Strategic Plan Progress Report

April 1, 2017 to March 31, 2018

Quality Care Assure the right care, in the right place, at the right time, by the right provider	**Ingrain patient safety**	**Improve access to care**

Goal	Initiative	Indicator
Ingrain patient safety	Implement a Quality and Patient Safety Plan	It is difficult to speak up if I perceive a problem with patient care

Successes

- Completed Quality and Patient Safety Plan
- Embedded "just culture" education into orientation program
- Identified patient safety champions for each program
- Initiated Good Catch Program
- Launched Red Rule – requirement for two patient identifiers
- Developed Integrated Risk Management System
- Increased supervision and security on Mental Health Inpatient Unit specifically in Child and Youth and Residential Withdrawal Management Services areas
- Revised Surgical Safety Checklist – requirement for two signatures
- Implemented bedside reporting in Surgery Program
- Completed monthly hospital-wide Morbidity and Mortality patient case reviews, with department reviews held at least semi annually

Challenges

- Fear of "speaking up"
- Trust in organization
- Influenza vaccination rate
- Limitations of documentation system

Key Priorities for 2018/19

- Readiness for Accreditation Canada Survey – April 2019
- Fall Reduction Strategy
- Illicit drug strategy to improve patient experience, ensure consistent practice and minimize risk (ED, ICU, and medicine)
- Additional strategies to increase influenza vaccination rate

Quality Care Assure the right care, in the right place, at the right time, by the right provider	Ingrain patient safety	Improve access to care

Improve access to care	Improve Emergency Department (ED) wait times	90th percentile length of stay for admitted patients

Successes

- ❑ Reconfigured beds and standardized model of care in Medicine unit, to allow for greater flexibility during surge periods and to accommodate patients with contact precautions
- ❑ Holiday and Influenza “Surge Planning”
- ❑ Dedicated pharmacy technicians in ED to improve quality of medication histories, support outpatients with COPD, and to collaborate closely with community partners
- ❑ Developed and implemented Geriatric Care Pathway in the ED
- ❑ Introduced Nurse Practitioner Role at CEEH site
- ❑ Increased patient access to Cardiac Clinic to ensure timely access to diagnostics and consultation for patients with chest pain and to reduce inpatient admission rates
- ❑ Patient Flow/ALC Avoidance Improvements
- ❑ Mental Health and Addiction Integration in ED to support community resources and access
    - o Addition of Psychiatric Assessment Nurse and greater CMHA after-hours coverage
    - o Improved response for psychiatry consultations in ED
    - o Ongoing engagement and expansion of Child and Youth Collaborative between BWH and St. Clair Child and Youth Services
    - o Implementation of BSharp for all Mental Health and Addictions patients, which includes use of interRAI, a standard assessment systems that better flags risk, and triggers Clinical Assessment Protocols
    - o Child and Youth Mental Health Inpatient Improvement Initiative
- ❑ Exceptional wait time results for many other priority indicators (CT, MRI, Hip/Knee/Cancer Surgeries, lab tests, etc.)

Other Access to Care Improvements

- ❑ Launched Critical Care Outreach Team (ICU and Respiratory Therapy with Intensivist support)
- ❑ Developed and implemented In-House Code Stroke Process
- ❑ Implemented 24/7 access to CT/CTA improving more timely access for endovascular therapy
- ❑ Introduced Iron Infusion Clinic in Dialysis Unit
- ❑ Expanded Palliative Care Services for Dialysis patients to improve quality of life
- ❑ Implemented anterior and SuperPATH hip replacements reducing the length of stay for these procedures
- ❑ Expanded Cancer Care Program with the addition of a second oncologist funded through Cancer Care Ontario

- Established Electroconvulsive Therapy Program
- Introduced Transesophageal echocardiogram services

Challenges

- Limited primary care access
- Appropriate resources and capacity to support specialized marginalized populations i.e. homelessness
- Mental Health & Addictions demand on the ED and patient flow
- Long-Term Care repatriation/admission processes when facilities are in outbreak
- Limited access to Interprofessional Community Based services/Outpatient Rehabilitation
- Limited physician coverage i.e. Rehab or psychiatric support on CCOG unit
- Consistent practices/processes with “Estimated Date of Discharge” (EDD)

Key Priorities for 2018/19

- No One Waits (NOW) initiative to improve time to inpatient bed and align with best practices in bed management/patient flow
    - Improve collaboration between Department of Psychiatry and ED to identify and implement opportunities to discharge patients to the community for follow-up as an alternative to admission to the Mental Health unit
    - Discharge Strategy – including real time reporting from Oculys Stay-Track boards, EDD practices, Patient Oriented Discharge Strategy (PODS)
    - Improve workflow in the ED to decrease left without being seen (LWBS) patients, improve wait times and patient experience, improve triage practices and minimize risk in the waiting room
    - Development of Pharmacist Discharge Facilitator Program to reduce afterhours backlog and ensure medication history is available in a more timely manner
    - Psychiatry Primary Care Collaboration/Outreach to decrease Form 1 and 2 patients presenting from Primary Care to the ED
- Implementation of Mobilization of Vulnerable Elders (MOVE) Program

Outstanding Performance Optimize roles, resources, revenues, technology and innovation	Ensure continuous investment in strategic infrastructure	Demonstrate accountability and efficiency

Goal	Initiative	Indicator
Ensure continuous investment in strategic infrastructure	Implement a sustainable plan for services, facilities, capital equipment and technology	Status of plan

Successes

- Five-year strategic capital plan finalized
- Submission of Stage 1 Parts A and B of the CEEH Capital Redevelopment Plan
- Opening of temporary Residential Withdrawal Management Services beds
- Real-time Location Service (RTLS) commissioned and fully installed

Challenges

- Dealing with end of life on equipment and substandard inpatient facilities at CEEH
- Managing public expectations on capital development projects

Key Priorities for 2018/19

- Continued development at CEEH
- Ongoing planning for permanent Residential Withdrawal Management Services and CEEH Capital Redevelopment Projects
- Ongoing participation in Regional Hospital Information System (HIS) project
- Further expansion of Pharmacy Retail Store
- Redesign and separate Child and Youth Mental Health Physical Space

Outstanding Performance Optimize roles, resources, revenues, technology and innovation	**Ensure continuous investment in strategic infrastructure**	**Demonstrate accountability and efficiency**

Goal	Initiative	Indicator
Demonstrate accountability and efficiency	Increase awareness and understanding of resource decisions	Cost per weighted case

Successes

- 3M Audit to identify weighted case opportunities
- Increased volume of hip and knee replacement surgeries
- Ongoing implementation and adoption of Choosing Wisely initiatives
- Improved collaboration with partners to repatriate ICU patients earlier
- Implementation of Oculys Stay-Track interactive boards on inpatient units
- Deployed Key Performance Indicator Boards across the organization to increase knowledge and align quality/performance indicators with strategic plan
- Successful expansion of Pharmacy Retail Store
- Fully implemented work order system

Challenges

- Decrease in non-elective weighted cases
- Recruitment challenges

Key Priorities for 2018/19

- Introduction of Clinical Documentation Specialist to ensure comprehensive documentation
- Introduction of Hip and Knee Bundled Quality Based Procedures (QBP)- an extension of the existing surgical QBP into a bundled model.
- Expansion of the Clinical Reserve Unit to broader the number of individuals able to work in multiple areas to address sick calls and vacation time
- Development of supply and parts inventory system
- Refinement of scorecard reporting using case costing data
- Optimization of Material Handler Cart to include pricing
- Implementation of MModal – front end voice recognition technology
- Continued focus with Professional Staff to ensure all diagnoses, comorbidities and procedures are documented to capture to accurate weighted case information

Inspired People Advance our culture of kindness with an intention to learn, lead, collaborate and celebrate	Focus on the experience of care and caring	Promote individual, team, and professional development

Goal	Initiative	Indicator
Focus on the experience of care and caring	Strengthen our culture of kindness	Patient: Treated with kindness
		BWH: Is a culture of kindness promoted at BWH?

Successes

- Culture of Kindness Employee Council established, with principles and action plan developed
- Established Well Being Advisory Team with representation from the Healthy Living Team, Culture of Kindness Employee Council and Employee Engagement team, with formalized aims and priorities for each team
- Dedicated focus on Professional Staff Wellness
- Creation of the Workplace Violence Prevention Committee with “No Excuse for Abuse” campaign to begin in June
- Resilience training embedded in leadership training and other workplace education sessions

Challenges

- Complexity of transformational culture change in a 24/7 - 365 environment
- Inspiring staff during surge periods or when staffing resources are stretched

Key Priorities for 2018/19:

- Solidify a Wellbeing Strategy by aligning current practices and expanding support for resilience education and prevention and or management of compassion fatigue
- Planning for ED redesign to improve workflow
- Development of workplace violence prevention metrics and increased staff training in workplace violence prevention
- Development of Staff Duress System with full deployment of staff duress buttons and policies/procedures to support usage
- Creation of action plan from Employee Engagement Results 2018
- Rollout of Kindness Plan

Inspired People Advance our culture of kindness with an intention to learn, lead, collaborate and celebrate	**Focus on the experience of care and caring**	**Promote individual, team, and professional development**

Goal	Initiative	Indicator
Promote individual, team and professional development	Enhance an environment of continuous learning	Supervisor helps access training and development

Successes

- Introduction of Personal Support Workers
- Talent development activities embedded in Human Resource and Organizational Development planning
- Fully implemented Knowledge Management Council, a multi-disciplinary team that shares education plans and collaborates on the organization calendar of development opportunities
- Training opportunities with Schulich School of Medicine & Dentistry for physicians to become Adjunct Professors
- Successful recruitments of new Professional Staff specialists
- Invited community partners to thought leadership and educational events
- 2017 leadership development opportunities
  - 2nd cohort - Leading in the Middle
  - Wave 4 - Innovative Management
  - 3rd program - Board of Governors Certificate Lambton College
  - Leadership Retreats – September 2017 and March 2017

Challenge

- Recruitment demands – high volume areas, specialty positions

Key Priorities for 2018/19:

- Continued development of Succession Planning Model
- Increase number of composite positions and expand Clinical Reserve Unit
- Create fourth development program for individuals expressing interest in future management careers
- Education on the LEADS leadership capabilities framework
- Train midwives to full scope
- Physician Management Institute (PMI) physician leadership educational session
- Partnering with Schulich School of Medicine & Dentistry at Western University to expand training opportunities, for example CCFP- EM (3rd year in Family Medicine – Emergency Medicine training position at Sarnia Emergency Department)

Exceptional Relationships Expand innovative partnerships and collaborations to improve experiences, services, transitions and community health	**Build sustainable partnerships and collaborations**	**Strengthen Patient and Family-Centred Care**

Goal	Initiative	Indicator
Build sustainable partnerships and collaborations	Provide a seamless patient journey across the continuum of care	Alternate level of care (ALC) rate

Successes

- Lambton Health Quality Partners collaborative work focused on care transitions
- Created shared Health Links/Patient Flow Coordinator position between BWH and the Lambton County Lake Huron Health Link
- Implemented Community Paramedic Program
- Enhanced relationships with community partners
  - weekly ALC reviews
  - enhanced discharge plans with Intensive Hospital to Home Program (IHH)
  - review of ALC leading strategies to identify gaps in practice
- Strengthened relations between Pharmacy team and community pharmacies
- Implemented Admission Family Conferences for patients admitted to CCOG unit
- Increased Social Work services dedicated to Mental Health Inpatient and Child and Youth programs
- Strengthened relationships between BWH Medical Affairs and health care providers not affiliated with BWH

Challenges

- Inconsistent messaging to patients/families around transition planning (Home First) when dealing with the myriad community agencies
- Community capacity for patients with behavioural issues
- Housing for marginalized populations

Key Priorities for 2018/19

- Ongoing advocacy with the ESC LHIN for continued support in the Intensive Hospital to Home program
- Lambton Health Quality Partners collaborative projects
- Improved flow of information between BWH and Primary Care Providers
- Improved coordination between Mental Health and Addiction Services to Community

Exceptional Relationships Expand innovative partnerships and collaborations to improve experiences, services, transitions and community health	**Build sustainable partnerships and collaborations**	**Strengthen Patient and Family-Centred Care**

Goal	Initiative	Indicator
Strengthen Patient & Family-Centred Care (PFCC)	Ingrain the four principles of Patient & Family-Centred Care	Overall rating of experience

Successes

- Created Indigenous Patient Navigator position
- Improved Transitions of Care and Discharge Planning
- Implemented Collaborative Model of Care across all units
- Launched paediatric, surgical pre-admit and MIC video tour on BWH website
- Opened Indigenous Birthing Room on Maternal and Infant Care Unit
- Initiated Anxiety and Fears Rounding with Patient Experience Partners (PEPs)
- Participation of PEPs in Skills Day to educate staff on role of PEPs
- Expanded Hospital Elder Life Program (HELP) to CEEH site
- Developed patient watch policy to ensure right level of service for supporting high-risk patients

Challenges

- Timeliness and subjectivity of data obtained through patient experience surveys to drive changes at the point of care

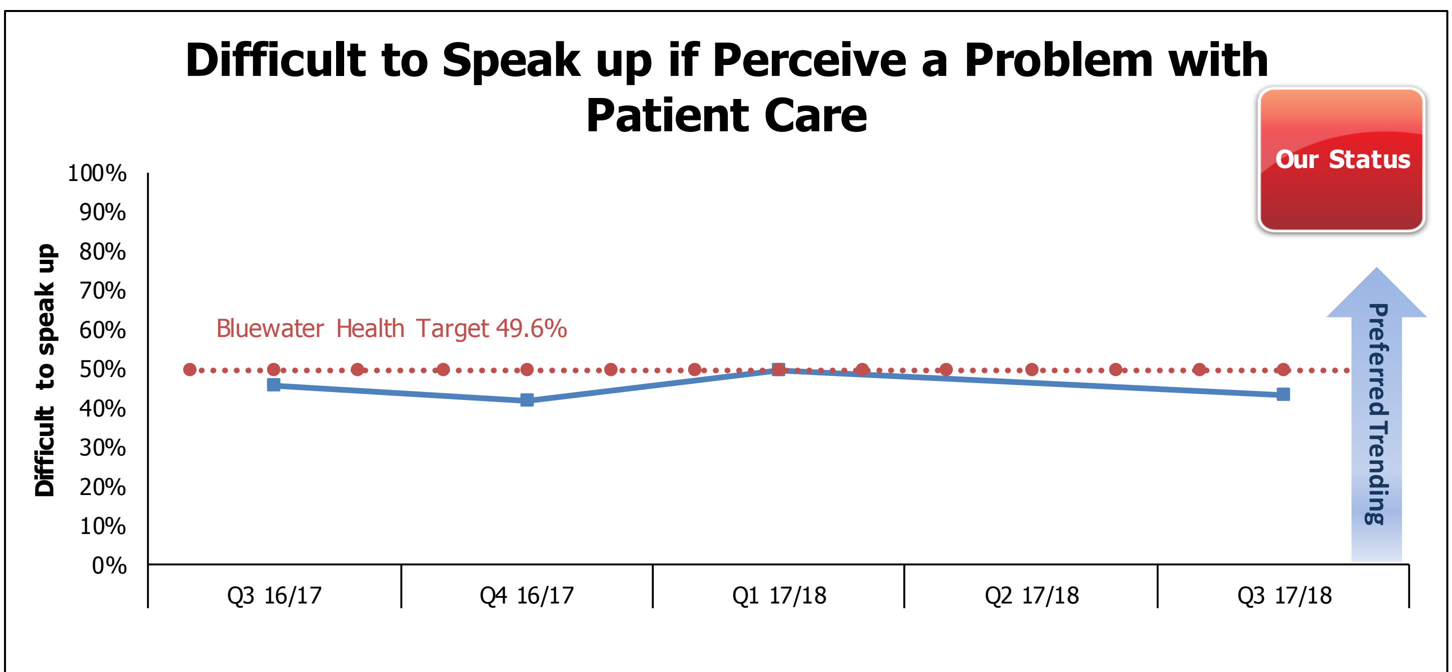
Key Priorities for 2018-19

- Staff education on anxiety and fears for patients
- Introduction of Patient Orientated Discharge Strategy (PODS) to improve communication and the overall experience
- Provision of Palliative Care services at CEEH site

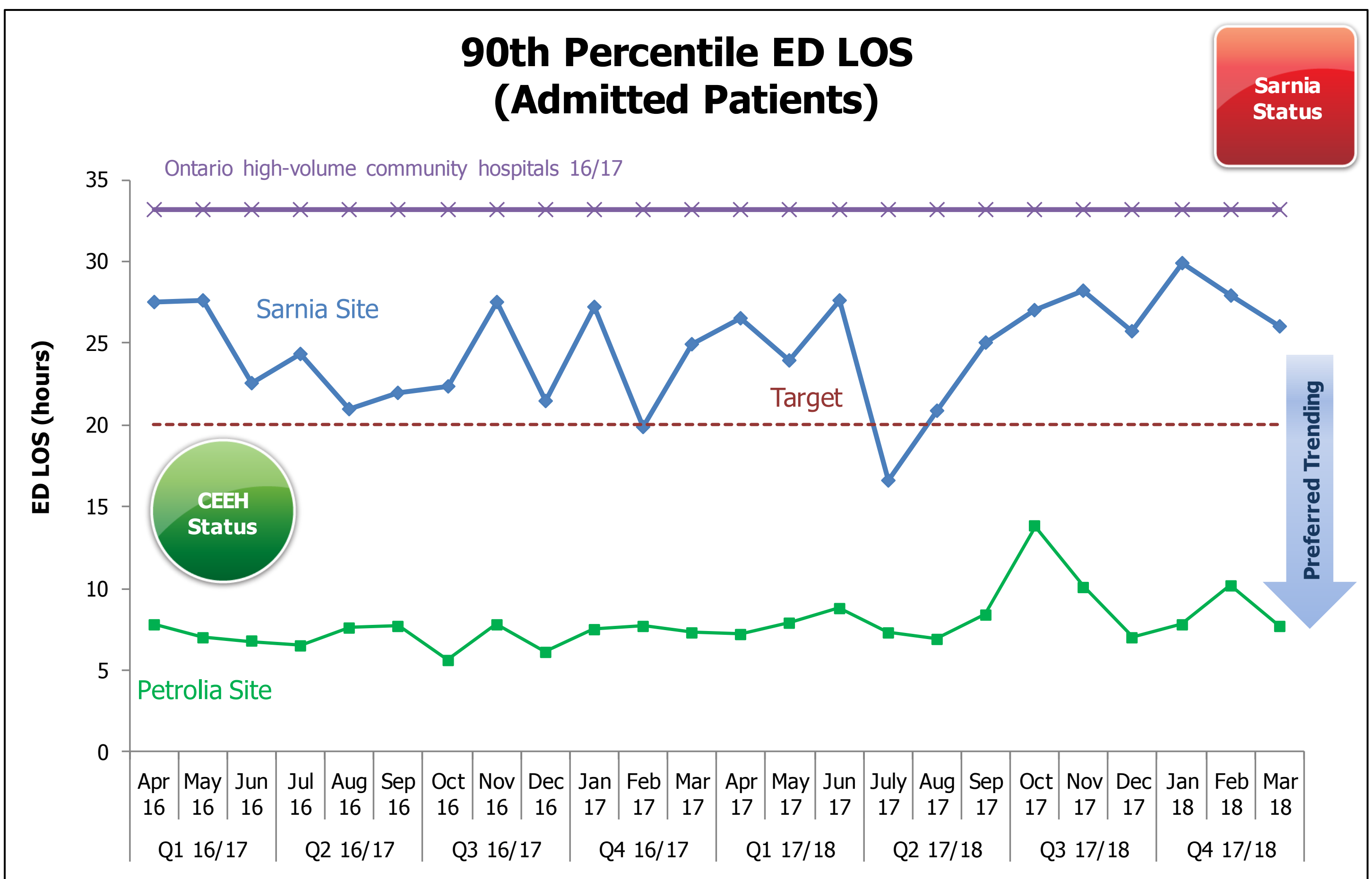
Strategic Plan: Kaleidoscope of Care
Monitoring Tool

Goal	Initiative	Indicator	Performance June 2016	Target Year 1 - 2017	Performance Year 1 - May 2017	Target Year 2 - 2018	Performance Year 2 - March 2018	Target Year 3 - 2019
Quality Care **Assure the right care, in the right place, at the right time, by the right provider**								
Ingrain patient safety	Implement a Quality and Patient Safety Plan	It is difficult to speak up if I perceive a problem with patient care	Collecting Baseline Data	To be determined	Jan - Mar 2017 41.9%	49.6%	April 2017 - Mar 2018 46.9%	50%
Improve access to care	Improve Emergency Department wait times	90th percentile length of stay for admitted patients	22 hours	20 hours	Sarnia - 24.6 hours CEEH - 6.8 hours	Sarnia - <=20 hours CEEH - <= 8 hours	Jan - Dec 2017 Sarnia - 24.9 hours CEEH - 8 hours	Sarnia - <=20 hours CEEH - <= 8 hours
Exceptional Relationships **Expand innovative partnerships and collaborations to improve experiences, services, transitions and community health**								
Build sustainable partnerships & collaborations	Provide a seamless patient journey across the continuum of care	Alternate level of care (ALC) rate	27.40%	25.00%	21.40%	21.00%	April 2017 - Mar 2018 15.00%	17.20%
Strengthen Patient & Family-Centred Care	Ingrain the four principles of Patient & Family-Centred Care	Overall rating of experience	Q2 2016/17 71.10 %	To be determined	Collecting baseline data	ED - 49.1%	Apr 2017 - Mar 2018 ED - 49.7%	ED - 50.6%
						Inpt - 75.9%	Apr 2017 - Mar 2018 Inpt. 68.6%	Inpt. 72.0%
Inspired People **Advance our culture of kindness with an intention to learn, lead, collaborate and celebrate**								
Promote individual, team and professional development	Enhance an environment of continuous learning	Supervisor helps access training and development	63.30%	65.30%	December 2016 66.3%	67.30%	Apr 2017 to Mar 2018 69.4%	NA
		NEW INDICATOR- The organization promotes staff health and wellness.	49.40%				51.60%	55.7%
Focus on the experience of care and caring	Strengthen our culture of kindness	Patient: Treated with kindness	Q2 2016/17 66.7%	To be determined	April - Sept. 2016 76.8%	ED - 64.5%	Apr 2017 to Mar 2018 ED - 66.8%	68.6%
						Inpt - 80.4%	Apr 2017 to Mar 2018 Inpt - 78.2%	81.4%
		BWH: Is a culture of kindness promoted at BWH?	Employees -61.9% Prof Staff -56.1% Volunteers -80.1%	Employees -63.9% Prof Staff -58.1 Volunteers -82.1%	December 2016 Employees -58.9% Prof Staff -56.1% Volunteers -88.6%	Employees -65.9% Prof Staff -60.1% Volunteers - 84.1%	Apr 2017 - Mar 2018 Employees - 69.9% Prof Staff - 69.1%	Employees - 71.9% Prof Staff - 71.1%
Outstanding Performance **Optimize roles, resources, revenues, technology and innovation**								
Demonstrate accountability and efficiency	Increase awareness and understanding of resource decisions	Cost per weighted case	2015/16 Q3 $5,537	$5,361	2016/17 Q3 $5,669	$5,366	Apr 2017 - Mar 2018 $5,788	$5,800
Ensure continuous investment in strategic infrastructure	Implement a sustainable plan for services, facilities, capital equipment and technology	Status of plan - Yr 1	No plan	Plan Developed	Under development	Plan Updated	Plan Updated	Plan Updated

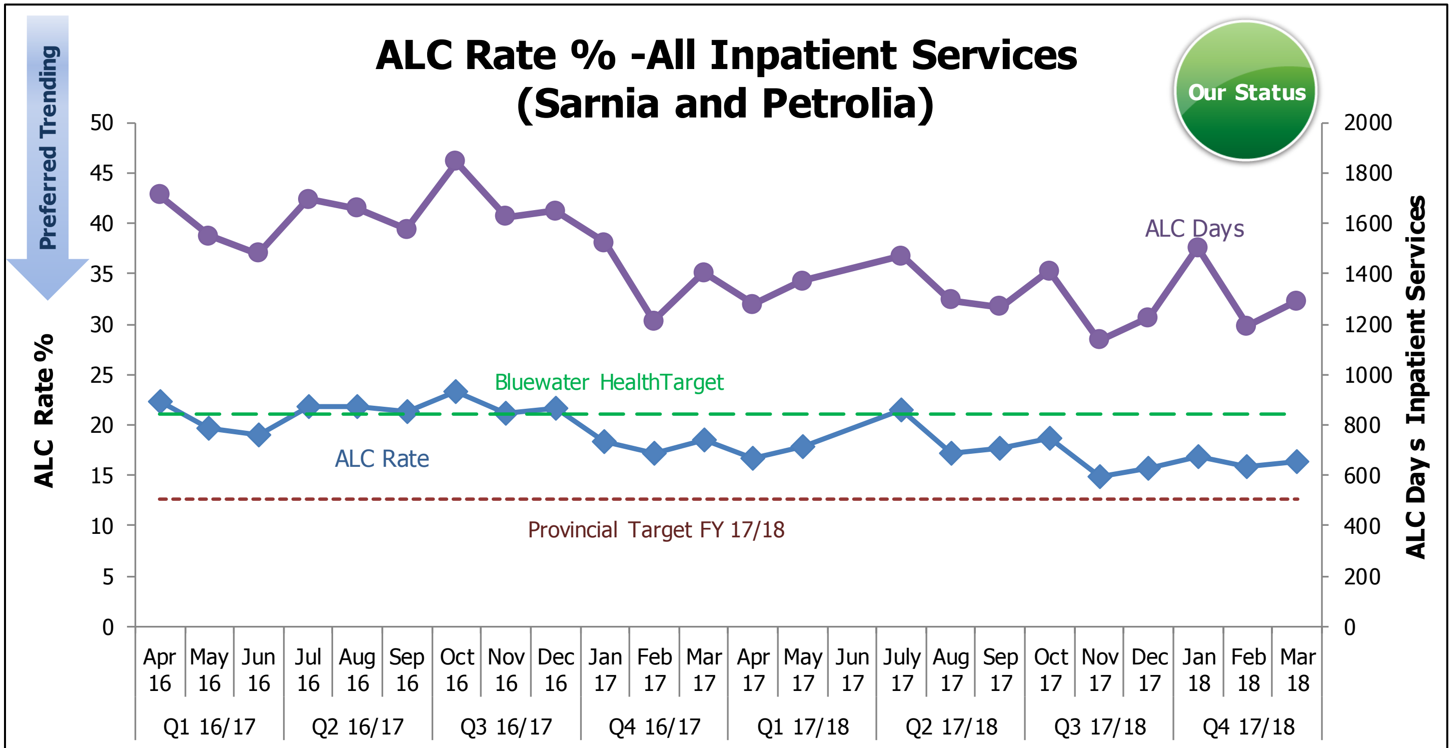
Indicator Name:	It is difficult to speak up if perceive a problem with patient care
Alignment:	Quality and Patient Experience Committee (QPEC)/Quality Committee of the Board (QCB)
Strategic Goal:	Ingrain Patient Safety
Definition:	This is a custom employee survey question that asks employees to respond to the statement "in this unit it is difficult to speak up if I perceive a problem with patient care". The top box responses request respondents to "strongly disagree" and "disagree" with the proposed statement. A higher percentage of employees disagreeing or strongly disagreeing with this statement is preferred.
Rationale:	"It is difficult to speak up if I perceive a problem with patient care" is a measure that comes from a reliable and valid survey through patient safety research. To ensure we can track and measure this indicator we will assess a baseline and target by sending staff surveys thorough a Survey Monkey process. This indicator is a measure indicative of patient safety culture throughout the organization and will identify how safe the inter-professional team feels to report patient safety incidents. The development, dissemination, education and implementation of a Quality and Patient Safety Plan will enable a culture of safety by enhancing knowledge transfer of the importance of reporting patient safety incidents to improve quality and safety of the patients we serve.
Additional Specifications:	This indicator was released in December 2016. Responses to this question are collected routinely in a Strategic Engagement survey.
Target for 17/18:	49.6%



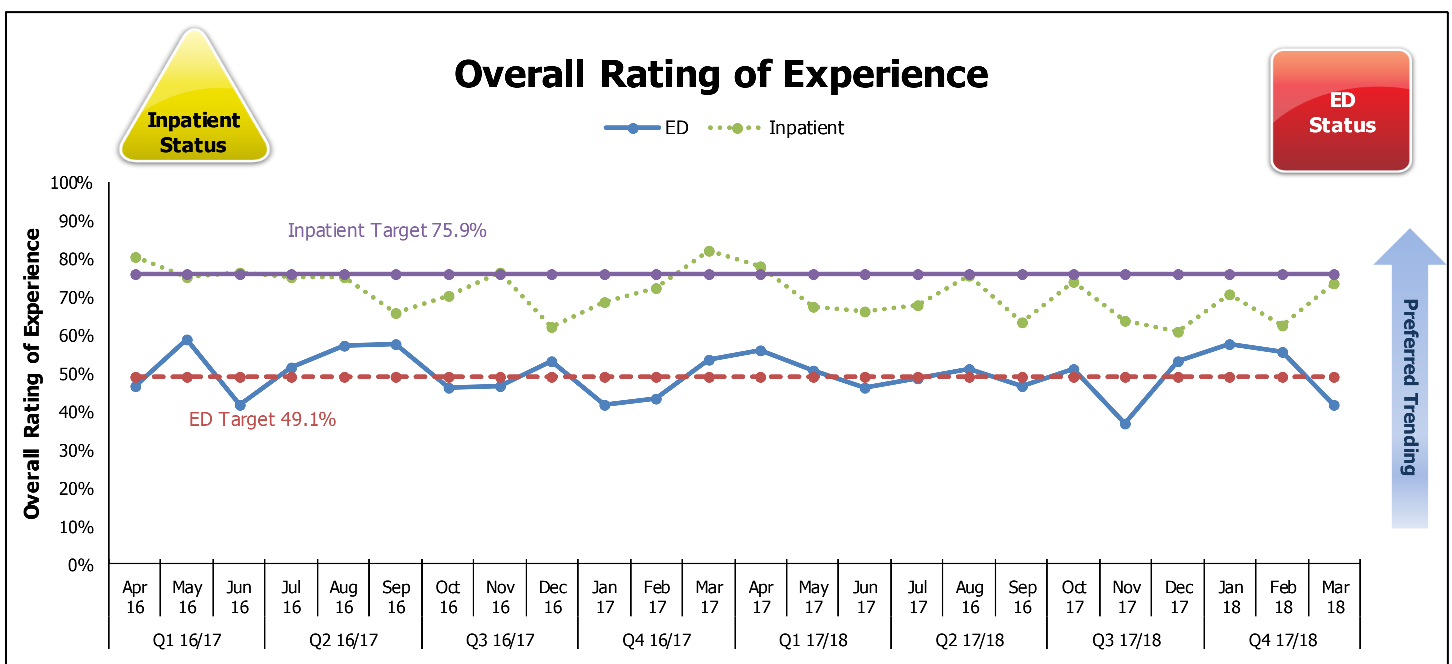
Indicator Name:	90th Percentile Emergency Department Length of Stay (LOS) for Admitted Patients
Alignment:	Performance & Utilization Committee (PUC)/Resource Utilization & Audit Committee (RUAC)
Strategic Goal:	Improve access to care
Definition:	ED length of stay for admitted visits is defined as the time from triage or registration, whichever comes first, to the time the patient leaves the ED to an inpatient bed. It is measured in hours. The 90th percentile is the maximum length of time in which 9 of 10 of admitted patients have completed their ED visit and have been moved to an inpatient unit. A small number is desirable.
Rationale:	Time is crucial to the effectiveness and outcome of patient care, especially for emergency patients. In conjunction with other indicators, this can be used to monitor the total length of time admitted patients spend in the ED in an effort to improve the efficiency and, ultimately, the outcome of patient care. This measure remains one of Bluewater Health's top priorities in our Quality Improvement Plan (QIP) and Strategic Plan.
Additional Specifications:	**Inclusions:** 1. Admitted unscheduled emergency visits 2. ED visits with a valid and known registration date/time or triage date/time and a valid and known date/time the patient left the ED **Exclusions:** 1. Scheduled emergency visits 2. Non-admitted unscheduled emergency visits 3. Visits with both unknown/invalid registration and triage date/time OR with unknown/invalid patient left ED date/time
Peer Comparator:	Ontario high-volume community hospitals, Sarnia Site only



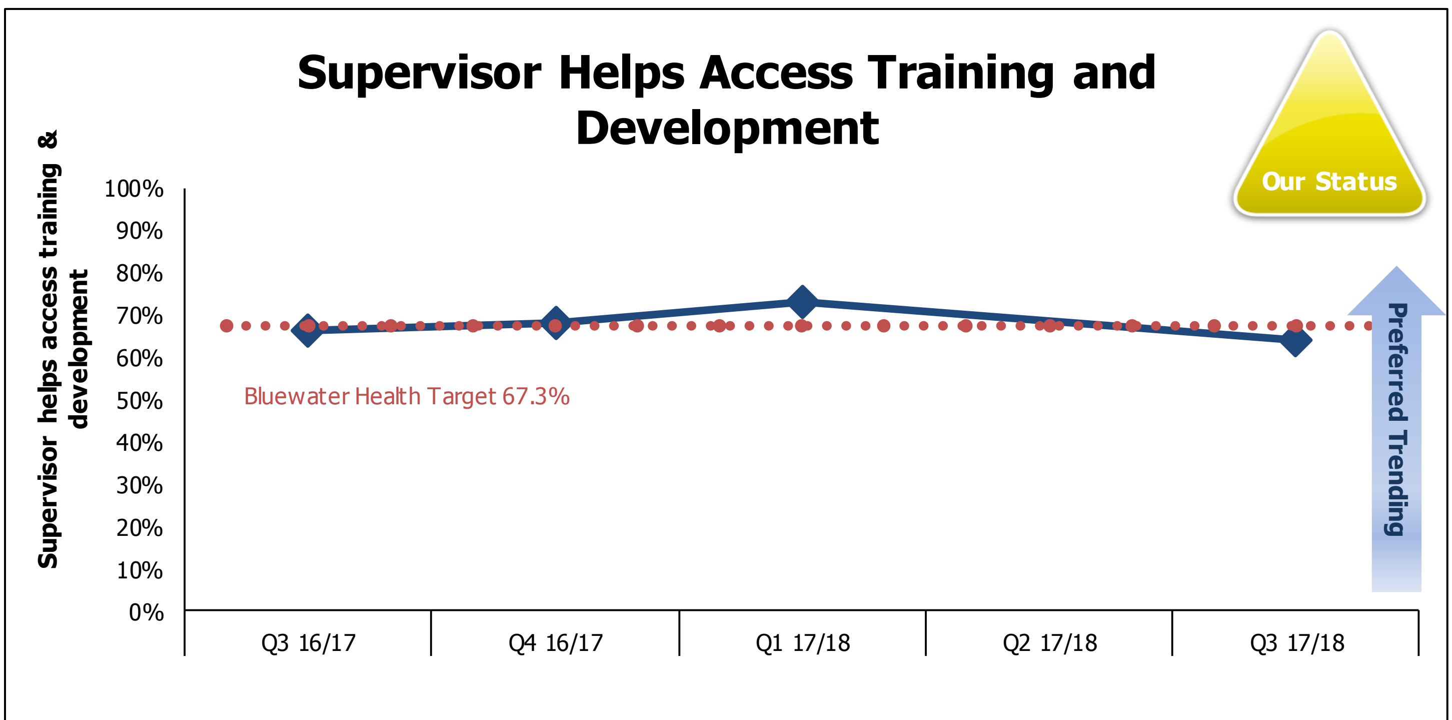
Indicator Name:	Alternate Level of Care (ALC) Rate %-All Inpatient Services
Alignment:	Quality and Patient Experience Committee (QPEC), Quality Committee of the Board (QCB), Performance & Utilization Committee (PUC), Resource Utilization & Audit Committee (RUAC)
Strategic Goal:	Build sustainable partnerships and collaborations
Definition:	The rate at which patients who have been designated ALC occupy inpatient beds.
Rationale:	Ensuring that each patient receives the appropriate level of care at all times during their healthcare journey is a priority at Bluewater Health. Our goal is for Emily to receive the right care, given at the right time, in the right place, always. The ALC rate represents an opportunity for inpatients to be transitioned to the next level of care, where their care needs and the services provided are better matched. Multiple factors can influence ALC rate, including overall hospital occupancy, and availability of resources both internal and external to the hospital.
Additional Specifications:	$\text{ALC Rate} = \frac{\text{Total number of ALC Days in a given period}}{\text{Total number of inpatient days in the same time period}} \times 100\%$
Peer Comparator:	Ontario hospital value



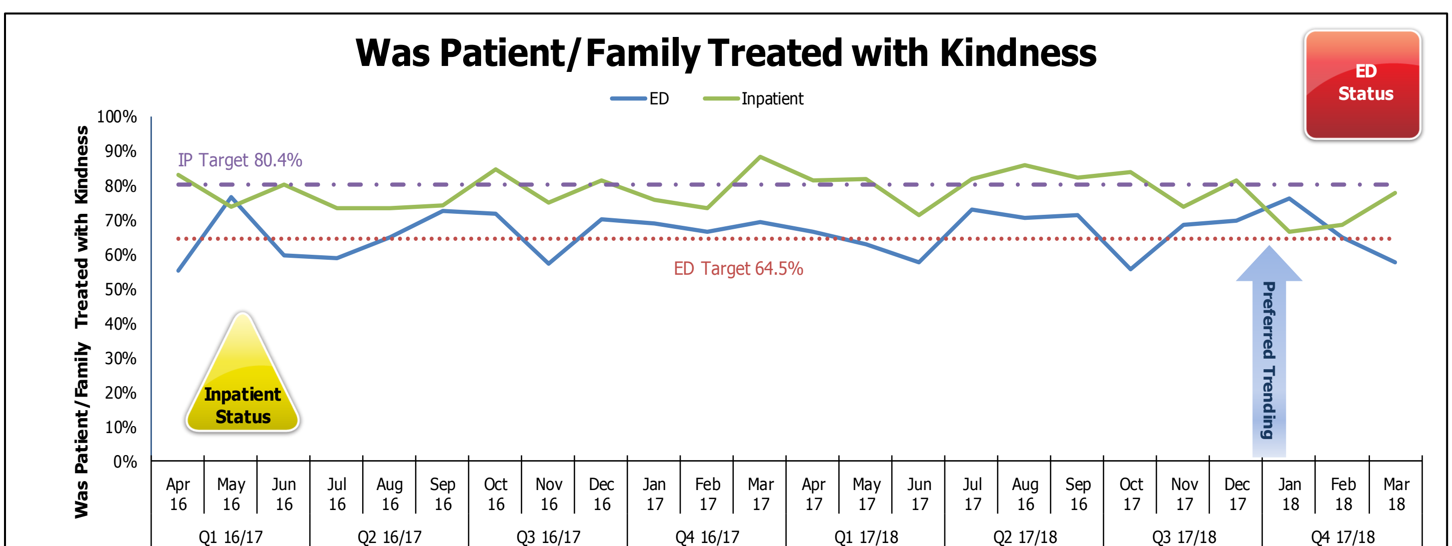
Indicator Name:	Overall Rating of Experience
Alignment:	Quality and Patient Experience Committee (QPEC)/Quality Committee of the Board (QCB)
Strategic Goal:	Strengthen Patient and Family-Centered Care
Definition:	Overall Rating of Experience: Inpatient (IP) and Emergency Department (ED), patients are asked to rate their hospital experience on a scale from 0 to 10, with 0 being I had very poor experience and 10 being I had a very good experience.
Rationale:	Patient experience measurement is an industry best practice and hospitals are required to survey patients at least once every fiscal year, according to Ontario's *Excellent Care for All Act* (ECFAA), 2010. "We create exemplary healthcare experiences with patients and families every time", is the mission of Bluewater Health. These questions reflect how well the hospital is achieving its overall mission. The patient experience is what we strive to excel at. Measurement of patient experience is important because it provides an opportunity to improve care, enhance strategic decision making, meet patients' expectations, effectively manage and monitor healthcare performance, and document benchmarks for the organization.
Additional Specifications:	Scores are calculated using the following measure recommended by the National Research Corporation Canada (NRCC): Positive - Positive measure type is calculated by counting "Positive" response (i.e., 9-10 or Yes, Definitely or Always) and dividing by the total number of responses. **Inclusion Criteria:** – Patients who have received active treatment at Bluewater Health – 18 years or older at the time of admission – Alive at the time of discharge **Exclusion Criteria:** – Patients who have notified Bluewater Health they wish to be excluded from the mailing list – Patients who are stillborn or deceased while in the hospital – Patients with no fixed address – Psychiatric patients (unless being specifically surveyed using the Mental Health inpatient or outpatient survey tool) – Patients who present with evidence of sexual assault or with sensitive issues (e.g., miscarriage)
Peer Comparator:	The Ontario Hospital Association Patient Reported Performance Management (OHA PRPM) benchmark includes OHA member hospitals. The Ontario Inpatient (IP) Community Hospital (Hosp) Average compares hospitals of the same size within the province. Peer comparators are updated quarterly. **Inpatient** OHA-PRPM – 68.2% Ontario IP Community Hosp Average – 65.0% **Emergency Department** (ED) There is no peer comparator as this is a Bluewater Health custom question for the Emergency Department Patient Experience of Care Survey (EDPEC)
Target for 2017/2018:	ED - 49.1% Inpatient – 75.9%



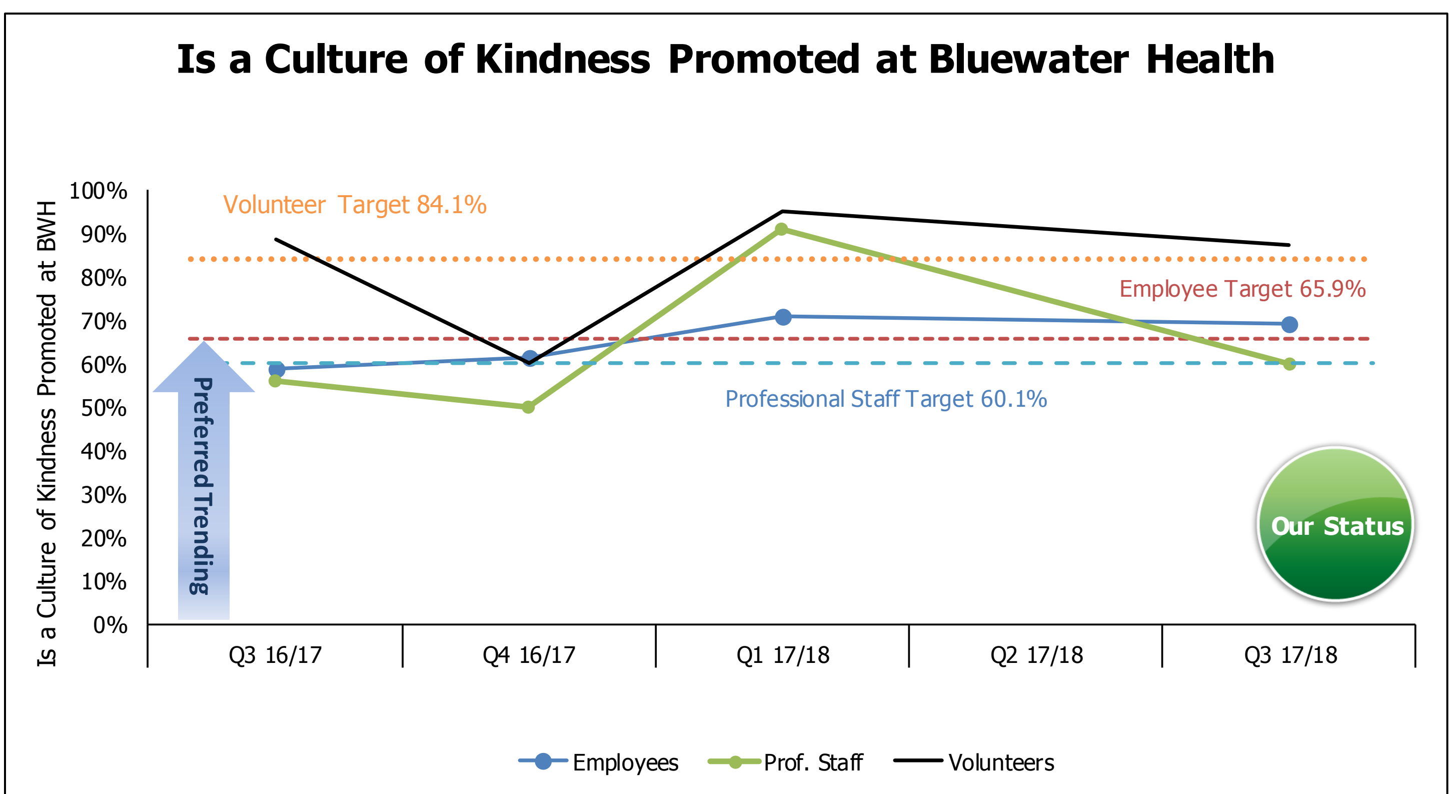
Indicator Name:	Supervisor helps access training and development
Alignment:	Quality and Patient Experience Committee (QPEC)/Quality Committee of the Board (QCB)
Strategic Goal:	Focus on the experience of care and caring
Definition:	This is a custom employee survey question that will ask "My Supervisor helps me to access training and development?" The top box responses request respondents to "Agree" and "Strongly Agree" with the proposed statement. A higher percentage of employees agreeing or strongly agreeing with this statement is preferred.
Rationale:	Ensuring that each patient receives the best care possible begins with exceptional care providers. Bluewater Health is committed to strengthening the skills and education of our employees. This commitment to education promotes inspired people who will advance our culture of kindness with an intention to learn, lead, collaborate and celebrate. Evidence suggests that investment in employee training and development leads to employees feeling more valued and willing and able to invest in their work. Employee training and development supports efficiencies and standardized procedures, risk reduction, patient safety and quality of patient care. Research links high levels of employee engagement with increased patient satisfaction when an organization focuses on processes and people. This reflects on the organization's ability to provide opportunities for personal development to stay up to date with latest techniques and technologies and recognize employees for acquiring additional skills and knowledge sets.
Additional Specifications:	This indicator was released in December 2016. Responses to this question are collected routinely in a Strategic Engagement survey.
Target for 2017/2018:	67.3%



Indicator Name:	Was Patient/Family Treated with Kindness
Alignment:	Quality and Patient Experience Committee (QPEC)/Quality Committee of the Board (QCB)
Strategic Goal:	Focus on the experience of care and caring
Definition:	This is a new, custom question for Bluewater Health's patient experience surveys which are mailed to a random selection of patients after they are discharged. Our aim is that the culture of kindness at Bluewater Health will be increasingly felt by our patients and families over time. This question asks Emily to reflect and respond to the statement "Were you and your family treated with kindness by employees, volunteers and physicians at Bluewater Health?" Responses available for this question are as follows: No/ Yes, somewhat/ Yes, mostly/ Yes definitely
Rationale:	Exemplary healthcare experiences begin with kindness. We understand that patients expect courtesy, respect and dignity, beginning with an expression and attitude of kindness and caring. We understand that having highly skilled and competent staff isn't enough. Ensuring that you and your family are treated with kindness is a key focus of Bluewater Health's commitment to Patient & Family-Centered Care. Patient experience measurement is an industry best practice and hospitals are required to survey patients at least once every fiscal year, according to Ontario's *Excellent Care for All Act* (ECFAA), 2010.
Additional Specifications:	Scores are calculated using the following measure recommended by the National Research Corporation Canada (NRCC): Positive - Positive measure type is calculated by counting "Positive" response (i.e., 9-10 or Yes, Definitely or Always) and dividing by the total number of responses. **Inclusion Criteria:** – Patients who have received active treatment at Bluewater Health **Exclusion Criteria:** – Patients who have notified Bluewater Health they wish to be excluded from the mailing list – Patients who are stillborn or deceased while in the hospital – Patients with no fixed address – Psychiatric patients (unless being specifically surveyed using the Mental Health inpatient or outpatient survey tool) – Patients who present with evidence of sexual assault or with sensitive issues (e.g., miscarriage)
Peer Comparator:	This is a Bluewater Health custom question and no peer comparator data is available. NRC Health establishes benchmarks/peer comparators based on the following requirements: - Made up of one year of data - Questions must be used by at least five facilities Must have at least 1000 responses for the question
Target for 2017/18:	ED - 64.5% Inpatient - 80.4%



Indicator Name:	Is a Culture of Kindness Promoted at Bluewater Health
Alignment:	Quality and Patient Experience Committee (QPEC)/Quality Committee of the Board (QCB)
Strategic Goal:	Focus on the experience of care and caring
Definition:	This is a custom survey question that will ask "Is a culture of kindness promoted at BWH?" Top Box responses from Employees, Professional Staff and Volunteers are displayed. The top box responses request respondents to "Agree" and "Strongly Agree" with the proposed statement. A higher percentage of employees agreeing or strongly agreeing with this statement is preferred.
Rationale:	Bluewater health is committed to strengthening our culture of kindness while we deliver Quality Care to Emily. Creating a kindness culture in the workplace reduces stress, fosters relationships, increases psychological wellness and health and leads to increased engagement, energy and resiliency at work. Evidence suggests that high engagement influences human resource goals of increased retention and recruitment, high job performance and lower absenteeism. Research links high levels of employee engagement with increased patient satisfaction when an organization focuses on processes and people. Caring for people creates a workforce with physical energy, mental focus and the emotional drive necessary to provide exemplary care to Emily every day. The culture of kindness has been measured in the "joy" people bring to work; it is palpable throughout the organization and referred to as measuring "humanity".
Additional Specifications:	This indicator was released in December 2016. Responses to this question are collected routinely in a Strategic Engagement survey.
Target for 2017/2018:	Employees – 65.9% Professional Staff - 60.1% Volunteers - 84.1%



Indicator Name:	Acute Cost per Weighted Case
Alignment:	Resource Utilization and Audit Committee (RUAC)/Performance Utilization Committee (PUC)
Strategic Goal:	Demonstrate accountability and efficiency
Definition:	Acute Cost per Weighted Case is an indicator that measures the cost associated with caring for a standard acute patient. It is calculated as total acute inpatient and newborn expenses (both direct and indirect) divided by acute inpatient weighted cases. The direct costs are the expenses incurred in the departments providing service to our acute patients (e.g., Medicine, Surgery, and Obstetrics). The indirect costs are an allocation of Administration and Support expenses (e.g., Housekeeping, Lab, Pharmacy, etc.). A weighted case is a case with an assigned Resource Intensity Weight (RIW).
Rationale:	This is an important indicator as it tracks how an organization is utilizing its resources. It combines the financial spending with the activity that drives the spending. By focusing on weighted cases, comparability is enhanced as differences in acuity, severity and complexity of cases are taken into consideration.
Additional Specifications:	
Peer Comparator:	No established peer comparator data