

Excellent Care  
For All.



2011-12

# Quality Improvement Plan



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## Part A:

# Trillium Health Centre's Quality Improvement Plan

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

Quality is more than a word. It's a promise of excellence. And that's exactly what Trillium Health Centre's patients have come to expect every time they use our services. Building upon a well-earned reputation for clinical excellence and quality performance, we will do everything possible to achieve quality in all that we do.

Achieving quality means that we consistently deliver exceptional clinical outcomes and exemplary patient and family experiences using evidence-based practices.

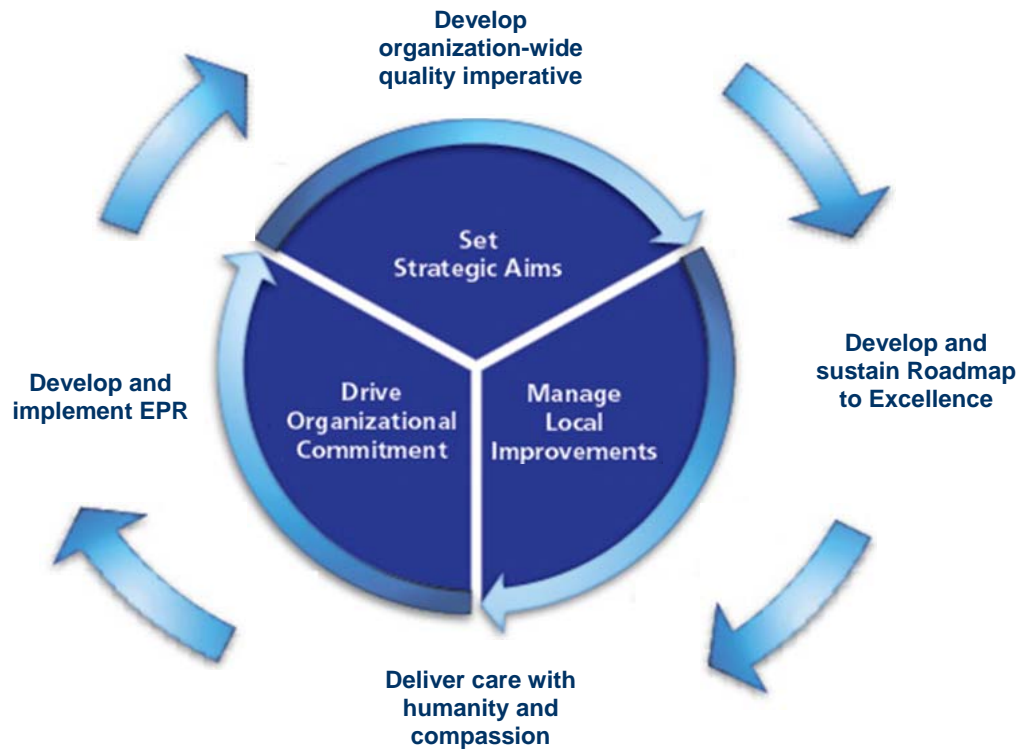
Quality by Design, one of our five strategic themes, means that:

- We set leading standards for safe, high quality care and service delivery
- We achieve superior outcomes for our patients while continually seeking improvements in care
- We are known and recommended for the best care experience.

*(From Trillium Health Centre's Strategic Plan, 2009/10 – 2011/12)*



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



### Our Quality Framework

The Quality Framework is a continuous improvement model. We measure, monitor and refine our efforts in the relentless pursuit of the highest quality care for our patients.

**Set strategic aims** – Our aims are to ensure our patients experience:

- No needless death
- No needless harm
- No needless pain
- No needless wait.

These strategic aims are the foundation of the measures set by Trillium's highest governing body – the Board of Directors – to ensure that Trillium meets its quality objectives.





**Managing local improvements** – Through intentional design, we can align and mobilize our care delivery, provide teams with the skills required for continuous improvement and hardwire improvement processes and best practice to ensure care is right the first time, all the time, for everyone.

**Drive organizational commitment** – Everyone has a role to play in providing patients with an exceptional experience that delivers superior outcomes. We will do this through establishing healthy workplaces, role maps/accountability, distributive leadership, a just culture and quality recognition.

## Strategic Directions

Improving patient safety and quality care are central to Trillium Health Centre's strategic plan. To act on these strategic priorities, Trillium has set five specific goals with clearly defined objectives to chart the organization's course over the span of three years. This provides all areas of Trillium with direction for improving the quality of care we provide our patients.

Our **overarching direction** is to be at the 75<sup>th</sup> percentile or better for all quality dimensions. By doing this, we will set leading standards for safe, high quality care and service delivery. We will achieve superior outcomes for our patients while continually seeking improvement in care.

- |                    |   |   |
|--------------------|---|---|
| <b>Direction 1</b> |    | We will develop and implement an organization-wide quality imperative and approach to reduce waste, drive process improvements and redesign the organization. By doing so, we will improve quality and timely delivery of services to provide the best possible care for our patients.  |
| <b>Direction 2</b> |    | We will develop and sustain a "Roadmap to Excellence". This will allow us to build on the organization's existing strengths and further cultivate excellence across the entire organization to achieve the best outcomes for our patients.  |
| <b>Direction 3</b> |    | We will deliver care and services through a culture of humanity and compassion. In so doing, we will continue to be known for the best patient care experience through treating our patients with respect, compassion and dignity.  |
| <b>Direction 4</b> |  | We will develop and implement an integrated information management system that includes an electronic patient record (EPR). This will help seamlessly connect all facets of interdisciplinary care and will ensure information is effectively shared among members of our team so that there are no gaps as patients move into and out of hospital. |

## Priority One Objectives

Trillium Health Centre's strategic directions will provide the foundation and structure to advance quality of services and care for our patients.

### **Key enablers for quality:**

1. **Board of Directors:** Trillium's Board of Directors has been driving quality for over 6 years. The Board Quality Committee has worked with management to make quality and patient outcomes an organization-wide imperative. The Board agenda has quality as its first and most important priority.
2. **Big Dots:** In 2009, Trillium established four Big Dot indicators with the Board of Directors at its annual retreat. These four Big Dots were selected to focus the organization's approach to quality improvement.
3. **Driver Diagrams:** Driver diagrams provide the framework and the plan to advance improvement on complex processes (Big Dots) on one page. *(See more detail below).*
4. **Incentives:** Trillium uses various incentives to drive quality throughout the organization. One key incentive is funding - our strategic plan has funding to ensure the directions are supported and enabled to move forward. As an example, the Strategic Innovation Fund provides one-time funding to different ideas from the staff that advance strategic directions. Another incentive is recognition awards. Annually, during Quality Week, the CEO recognizes exceptional quality improvement initiatives and outstanding quality contributions from staff.
5. **Our People:** Quality improvement is only achieved through the dedication, commitment, innovation and ingenuity of our people. Trillium supports staff, volunteers and physicians to achieve success in quality improvement through ongoing training, development and other tools to enable change. Trillium strives to create the right environment to attract and retain the best and brightest people.

## Priority One Objectives

### Safety

**Objective:** Avoid new pressure ulcers

**Strategic Aim:** No needless harm

**Specific Aim:** Reduce % of acute care patients who develop pressure ulcers while in hospital from 5% in 2010/11 to 4.5%

Reduce % of complex continuing care (CCC) patients who develop pressure ulcers while in care from 4% in 2010/11 to 2.6%

**Outcome Measure/Indicator:** % of CCC residents with new pressure ulcer in the last three months (stage 2 or higher)  
% of acute care patients with hospital-acquired pressure ulcers

**Change Ideas:**

- Develop a methodology to measure monthly the incidence of pressure ulcers across the organization. Each day, use safety crosses (a visual display of pressure ulcer incidence) on all inpatient units
- Determine if Health Outcomes for Better Information and Care (HOBIC) data can be used to measure and understand the incidence of pressure ulcers
- Daily skin assessments for all patients documented electronically
- Digital photos of complex wounds taken to facilitate interdisciplinary discussion

### Effectiveness

**Objective:** Reduce unnecessary time spent in acute care

**Strategic Aim:** No needless wait

**Specific Aim:** Reduce the number of patients waiting for alternative levels of care (ALC) in acute care beds from 12% in 2010/11 to 10%

**Outcome Measure/Indicator:** Percentage of ALC days: Total number of inpatient days designated as ALC, divided by the total number of acute inpatient days (Note: improvement against this measure will also require changes in community capacity that are beyond the hospital's control)

**Change Ideas:**

- Develop a measurement system to capture waits that are within the hospital's control
- Continue joint process improvement sessions (using Lean methodology) with the Community Care Access Centre (CCAC) and patient navigators to remove waste in the discharge process and create standard work processes for discharge
- Early discharge identification will enable smoother transitions for patients
- Create a High Intensity Case Management Team to respond rapidly to patients who present with complex conditions that will require expertise to navigate ethical, legal, social and medical requirements.
- Create a Transition and Readmission Team (TReaT) to respond rapidly to patients who present with complex conditions requiring expertise to expedite timely discharge, avert admissions and readmission.

### Effectiveness

**Objective:** Reduce readmission within 30 days for selected case mix groups (categories of diagnosis, treatment, and intensity)

**Strategic Aim:** Reduce readmission for seniors and people with chronic diseases

**Specific Aim:** Reduce the percentage of inpatients who are readmitted within 30 days from 12.5% in 2010/11 to 11.5% (represents the 90<sup>th</sup> percentile provincial performance)

**Outcome Measure/Indicator:** 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

**Change Ideas:**

- Engage patients and families to identify root causes for readmissions
- Undertake a pilot with risk assessment tool (LACE) to identify patients at high risk for readmission in acute medicine
- Provide high risk patients with the resources in the Senior Medical Outreach Team

## Access

**Objective:** Reduce wait times in the Emergency Department (ED)

**Strategic Aim:** No needless wait

**Specific Aim:** 38% of admitted patients will spend less than 8 hours in ED, compared to 33% in 2010/11 (Feb YTD).

**Outcome Measure/Indicator:** ED length of stay for admitted patients will be less than 8 hrs

**Change Ideas:**

- Continue to focus on improving key ED processes (using Lean methodology).
- Establish a plan to redevelop the physical layout of the ED to improve patient focused care.

## Patient-centred

**Objective:** Increase the percent of patients who respond “definitely yes” to question “health centre did all it could to control pain”

**Strategic Aim:** No needless pain

**Specific Aim:** Increase the % of patients who respond “definitely yes” to a survey question on efforts to control pain from 78% in 2010/11 to 79% in 2011/12

**Outcome Measure:** NRC Picker survey of inpatients in acute care

**Change Ideas:**

- Form a committee reporting to Medical Advisory Committee (MAC), Nursing Advisory Council (NAC), and Professional Advisory Council (PAC) to evaluate and advance pain management practice across the organization.
- Develop inter-professional collaboration in pain management practice throughout the organization.
- Empower patients and families through education (using different methods which include, but are not limited to, pamphlets, internet information on the Trillium website, educational TV channels, and face-to-face education at preoperative clinic) to participate in assessing and managing their pain.
- Develop a pain management database for quality assurance, enhancing patient safety, identifying areas for improvement, and facilitating evidence-based practice.

## Driver Diagrams at Trillium

Trillium’s four major measures, called big dot indicators, each have a driver diagram to drive improvement. A big dot is both a measure of the overall success of specific processes and projects, as well as a leading indicator for the overall quality of patient care. Big dots are influenced by underlying drivers, which connect to key process improvement initiatives. Senior leaders, staff and physician leaders collaboratively devised the driver diagrams related to each big dot.

A driver diagram is a tool for translating a quality improvement plan into a concrete, logical sequence of actions and results. These one-page documents incorporate external targets and publicly-reported measures and align an individual staff member’s contributions to achieving big dot goals.

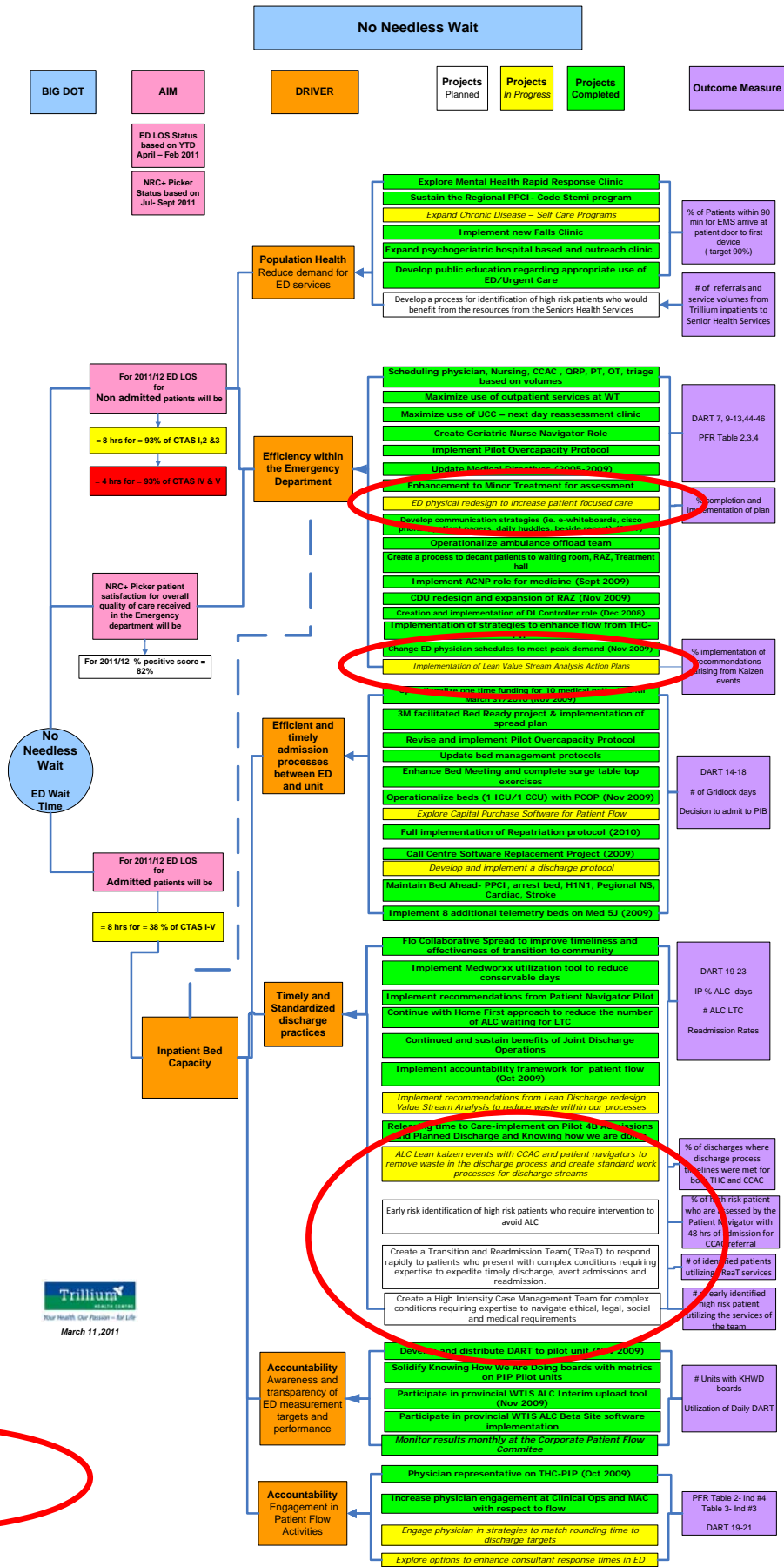
Each big dot has drivers or root causes. The driver diagram assists staff and physicians in understanding their roles in improving the outcomes for patients. This further helps the Board understand how improvement is planned and what potential barriers for improvement might be. The driver diagrams allow Board members to understand quality-related issues in a simple, visual way. They provide the Board with easy access to clear, transparent information on which to base governance decisions. This visual management technique facilitates the translation of clinical knowledge into widely comprehensible status reports.

The driver diagrams speak to the need for every member of a health care organization – from Board members through physicians, executives, nurses and other staff – to understand the root causes of quality and the process improvement initiatives that can create changes. The driver diagrams support both accountability and transparency, while being an effective way to foster staff engagement in quality initiatives.

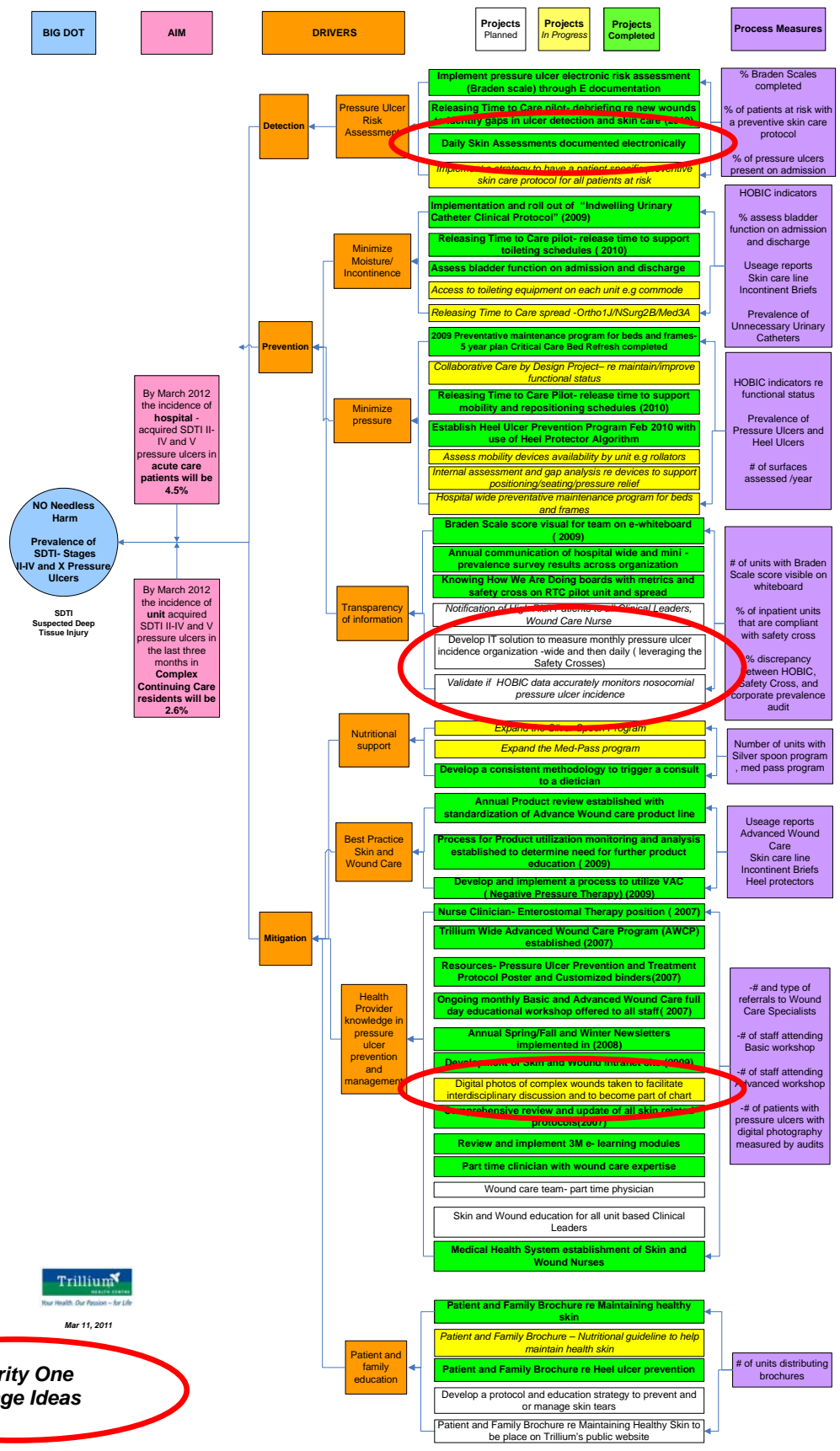
Driver diagrams enable Trillium’s staff to see how their work contributes to influencing the big dots. Introduction of the diagrams has galvanized clinical staff in a shared effort to achieve measurable targets, and provide new insights that link their daily work to more long-term, large-scale organizational goals.

The introduction and use of driver diagrams has enabled Trillium to focus its quality efforts and unite the contributions of staff, physicians, management and the Board of Directors toward the common goal of improving the health of the community.

Trillium's driver diagrams follow and demonstrate how the change ideas for all Priority One indicators are supported.



**No Needless Harm**



**Priority One Change Ideas**



# No Needless Pain (Draft 9)

**BIG DOT**  
Currently big dot excludes Rehab, Obs, ED and Paeds

**AIM**  
Recommended target suggested by NRC + Picker

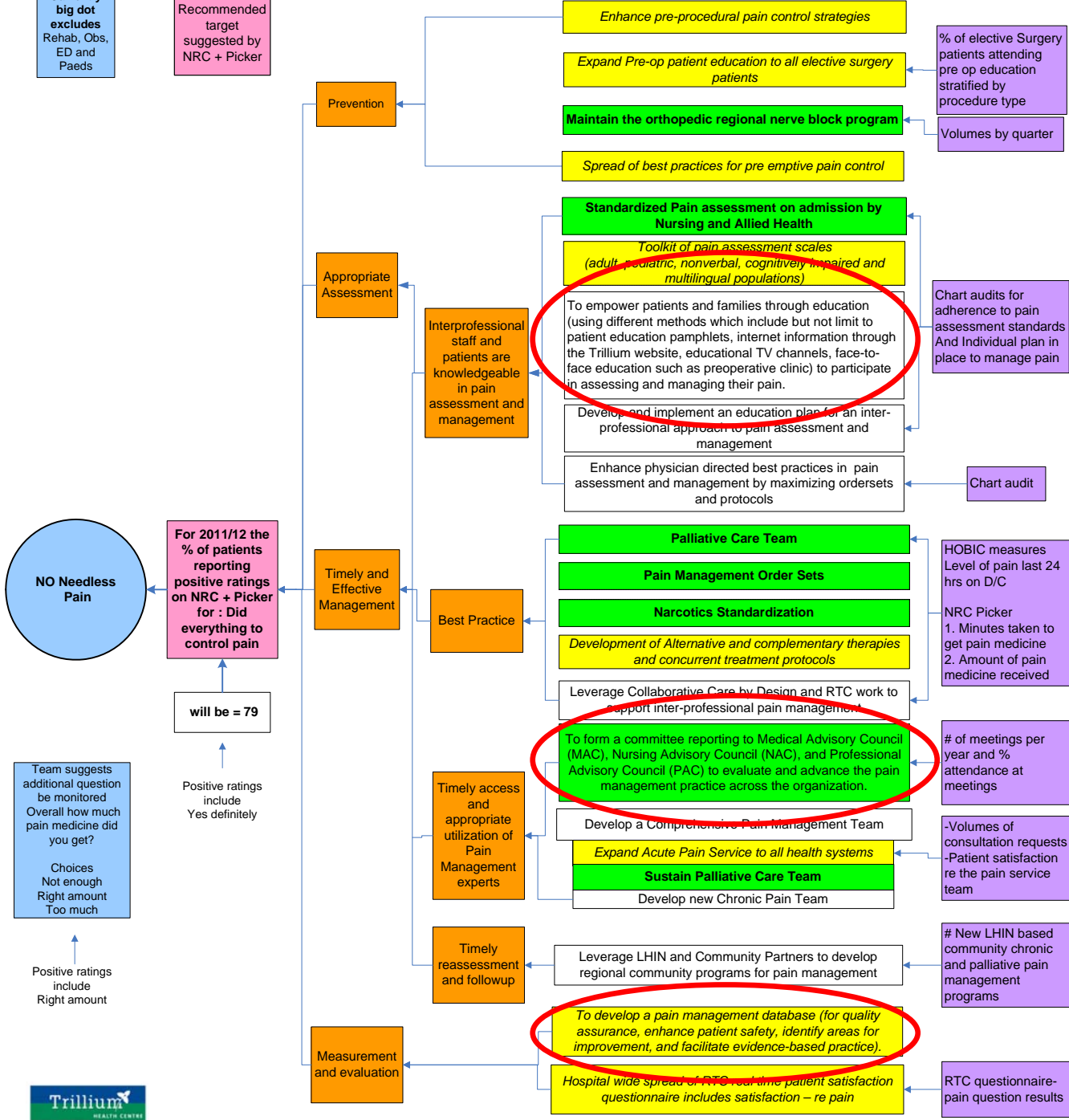
**DRIVERS**

**DRAFT**  
Projects Ideas

**Projects In Progress**

**Projects Completed**

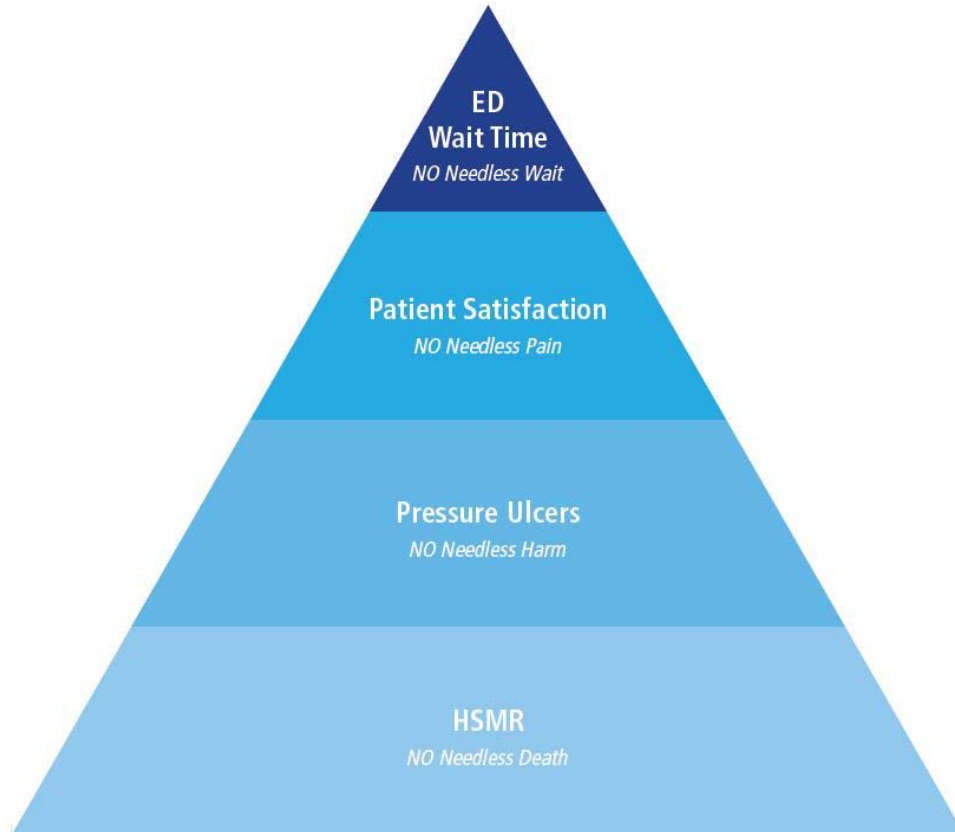
**Process Measures**



Mar 11, 2011

**Priority One Change Ideas**

## Trillium Health Centre's Four Big Dots



### 3. How the plan aligns with the other planning processes

Trillium Health Centre's Quality Improvement Plan (QIP) aligns with our annual business planning cycle and is also drawn from a three-year *Quality by Design* plan. Our strategic planning process (*Figure A*) at the Board level as well as local planning at the health system (HS) and business unit (BU) level informs the development of the QIP. The process begins with the overarching strategy and a corresponding set of measures and targets. Subsequently, each health system and business unit is charged with articulating a set of objectives, measures, targets and action plans in support of corporate strategy.

To facilitate this alignment, Trillium has developed the *Roadmap to Excellence in Healthcare* framework (*Figure B*) to implement strategy and support the ongoing pursuit of excellence in the delivery of all care and services. Through extensive engagement and using step-by-step methodology, each health system and business unit across the organization uses evidence-based criteria to assess where it is today, where it wants to be and how it plans to get there. The inputs to each health system's plan mirrors those for the QIP, including:

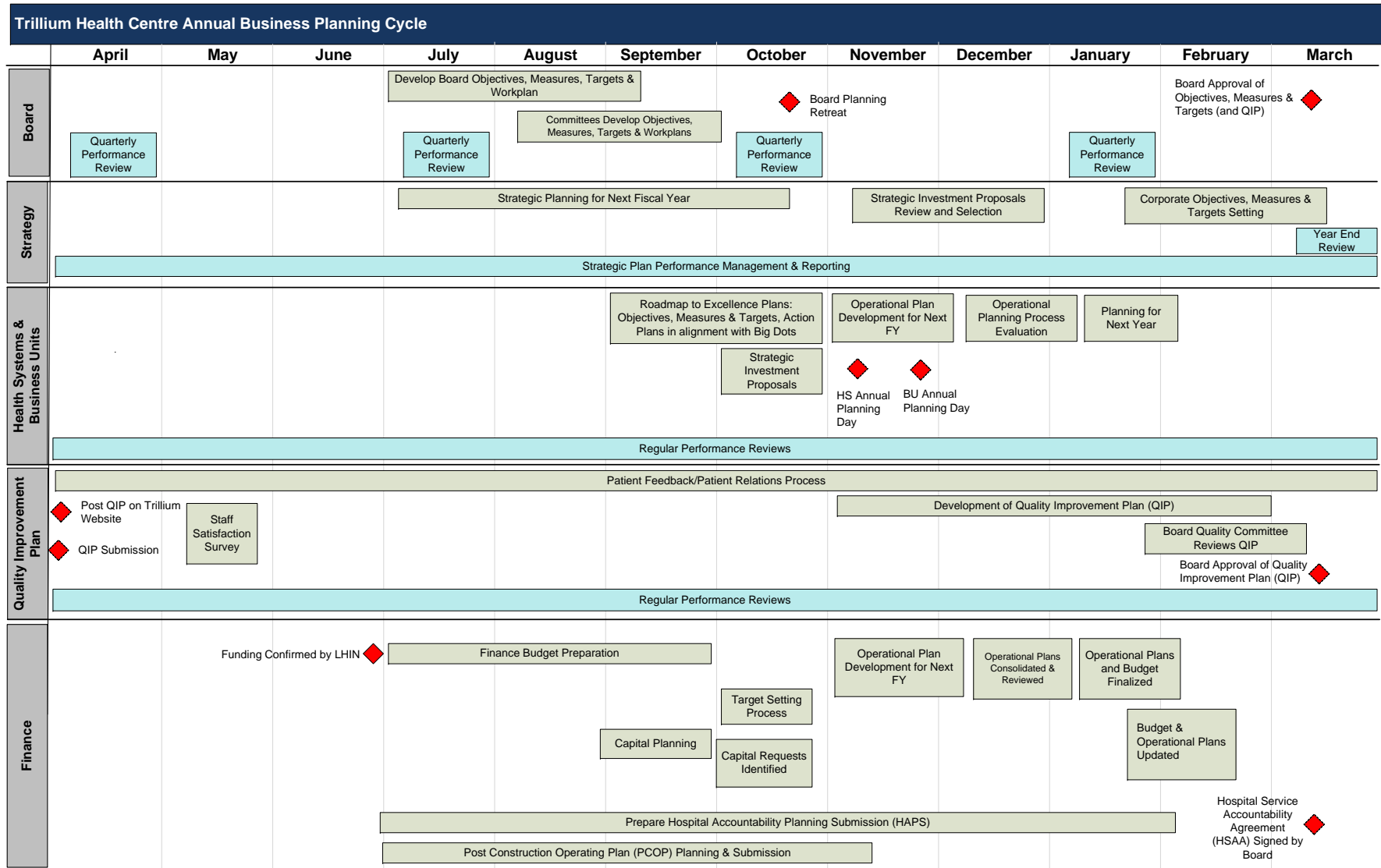
- Patient satisfaction results
- Patient Relations summary
- Risk data
- Healthy Workplace survey results
- Key quality indicators and metrics
- Financial stewardship outcomes.

The output of this process is that each health system and business unit creates a plan that defines objectives, outcome measures and action plans in alignment with Trillium's strategic plan and key performance measures (big dot measures).

On an annual basis health systems and business units refresh *Roadmap to Excellence* plans. At this time, teams assess current performance against identified targets, assess the actions taken and make necessary changes to improve performance and alignment. Planning days occur each year where *Roadmap to Excellence* plans are shared and considered collectively. The objective of the annual planning day is to create awareness and understanding of specific priorities that health systems and business units have set out in Roadmap plans as well as the challenges and opportunities associated with achieving them. The planning day is an opportunity to engage senior leaders in priority-setting to ensure health system and business unit objectives and targets are met. This process then informs the development of the Operational Plan and the QIP.

A performance management and reporting system (*Appendix A*) is used to monitor and track performance from the Board level to frontline staff to ensure accountability and transparency to drive improvement and achieve excellence across the organization throughout the year.






**Figure A**



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**Figure B**



Trillium Health Centre Roadmap to Excellence in Healthcare Progression Stages			
Stage 0: Emerging	Stage 1: Achieving	Stage 2: Excelling	Stage 3: Leading
 <ul style="list-style-type: none"> <li>Outcomes not consistently meeting known benchmarks</li> <li>Standards of practice not consistently or fully implemented</li> <li>Processes are emerging</li> </ul>	<ul style="list-style-type: none"> <li>Outcomes consistently meeting known benchmarks</li> <li>Competent delivery of care</li> <li>Standards of practice consistently implemented</li> <li>Processes are repeatable</li> </ul>	<ul style="list-style-type: none"> <li>Outcomes consistently above known benchmarks</li> <li>Quick adopter of best practices</li> <li>Processes are standardized</li> <li>Reproducible results</li> <li>Active quality improvement – quality agenda is integrated in all work</li> </ul>	<ul style="list-style-type: none"> <li>Set leading standards/benchmarks for safe, high quality care and service delivery</li> <li>Known and recommended for the best care experience – top percentage for patient/staff satisfaction</li> <li>Internally and externally recognized and sought after for outstanding best practice</li> </ul>
 <ul style="list-style-type: none"> <li>Basic infrastructure and technology being developed</li> <li>Not financially sustainable</li> </ul>	<ul style="list-style-type: none"> <li>Basic infrastructure and technology is in place</li> <li>Higher costs than benchmark</li> <li>Working towards financial sustainability</li> </ul>	<ul style="list-style-type: none"> <li>Latest technologies are in place</li> <li>Alignment with average cost per weighted case</li> <li>Operates efficiently – cost equal to benchmark</li> <li>Financial plan is sustainable</li> </ul>	<ul style="list-style-type: none"> <li>Financial plan is sustainable and provides for the investments needed to allow us to deliver superior outcomes</li> <li>Effectively and efficiently align our strategies, people, facilities and technology to support best practice</li> <li>Setting the standard for clinical and cost effectiveness and efficiency</li> </ul>
 <ul style="list-style-type: none"> <li>Partnerships not yet formed</li> </ul>	<ul style="list-style-type: none"> <li>Engagement process in place</li> <li>Key areas for partnering and integration identified</li> </ul>	<ul style="list-style-type: none"> <li>Programs are aligning</li> <li>Some partnerships have been created</li> <li>Some integration across organization, health system</li> </ul>	<ul style="list-style-type: none"> <li>Purposely partner with others to create an integrated and seamless health care system for patients</li> <li>Holistic inter-professional and inter-program collaboration</li> <li>Advance innovation in health care by partnering with government and leading public, private and academic organizations</li> </ul>
 <ul style="list-style-type: none"> <li>Reactive</li> <li>Not actively involved in innovation, teaching and research</li> </ul>	<ul style="list-style-type: none"> <li>Becoming more reflective</li> <li>Late adopters of best practice</li> <li>Limited involvement in innovation, teaching and research</li> </ul>	<ul style="list-style-type: none"> <li>Reflective</li> <li>Early adopters of best practice</li> <li>Beginning to be involved in innovation, teaching and research</li> </ul>	<ul style="list-style-type: none"> <li>Lead in the development and timely adoption of best practice</li> <li>Active teaching and applied research</li> <li>Reputation for expertise of a specific clinical problem or condition</li> <li>Use of leading edge technology and specialty facilities (imaging, ORs, ICU, etc.)</li> </ul>
 <ul style="list-style-type: none"> <li>Most, but not all clinical providers are adequately performing core competencies and meeting accepted standards of practice</li> </ul>	<ul style="list-style-type: none"> <li>Clinical providers adequately meet core competencies and accepted standards of practice</li> <li>Multi-disciplinary team approach to care</li> </ul>	<ul style="list-style-type: none"> <li>Attracting expert clinical providers</li> <li>Clinical providers exceed required core competencies and accepted standards of practice</li> <li>Interdisciplinary team approach to care</li> </ul>	<ul style="list-style-type: none"> <li>Inter-professional approach to care</li> <li>Passionate and dedicated leader(s)</li> <li>A strong joint collaborative and unified vision that compels team work</li> <li>Attract, retain and develop a courageous, expert and dedicated team</li> </ul>

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## 4. Challenges, risks and mitigation strategies

Trillium Health Centre's Quality Improvement Plan sets out clear goals and targets for improvement in 2011-12, along with an approach and specific changes that will be implemented to drive that improvement. The performance goals and targets set out in the plan have been established within the context of key challenges and risks impacting the organization – both externally and internally.

In the external environment, Trillium faces similar challenges to other large health centres serving rapidly-growing communities. According to a recent Mississauga Halton LHIN study on acute care needs<sup>1</sup>, Trillium expects to see a 68% increase in inpatient acute weighted cases over the next 15 years. Weighted cases for the population aged 75+ are expected to increase 95% during the same time frame. Caring for the projected elderly population with intense needs related to complex, chronic diseases will be the key challenge. This problem is accentuated for Trillium because of the lack of long term care beds in the Mississauga Halton LHIN region – the lowest per capita in the province.

Combined with the pressure of increased demand is the reality of constrained funding. As the provincial government works to eliminate the deficit by 2017-18, it has expressed the need to slow the growth in major spending areas, including health care. Recent funding increases have not kept pace with inflation and this is expected to continue as the government moves toward a balanced budget.

To mitigate risks in the external environment, Trillium works closely with the Mississauga Halton LHIN to plan for short, medium and long-term needs across the continuum of care and help shape regional activity based on provincial directions. Trillium works directly with regional partners, including the Mississauga Halton Community Care Access Centre and Credit Valley Hospital, on plans to better integrate services and deliver them more effectively. Trillium is also establishing a specific strategy on seniors' care that includes the development of a long term care facility to expand this critical capacity in the area. In addition to these actions, Trillium is continuously implementing changes to improve flow and efficiencies and increase productivity.

Our people drive quality improvement – Trillium's success is dependent on their success. That is why Trillium has taken very seriously key challenges that directly impact our staff. Primary among these is the current wage freeze for non-unionized employees that has unfairly impacted health care professionals at Trillium. Additionally, the aging workforce and overall shortage of health care professionals puts pressure on our staff and leaders. Trillium is working hard to address these challenges and has implemented a variety of strategies to support staff and press for changes at the provincial level that will address these challenges.

Other key challenges include the need for redevelopment of key parts of the hospital's physical plant and a robust system to share information between providers. While Trillium's Quality Improvement Plan assumes these key challenges will persist in 2011-12, the leadership of the organization is working to address these issues at the regional and provincial levels.

Additionally, Trillium recognizes that this plan could be at risk without clarity of focus and accountability within the organization. This risk will be mitigated through the implementation of a cascading accountability framework and business planning process, as described in this plan.

Trillium Health Centre has a long history of quickly and effectively responding to changes in the external and internal environment. While the goals and targets in this Quality Improvement Plan are predicated on these known challenges and risks, Trillium recognizes that new risks may be presented in the coming year. The organization will use the well established governance and management mechanisms in place to respond to changes effectively and deliver improved quality care.

<sup>1</sup> Long -Term Health Service Planning in Mississauga Halton LHIN: Trillium Health Centre Profile. August 2010

# Part B: Our Improvement Targets and Initiatives



BEFORE YOU BEGIN...	
<p>As part of the <b>ECFAA Legislation</b>, the annual quality improvement plan must be developed having regard to:</p> <ul style="list-style-type: none"> <li>- The results of the surveys (patient and staff - if available)</li> <li>- Data relating to the patient relations process</li> <li>- Aggregated critical incident data</li> </ul> <p>Please ensure this information is reviewed and considered in the process of developing your plan.</p> <p>Helpful hints for how to review this information are provided in the guidance document.</p> <p><a href="#">Link to Online Updates</a></p>	
Key messages	Technical Information
PART B: Improvement Targets and Initiatives	
<p><b>Measures</b> (columns B-F) –There is a core set of measures identified within this spreadsheet. This is to ensure alignment, consistency and standardization of reporting. There is however, an expectation that measures will be added that align with your own hospital and regional priorities</p>	<p><b>Current performance:</b> What is your organization’s current performance data/rate? A timeframe is specified within the table for core indicators.</p>
	<p><b>Performance goal 2011/12:</b> At the end of the improvement initiative, what is the outcome your organization expects to achieve?</p> <p><b>Priority:</b> Only indicators assigned as Priority 1 require a change plan (columns G-K). Please see the <b>guidance document</b> for more information.</p>
<p><b>Change plan</b> (columns G-K) – These columns should be completed where you have flagged a measure as Priority 1 (column F). Understanding that hospitals do not all have the same priorities, we expect these plans to be developed with your own hospital's priorities in mind. Change priorities should be focused on areas where improvement is necessary.</p>	<p><b>High-level improvement plan:</b> This section defines the details of the quality improvement initiative. Hospitals are required to complete the change section for <b>all high priority (1) initiatives</b>.</p>
	<p><b>Methods and results tracking:</b> Include your measures/current data (i.e. process measures) as appropriate</p>
	<p><b>Target for 2011/12:</b> All Priority 1 indicators must have a target defined for 2011/2012. Organizations should aim to review their existing data over time to set “stretch targets” on a select number of objectives. Please see the Guidance document for more information on target setting.</p>
	<p><b>Target justification:</b> Why was the specific target selected? i.e. is the target based on research literature; best practice; provincial or other defined benchmarks; scientific evidence; <b>organizational targeting exercise?</b></p> <p><b>Comments:</b> If there are any additional comments that you would like to make about the initiative, please indicate these here.</p>

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**PART B: Improvement Targets and Initiatives**



Trillium Health Centre, 100 Queensway West, Mississauga, Ontario

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

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
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	Miss - 0.31 WT - 0.08	0.28	3	2) ...N)			0.28	75th percentile	
	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	Jan-Dec 2010 Rate 1.54 (n=13)	2	3	1) 2) ...N)			2	75th percentile	
	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	WT = 80% ; M = 60%	85% 85%	2	1)			85% 85%	75th percentile	
	Reduce rate of central line blood stream infections	Rate of central line blood stream infections per 1,000 central line days: total number of newly diagnosed CLI cases in the ICU after at least 48 hours of being placed on a central line, divided by the number of central line days in that reporting period, multiplied by 1,000 - Average for Jan-Dec. 2010, consistent with publicly reportable patient safety data	Jan-Dec 2010 Rate 0.46 (n=4)	0	3	1) 2) ...N)			0	Best practice	
	Avoid new pressure ulcers	Pressure Ulcers: Percent of complex continuing care residents with new pressure ulcer in the last three months (stage 2 or higher) - FY 2009/10, CCRS		4.00%	2.60%	1	1) See Below 2) ...N)	See Below	2.60%	Prov. Avg 2009/10 = 2.6%	
	Avoid falls	Falls: Percent of complex continuing care residents who do not have a recent prior history of falling, but fell in the last 30 days - FY 2009/10, CCRS		2.30%	2%	3	1) 2) ...N)		2%	Prov Avg, 2010 = 13.1%; Usually Trillium result is > 2 but scored < 2 in one quarter (2009 Q1).	
	Avoid new pressure ulcers	Pressure Ulcers: Incidence of new pressure ulcer (stage 2 or higher) for acute inpatients (March 2011)		5%	4.5%	1	1) Develop IT Solution to Measure monthly pressure ulcer incidence organization wide & then daily leveraging use of Safety Crosses 2) Validate if HOBIC data accurately measure nosocomial pressure ulcer incidence 3) Daily skin assessments documented electronically 4) Digital photos of complex wounds taken to facilitate interdisciplinary discussion	% of inpatient units that are compliant % discrepancy between HOBIC, Safety Cross, and corporate prevalence audit % of patients at risk with a preventative skin care protocol # of patients with pressure ulcers with digital photography measured by audits	100.0% <5% 100%	Best practice Best practice	
Effectiveness	Reduce unnecessary deaths in hospitals	HSMR: number of observed deaths/number of expected deaths x 100 - FY 2009/10, CIHI		85	85	2	1) 2) ...N)		85	Between 75th & 90th percentile	
	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		12.50%	11.5%	1	Develop a process for identification of high risk patients who would benefit from the resources from the Seniors Health Services	# of referrals and service volumes from Trillium inpatients to Senior Health Services	increase 10%		
	Reduce unnecessary time spent in acute care	Percentage ALC days: Total number of (acute) inpatient days designated as ALC, divided by the total number of inpatient days. Q2 2010/11, DAD, CIHI		13%	10%	1	1) See Below 2) ...N)	See Below	10%	LHIN target = 8%; Jan10 - Dec10 = 12%	
	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		0.50%	0%	2			0%	Balanced budget according to HSA.	
	Space for additional indicators	ALC patient days as a % of total beds (acute and nonacute) (Jan 10 to Dec 10)		8%	7.8%	1	ALC Lean kaizen events with CCAC and patient navigators to remove waste in the discharge process and create standard work processes for discharge streams	% of discharges where discharge process timelines were met for both THC and CCAC.	80%		
							Early risk identification of high risk patients who require intervention to avoid ALC	% of high risk patient who are assessed by the Patient Navigator with 48hrs of admission for CCAC referral	80%		
Access	Reduce wait times in the ED	ER Wait times: 90th Percentile ER length of stay for Admitted patients. Q3 2010/11, NACRS, CIHI		28.2 hrs	28.2hrs	2	1) 2) ...N)		28.2hrs	MHLHIN Target 28.2; Prov Avg. 32.2hrs	
		ER Wait times: 90th percentile ER Length of Stay for Complex conditions. Q3 2010/11, NACRS, CIHI		8.7hrs	7hrs	2	1) 2) ...N)		7hrs	MHLHIN Target 7hours; Prov Avg = 7.5 hours	
	Space for additional indicators	% of admitted Emergency Department (ED) patients treated within a length of stay of 8 hours.(Apr10 to Feb11)		33%	38%	1	1) Implementation of Lean Value Stream Analysis Action plans 2) ED physical design to improve patient focused care	% implementation of recommendations arising from Kaizen events % completion and implementation of plan	100% 90%	Best practice	
Patient-centre	Improve patient satisfaction	Please choose the question that is relevant to your hospital:  NRC Picker (Corporate acute inpatient): "Would you recommend this hospital to your friends and family?" (add together percent of those who responded "Definitely Yes")  In-house survey (if available): provide the percent response to a summary question such as the "Willingness of patients to recommend the hospital to friends or family" (Please list the question and the range of possible responses when you return the QIP)		77.4%	79%	2	1) 2) ...N)		79%	75th to 90th percentile; Q2 - Ont Avg 74.3%, Community Hosp 69.4%, GTA 74.3%	
	Space for additional indicators	NRC Picker: "Do you think that the hospital staff did everything they could to help control your pain (add together percent of those who responded "Definitely Yes")?"		78%	79%	1	To form a committee reporting to Medical Advisory Council, Nursing Advisory Council and Professional Advisory Council to evaluate and advance pain management practices across Trillium.	# of meetings per year and % attendance at meetings	80%		
							Develop and implement an education plan for an interprofessional approach to pain assessment and management	Chart audit of adherence to pain assessment standards and individual plan in place to manage pain	10% increase		
							Empower patients and families through education to participate in assessing and managing their pain.	% of elective surgery patients attending pre-op education stratified by procedure type	10% increase	Best practice	
							To develop a pain management database for quality assurance, enhance patient safety, identify areas for improvement, and facilitate evidence-based practice.	Monthly usage rate of database and % of eligible patients that are entered.	80%	Best practice	

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

In support of our current practice of being a quality driven organization, for 2011-2012, in compliance with the Excellent Care for All Act (ECFAA), Trillium Health Centre will be implementing a performance-based executive compensation plan linked to key quality measures in our Quality Improvement Plan (QIP).

The executives who will participate in the plan and be subject to three percent compensation-at-risk include:

- President & Chief Executive Officer
- Chief of Medical Staff
- Executive Vice President & Chief Operating Officer
- Vice President, Patient Services & Quality / Chief Nursing Officer
- Vice President, Corporate Services and Chief Financial Officer
- Vice President, Strategy & Business Transformation
- Vice President, Medical Affairs
- Shared Vice President, Information Technology & Chief Information Officer
- Shared Vice President, People Services & Organizational Effectiveness

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

Our executives' compensation is linked to performance in the following way:

Executive Compensation Metrics ~ each indicator is weighted equally.

Quality Dimension	Indicator	Current Result	2011/12 Target	Definition
Safety	Avoid new pressure ulcers in complex continuing care patients in the last 3 months (stage 2 or higher)	4%	2.6%	% of complex continuing care residents with new pressure ulcer in the last 3 months (stage 2 or higher)
Effectiveness	Hospital Standardized Mortality Rates (HSMR): unnecessary deaths in hospital	85	85	Ratio of actual in-hospital deaths to expected in-hospital deaths
Effectiveness	Total Margin: organizational financial health	0.50%	0%	% by which total revenues exceed total expenses
Patient-Centred	Patient Satisfaction Positive Response: NRC Picker Results in Acute Care "Did Everything To Control Pain"	78%	79%	% of patients who respond "definitely yes" to a survey question on efforts to control pain

## 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.



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Anne Sado  
Board Chair



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Alan Torrie  
Quality Committee Chair



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Janet Davidson  
Chief Executive Officer