Hospital Quality Improvement Plans

Frequently Asked Questions

Data & Indicators

Health Quality Ontario's QIP Navigator will be prepopulated with site- and/or corporation-specific data in February. Hospitals are encouraged to consider the following when developing your organization's QIP:

- You likely already have a sense of how your hospital is performing and where quality improvement (QI) initiatives are needed. Current performance is only one piece of the larger picture in your QI plan. For Board review, you can provide an interim number for current performance or a time frame for when the Board will receive a final number for current performance (i.e. the week of February 9, 2015). This should allow you to proceed with a plan to propose to your Board.
- The interim values that the QI team has for the indicators they have chosen can guide the discussion with the Board. QI teams may be able to obtain Board approval of the QI plan in principle, and the Board chair may have the authority to sign off when the final data point becomes available.
- If you are uncertain of the absolute targets to propose for Board approval, you can include relative reductions in your QIP submission or identify targets based on high performers from previous years, provincial averages or benchmark values where available.
- An important aspect of the QIP is the implication/impact that the change ideas you propose will have in terms of budget, resources, and time. This is something that you (QI teams) should be able to develop before your current performance is finalized.

Q. What is it referring to in the QIP Guidance Documents when it says "reporting period"?

A. Current performance for all indicators is calculated using a specific time period; this is the "reporting period" listed in the QIP Guidance Documents.

Q. Where can I find definitions for each QIP indicator?

A. Indicator definitions can be found in the Indicator Specifications Document, which is an appendix of the QIP Guidance Document. Another resource is the Ministry of Health and Long-Term Care Resource for Indicator Standards, an online catalogue of the technical documentation for the indicators.

Definitions of all indicators can also be found in the Workplan in the QIP Navigator.

Q. I have questions about completing my QIP. Where can I find answers?

A. There are five places where you can find support and guidance for developing your organization's QIP.

I. Health Quality Ontario's website includes general as well as sector-specific QIP information; the QIP Navigator is accessed via HQO's website
II. The Ministry of Health & Long-Term Care's website includes the QIP documents as well as robust information about the Excellent Care for All Act.
III. The QIP Navigator has built-in help functions (see Question mark icons) to guide you through the process and provide you with helpful examples
IV. An extensive suite of resources is available on the Resources page of the QIP Navigator
V. You can contact an HQO QIP specialist at QIP@hqontario.ca

Q. What is a crude rate?

A. "Crude rate" is another term for *unadjusted rate*. A crude rate is the number of events that have occurred (the numerator) divided by the patient/client population (the denominator). The crude/unadjusted rate is best used to gauge performance over time within a facility; providing accurate information about the frequency of a quality-of-care outcome.

Q. What is an adjusted rate?

A. Adjusted rates are used to account for the characteristics of a patient population that may have an effect on your data. Adjusted rates are summary measures calculated using statistical procedures that mitigate the influence of population differences (e.g., age of patients/clients). For example, rates for the falls indicator can be adjusted to reflect those factors that may lead to falls, but which a hospital cannot control. Adjusted rates are best used when comparing performance across facilities or jurisdictions.

Q. Why does the QIP Navigator provide crude rates instead of adjusted rates?

A. Crude rates have certain advantages over adjusted rates when it comes to quality improvement initiatives. Crude rates are easier to calculate with the information available in clinical records and electronic medical records (EMRs). Crude rates also make it easier to track performance over time, so you can see if your change ideas are having the desired effect.

Adjusted rates are summary measures that do not reflect the actual volume or number of events in a hospital. Furthermore, additional information (which may not be accessible to hospitals) is required to calculate the adjusted rate for any indicator.

Q. For the pressure ulcer and falls indicators, the current performance provided is an unadjusted rate, while the provincial benchmarks are based on adjusted rates. How can I determine whether or not these are areas in which there is room for improvement?

A. In addition to providing unadjusted current performance for these indicators, HQO also provides the crude provincial rate in the QIP Navigator help box. This crude provincial rate can be used to compare your hospital's unadjusted rate to the unadjusted provincial average, which may inform your hospital's improvement priorities.

Adjusted rates on these indicators can be found in eReports published by the Canadian Institute for Health Information (CIHI). Hospitals can compare their adjusted rates to provincial benchmarks to assess how they performing compared to the provincial average or aspirational targets. For more information on eReports please visit CIHI's website.

Q. How should I report on Medication Reconciliation? Where can I find resources for this indicator?

A. All hospitals should be working towards full implementation of medication reconciliation. Medication reconciliation at care transitions has been recognized as a best practice and is increasingly becoming a system-wide standard. As such, organizations that were previously reporting medication reconciliation at admission for a unit/service/program or target population in their QIPs should now aim to report current performance and set targets at the organization-level.

While hospitals are asked to report medication reconciliation at an organizational-level, hospitals may wish to focus specific change initiatives, process measures, and change idea goals, on a specific unit/service/program or target population.

If your hospital/corporation has *not* implemented medication reconciliation throughout the entire organization, your hospital/corporation should calculate medication reconciliation in the following way: 1) the current performance for the unit (or group/sample) selected, and 2) weight current performance by the proportion of all admissions to the hospital that the unit (or group/sample) covers.

For Example:

1. Calculate the current performance for the selected unit/group/sample for the reporting period:
- The hospital focuses on or selects one unit
- 100 patients were admitted to that unit during the reporting period
- Of those 100 patients, 90 had a medication reconciliation completed
- The hospital reports that current performance is 90/100 or 90% for that unit

2. Calculate the proportion this sample/unit covers of all admissions to that hospital (for the same time period):

- The selected unit had 100 admissions during the reporting period
- For the same time period, the entire hospital had a total of 200 admissions for all units (including the unit being studied)
- The hospital reports that the sample was based on half (or 50%) of the total number of admissions during the reporting period (i.e., 100 of 200 total admissions).
- The hospital reports that the weighted current performance is 50% of 90 or 45% for the organization.

To provide context to this weighted medication reconciliation rate, please describe the areas in which medication reconciliation is being performed in the comments section of your Workplan.

To reflect the shift toward full implementation of medication reconciliation, medication reconciliation on discharge has been added as an 'additional' indicator to the 2015/16 QIP. Medication reconciliation on discharge is calculated as the total number of discharged patients for whom a Best Possible Medication Discharge Plan (BPMH) was created as a proportion of the total number of patients discharged.

Hospitals are encouraged use the resources on the ISMP Canada and Safer Healthcare *Now!* websites to inform their approaches to medication reconciliation and identify evidence-informed change ideas.

Q. Why is a rate not provided for some indicators?

A. A rate may have been left blank for one of the following reasons:

Rates were left blank if they were indicators where HQO does not have access to the administrative databases (i.e. patient satisfaction, or medication reconciliation).

Rates have also been left blank if the indicator in question was not applicable to your hospital. For example, some hospitals do not have an Emergency Department (ED). Therefore, the ED Length of Stay indicator is inapplicable to that site.

However, for some indicators, a blank means that the value was suppressed. Values were suppressed if the numerator was between one (1) and four (4), or the denominator was less than 30.

If you have questions about why a particular rate is blank, please contact QIP@hqontario.ca

Q. What should I do if I think the rate provided for a specific indicator is incorrect?

A. If you believe that the rate provided for an indicator is incorrect, please ensure that you have used the reporting period specified in the Indicator Specification Document and that the rate you have calculated is *not* an adjusted rate.

If you have difficulty replicating the rate, contact HQO (QIP@HQontario.ca) and provide the name of your hospital, your institution or corporate number, and the rate that you believe it is supposed to be. One of HQO's QIP specialists will determine whether or not the rate is indeed correct.

Q. When were indicator rates calculated?

A. The rates provided in the QIP Navigator reflect data collected in January.

Due to the fact that open year data is used to calculate each rate (i.e., data that is still in the process of being provided to CIHI and corrected), rates may shift slightly after pre-population in February however values will not be changed in the QIP Navigator.

Q. I have been provided site-specific rates for each indicator, but have not been given overall, corporate rates. What should I do?

A. The advantage of site-level data for indicators is that it provides information on where quality improvement efforts can be focused for maximum effect.

Example: A corporation has two sites. The rate of hand hygiene compliance is 95% at one site and 50% at the other. At the corporate level, the rate of hand hygiene compliance is 72% (an average of

the two sites). Based on the overall number (72%), one might be tempted to think that quality improvement efforts to improve hand hygiene rates are unnecessary. In reality, quality improvement is necessary, but only site-specific rates would indicate that the second site is not performing as well as the first.

It is recommended that additional information, such as corporate rates, is included in the comments or as part of the target justification.

Q. Why was data for the total margin indicator not pre-populated?

A. Total margin was not pre-populated because the data for the last quarter of the reporting period (as defined in the Guidance Documents) was not available in early February.

Please refer to the Ministry of Health & Long-Term Care's Health Data Branch Web Portal for your organization's rates (click on the *Healthcare Indicator Tool* section). Once your hospital has its complete data, it can be included under 'current performance' in the QIP Navigator.

Q. Why was data for the hand hygiene indicator not pre-populated?

a. Hand hygiene was not pre-populated because the data is provided to HQO annually by fiscal year. HQO does not receive the data broken down in such a way that we can calculate the rate for the calendar year as required by the QIP (as defined in the Guidance Documents).

Q. Have the reporting periods for indicators changed?

A. No. The reporting periods defined in the QIP Guidance Documents have not changed since last year. There may have been slight changes in the way reporting periods are described (months instead of quarters or calendar years) but the reporting periods have remained the same.

Q. What is the difference between priority indicators, additional indicators, and other indicators?

A. HQO and the Ministry of Health & Long-Term Care use consistent language within all sectors' QIPs to support quality improvement capacity building and facilitate health system integration.

Although QIPs are owned by organizations, they are developed under the umbrella of a provincial vision of a high-performing health system and provide a system-wide platform for quality improvement. This provincial quality framework is expressed through the priority themes and indicators that are included in the QIP. These quality themes reflect Ontario's vision for a high-performing health care system and were prioritized based on an extensive consultation process that involved key stakeholders, representative associations, and was informed by partner organizations. The priority indicators reflect the transformational priorities that exemplify Ontario's commitment to delivering patient-centred care.

"Priority" indicators focus on system-level improvement and contribute to province-wide comparison and reporting. By encouraging the standardization of measurement and by aligning Ontario's quality agenda with integration, the goal is to achieve cross-sectorial improvement efforts. Priority indicators will appear on the landing page of the Workplan. *If your organization elects not to include a priority indicator in the QIP, then this should be documented in the comments section of the QIP Workplan.*

"Additional" indicators are those indicators that have a standard definition, and have had their administrative data pre-populated where available. Additional indicators are available for hospitals to select by using the drop-down list.

"Other" indicators refer to any other indicators organizations include as due to their relevance to organizational quality improvement initiatives.

Q. Data has been provided for some indicators that our organization had not planned on including in our QIP. Do we have to provide information for every indicator with prepopulated data?

A. No. Organizations still have flexibility and the option to choose which indicators they would like to work on. Although current performance is populated, organizations can choose to leave the indicator blank.

Q. In previous years, only some (improve/priority 1) indicators required change ideas and process measures. Now that priority levels have been removed, do all seven (7) priority indicators require identified change ideas, process measures and improvement projects?

A. All indicators that the hospital chooses to include on the QIP require associated change ideas and process measures.

Organizations continue to have flexibility and the option to choose which indicators they would like to include in their QIP. For each of the seven priority indicators, hospitals are asked to review their current performance and identify which of the indicators they will actively work on during the next fiscal year.

If any of the seven priority indicators are left blank hospitals are asked to provide a rationale for not including the indicator in the Narrative portion of the QIP.

If the additional indicators are left blank, HQO assumes the hospital has not selected the indicator, and the indicator will not export into your Workplan for public posting.

QIP Progress Report

Q. Why has the Progress Report changed?

A. The progress report has been modified to better understand which change ideas are leading to improvement, and which change ideas are not, as well as which change ideas are posing challenges to organizations. Using the modified template, hospitals are asked to reflect upon the past QIP cycle and determine which change ideas were ADAPTED, ADOPTED, or ABANDONED. Use the comments space to share learning with your peers.

Q. Why are some indicators prepopulated in the Progress Report?

A. HQO has prepopulated the progress report with indicator performance, targets, and their associated change ideas as stated in organization's QIP from the previous year. Thus, organizations will not have to go back and copy and paste that information into this year's submission. HQO encourages organizations to take the time to fill out the Comments section and include details such as key lessons learned, what change ideas were implemented and what effect they had on performance. HQO is interested in the understanding every organization's experience with implementing the previous year's QIP, regardless of whether or not targets were met, so we can share lessons learned and build quality improvement capacity.

QIP Narrative

Q. There is a new Patient/Client/Resident Engagement field within the Narrative. What information should hospitals include?

A. Patient engagement refers to how the hospital is using patient and family feedback to improve the patient experience and quality of care, manage risk, and identify gaps between patient expectations and experiences of care.

Feedback can be either written or verbal in the form of compliments, concerns/complaints, suggestions, inquiries, and consultations. Feedback can be received by the hospital in a variety of ways, such as, formal committees, satisfaction surveys, patient rounds, incident reports, or follow-up phone calls to name just a few.

The Ontario Hospital Association has developed a Patient Relations Toolkit to support hospitals in the ongoing development of their patient relations program. The toolkit has brought together the existing ways hospitals are implementing patient relations and the gaps that may exist.

Q. Where can I find direction about the expectations related to executive compensation?

A. Executive compensation remains a requirement of ECFAA. The guidance from 2012/13 has not changed and is provided on the ECFAA website, which should help to inform some of the standard questions and parameters.

If you have further questions about performance-based compensation, the primary point of contact for this topic is the Ministry of Health and Long Term Care which can be reached by emailing ECFAA@ontario.ca

QIP Workplan

Q. Where can I find the improvement targets and initiatives worksheet?

A. Referred to as the QIP Workplan, this Excel spreadsheet can be found under the "Our QIPs" tab. From this tab, click 'edit' on the QIP you are currently working on. The three components of the QIP will be visible (the Narrative, Workplan, and Progress Report). Click on the Workplan to access the spreadsheet.

Q. The QIP Workplan has columns for Methods and Process Measures. What should go in each column?

A. Methods are the steps organizations will take to track progress on their planned improvement initiatives. In this column, include details such as how data about the effectiveness of the change ideas will be collected, analyzed and who is accountable for regular review of these data. For example, the RN will collect assessments and review with the quality team on a monthly basis.

Process measures for each change idea should clearly articulate how teams will evaluate the progress and success of their improvement initiatives. Process measures are essential to achieving improvement goals, as they allow teams to determine whether or not their changes are having the desired effect. In this column, include your change idea's process measures, which are commonly expressed as a percentage or number. For example, the percentage of fall risk assessments completed on admission/per month.

Q. What should we do when each hospital site is listed for an indicator, but the indicator only applies to one location?

A. In this instance, organizations only need to include data, targets, and change ideas for the applicable sites. If the indicator is not applicable to a certain site, then that site can be left blank.

Q. When inputting measures data, why am I not able to put any text or a "<" or ">" sign for my targets?

A. The QIP Navigator will only accept numerical data in the measures section. If you would like to include "<" or ">" signs or a rationale, please include them within the target justification field.

Q. In the Measures edit box, 'absolute target' is where you enter data for the 'target performance' section on the QIP Workplan. Why are these labelled differently?

A. The target performance on the Workplan and your absolute target are the same. It is labelled absolute target within the edit box to differentiate between the relative target (which is read only and automatically calculated).

- Absolute target: The performance level you want to achieve, expressed in the same units as your current performance. It represents best practice or the ideal state.
- Relative target: The relative target is calculated automatically. It is the difference between your current performance and target performance, but stated as a percentage.

Q. Where can I find information to help with target setting?

A. Hospitals should first look to their Board-approved Hospital Service Accountability Agreement (HSAA) targets for indicators that exist on both the QIP and HSAA. For an indicator where the organization is not meeting the HSAA target, the HSAA target should be considered, or set an interim annual target

that enables the organization to work towards the HSAA target; reference HSAA target in the target justification column (recognizing the HSAA are 3-year plans, and the QIP is a 1-year plan). For an indicator where the organization is already meeting or exceeding the HSAA target, the hospital should continue to strive for further improvement and set a target better than the HSAA target.

Additionally, on the Resources page there is a link to a benchmark update that HQO released in the spring of 2013. Provincial averages and benchmarks can also be found within the Help text for those indicators where they are available.

Submission Process

Q. How do we attach the sign off section of the narrative in Navigator?

A. When you hit the 'submit' button in Navigator, a pop-up window will appear, and this is where you will enter hospital CEO, Board Chair, and the Quality Committee chair's information. By entering this information in Navigator, these individuals are acknowledging that they have reviewed and signed-off on the QIP. The hospital should maintain the physical copy of the signed paper document. It is not necessary to post the signed copy on the hospital website.

Q. Can I submit a QIP for more than one hospital using the same username?

A. No. Each organization was provided with a unique user ID and password that are to be used to submit their QIPs. Hospital organizations with multiple sites will submit one QIP, but will be able to submit site-specific data. Hospitals are no longer able to submit group QIPs.

Q. How often can I edit my QIP?

A. You can edit and save your plan as many times as you wish until it is formally submitted to HQO, at which time it becomes read-only. Should an organization discover an error in their QIP after it is submitted, they are urged to contact HQO as quickly as possible at QIP@hqontario.ca. The organization and HQO will collaboratively determine the best approach to addressing the error.

Q. How can I compare my organization's QIPs to those of my peers?

A. On the "Sector QIPs" page you can access all QIPs and sort them alphabetically or by fiscal year, sector, LHIN, and model/ type.

Please contact QIP@hqontario.ca should you have further questions