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 |
| Safety | 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 | Strategies are linked to achieving the strategic aim of eliminating preventable harm by 2012/13 (hospital-acquired infections and falls) |
| | | | | | | 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 | |
| | | **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 | |
| | 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. |

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| | 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)<br>2) Efficiency reviews / process improvement initiatives<br>3) Revenue optimization strategies | Monthly variance analysis of actual to budget<br>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<br>2) Implement Home First Program<br>3) Implement daily corporate bed management process<br>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 |