the number of observed hand hygiene indications for before initial patient contact multiplied by 100 - 2009/10, consistent with publicly reportable patient safety data	*46.3%*	*80%*	*1*	*1) Offer continuing education to all staff* *2) Consolidate the audit program in cooperation with the Handy Audit initiative of the Council of Academic Hospitals of Ontario's (CAHO) ARTIC program* *3) Promote the active participation of patients by encouraging them to wash their hands and to ask health service providers to wash their hands.*	*Verification showing the training of 80% of clinical staff* *Auditor training to collect 30 to 50 observations per month/unit* *Measure the percentage of patients who have received this training; target of 75%*	*65%*	*First 12 months : 50% reduction of the gap between actual performance with the new tool and the long term objective; 12 to 24 months : achieve the 80% objective.*	*During the third quarter, Hôpital Montfort increased the frequency and number of observations of hand hygiene practices. The conformity percentage went from 79% (cum. Q2) to 46.3% (cum. Q). This decrease is also evident province-wide with the increase in observations. In February 2011 Hôpital Montfort started participating in the "Handy Audit" program sponsored by the Council of Academic Hospitals of Ontario (CAHO) that promotes the use of a more rigorous method for documenting observations. It is possible that the use of this new tool will give us results that are different from those traditionally measured. The hospital will do a baseline measure for one month to establish a new benchmark and will set an objective for closing the gap from 46.3% to 80%. This indicator is tied to the compensation of managers.*

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	Reduce rate of central line blood stream infections	**4) Rate of central line blood stream infections per 1,000 central line days:** total number of newly diagnosed CLI cases in the ICU after at least 48 hours of being placed on a central line, divided by the number of central line days in that reporting period, multiplied by 1,000 - Average for Jan-Dec. 2010, consistent with publicly reportable patient safety data.	*2.96*	*≤ provincial average of 1.5*	*2*	*1) Conform to best practices*	*Cumulative average for last 12 months*	*≤ 2.25*	*First 12 months: 50% reduction of the gap between actual performance and the provincial average; 12 to 24 months : achieve the provincial average (1.5).*	
	Reduce post-operative infection rates for abdominal hysterectomies	***7) Post operative infection rates - abdominal hysterectomies*** *(no. infections. / 100 proc.) NHSN*	*8.9 (cum. Q2)*	*1.65*	*1*	*1) Comply with best practices*	*Measure the compliance rate for best practices; target of 95%*	*≤5.28*	*First 12 months : Reduction of the gap between actual performance and the average in the NSHN data base by 50%; 12 to 24 months : achieve the average in the NSHN data base.*	*The average rate of cases reported by the National Healthcare Safety Network (NHSN) in the US is 1.65. This indicator is tied to the compensation of managers.*
						2) Prophylactic antibiotic therapy for all abdominal hysterectomies	*Compliance rate of 100%*			*Cumulative actual performance in Q3: 97.3%*
Effectiveness	Reduce unnecessary hospital readmission	**Readmission within 30 days for selected CMGs to any facility:** The number of patients with specified CMGs readmitted to any facility for non-elective inpatient care within 30 days of discharge, compared to the number of expected non-elective readmissions - Q1 2010/11, DAD, CIHI	*13.5%*	*< expected*	*3*			*< expected*	*Hôpital Montfort continues to monitor readmission rates for a group of complex cases such as cardiac, pulmonary and diabetic.*	*The gap between the actual rate of readmission compared to the number expected in 2009 was only 0.2%*
	Reduce unecessary time spent in acute care	**Percentage ALC days:** Total number of inpatient days designated as ALC, divided by the total number of inpatient days. Q2 2010/11, DAD, CIHI.	*18%*	*12.8%*	*1*	*1) Increase the efficiency of ALC patient evaluations in the preparation of their discharge plan*	*Patient rate by caregiver where the initial evaluation was done less than 24 h after the request; target of 75%.*	*16.7%*	*First 12 months : 25% reduction of the gap between actual performance and the Champlain LHIN average (12.8%); 12 to 36 months : achieve the Champlain LHIN average (12.8%).*	*This indicator is tied to the compensation of our managers.*
						2) Prevent social admissions - ALC	*Number of ALC declarations 48 hours or less after admission.*			
						3) Work with all partners to establish service level agreements with regard to the management process for the discharge of ALC patients	*Percentage of partnerships with service level agreements; target of 75%*			
						4) Maximize the "Home first" program	*Case file review to measure the percentage of eligible patients who received the services; target of 90%*			
	Improve organizational financial health	**Total Margin (consolidated):** Percent by which total corporate (consolidated) revenues exceed or fall short of total corporate (consolidated) expense, excluding the impact of facility amortization, in a given year. Q3 2010/11, OHRS	*4.5%*	*N/A*	*3*					*Hôpital Montfort's total margin is among the best in the province.*

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Access	Reduce wait times in the ED	**ER Wait times:** 90th Percentile ER length of stay for Admitted patients. Q3 2010/11, NACRS, CIHI	*34.1 hours*	*≤ provincial average (cum. Q3) of 31.1 hours*	*1*	*1) Training of caregivers on the "LEAN" approach and wait times management* *2) Patient Lounge for 10 a.m. discharges on units* *3) Implementation of teletracking system to obtain real-time data and improve the coordination of patient services*	*"LEAN " training of at least 12 employees per quarter.* *Measure the percentage of discharges before 10 a.m.; target of 90%* *Survey to measure satisfaction rate; target of 75%.*	*33.4 hours*	*First 12 months : 25% reduction of the gap between actual performance and provincial average; 12 to 24 months: achieve provincial average (31,1 hours).*	*LEAN is a continuous system improvement method to fight inefficiency and solve problems closer to where they occur by involving operational staff as much as managers (Wikipedia). This indicator is tied to managerial compensation.*
		ER Wait times: 90th percentile ER Length of Stay for Complex conditions. Q3 2010/11, NACRS, CIHI	*16.1 hours*	*≤ provincial average (cum. Q3) of 11.4 hours*	*1*	*1) Training of caregivers on the "LEAN" approach and wait management* *2) Implementation of teletracking system to obtain real-time data and improve the coordination of patient services*	*"LEAN " training of at least 12 employees per quarter.* *Survey to measure satisfaction rate; target of 75%.*	*14.9 hours*	*First 12 months : 25% reduction of the gap between actual performance and the provincial average; 12 to 36 months : achieve the provincial average (11.4 hours).*	
	Reduce delays for elective surgeries	***Percentage of elective oncological surgeries performed according to prescribed time** : Ratio of the number of oncological surgeries performed within prescribed time compared to the total number of elective oncological surgeries recorded for the period.*	*80%*	*provincial target is 85%*	*2*	*1) Increase in operating time and follow-up of Cancer Care Ontario's Surgical Efficiency Targets Program (SETP) initiatives.* *2) Management of wait lists according to priorities*	*% of use of daytime shift (7 a.m. to 3 p.m.); target of 90% and % of first cases of the day that started on time; target of 85%.* *Monthly follow-up of delays by priority level; target of 100%.*	*85%*	*Achieve the 85% provincial target for best clinical practices (Cancer Care Ontario's Surgical Efficiency Targets Program (SETP)).*	

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Patient-centred	Improve patient satisfaction	NRC Picker / HCAPHS Survey: "Would you recommend this hospital to your friends and family?" (add together percent of those who responded "Definitely Yes") *Inpatients*	*73.9%*	*85%*	*1*	*1) Expect behaviours that reflect our values: compassion, respect, excellence and commitment.*	*Increase the number of satisfied complainants after follow-up by 20%*	*85%*	*The provincial average is 74.3%. Hôpital Montfort wishes to maintain a high degree of patient satisfaction.*	*This indicator is tied to the compensation of managers.*
		NRC Picker/Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey: Q.50 "Willingness of patients to recommend the hospital to friends or family" Emergency	*69.3%*	*80%*	*2*	*1) Expect behaviours that reflect our values: compassion, respect, excellence and commitment.*	*Survey to measure the satisfaction rate with wait times in emergency department*	*75%*	*First 12 months : 50% reduction of the gap between actual performance and the long term objective (80%); 12 to 24 months : achieve the long term objective (80%).*	*The provincial average is 58.5% and the hospital with the best performance has a rate of 83.8%.*
	Improve staff engagement towards patients	*Pulse Accreditation Canada (2010) Survey: Q. 19 "How often do you feel you can do your best quality work in your job?"*	*77%*	*85%*	*2*	*1) Walkaround/rounding program for managers*	*Minimum of one visit/month/unit*	*81%*	*First 12 months : a 50% reduction of the gap between actual performance and the long term objective (85%); 12 to 24 months : achieve the long term objective (85%).*	
						2) Implementation of an annual survey	*Comparison with peers; target ≥ provincial average*			