Excellent Care For All.

2011-12

Quality Improvement Plan

(Short Form)

Children's Hospital of Eastern Ontario

April 1, 2011

Ontario

Part A: Overview of Our Hospital's Quality Improvement Plan

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

CHEO's mission is to make a difference in the life of children, youth and their family. Our vision for quality is: "Our promise to you is to do everything possible, every minute of everyday, to make you better, keep you safe and be kind along the way."

We have five strategic directions, the first one being to "provide the highest possible quality of evidence-based specialized pediatric care, focusing on outcomes**.**

Every year, we prepare priorities and objectives that are approved by the Board of Trustees, and we report quarterly on their achievement.

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

The main objectives to improve quality and safety in 2011-12 are the following. There is no numerical measure possible for most of these objectives. It is either yes or no.

1- Implementation of a unit dose system for the distribution of medication. This is a major undertaking, requiring an important investment in equipment and staff, that will reduce the number of medication errors.
2- Implementation of new volumetric pumps. All our old pumps are being replaced in 2011-12. This requires a major capital investment as well as training of hundreds of staff.
3- Major modification to the Block Schedule in the Operating Room. This will allow for a more efficient OR that will be able to serve more patients.
4- Perform an external review of our Cardiovascular Surgery program to ensure that the program meets the utmost requirements of quality and safety
5- Improve our pain management service
6- Formally adopt a definition of excellence and institute a program to promote the pursuit of excellence in all departments and programs.
7- Obtain full accreditation from Accreditation Canada (survey scheduled for September 2011)

The following targets have also been set:

1- Obtain an overall satisfaction rate of 65% of respondents (satisfied and very satisfied) to the staff and physician satisfaction survey (to be performed in the fall of 2011)
2- Obtain an overall satisfaction rate of 75% (Emergency Dept) and 92% (Inpatient) for our client satisfaction surveys.
3- Obtain a rate of hand washing compliance that is within the 25th highest performance in the province and at least 80%
4- Achieve a surgical checklist compliance of 93%
5- Be within the provincial target for 2 of the 4 wait time indicators in the Emergency Room

3. How the plan aligns with the other planning processes

CHEO uses a very extensive planning process that includes:

1- Five strategic directions related to patient care, our role in the community, our academic mission, our role as an employer, and an efficient administration.
2- Each strategic direction is supported by long term goals that are reviewed on a yearly basis.
3- Each goal is supported by several 3 to 5 year priorities. We ensure that these priorities are totally aligned, and take into account, the LHIN's priorities
4- From these goals and priorities, annual corporate objectives are set. The progress in the achievement of these objectives is reported to the Board in September and January, while a final report is tabled in April of each year.
5- Each corporate goal is assigned to a member of the senior management team as part of their performance appraisal.

6- In turn, each member of the senior management team follows a similar process within his/her portfolio with his/her subordinates.
7- We also publish annually a Balanced Score Card and quarterly a Dashboard, which is very similar to the one presented in this QIP.

4. Challenges, risks and mitigation strategies

The major risks are as follows:

1- Finances: Although we have already committed significant amounts to the objectives stated above, this is based on our capacity to balance our budget. The level of government funding for this year may prevent us from completing some of these objectives.
2- Out-of-province: Only 67% of our revenues come from the Ministry of Health. We depend heavily on out-of province revenues ($30M per year). These revenues vary widely from one year to another and may affect our capacity to fund our projects.
3- LHIN: There is a new CEO and a new Chair at the Champlain LHIN. They may set new priorities that could force us to divert staff and money to other projects
4- A major outbreak (similar to H1N1 for example) may force us to defer all non-essential projects for several months, as it did in 2009.

Part B: Our Improvement Targets and Initiatives

Children's Hospital of Eastern Ontario 401 Smyth Road, Ottawa, ON K1H 8L1

AIM		MEASURE				CHANGE				
Quality dimension	**Objective**	**Outcome Measure/Indicator**	**Current performance**	**Performance goal 2011/12**	**Priority**	**Improvement initiative**	**Methods and results tracking**	**Target for 2011/12**	**Target justification**	**Comments**
Safety	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; current performance as of April 30, 2010	79.0%	80%	1	Implement new Handyaudit Program for hand hygiene auditing, using new electronic tool to audit in select areas; work with area managers and Partnership Councils with existing *train the trainer* model	Work with Handyaudit team and managers to continue to highlight the importance of hand hygiene through mechanisms that staff identify as effective for their clinical environment	Compliance of at least 80% and within the top 25% of provincial hospitals in areas identified for mandatory reporting.	Although current cumulative rates exceed the target of 80%, some healthcare provider categories are less than 80%. In addition, staff that do not report to that clinical area may not receive the same communication material as staff on the unit, identifying an opportunity to improve communication to those clinicians.	Compliance rates improve with engagement of clinical staff through means that are unit specific and self identified.
	Clostridium difficile Infection Rate	**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	0.25	0	2					

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	Surgical Checklist Compliance	**Sugical Checklist Compliance:** number of times use of surgical checklist was completed at all 3 opportunities Average for April-December. 2010, consistent with data reported to the OR Benchmarking Collaborative (ORBC)	93.0%	93.0%	2	Maintain or improve compliance in OR with all 3 points of checklist noted as "yes" as per protocol	New Governance structure that emphasizes Data Driven Decisions and Policy compliance.	93%	Provincial academic mean for the same period (86%)	
Effectiveness	Reduce unnecessary hospital readmissions	**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	7.5%	7.5%	3					Provincial target is 10.4%
	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	1.2%	1.2%	3					
	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	3.1%	0	3					

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Effectiveness	Improve operating room utilization	**Perform more incremental cases and reduce surgical wait times** in the Operating Room by maximizing overall schedule utilization to industry standard (80%)	73%	80.0%	1	Block Schedule Redesign: improve case booking and patient flow to be responsive to need for emergency and incremental case additions (incremental case increase)	Allocate emergnecy OR time during regular hours; reduce peaks and vallyes of patient flow activity	Incremental case increase for orthopedic (25) and dental (35) cases	Lean imrpovements in the OR will allow us to take on additional cases, thus imrpoving access to services for patients	
						First Case Starts: Improve patient flow by ensuring maximum cases start on time at beginning of work day	Daily tracking using both manual data collection & Surgical Information System (SIS) records	85%	Set by ORBC as part of the surgical efficiency target program (SETP); SETP definition is %First Case On-time or Early.	Measures the percentage of first cases with a patient in room time that is either early or not more that 5 minutes after the scheduled start time over all first cases. January-December 2010, consistent with publicly reportable patient safety data
	Staff Satisfaction	**Staff Satisfaction**: obtain minimum 65% on staff satisfaction survey overall commitment category	63.5%	65.0%	1	Obtain an overall satisfaction rate of 65% of respondents (satisfied & very satisfied) to the staff and physician satisfaction survey (Fall 2011) - Overall Commitment category	NRC Picker survey	65.0%	Staff/Physican survey last completed in 2008	
Access	Reduce wait times in the ED	**ER Wait times:** 90th Percentile ER length of stay (in hrs) for Admitted patients (ER Length of stay is defined as the time from triage to the time the patient leaves the ED). Q3 2010/11, NACRS, CIHI (Perf goal: using 2010/11 P4R target as new targets not available as of March 30/11)	12.0	8.0	1	Achieve 90th %ile target with use of "Admit/Patient Flow Nurse" resource to ensure optimal patient flow	ED WTIS	8	Methodology determined by H-SAA, Pay for Results (P4R) and ED WTIS	All indicators are tracked via a real time dashboard for the team to view throughout the shift

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Quality dimension	**Objective**	**Outcome Measure/Indicator**	**Current performance**	**Performance goal 2011/12**	**Priority**	**Improvement initiative**	**Methods and results tracking**	**Target for 2011/12**	**Target justification**	**Comments**
Access		**ER Wait times:** 90th percentile ER Length of Stay (in hrs) for Complex conditions (CTAS 1-3 Non Admitted). Q3 2010/11, NACRS, CIHI (Perf goal: using 2010/11 P4R target as new targets not available as of March 30/11)	6.0	8.0	1	Maintain 90th %ile LOS or better with use of acute and non-acute patient zones in ED to allocate resources and space to see complex patients efficiently	ED WTIS	8	Methodology determined by H-SAA, Pay for Results (P4R) and ED WTIS	All indicators are tracked via a real time dashboard for the team to view throughout the shift
		ED Wait times: Time to Physician Initial Assessment (in hrs) 90th percentile (all patients) (Perf goal: using 2010/11 P4R target as new targets not available as of March 30/11)	2.9	3.2	1	Maintain current target or better by exploring possible float shift for physicians during peak periods.	ED WTIS	3.2	Methodology determined by H-SAA, Pay for Results (P4R) and ED WTIS	All indicators are tracked via a real time dashboard for the team to view throughout the shift
		ER Wait times: 90th percentile ER Length of Stay (in hrs) for Low Acuity conditions (CTAS 4 & 5 Non Admitted). Q3 2010/11, NACRS, CIHI (Perf goal: using 2010/11 P4R target as new targets not available as of March 30/11)	4.2	4.0	1	Achieve 90% ile target with use of acute and non-acute patient zones created to allocate resources and space facilitate patient flow for low acuity patients	ED WTIS	4.2	Methodology determined by H-SAA, Pay for Results (P4R) and ED WTIS	All indicators are tracked via a real time dashboard for the team to view throughout the shift
Patient-centred	Improve patient satisfaction									
		NRC Picker / HCAPHS: "Would you recommend this hospital to your friends and family?" INPATIENT SURVEY	91.2%	92%	2					
		NRC Picker / HCAPHS: "Would you recommend this hospital to your friends and family?" ED DEPT SURVEY	68.3%	75%	2					

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

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

CHEO's Remuneration Plan for Executives

The Executive Group covered by the ECFAA includes the CEO, the Chief of staff, the Vice-Presidents, the CIO, as well as the corporate Directors of Public Affairs, Advocacy and Partnerships and Quality Management, who report directly to the CEO for a total of 10 people.

1- **Salary:**
- The three members at the director's level are part of the overall salary structure of the non-unionized staff, which means they have a salary range with minimum, maximum and steps. Every year, on their anniversary date, they move up one step until they reach the maximum. The ranges are increased yearly by a decision of the Board. The ranges are frozen in 2010, 2011 but those who are not at the maximum continue to move up the ladder.
- The CIO and the VPs do not have a salary range. Their salary is set based on market rate for similar positions. It may be adjusted from time to time based on the evolution of the market. Generally, our salaries have tended to be lower than in similar hospitals. Short of these market adjustments (which are rare and far between), they receive a yearly increase as determined by the Board (frozen in 2010 and 2011)
- The COS salary has been determined upon hiring by discussion between her, the Chief of Paediatrics and the CEO. It is paid by the Paediatric AFP and part of it is reimbursed by CHEO to the AFP.
- The CEO's salary is set by the Board and does not include a range.

2- **Performance bonus:** All Executives are entitled to a performance bonus, based on their performance of the previous year. The bonus is paid in the form of time owing added to their vacation bank; it is pensionable and cumulative from one year to another without limit. The employee may cash the accumulated time owing at his/her discretion. It is decided by the CEO (or the Board for the CEO and the COS) after completion of the performance appraisal (usually in April). Through the years, bonuses have varied from 0 to 5 weeks (10%).
For accounting purposes, the bonuses are accrued in the fiscal year they are earned.
Every year, the Executive Team prepares corporate objectives (between 25 and 35). The corporate objectives fall into five categories: patient care; relations with the community; teaching and research; human resources; administration. These corporate objectives are tabled to the Board in early April; progress reports are presented to the Board in September and January, with a final report at the May Board meeting.
For the VPs and corporate directors, the performance appraisal is prepared every year in April by the CEO and includes objectives in three categories: 1- A certain number of corporate objectives are assigned to each VP or corporate director; 2- there are objectives specific to the portfolio for which the VP or director is responsible; 3- there are objectives of personal development.
A bonus of 0 to 10% (given as time owing) is offered to each individual based on the level of achievement of these objectives and special unplanned circumstances that may have occurred during the year. For example, an individual may have worked a large number of week ends or evenings because of a particular project; another may have played a key role in obtaining funding for a new program; another may have found a new important source of revenues; etc…

For the CEO and the Chief of staff, the process is the same, except that it is conducted by the Board Chair.

3- Complying with ECFAA

a) **2010-2011:** For the fiscal year ending March 31st, 2011, there will be no change to the process described above.

b) **2011-2012**: For the fiscal year starting April 1st 2011,

1. Five targets of the quality and safety dashboard included in the Quality Improvement Plan will be considered a collective responsibility of the Executive Team. As such, all members, including the CEO and the COS, will receive 0.5% for each target achieved or surpassed, up to a maximum of 2.5% (paid as time owing);These are:
    - Overall inpatients who would recommend CHEO to others at 92% and Emergency Department at 75%
    - Overall employee commitment at 65%
    - Wait time in Emergency at or below targets on 2 of the 4 indicators
    - Hand hygiene in the 25th higher % of the province
    - Positive margin

2. The other 7.5% (paid as time owing) will continue to be awarded based on the achievements of corporate objectives, portfolio specific objectives and special unplanned circumstances as described above.

c) Beyond 2011-2012

Starting in fiscal year 2012-2013, as salaries are no longer frozen, the % available for performance pay will increase annually by a % decided by the Board until it reaches 15% for the VPs and corporate directors and 20% for the CEO and Chief of Staff.
If, between now and 2012, a position becomes vacant, the new incumbent will have the same % at risk as his/her colleagues.
The Board may also decide, after 2011-2012, at its discretion, to pay the performance bonus in money rather than time owing.

Part D:
Accountability Sign-off

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

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

Johanne Levesque	Chantal Courchesne	Michel Bilodeau
Board Chair	*Quality Committee Chair*	*Chief Executive Officer*