Hospital Quality Improvement Plans

Frequently Asked Questions

Data & Indicators

Health Quality Ontario's QIP Navigator has been prepopulated with site- and/or corporation-specific data. Hospitals are encouraged to consider last year's approach to Quality Improvement Plan (QIP) development and target setting when completing this year's QIP. Other things to consider when developing your organization's QIP:

- Given that this is the fourth year of hospital QIPs, you likely already have a sense of how your hospital is performing and where quality improvement (QI) initiatives are needed. However, 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 10). 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 finalized.

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

A. Current performance for all indicators should reflect 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 Ministry of Health & Long-Term Care's Indicator Technical Specifications document. Another ministry resource information on indicators is their Indicator Standards webpage.

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

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).

Q. What is an adjusted rate?

A. Adjusted rates are used to account for the characteristics of your 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.

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 hospitals 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. Should I be reporting on Medication Reconciliation? If so, where can I find resources for this indicator?

A. If your hospital/corporation has implemented medication reconciliation in all units, it is recommended that this indicator be reported at the organizational level for the entire hospital.

If your hospital/corporation has *not* implemented medication reconciliation throughout the entire organization, you may decide to focus on a specific group of patients or a unit where it has been implemented. If this is the case, your hospital/corporation should calculate and provide two statistics: 1) the current performance for the unit (or group/sample) selected, and 2) what proportion of all admissions to the hospital that the unit (or group/sample) covers. The latter provides contextual information.

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 of the total number of admissions during the reporting period (i.e., 100 of 200 total admissions). Therefore, the unit studied had 50% of all admissions during the reporting period

HQO recommends the unit-specific measurement be entered as a distinct field in Navigator, and then the proportion this represents entered into the comments or target justification column. 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. HQO prepopulated rates for 11 of the 17 indicators. Rates were left blank if they were related to those indicators that were not prepopulated. 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 QIP Guidance Documents 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 updated?

A. The rates provided in the QIP Navigator reflect data collected in January 2014.

Although rates may shift slightly after February 15, 2014, 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), 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. 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 (based on quarters or calendar years) but the reporting periods have remained the same.

Q. Why has the language changed from "core/non-core indicators" to priority indicators, additional indicators, and other?

A. HQO and the Ministry of Health & Long-Term Care felt that consistent language within all sectors' QIPs would 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.

"Key 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. For each priority indicator (identified in red font in the Workplan), organizations are expected to identify whether they will work to improve performance or maintain current performance.

"Additional" indicators are those indicators that have a standard definition, may have been in the QIP before, and have had their administrative data pre-populated where available. "Other" indicators refer to any others 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 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. Organizations continue to have flexibility and the option to choose which indicators they would like to work on. For each of the seven priority indicators, hospitals are asked to review their current performance and identify which of the indicators they will actively "improve", and those which they will "maintain" current performance and monitor.

Improve - This is a key priority where organizations are actively trying to improve. Change ideas are included.

Maintain - Organizations are aiming to sustain their gains and maintain current performance; change ideas are encouraged.

The indicators designated as "improve" should be treated as Priority 1 indicators were in the past (i.e., include change ideas/projects). If any of the seven priority indicators are left blank (i.e., neither improve nor maintain), hospitals are asked to provide a rationale for not including the indicator in the Narrative portion of the QIP.

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

A. HQO has prepopulated the progress report with indicator performance and targets as stated in organizational QIPs. Thus, organizations will not have to go back and copy and paste that information into this year's submission. HQO encourages organizations will 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 QIP experience of every organization last year, regardless of whether or not targets were met, so we can share lessons learned and build quality improvement capacity.

Q. What is the information provided in brackets in the Indicator column of the Progress Report?

A. The information in the brackets is the attributes for each indicator (e.g., unit, population, period, data source, priority). Due to the fact that this is the first year for entering data in pop-up windows that capture standardized and specific attribute information, the information from last year's QIP does not populate homogeneously (and therefore the attribute label shows up). Going forward, the specific attributes from the indicators will be listed.

Q. There is no Executive Compensation field within the Narrative. Where should hospitals include these details?

A. Hospitals are the only organizations currently required to adhere to this particular component of the *Excellent Care for All Act, 2010*. Thus, they are required to establish targets in their QIPs which are linked to executive compensation for the hospital CEO and other executives. Please provide these details within the Accountability Management field in the Narrative.

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. Primary care organizations are not required to submit at the practice level, but rather submit one QIP for their primary care organization as a whole. Hospital organizations with multiple sites will also 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 want 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 2012/13" page you can access all current QIPs and sort them alphabetically or by Sector, LHIN, and model/ type.

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 on the change ideas will be collected, analyzed and which group is accountable for the review. 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 on provincial averages or benchmarks, which will help with target setting?

A. 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.

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