

Excellent Care
For All.



2011-12

Quality Improvement Plan

(Short Form)



Bridgpoint Health

April 1, 2011

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 the OHQC in the format described herein.

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Part A:

Overview of Our Hospital's Quality Improvement Plan

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

Bridgepoint places the highest priority on patient safety and the quality of care and services it delivers for patients with complex, chronic illness and disability. To facilitate quality and safety improvements at the system level, Bridgepoint's Executive Council and Board of Directors have embraced a framework that includes the four dimensions of quality: safety, effectiveness, access and patient satisfaction. We have also selected two system-level aims for quality improvement: a) Eliminate preventable harm associated with falls and hospital-acquired infections (MRSA and VRE); b) achieve 100% safe, effective and timely patient flow and transitions. These system-level aims are at the core of and inform our quality agenda from now until 2013.

Our 'Safety First' strategy is strongly represented in this year's Quality Improvement Plan. Implementing the change ideas and achieving the targets for 2011-2012 means that we will have successfully implemented a number of strategies that are linked to achieving our aim of eliminating preventable harm and being responsive to the needs of patients waiting for our services; at the same time ensure patient are satisfied with the information they receive when leaving Bridgepoint to help them continue their recovery at home.

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

By March 31, 2012, we will be closer to achieving the system-level aim of eliminating preventable harm caused by hospital acquired infections and falls with serious injury or death, by:

- Increasing our staff's hand hygiene compliance rates before patient contact from 76% to 84%
- Screening 100% of patient who have received an antibiotic for Vancomycin-Resistant Enterococci (VRE) on one pilot unit and evaluating the results
- Screening 100% of long stay patients for Methicillin-resistant Staphylococcus aureus (MRSA) on one unit and evaluating the results
- 90% compliance with use of screening tools and treatment plans for C-Difficile on pilot unit
- Developing and implementing two antibiotic usage guidelines
- Completing a fall risk assessment on 90% of all patients within 8 hours of being admitted to Bridgepoint

From April 2011 to March 2012, we will focus resources on the following change ideas that are linked to achieving the system-level aim of eliminating preventable harm caused by hospital acquired infections and falls with serious injury or death:

- Completing a gap analysis between current infection Control practices and the Provincial Infectious Diseases Advisory (PIDAC) Committee and develop and align resources to address identified gaps
- Dedicating physician and pharmacy resources to develop an Antibiotic Stewardship program for Bridgepoint Health
- Develop and implement a screening tool based on Provincial Infectious Disease Advisory Committee (PIDAC) guidelines for the early detection and treatment of C-Difficile Infection (CDI) on one pilot unit
- Measuring and monitoring compliance with the Falls Prevention Program through a post-implementation evaluation and sustainability plan supported by a dedicated project lead

By March 31, 2012, we will be closer to achieving the system-level aim of 100% safe, effective and timely transitions, by:

- Assessing 100% of patients for the home first program prior to submitting an application for Long-term Care.
- Improving patient satisfaction by 5 to 10 percentage points with the level of information their receive about their medications and what problems to look for when they are discharged from hospital

*From April 2011 to March 2012, we will focus resources on achieving the following change ideas linked to achieving **our strategic goal of 100% safe, effective and timely transition**:*

- Completing year 1 of a multi-year patient flow and transitions project supported by a dedicated project lead
- Integrating and more closely aligning orthopaedic rehabilitation and activation programs to enable smooth transitions for patients and to optimize bed occupancy
- Working with the Toronto Central CCAC to fully implement the 'Home First' Program across all inpatient units for eligible patients
- Targeting strategies aimed at improving patient satisfaction with the discharge process; specifically what to expect when they go home, how to take their medications safely, and the level of activities and exercise they can do at home.

3. How the plan aligns with the other planning processes

- The system-level aims were developed following involvement with The Centre for Healthcare Quality Improvement (CHQI) Leadership for Performance Excellence program and through a Strategic Planning process
- Bridgepoint Health has embarked on a bold new research initiative through the funding of research and the development of a Collaboratory for Research and Innovation. Results from its inaugural research will contribute to future Bridgepoint Quality Improvement Plans.
- The plan aligns with the Hospital Service Accountability Agreement and includes key measures such as Total Margin and the percentage of Alternate Level of Care (ALC) days
- Specific targets and strategies to address the percentage ALC target have been identified through collaboration with the Toronto Central CCAC and the development of a joint operating plan with shared objectives, deliverables and performance targets e.g.: Home First. It is also in line with the MOHLTC ED/ALC strategy
- Access and patient flow initiatives are also linked to Stroke and Musculoskeletal best practice LHIN initiatives.
- The plan also identifies the planned partnership with St. Michael's Hospital to conduct a CDI prevalence study to understand the rate of C-Diff colonization in the patient population admitted to a CCC & Rehab hospital
- The change ideas related to eliminating falls with serious injury or death are based on Accreditation Canada's Required Organizational Practice for Falls Prevention and is adapted from the Registered Nurses Association of Ontario's (RNAO) Best Practice Guidelines for Falls Prevention
- A significant part of achieving the quality and patient safety strategy is the transition planning process for the new Bridgepoint Hospital

4. Challenges, risks and mitigation strategies

Bridgepoint is undergoing a significant transformation in relation to our clinical model of care, academic and research agendas as well as building a new hospital. We have an aggressive 18 month transition plan with very concrete timelines and this is therefore a major focus for Bridgepoint's leadership team. As with other CCC and Rehab hospitals we are dependant on building and sustaining collaboration and partnerships with our acute care partners and the Toronto Central CCAC in order for us to achieve our ALC and patient days targets.

In order to address the above challenges the Quality Improvement Plan has been closely linked with our hospital operating plan and built into the corporate objectives with clear alignment and accountabilities identified for each leader through their individual leadership plans and executive compensation plans. Progress in achieving the performance goals will be regularly monitored by the Quality, Safety and Professional Affairs committee and reported to the Quality, Safety and Service Committee of the Board.

In 2011/12 the Executive team will dedicate specific resources to achieving the quality and safety strategy. We are also making strategic investments in building capabilities in quality improvement and performance measurement. In addition each priority 1 project will have a comprehensive project plan and will be supported by dedicated project management and executive sponsorship.

PART B: Improvement Targets and Initiatives



Bridgepoint Health 14 St. Matthews Road, Toronto, ON, M4M 2B5

AIM		MEASURE				CHANGE				
Quality dimension	Objective	Outcome Measure/Indicator	Current performance	Performance goal 2011/12	Priority	Improvement initiative	Methods and results tracking	Target for 2011/12	Target justification	Comments
	Eliminate Hospital-Acquired Infections	VRE Colonization (cases): Nosocomial infections in hospitalized patients in whom the infection was not present or incubating at the time of admission. (Nosocomial cases Jan 2010 - Dec 2010)	6	3	1	1) Conduct a gap analysis between current practice and WHO's "Just Clean your hands" tool kit and implement change ideas to address identified gaps	Hand Hygiene audits conducted on all inpatient units. Data is collected daily and reported regularly to the unit.	84% hand hygiene compliance rate before patient contact.	Currently above provincial average of 66%. Performance goal for 2011/12 is 50% of the goal to reach a 90% compliance rate	Process measures linked to achieving the strategic aim of eliminating Hospital Acquired Infections (MRSA/ VRE) and C-Difficile)
						2) Conduct a gap analysis between current infection control practices and the Provincial Infectious Disease Advisory Committee (PIDAC) best practice guidelines and implement change ideas to address identified gaps	% of project milestones completed and identify appropriate process measures once the gaps have been identified.	*	*A high level of compliance (85-100%) with a process measure is required in order to affect the outcome	
						3) Implement VRE screening in all patients post antibiotic use on selected pilot unit.	Infection Control Practitioner alerts through line list process to screen post Antibiotic usage	90% of patients will be screened for VRE post antibiotic use on pilot unit & new cases placed on contact precautions.	A high level of compliance with a process measure is required in order to affect the outcome	Strategies are linked to achieving the strategic aim of eliminating preventable harm by 2012/13 (hospital-acquired infections and falls)
		MRSA Colonization (cases): Nosocomial infections in a hospitalized patients in whom the infection was not present or incubating at the time of admission. (Nosocomial cases Jan 2010 - Dec 2010)	20	12	1	4) Implement a pilot (7 East) of an enhanced MRSA screening program to include screening patients every 30 days (4 rounds of screening) and analyze results to inform future protocol development and appropriate treatment for new cases.	% patients on target unit (7East) screened every 30 days for 4 months & placed on appropriate precautions.	100% patients on 7 East screened & new cases placed on appropriate IC Precautions.	A high level of compliance with a process measure is required in order to affect the outcome	
Safety	Avoid Falls	Falls resulting in significant harm / injury or death: Number of patient who fell who sustained significant harm / injury or who died as a result of a fall. (Total number of cases FY2010-11)	3	0	1	1) Monitor and evaluate compliance with Falls Prevention strategies through the post-implementation sustainability plan	% patients who have a Fall Risk Assessment within 8 hours of admission and are placed on appropriate interprofessional plan of care for falls risk reduction.	90%	A high level of compliance with a process measure is required in order to affect the outcome	Strategies are linked to achieving the strategic aim of eliminating preventable harm by 2012/13 (hospital-acquired infections and falls)
		Falls: percentage of complex continuing care residents who fell in the last 30 days (average from last 4 quarter data)	Not a focus at this time							
	Reduce clostridium difficile associated diseases (CDI)	C- Difficile Infection related significant harm / injury or death: The number of patients who required acute care hospitalization or surgical procedures (ie., Colectomy) or the death of a patient within 30 days of a hospital-acquired infection of CDI. (Confirmed by a panel within 48 hours of event).	1	0	2	1) Develop and implement a screening tool based on PIDAC guidelines for the early detection and treatment of CDI on one pilot unit to increase awareness of C-difficile diarrhea risk factors	% of admitted patients who are screened for C-Difficile risk factors and who are placed on an appropriate treatment plan	90% compliance with the use of screening tool and treatment plan on pilot unit	A high level of compliance with a process measure is required in order to affect the outcome	Reduce delays in the diagnosis and treatment of C-Difficile Infection. The early detection of cases with C. difficile diarrhea is vital in preventing hospital outbreaks
						2) Develop an Antibiotic Stewardship program for Bridgepoint Health	Antibiotic guidelines developed	2 Antibiotic guidelines developed	This is a reasonable target for 2011/12 give all other priorities for medication management	Antibiotic Stewardship program is a collaboration between physicians and pharmacists.

AIM		MEASURE				CHANGE				
Quality dimension	Objective	Outcome Measure/Indicator	Current performance	Performance goal 2011/12	Priority	Improvement initiative	Methods and results tracking	Target for 2011/12	Target justification	Comments
	Reduce incidence of Ventilator Associated Pneumonia (VAP)	VAP rate per 1,000 ventilator days: the total number of newly diagnosed VAP cases in the ICU after at least 48 hours of mechanical ventilation, divided by the number of ventilator days in that reporting period, multiplied by 1,000 - Average for Jan-Dec. 2010, consistent with publicly reportable patient safety data	Not Applicable							
	Improve provider hand hygiene compliance	Hand hygiene compliance before patient contact: The number of times that hand hygiene was performed before initial patient contact divided by the number of observed hand hygiene indications for before initial patient contact multiplied by 100 - 2009/10, consistent with publicly reportable patient safety data	Process measure for avoiding hospital-acquired infections							
	Reduce rate of central line blood stream infections	Rate of central line blood stream infections per 1,000 central line days: total number of newly diagnosed CLI cases in the ICU after at least 48 hours of being placed on a central line, divided by the number of central line days in that reporting period, multiplied by 1,000 - Average for Jan-Dec. 2010, consistent with publicly reportable patient safety data	Not Applicable							
	Avoid new pressure ulcers	Pressure Ulcers: Percent of complex continuing care residents with new pressure ulcer in the last three months (stage 2 or higher) - FY 2009/10, CCRS	Not a focus at this time							
Effectiveness	Improve organizational financial health	Total Margin (consolidated): Percent by which total corporate (consolidated) revenues exceed or fall short of total corporate (consolidated) expense, excluding the impact of facility amortization, in a given year. Q3 2010/11, OHRS	0.57	0	2	1) Reduction of 3.0 FTE (11/12 Budget initiative) 2) Efficiency reviews / process improvement initiatives 3) Revenue optimization strategies	Monthly variance analysis of actual to budget Process indicators will be identified subsequent to identification of improvement initiatives	To be confirmed in 2011/12 HSAA .		H-SAA agreement for FY11-12 is currently being negotiated with the Toronto Central LHIN and the MOHLTC
	Reduce unnecessary deaths in hospitals	HSMR: number of observed deaths/number of expected deaths x 100 - FY 2009/10, CIHI	Not Applicable							
	Reduce unnecessary hospital readmission	Readmission within 30 days for selected CMGs to any facility: The number of patients with specified CMGs readmitted to any facility for non-elective inpatient care within 30 days of discharge, compared to the number of expected non-elective readmissions - Q1 2010/11, DAD, CIHI	Not Applicable							
Access	Reduce unnecessary time spent in CCC and Rehabilitation	Percentage ALC days: Total number of inpatient days designated as ALC, divided by the total number of inpatient days per quarter. (2011 YTD)	19.38%	15%	1	1) Implement WTIS / ALC project to improve data quality and reporting 2) Implement Home First Program 3) Implement daily corporate bed management process 4) Role reviews: Social Work and CCAC Coordinator	% of patients who make a Long-Term Care Application have been assessed through the Home First Program; identification of other process measures currently underway	90% on identified process measures	Early phases of these projects will establish change ideas and process improvements. Specific process measures will be developed to monitor the effectiveness of the strategies as they are implemented	Strategies are linked to improving access to CCC/Rehab beds and achieving the strategic aim of 100% safe, effective patient flow and transitions
	Reduce wait times in the ED	ER Wait times: 90th Percentile ER length of stay for Admitted patients. Q3 2010/11, NACRS, CIHI	Not Applicable							
Patient-centered	Improve patient satisfaction	NRC Picker: "Would you recommend this hospital to your friends and family?" (add together percent of those who responded "Definitely Yes") Current performance is a 4-quarter rolling average Sept 1, 2009 - Aug 31st, 2010	77%	80%	2	Targeted strategies aimed at improving patient satisfaction with continuity and transitions, specifically the satisfaction with information provided at discharge for medication and what to expect when patients go home.	3 - 4 questions asked of patients on discharge related to satisfaction with continuity and transitions. Also quarterly data supplied by NRC Picker Survey will monitor global satisfaction indicator.	5 - 10 percentage point increase in scores for questions related to continuity and transitions	A 5 - 10 percentage point increase in measures related to continuity and transitions should lead to an increase in the more global question "Would you recommend... performance goal."	Patient satisfaction with continuity and transitions is linked to achieving the strategic aim of 100% safe, effective patient flow and transitions

Part C:

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

Our executives' compensation, including the percentage of salary at risk and targets that the executive team is accountable for achieving is linked to performance in the following way:

CEO – 5% of compensation is linked to achieving high leverage QIP targets outlined below.

Chief Nursing Executive – 5% of compensation is linked to achieving high leverage QIP targets outlined below.

VP Medicine – 5% of compensation is linked to achieving high leverage QIP targets outlined below.

VP Finance/CAO – 5% of compensation is linked to achieving high leverage QIP targets outlined below.

VP Strategy – 5% of compensation is linked to achieving high leverage QIP targets outlined below.

The five percent (5%) performance component of executive compensation is linked to achievement of the following high leverage QIP targets:

- 84% Hand Hygiene compliance (1%) - a Process measure linked to achieving MRSA/ VRE and C-Difficile outcome measures.
- 100% of patients screen for MRSA (pilot unit) (1%) - detection of patients is vital in preventing hospital outbreaks. Patients with longer length of stay may be more exposed on higher prevalence units
- 90% of patients who have a Fall Risk Assessment within 8 hours of admission (2%) - key process measure that will demonstrate compliance with the Falls Prevention Program and achieve reduction in adverse events related to falls.
- 90% of patients who make a Long-Term Care Application have been assessed for Home First Program (1%) - process measure linked to reducing % total ALC days and effective patient flow.

Part D:

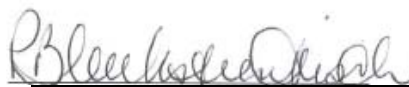
Accountability Sign-off

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

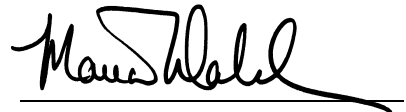
1. Was developed with consideration of data from the patient relations process, patient and employee/provider surveys, aggregated critical incident data, and patient safety indicators;
2. Contains annual performance improvement targets, and justification for these targets;
3. Describes the manner in and extent to which, executive compensation is tied to achievement of QIP targets; and
4. Was reviewed as part of the planning submission process and is aligned with the organization's operational planning.



Valerie Gibbons
Vice Board Chair



Paula Blackstien-Hirsch
Quality Committee Chair



Marian Walsh
Chief Executive Officer