Excellent Care For All.

2013/14

Quality Improvement Plan for Ontario Hospitals

(Short Form)

BLUEWATER HEALTH

March 28, 2013

This document is intended to provide public hospitals with guidance as to how they can satisfy the requirements related to quality improvement plans in the *Excellent Care for All Act, 2010* (ECFAA). While much effort and care has gone into preparing this document, this document should not be relied on as legal advice and hospitals should consult with their legal, governance and other relevant advisors as appropriate in preparing their quality improvement plans. Furthermore, hospitals are free to design their own public quality improvement plans using alternative formats and contents, provided that they comply with the relevant requirements in ECFAA, and provided that they submit a version of their quality improvement plan to HQO in the format described herein.

Ontario

Overview of Our Organization's Quality Improvement Plan

Overview of our Quality Improvement Plan (QIP) for 2013-14

The mission of Bluewater Health is "We create exemplary healthcare experiences for patients and families every time" and our vision is "Exceptional Care-Exceptional People-Exceptional Relationships". From experience, we know that the development of a quality improvement plan ensures that we remain on track to meet these high standards and expectations.

Building on the successes and learnings from the 2011-12 and 2012-13 QIPs and through the engagement of our staff, physicians, and community partners, we will achieve excellent outcomes in the following quality dimensions:

- Safety – Improved hand hygiene practices and improved medication reconciliation reliability.
- Access - Reduced Emergency Department wait times.
- Patient- and Family-Centred Care – Improved respect for patient preferences.

For 2013-14, Bluewater Health will also continue with improvement strategies that reach out even further "beyond the hospital walls" to support the following dimension of quality:

- Integrated—Reduced unnecessary hospital readmissions.

Objectives of the QIP and how the quality of services and care will be improved

Bluewater Health has developed quality improvement plans around "priority 1" measures, or those measures that have the highest priority because they align with our local and strategic priorities or accreditation priorities, are supported by external funding, or demonstrate an opportunity for us to improve from our current performance. A regular review of the following has also guided our prioritization and selection of measures to improve through the QIP process:

- patient relations and patient experience data, trends, and comments (i.e. NRC Picker survey, Feedback Monitor Pro)
- peer and provincial benchmarks available through such initiatives as the Canadian Hospital Reporting Project (CHRP) (click here), Health Quality Ontario (HQO) patient safety measures (click here) and Quality Monitor Report (click here), and the Ministry of Health and Long-Term Care (MOHLTC) wait times (click here)
- select measures linked to hospital quality improvement initiatives

Specifically, by March 31 2014, the QIP will guide us to:

1. Improve the percentage of times staff and physicians clean their hands before coming into contact with a patient or patient environment (room) to 90% by:
    - Increasing auditing, providing regular reports, and establishing a feedback and recognition system.

2. Improve the percent of medication reconciliations completed within 24h of inpatient admission to 90% by:
    - Adding additional Pharmacy Medication Reconciliation Technician shifts on weekends, providing ongoing education for nurses, and adding additional Admissions Nurse shifts on weekends in the Emergency Department.

3. Reduce the time admitted patients spend in the Emergency Department (ED) waiting for an inpatient bed by nearly 20% to 19h by:
    - Adding additional Admissions Nurse shifts on weekends, implementing new discharge processes to reduce the Alternate Level of Care (ALC) census and improve bed availability, and increase Geriatric Emergency Medicine (GEM) coverage on weekends to help prevent admissions to hospital.

4. Improve patients' perceptions that their preferences have been respected while in hospital by :
    - Increasing staff awareness of patient experience data and comments, implementing best practice guidelines (Client Centred Care, Establishing Therapeutic Relationships, and Supporting and Strengthening Families through Expected and Unexpected Life Events), and engaging patients in real-time for their feedback.

5. Reduce the number of hospital readmissions for chronic obstructive pulmonary disease (COPD) and congestive heart failure (CHF) by 35% by:
    - Providing focused discharge education to promote chronic disease self-management and maximizing discharge follow-up arrangements with the Community COPD Team, primary care providers, and rehabilitation services.

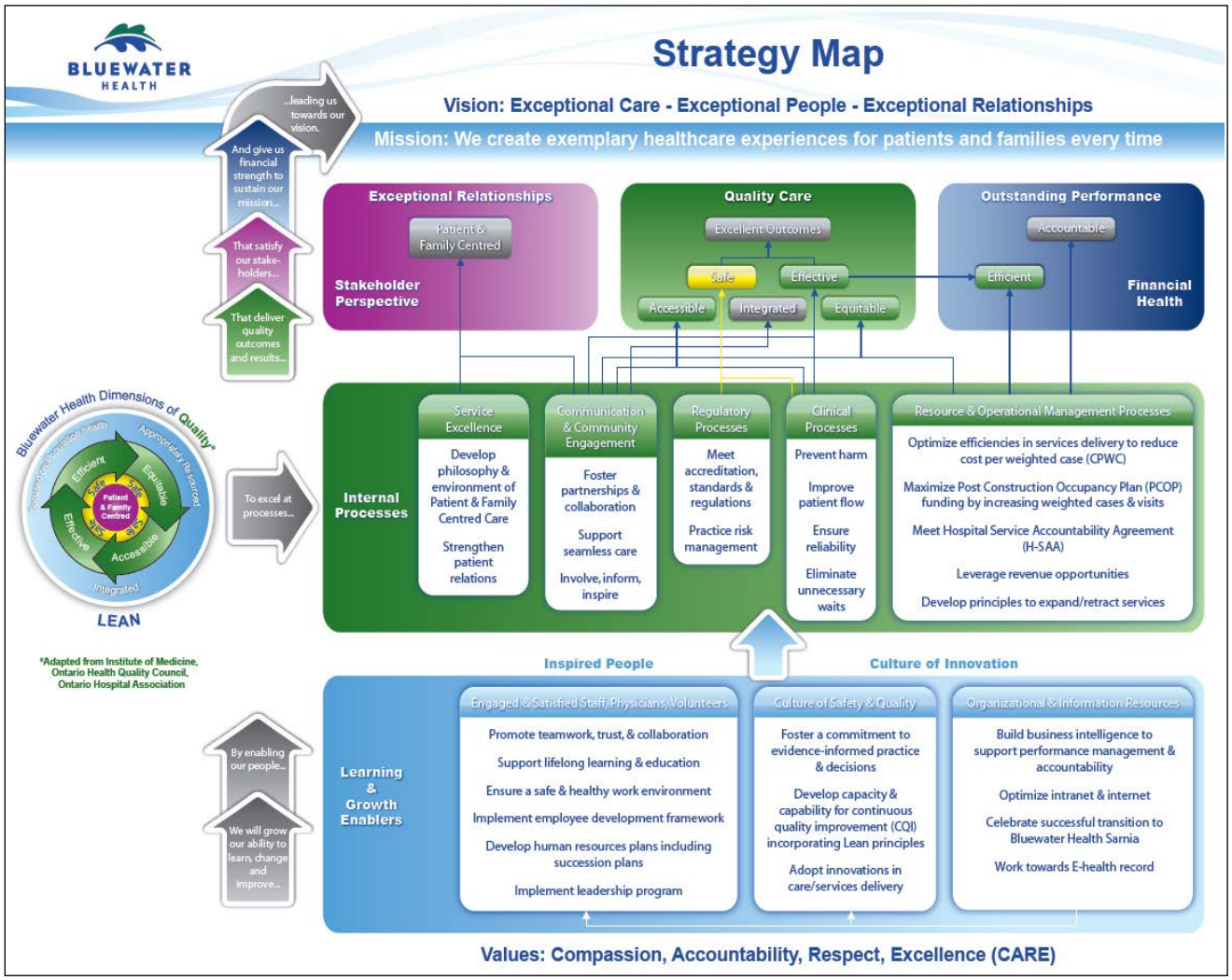
How the plan aligns with the other planning processes

Bluewater Health's strategy map (below) highlights that the dimensions of quality healthcare are fundamental to our strategic priorities and strategic plan. The quality improvement plan (QIP) is also very much linked to the following:

- H-SAA (Hospital Service Accountability Agreement) - ED Wait Times, Readmissions, Total Margin, Pressure Ulcer Incidence, and ALC days.
- Bluewater Health's Safety Plan and Accreditation Canada Required Organizational Practices - C. Difficile rates, Ventilator Associated Pneumonia (VAP) rates, hand hygiene compliance rates, Central Line Infection (CLI) rates, fall rates, and medication reconciliation completion rates.

The majority of QIP measures are also monitored through balanced scorecards reported to our Quality Committee of the Board, Medical Quality and Utilization Committee, and Quality and Performance Committee and many are also reported on our website for the public to access (http://www.bluewaterhealth.ca/Performance_Reporting).

The QIP serves not only as a means of communicating our plans to improve and deliver high quality healthcare experiences at Bluewater Health, but also as an indication of our commitment to accountability and transparency to our community, patients, and staff.



Integration and continuity of care

In prioritizing both ED wait times for admitted patients and readmissions for certain chronic conditions as top priority areas of improvement and in outlining a plan for improving these two measures, Bluewater Health has demonstrated its commitment to collaborate with community partners and agencies to improve care transitions and continuity of care and help ensure that care is provided in the right place at the right time by the right provider at the right cost.

Incorporating Health System Funding Reform (HSFR) into quality processes

While Bluewater Health has not selected Total Margin as a priority 1 measure, we remain committed to improving our financial health and achieving a balanced budget as a strategic priority and as an obligation to the Local Health Integration Network through the Hospital Annual Planning Submission (HAPS) and H-SAA processes.

Significant time and energy is being invested to better understand HSFR implications to Bluewater Health and how the hospital can become more efficient to bring actual costs and service volumes in line with expected costs and service volumes.

In addition, Bluewater Health has invested in the creation of a Performance + Transformation System to build capacity in our front-line staff, leaders, and physicians to identify opportunities to become more efficient and innovate and create solutions to do so.

Challenges, risks and mitigation strategies

Changes and improvements are not always easy to implement and are even more difficult to sustain[1]. The following are some potential challenges that Bluewater Health may encounter in working on our Quality Improvement Plan (QIP) activities and strategies to mitigate these challenges:

Potential Challenges:	Mitigating Strategies:
• Competing priorities: local and organizational needs and priorities versus ECFAA QIP measures	• Strategic plan devised based on balanced scorecard perspectives to ensure efforts remain balanced in achieving quality care, exceptional relationships, inspired people, and outstanding performance. • Limit improvement efforts and plans to target a manageable number of priority 1 measures (5). • Optimize alignment between ECFAA QIP measures and strategic priorities. • Develop “energy grid” to monitor and plan for optimal use of human resources.
• Not all changes lead to improvement in outcome measures	• Develop leadership skills in continuous quality improvement, including measuring and monitoring outcomes.
• Not all ideas from other organizations can be adapted locally	• Develop Performance + Transformation system to teach continuous quality improvement skills and engage frontline staff in idea generation, problem solving, and decision making.

[1] Ontario (January 2011). Quality Improvement Plan Guidance Document. Available online: Ontario.ca/ExcellentCare

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

Purpose of Performance-based compensation:
The purpose of performance-based compensation related to ECFAA is to drive accountability for the delivery of quality improvement plans. Performance-based compensation can help organizations to achieve both short and long-term goals. Performance-based compensation will enable organizations to:

1. To drive performance and improve quality care
2. To establish clear performance expectations
3. To create clarity about expected outcomes
4. To ensure consistency in application of the performance incentive
5. To drive transparency in the performance incentive process
6. To drive accountability of the team to deliver on the Quality Improvement Plan
7. To enable team work and a shared purpose

Organizational positions to which performance-based compensation applies:
Compensation for the *following executive positions at Bluewater Health* will be linked to our organization's achievement of quality improvement targets set out in our annual Quality Improvement Plan:

- Chief Executive Officer
- Chief of Professional Staff/Vice President, Medical Affairs/Chief Quality, Patient Safety, Risk Management
- Vice President, Operations/Chief Operating Officer
- Vice President, Operations
- Chief Nursing Executive, Interprofessional Practice, Organizational Development
- Chief, Communications and Public Affairs

Linking compensation to the Quality Improvement Plan
Our 2013-14 Pay for Performance Plan is in compliance with ECFAA and the *Public Sector Compensation Restraint to Protect Public Services Act, 2010*.

For all of our executives, **2%** of their current base salary will be withheld and will now be "at risk" and linked to Bluewater Health achieving the targets set out in its 2013-14 Quality Improvement Plan on the indicators outlined below. Specifically, the linkages are with the following:

Quality Dimension	**Objective**
Safety	Improve provider hand hygiene compliance
Safety	Improve medication reconciliation process at admission
Effectiveness	Improve organizational financial health
Access	Reduce wait times in Emergency Department
Integrated	Reduce unnecessary hospital readmission for Chronic Obstructive Pulmonary Disease (COPD) and Congestive Heart Failure (CHF)
Patient & Family-Centred	Improve respect for patient preferences

It is intended that the hospital must achieve 100% of the targeted improvement set out in the QIP for an objective in order for the performance-based compensation for that objective to be earned. Each objective is weighted at 0.5% of current salary, so that the full 2% of base salary can be earned back if the hospital achieves or exceeds its QIP targets in 4 of the 6 objectives. In no circumstances will the payout of performance-based compensation exceed 2% for the 2013-14 fiscal year.

The Board of Directors has the residual discretion to modify the amount of performance-based compensation (subject to the 2% maximum) following assessment of the Hospital's performance related to the QIP, in the event that there has been significant achievement of the objectives specified above but the targets set out in the QIP have not been achieved.

Accountability Sign-off

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

Stéphane Thiffeault
Board Chair

Bob McKinley
Quality Committee Chair

Sue Denomy
Chief Executive Officer

Bluewater Health
89 Norman Street, Sarnia ON, N7T 6S3

Our Improvement Targets and Initiatives

See attached spreadsheet

2013/14 Quality Improvement Plans for Ontario Hospitals
Improvement Targets and Initiatives

Bluewater Health, 89 Norman St. Sarnia, ON N7T 6S3

AIM		MEASURE					CHANGE			
Quality dimension	**Objective**	**Measure/Indicator**	**Current performance *(for period specified)***	**Target for 2013/14**	**Target justification**	**Priority level**	**Planned improvement initiatives (Change Ideas)**	**Methods and process measures**	**Goal for change ideas (2013/14)**	**Comments**
Safety	Reduce hospital acquired infection rates	**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. 2012, consistent with publicly reportable patient safety data	0.41	0.34	Match provincial average	2	1)			
							2)			
							… N)			
		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 - Jan-Dec. 2012, consistent with publicly reportable patient safety data	85.85%	90%	Continued target from 2012/13	1	1. Provide standardized reports to each inpatient department by provider type (physician, nursing, and support services).	- # months data is provided to each department - Inclusion of hand hygiene data at departmental meeting agendas.	Agenda item at 100% of meetings each quarter.	Measurement & Feedback
							2. Increase the number of audits within each provider category - identify and obtain the specified number of audits each quarter. Provide standardized reports identifying status of achievement of audit numbers.	- 100% of audit targets established. - # of months established audit thresholds achieved.	100% of targets established and achieved.	Measurement & Feedback
							3. Recognition - Highlight areas that are achieving the targets in the BedPost quarterly.	# of quarters with an article included.	Article included each quarter	Incentives/ Motivation
							4. Recognition - Increase the number of publicly posted hand hygiene champion posters.	Locations for hand hygiene posters on all levels will be identified and mounted.	100% of posters mounted	Incentives/ Motivation
		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. 2012, consistent with publicly reportable patient safety data	0	0	Match best performance	3	1)			
							2)			
							… N)			
		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. 2012, consistent with publicly reportable patient safety data	0	0	Match best performance	3	1)			
							2)			
							… N)			

AIM		MEASURE					CHANGE			
Safety	Reduce incidence of new pressure ulcers	**Pressure Ulcers**: Percent of complex continuing care residents with new pressure ulcer in the last three months (stage 2 or higher) - Q2, FY 2012/13, CCRS	Sarnia: 3.2% CEEH: 9.4%	zero incidence of new stage 2 or greater pressure ulcers	Represents stretch to improve; aligns with RTC™ targets	2	1)			
							2)			
							… N)			
	Avoid patient falls	**Falls**: Percent of complex continuing care residents who fell in the last 30 days - Q2, FY 2012/13, CCRS	Sarnia: 7.2% CEEH: 20.1%	5%	Match provincial risk-adjusted benchmark (5%)	2	1)			
							2)			
							… N)			
	Avoid patient falls	**Falls:** Number of Category 3 falls by inpatients across entire organization. Category 3 - Event/error results in permanent harm/damage. Additional monitoring, prolonged stay and extensive follow-up required. - Total reported events for Jan-Dec 2012	7	5	Internal target - 20% reduction	2	1)			
							2)			
							… N)			
	Reduce use of physical restraints	**Physical Restraints:** The number of patients who are physically restrained at least once in the 3 days prior to a full admission assessment divided by all cases with a full admission assessment - Q4 FY 2010/11 - Q3 FY 2011/12, OMHRS	4.9% (using FY 11/12 OMHRS report as per OHA)	Sustain =<4.9%	Program-wide training & correction of past error reports in 2012/13	3	1)			first fiscal year with improved data quality
							2)			
							… N)			
	Reduce rates of deaths and complications associated with surgical care	NEW **Rate of in-hospital mortality following major surgery:** The rate of in-hospital deaths due to all causes occurring within five days of major surgery - FY 2011/12, CIHI CHRP eReporting tool	4.93 (per 1000)	Sustain <5 (per 1000)	LHIN= 9.46; Province= 9.18; Peer= 8.58; target is well below BWH 5 yr avg	3	1)			Hospital adjusted rate: CHRP release March 2013
							2)			
							… N)			
		Surgical Safety Checklist: number of times all three phases of the surgical safety checklist was performed ('briefing', 'time out' and 'debriefing') divided by the total number of surgeries performed, multiplied by 100 - Jan-Dec. 2012, consistent with publicly reportable patient safety data	99.75%	100%	Theoretical best	3	1)			
							2)			
							… N)			
	Increase proportion of patients receiving medication reconciliation upon admission	NEW PC **Medication reconciliation at admission:** The total number of patients with medications reconciled as a proportion of the total number of patients admitted to the hospital - Hospital-collected data, most recent quarter available (e.g., Q2 2012/13, Q3 2012/13)	Q3: 84.44%	90%	Continued target from 12-13; 90% is Accreditation Canada target	1	1)Nurse Refresher training by pharmacists, nursing informatics and nurse educators early in Q1	% of nurses participating in refresher course	100%	Skills Development
							2) Supplement existing Med Rec Tech shifts with weekend day shifts (add 0.4 FTE)	# of med recs completed per day by Techs (for ED admissions)	7 per day	Targeted Investment
							3) Increase Admissions Nurse in ER to 7 days per week	see below		

AIM		MEASURE					CHANGE			
Effectiveness	Reduce unnecessary deaths in hospitals	**HSMR:** number of observed deaths/number of expected deaths x 100 - FY 2011/12, as of December 2012, CIHI	92	<100	Remain below the overall national average rate	3	1)			
							2)			
							… N)			
	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 2012/13, OHRS	-0.63%	0.00%	Balanced budget to comply with Ministry requirements.	2	1)			This can only be achieved if we receive a reconciliation regarding our PCOP funding.
							2)			
							… N)			
Access	Reduce wait times in the ED	**ER Wait times:** 90th Percentile ER length of stay for Admitted patients. Q4 2011/12 – Q3 2012/13, iPort (ER Pay For Results-P4R- Site)	23.6h	19.0h	Continued target from 12-13; remain well below provincial target of 25h	1	1) Increase Admissions Nurse in ER to 7 days per week to expedite admission process.	1) All admissions completed by Admissions Nurse (during worked hours). 2) Med Rec is initiated by Admissions Nurse. 3) Med Rec is completed by Admissions Nurse.	100% 100% 50%	Targeted Investment and Measurement & Feedback
							2) Create and implement new discharge processes to reduce the number of Alternate Level of Care (ALC) patients waiting for Long-Term Care (LTC) and decrease ALCs in acute beds.	ratio: newly designated ALC-LTC discharged ALC-LTC	<1	Process Improvement
							3) Increase Geriatric Emergency Medicine (GEM) hours as an admission avoidance strategy	All patients (70+ years of age) seen by GEM Nurse (during worked hours).	25% more patients captured	Targeted Investment

AIM		MEASURE					CHANGE			
Patient- & Family-Centred	Improve patient satisfaction	**From NRC Picker / HCAPHS:** "Would you recommend this hospital to your friends and family?" (add together percent of those who responded "Definitely Yes" or “Yes, definitely”)	72.8 (Oct '11-Sep'12)	75	Continued target from 11-12; Pt/Fam Cent strategies will impact overall score	2				
		From NRC Picker: "Overall, how would you rate the care and services you received at the hospital?" (add together percent of those who responded "Excellent, Very Good and Good")	96.2 (Oct '11-Sep'12)	98	Return to previously achieved high score of 97.7 which is stats. sig higher than the ON commun hosp avg	2				
		****From NRC Picker:** Respect for Patient Preferences Dimension Score (roll-up score of "Treated you with respect/dignity", "Enough say about treatment", Drs & Nurses did not talk in front of you as if you weren't there"	80.9 (Oct'11-Sep'12)	85	Build on not-yet-sustained 12-13 target of 83 towards ON high performer of 90.2	1	1) Increase staff awareness of monthly NRC Picker data for their own area and link data to practice	Best Practice Guideline (BPG) Champions review data with managers monthly; Post data and review at Unit Based Councils.	Reports reviewed monthly by 100% of clinical units (starting May 2013)	Measurement & Feedback
							2) Engage Best Practice Spotlight Organization (BPSO) Champions and managers in implementing the following best practice guidelines: Client Centred Care, Establishing Therapeutic Relationships, and Supporting and Strengthening Families through Expected and Unexpected Life Events.	-# staff trained to be therapeutic dialogue facilitators (beginning May 2013) -staff receiving 2 hour introduction to therapeutic dialogue -inclusion of therapeutic dialogue training in orientation for new employees (by July)	-12 BPSO Champions, 4 Patient Experience Partners (PEPs) & clinical managers -50% of clinical staff by Oct 1; 75% by Dec 1; & 100% by Feb 1	Skills Development
							3) Engage patients in real time for their feedback measures of "treated with respect"	-Patient feedback to refine therapeutic dialogue and attitude of staff (beginning May 2013) -Feedback methods including rounding, comment cards, & internet	Monthly rounding and feedback	Measurement & Feedback

AIM		MEASURE					CHANGE			
Integrated	Reduce unnecessary time spent in acute care	**Percentage ALC days:** Total number of inpatient days designated as ALC, divided by the total number of inpatient days in acute care. Q3 2011/12 – Q2 2012/13, DAD, CIHI	Sarnia: 14.09% CEEH: 9.65%	<9%	Ministry-LHIN Performance Agreement (MLPA) target and a stretch to achieve consistently	2	1) 2) … N)			
	Reduce unnecessary hospital readmission	PC **Readmission within 30 days for selected CMGs to any facility:** The number of patients with select CMGs readmitted to any facility for non-elective inpatient care within 30 days of discharge, compared to the number of expected non-elective readmissions - Q2 2011/12 – Q1 2012/13, DAD, CIHI	14.41%	<13.5%	Continued 12-13 target and better than most recent evidence based expected target of 14.43% (for FY 11-12)	2	1) 2) … N)			
	Reduce unnecessary hospital readmission	PC ****Readmission to Bluewater Health within 30 days for Chronic Obstructive Pulmonary Disease (COPD) and Congestive Heart Failure (CHF) :** The per cent of patients with specified COPD or CHF CMGs readmitted to Bluewater Health within 30 days of discharge. Q2 2011/12 – Q1 2012/13, DAD, CIHI	19.3%	13%	Continued 12-13 target (which was a 35% reduction); planning a # of new initiatives in 13-14	1	1) Focused discharge education to promote chronic disease self-management 2) Chronic Disease Program link to Sarnia-Lambton COPD Pathway Implementation	1) All patients discharged with COPD referred to community teams. 2) All patients discharged with COPD, CHF (and stroke) will have their discharge plan documented including where/how to seek help at early signs of deterioration. 1) All patients discharged with COPD, CHF (and stroke) will have a primary care follow-up appointment confirmed at discharge. 2) All rehab appropriate patients discharged from acute care will be referred to inpatient and/or community rehab services.	100% 100% 100% 100%	Process Improvement Process Improvement

LEGEND:

PC This icon indicates those core indicators and processes that particularly encourage linkages with the primary care sector. Healthcare organizations are encouraged to select these indicators in an effort to improve the patient care experience with other system partners

NEW This icon indicates new core indicators for 2013/14

**Added by Bluewater Health