Let's Make Healthy Change Happen.

Quality Improvement Plan (QIP) Narrative for Health Care Organizations in Ontario

Holland Bloorview Kids Rehabilitation Hospital

3/31/2014

This document is intended to provide health care organizations in Ontario with guidance as to how they can develop a quality improvement plan. While much effort and care has gone into preparing this document, this document should not be relied on as legal advice and organizations should consult with their legal, governance and other relevant advisors as appropriate in preparing their quality improvement plans. Furthermore, organizations are free to design their own public quality improvement plans using alternative formats and contents, provided that they submit a version of their quality improvement plan to HQO (if required) in the format described herein.

Overview

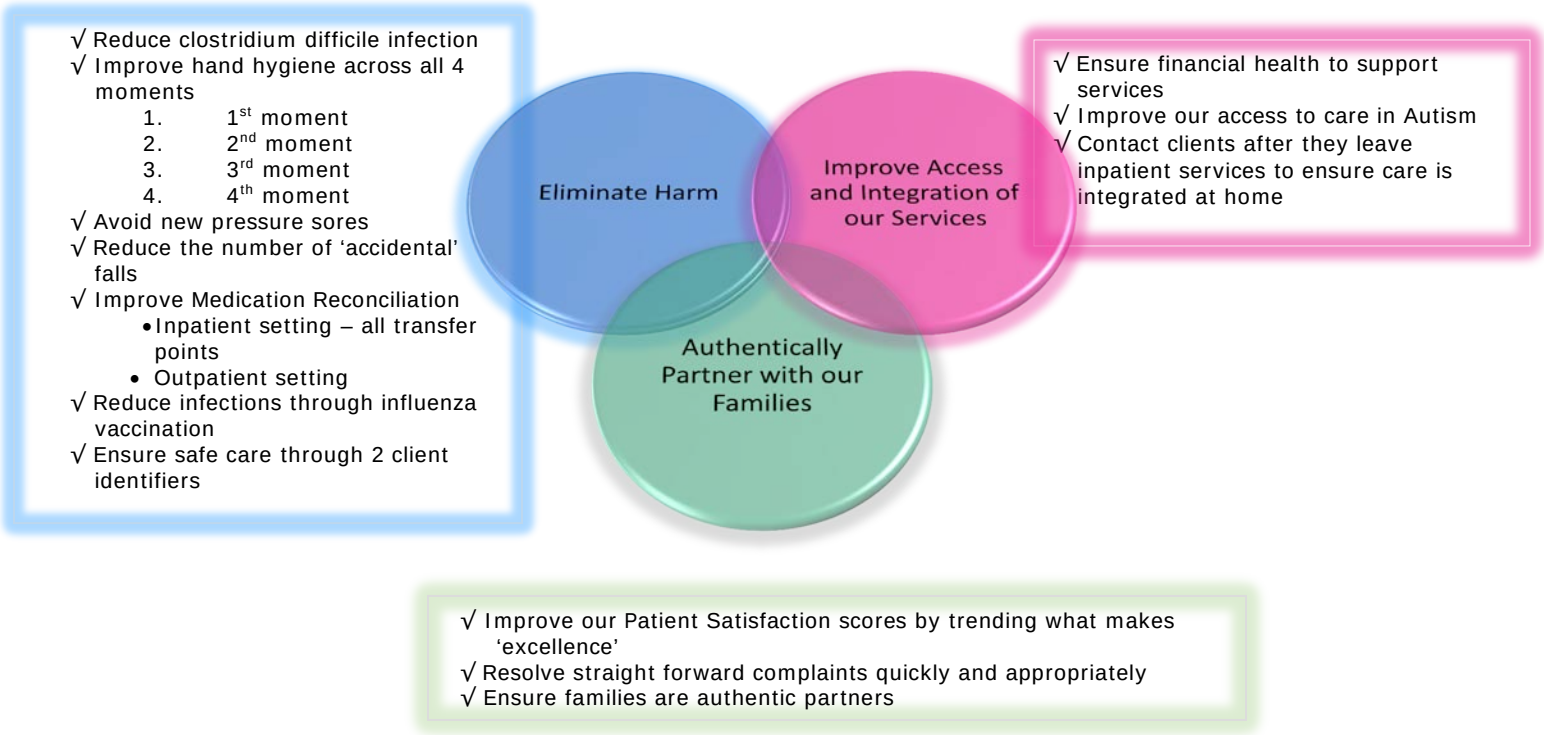
Holland Bloorview continues to advance the quality journey through our commitment to excellence, partnership with families, and our focus on system challenges and accountability. This year, Our 2014/15 Quality Improvement Plan (QIP) is centred on ***'bridging system gaps'*** through partnership, innovation and leadership in Quality and Safety.

Our clients and families, staff, Board of Trustees and Leadership teams, are firmly committed to providing the highest quality and safest care possible. We do this by:

- partnering through system transitions;
- providing timely access to services;
- utilizing evidence based care and;
- authentically valuing and including the 'voices' of our families to co-create excellence in the care experience.

In 2014 Holland Bloorview will continue to focus on **three strategic <u>quality</u> aims:** eliminating client harm, improving the access and integration of services for our clients/families and authentically partnering with our families to further advance our commitment to client and family centred care.

These aims are fully aligned with our strategic plan, as well as national (Accreditation Canada), and provincial (MOHLTC, Toronto Central LHIN and CCAC) accountabilities and partnerships.



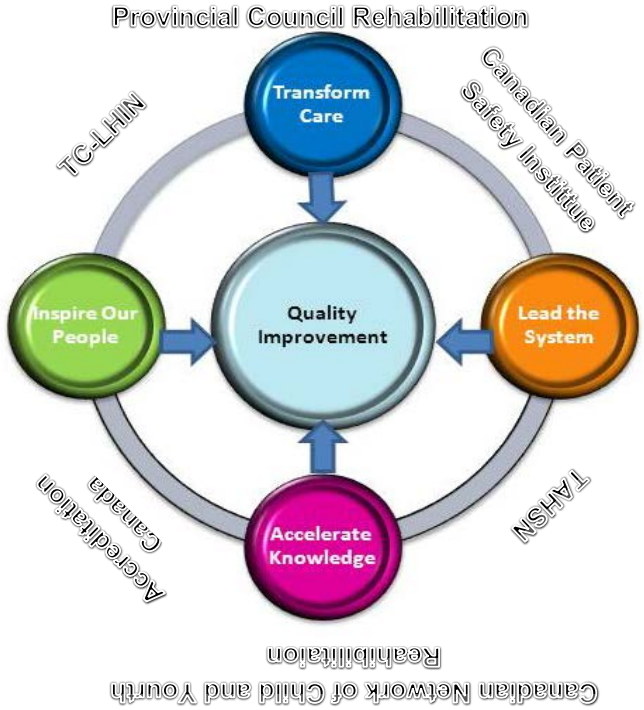
Our performance over the past year, once again, demonstrates an organization that is fully entrenched in quality, safety and client and family engagement at all levels. Our success is achieved through the support and commitment from the Quality Committee of the Board and leadership oversight in the execution and advancement of quality. Holland Bloorview, in the past twelve months, has engaged and led several system wide initiatives as they relate to access, system transitions and adoption of an electronic health record.

In 2014/15 we will continue to have an intensive focus on access to our services. This focus will extend beyond Holland Bloorview onto a national scale. As part of the Canadian Association of Paediatric Health Centres (CAPHC) and the Canadian Network for Child and Youth Rehabilitation (CN-CYR) we will look at understanding access and outcomes for children with childhood disability in an effort to influence the national health system. This national initiative, led by Holland Bloorview, will be fully partnered with the Canadian Institute for Health Information (CIHI) in 2014 with a view to launching a new Paediatric Rehabilitation Reporting System (PRRS). This, system leadership is essential as currently minimal information exists on rehabilitation services, and the impact paediatric rehabilitation has on clients and families.

What is Our Focus? In 2014/15 we are challenging ourselves to set further 'stretch goals' with several of our targets attempting to achieve the 'theoretical maximum' as we have approached the ceiling of performance. We are also advancing our measures to challenge ourselves in advancing safety, sustaining our 100% achievement of standards from of Accreditation Canada and focusing on system transfers in care to the community.

We are committed to leadership in paediatric rehabilitation and provide a platform for other children treatment centres to contribute and advance quality and safety in this unique population. Our leadership in the QIP in 2014/15 will include:

Leading in Patient Safety: Safety is a key priority at Holland Bloorview. Safety is anchored within our new strategic plan themes of transforming care, leading the system, accelerating knowledge and inspiring our people, while building strong partnerships with external stakeholders to drive our safety agenda. Our aim is to eliminate all harm by ensuring we incorporate a multi-pronged approach on how we educate, audit, provide feedback, share information and mentor our staff in providing the safest care. Our Accreditation survey in 2013 highlighted and confirmed Holland Bloorview's commitment to excellence in safety which will continue to be a priority in our QIP.



Over the past few years our focus has been on addressing nosocomial spread through stellar hand hygiene practices and reducing medication error through focused medication

reconciliation in both our inpatient and outpatient settings. These foci continue to be relevant and the organization is advancing its progress through our 'new' and revised indicators. Our indicators will focus on:

i. **C-difficile** – continuing to maintain our strong performance;
ii. **Hand Hygiene** – continuing to maintain performance across all 4 moments of care;
iii. **Newly Acquired Pressure Ulcers** – exceeding the provincial benchmark;
iv. **Falls** – advancing our measuring to focus on those children identified as 'high' risk who still continue to fall. Implementing our new Falls Strategy to ensure we will reduce the number of 'accidental' falls in this population;
v. **Medication Reconciliation (inpatients)** – we are advancing this indicator with a focus on medication reconciliation across all transfer points (admission, transfer and discharge) to reduce the risk of medication error and address the system gap in safe care across transitions;
vi. **Medication Reconciliation (outpatients)** – we are advancing our target to the theoretical maximum of 100% for all of our outpatient clinics where medication is managed. Our organization will have medication reconciliation across all inpatient, outpatient and community programming;
vii. **Influenza Vaccination** – to reduce the community spread and impact for our clients, we will be aiming to have 80% of our eligible staff and volunteers vaccinated in 2014/15.This indicator is linked to reduction of nosocomial infections organizationally, while keeping our staff healthy and able to provide care;
viii. **2 Client Identifiers for Therapy** – building on the success of our 100% Accreditation standards results in 2013, we want to sustain our practice of ensuring all clients are accurately identified for all types of care, all the time. Our goal is to leverage this indicator to assist in further shifting our culture to that of safer practice.

Effectiveness: Our health care system continues to experience fiscally challenging times and our organization will continue to focus on Total Margin as an indicator which measures the financial health of an organization and our ability to delivery services in a seamless and client focused manner. We will continue to focusing on reducing waste within the system through process improvement strategies that will assist in achieving our goal of balancing our budget.

Access: Access to services continues to be a system issue, with all organizations trying to look at different ways to ensure the 'right care at the right time'. Our focus will be to ensure we address access issues by implementing novel change ideas such as new models of service delivery, single point of entry and service coordination to ensure that clients and families are entering the system in a seamless fashion thereby reducing redundancies and inefficiencies. Our measure of success is focused on the wait for clients and their families for Autism services.

- **Autism Wait Time** – 80th percentile wait in days for any autism assessment service at Holland Bloorview

Leading in Client and Family Centred Care: Holland Bloorview continues to lead our healthcare system in its client and family centred mandate. Families are fully engaged and partnered with across all improvement initiatives from inception, execution to evaluation. Our families partner with Holland Bloorview in our academic scholarship, co-authoring abstracts and presenting at national and international forums. Our families are integral to our safety strategy, trained in the

Patient Safety Education Program from the Canadian Patient Safety Institute, contributing to our safety plan and agenda and assisting to define quality within Holland Bloorview. Our families are part of the fabric of the organization, closely partnering with our strategic quality initiatives. This past year alone our families have participated in over 100 committees that meet monthly on quality/corporate initiatives. Our families 'voices' are meaningful and informative as they ensure that services meet their needs as users, while often bringing their world experiences in business, industry, academia and research to assist in finding novel ways to provide care. Families bring honesty, practicality and accountability in how we build and revise our services – using their collective wisdom/voice in all of our quality/safety initiatives ensures a safer system for all users. The indicators we will be focusing on this upcoming year include:

i. **Patient Satisfaction** – Overall how would you rate the care at Holland Bloorview? This indicator has been modified to focus solely on the 'excellent' rating of patient satisfaction. Historically, our performances of 'good' and 'excellent' ratings have exceeded 96% with minimal information that could be used for meaningful impact. The focus of the organization over the next few years is to shift our understanding of what makes an excellent experience for our families and implement improvement based on the feedback.

ii. **Client & Family Relations** – Authentically listening to our families is critical in the complaint resolution process. In 2011/12, our organization initiated a resolution process that committed to our families that initial contact, regarding a complaint, would occur within two days. We have exceeded this target for the past two years, and the upcoming years focus will be to commit to resolving 'straight-forward' complaints seventy percent of the time within 10 business days. By setting a target timeline to resolution, it ensures that our families that concerns are important and that dedicated resources are in place to resolve complaints.

Developing new 'integrated' partnerships to address system gaps: Health-care is a continuum of 'hand overs' within the system, and bridging the gap to ensuring that clients and their families are supported when then re-enter the community is imperative. Care which families receive should be supported, safe and evaluated transition point. Bridging this gap and evaluating the transition is imperative to creating a system view of health. Holland Bloorview has focused its efforts on system integrated partnerships in two ways:

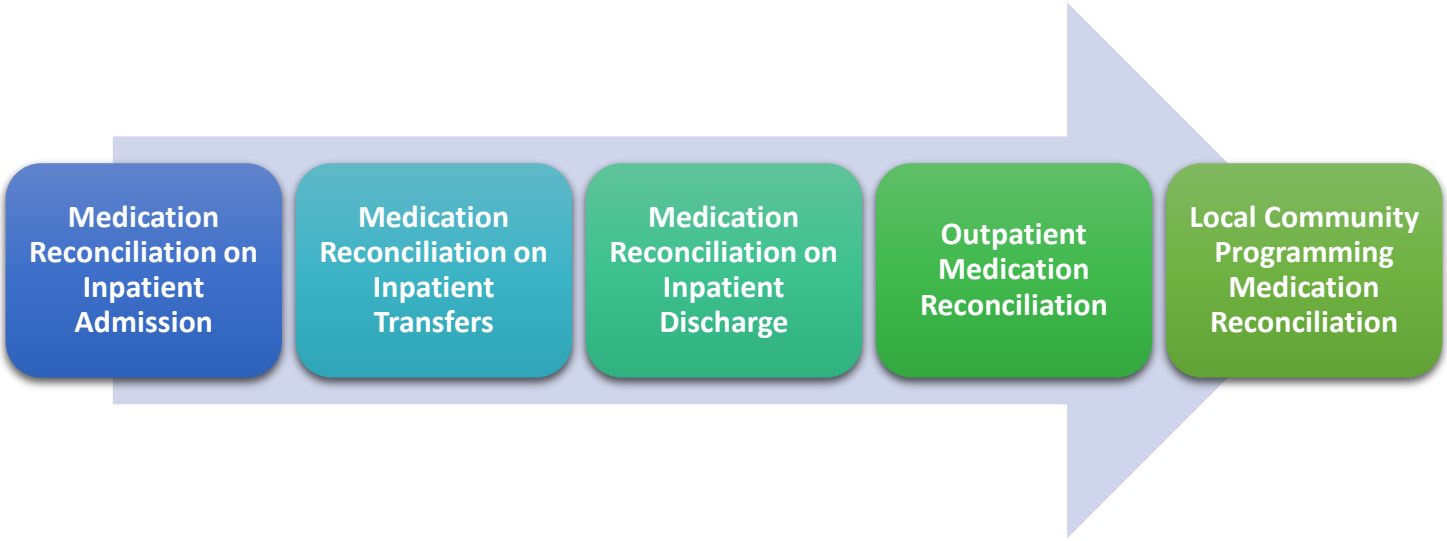
i. **Authentic Partnership:** Partnering with our families to ensure they have a voice in the care journey and feel empowered to advocate for their needs allows them to be the integrator and system connector for their child. We will continue to focus on ensuring that all families who partner with us in quality, safety and organizational initiatives feel that their experience was authentic and instrumental in the shared decision making process. We will continue to evaluate the partnership experience this upcoming year with expectations that we provide 'authentic partnership' experience 90% of the time to our families throughout their interactions with us. We will continue to survey our 'Family Leaders' to better understand the degree of authenticity and the impact of their engagement.

ii. **Community Integration Post-Discharge:** Discharge from any hospital based organization is often where the greatest potential of error and readmission occurs. Over the next two years, we will focus on system transitions when our clients and families leave Holland Bloorview. We will introduce a follow up process that includes a telephone survey at 3 and 30 days after their discharge. This upcoming year, we will be focusing on evaluating and measuring how we connect with our clients and families 3 business days after discharge.

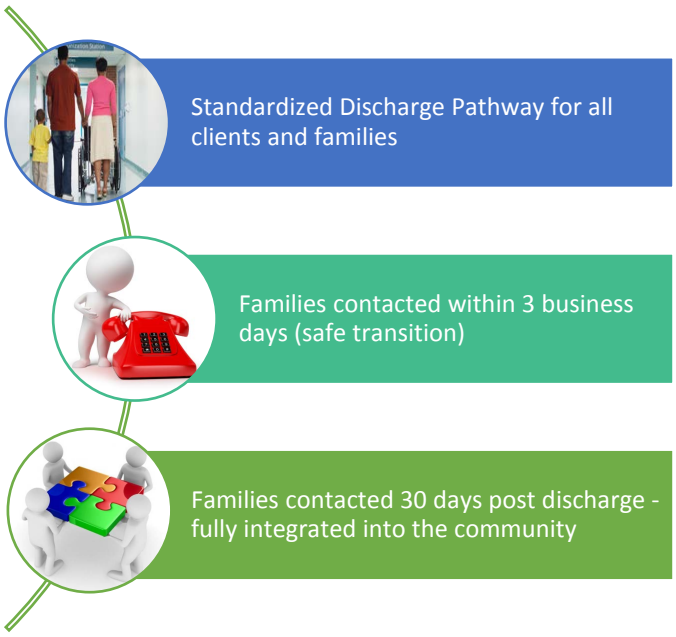
Integration & Continuity of Care

System integration is a key focus of all health systems to ensure that care does not stop when clients leave a hospital, and that transition points across the care continuum are seamless to reduce risks that may result in harm. Within a paediatric population, ensuring that integration happens smoothly is critical, not only for our clients, but their families as well. At Holland Bloorview, system planning and integration occurs at registration of each of our clients, whether the purpose is for inpatient services or ambulatory care services. The organization is able to concretely demonstrate this through many of its improvement initiatives, and how we measure success. Examples of this include our medication reconciliation process, discharge process (figures below).

Medication Reconciliation – Medication reconciliation is a key element of patient safety and reduction of harm, and often it does not occur across transition points. Holland Bloorview, over the past 3 years, has focused on addressing medication reconciliation throughout the hospital. It includes our inpatient settings, all of our ambulatory settings and has also included an external review from the Institute of Safe Medication Practices (ISMP). We also saw the need to look at our community programming where typically developing and disabled children partake in "camp-like" settings on site, and ensuring through Failure Mode Effect Analysis (FMEA) that medication reconciliation was also integrated in other programs within community locations. Our QIP will continue to reflect our belief in reducing medication errors through integration and continuity of practices across the continuum.



Discharge – Discharge is often one of the most challenging elements within a client and families journey through the health system. This aspect of care often signals to families that they can continue the recovery process within the community. While this process often occurs in a seamless and uneventful fashion, there are instances where families of medically complex children or marginalized populations where further support is required to have a successful integration. Holland Bloorview is focusing attention on this transition point over the next few years to ensure clients and families post inpatient discharge are followed up within 3 and 30 days to ensure community integration. While this will be a multi-year initiative, with measures evolving over time to reflect the maturity of the process, our initial evaluation will be to ensure that families are contacted within 3 business day.



Challenges, Risks & Mitigation Strategies

The dimension of *access* continues to be influenced through Provincial policy changes to the enhanced 18-month well-baby visit, as well acquiring a new Child Development Clinic from North York General Hospital for autism assessments increasing demand for services. Through this increased focus on developmental milestones, we anticipate a continued increase in the referral rates by primary care doctors and pediatricians to specialized neuromotor and autism services. This increase in referrals will impact 'downstream' programs as children and their families may require additional services on-site that are not available in the community. Ultimately, this may increase wait times for assessment and therapy services.

Mitigation Strategies:

- Over the past three years there has been a concentrated focus on process improvement using Lean methodology and other improvement science tools to streamline processes, redesign models of service delivery and increase efficiency and effectiveness of services without additional costs. We will continue to use improvement science methodologies to identify and eliminate system inefficiency and look internally for capacity, while creating new community partnerships that will improve transitions and integrate care.

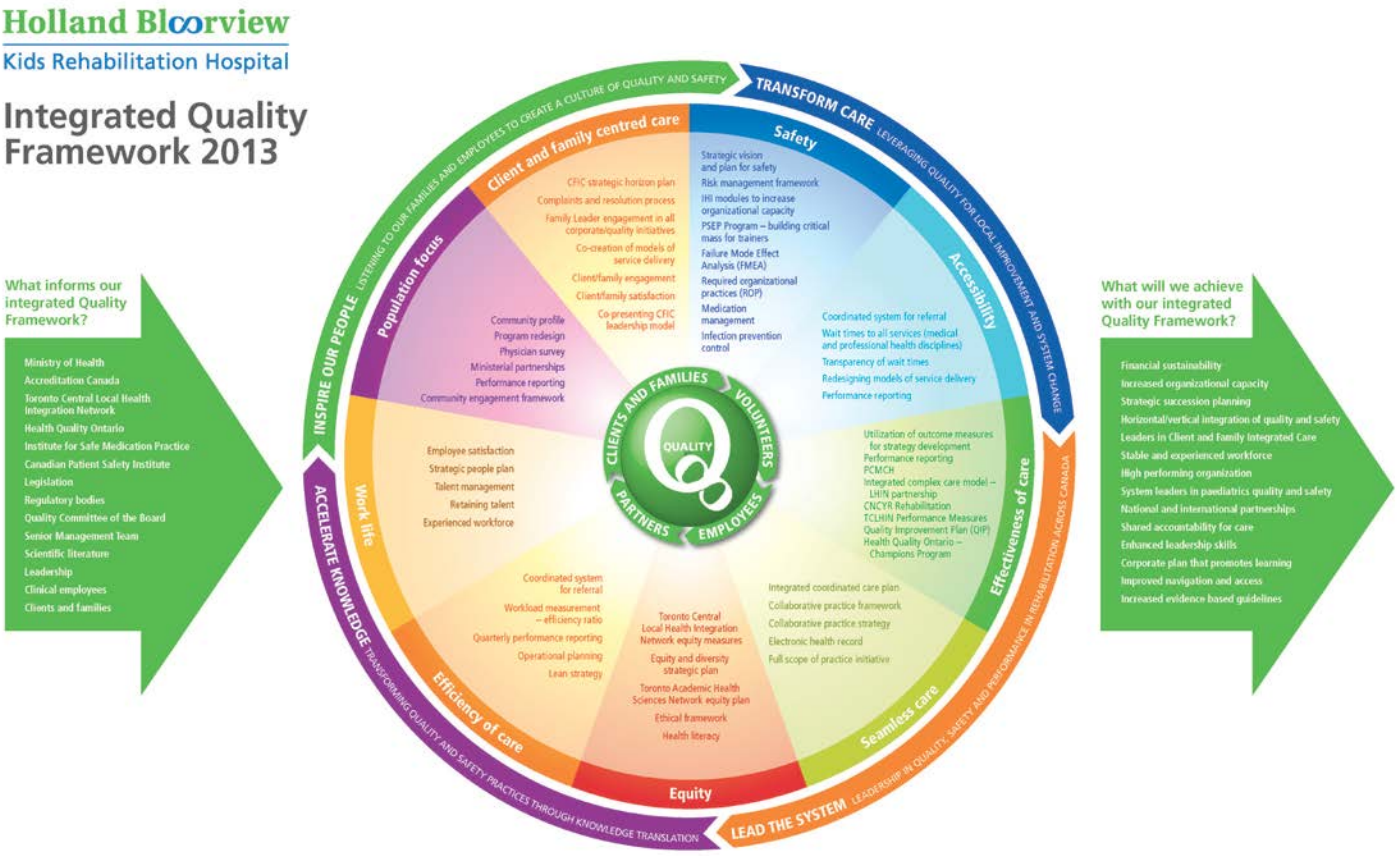
Environmental scanning through our networks of care providers to adapt and respond quickly to changing service levels in the community which may impact our clients and families across Ontario.

Information Management Systems

Adoption of electronic systems continues to be key drivers for organizations to centralize and integrate information into one comprehensive strategy. Holland Bloorview has led the adoption of electronic integration over the past several years measured by the electronic medical record adoption model (EMRAM) score. Our organizational EMRAM score in 2012/13 was 4.23 with the LHIN average being 2.4 and our peers at 1.18. Our score is anchored in the entire organization having health information documentation in an electronic platform, electronic scheduling and point of care devices for clinicians to document in a contemporaneous fashion. We also use our information management systems to provide valuable data on incidents, complaints, performance, efficiency, resource utilization, access and other elements that guide our business operations to optimize effectiveness. Our ongoing innovation is anchored in coupling quality and safety with leading technology to enable integration, information sharing and improvement.

Engagement of Clinical Staff & Broader Leadership

Quality improvement is a shared commitment across the organization. Our staff engages in every aspect of the development of the integrated quality management plan, process improvement initiatives, change strategies and communication platforms. Staff across the organization actively participates in various quality committees, working groups and engage in quality huddles during the implementation of initiatives. Annually, staff is engaged in the QIP development process, as well as other activities such as our Integrated Quality Management Plan (figure below) FMEA's, Root Cause Analysis, Risk Resolution, Risk Rounds and other quality venues to build capacity in understanding and generate ideas for improvement. We measure our success through our incident reporting system where staff feel 'safe' to report elements that are of concern, or provide ideas for improvement that are vetted through our committees and centralized process to address change. Over the next three years our plan is to further leverage the commitment to formally build capacity with an internal education program that will benefit the entire system through collaboration and networking.



Accountability Management

For the past three years the executive compensation has been anchored to high priority activities linked to the strategic objectives of the organization and where performance would require a stretch. Historically, HQO has suggesting linking executive compensation to 'priority 1' indicators. The new guidance document has removed the priority indicator ranking and suggests organizations self-determine priority of focus for quality initiatives [1].

Recommended for 2014/15 QIP are the following indicators to be tied to executive compensation as they represent organizational focus in the areas of safety, access, client and family centred care delivered in a fiscally responsible model (business optimization). The indicators are recommended to be equally weighted, as well equally distributed in responsibility across the senior management team (SMT). Similar to previous years, the compensation will be linked to performance corridors to address the typical variability seen within measurement [2].

Dimension	Measures	Target	Performance Corridor		
			Zero payout	100% payout	120% payout
Safety	% of eligible staff and volunteers receiving influenza vaccine annually	80%	Less than 72%	72% to 84%	Greater than 84%
Effectiveness	Ensure our total financial margin is within a range of 0 to 1%	0.5%	Less than 0%	0% to 1%	1.05%
Access	80th percentile of clients accessing Autism Spectrum Disorder (ASD) services within 151 days	151 days	Greater than 166 days	143 days to 166 days	Less than 143 days
Patient Centred	% of 'straight forward complaints' resolved within 10 business days	70%	Less than 63 %	63% to 73.5%	Greater than 73.5%

The corridors outlined in the table above are aligned with our performance corridors in the QIP with a maximum of 10% variation below the proposed target in order for executive compensation to be paid out at 100% payout. To achieve the 120% payout, required is performance to exceed the proposed target by 5%.

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[1] Guidance Document HQO – 2014/15

[2] **Target –** Targets represent what the organization aspires to achieve using provincial benchmarks, theoretical best, industry, literature or matching against peers at the 90th percentile as guidelines when determining the values. Targets should be set for performance; however, they need to be based on the organization's historical data and performance, or based on another organization with similar structure and resources. Setting arbitrary or unachievable targets can be demoralizing to staff (Health Quality Ontario 2012 and BC Quality Committee 2010)

Performance Corridor – Corridors are **ranges of acceptable performance** based upon historical data, statistical measures, or agreed upon ranges by stakeholders (e.g. 5%, 10% variation) – they are not targets. Corridors account and adjust for natural variation that exists in all processes and ensures that an organization can confidently determine if performance is due to random variation or issues in the system. In systems where the rate of occurrence is very small ensuring that the corridor is anchored in data is critical to minimize 'false positives' and enable senior leadership or Boards to appropriately determine where focus should be placed (BC Quality Committee 2010).

Health System Funding Reform

The new HBAM funding formula and Quality Based Procedures (QBPs) do not currently apply to Holland Bloorview as it is a specialized, paediatric rehabilitation hospital serving the Province. However our fiscal stewardship and desire to look at service models and clinical practice evidence based guidelines is evident. Our new strategic plan under 'Transform Care' focuses on clinical practice guidelines, business optimization, decision analysis that will not only provide the best care to clients, but in the most efficient and effective way. Our Evidence to Care Unit was recently expanded with matching funding from the Ministry of Health and Long Term Care. It is a key part of our culture in ensuring that the right care is provided at the right time, by the right people. Not only will we ensure the uptake and use of guidelines within Holland Bloorview, but we will be producing guidelines that, through knowledge translation, can be utilized by health professionals throughout the health system.

Our consistent use of data to better understand demographics of our population, demand and capacity issues, variation within processes has been the cornerstone of all of our quality improvement initiatives and decision making processes. A strong performance framework has enabled solid and evidence based decision making, while allowing for opportunities for improvement in patient to emerge.

Sign-off

It is recommended that the following individuals review and sign-off on your organization's Quality Improvement Plan (where applicable):

I have reviewed and approved our organization's Quality Improvement Plan

Board of Trustees Chair – Julia Hanigsberg

Quality Committee Chair – Dr. Ron Laxer

President & Chief Executive Officer – Sheila Jarvis

2014/15 Quality Improvement Plan for Ontario Hospitals

"Improvement Targets and Initiatives"

Holland Bloorview Kids Rehabilitation Hospital 150 Kilgour Road

AIM		Measure								Change				
Quality dimension	**Objective**	**Measure/Indicator**	**Unit / Population**	**Source / Period**	**Organization Id**	**Current performance**	**Target**	**Target justification**	**Priority level**	**Planned improvement initiatives (Change Ideas)**	Methods	Process measures	Goal for change ideas	Comments
Access	**Reduce wait times in the ED**	ED Wait times: 90th percentile ED length of stay for Admitted patients.	Hours / ED patients	CCO iPort Access / Q4 2012/13 – Q3 2013/14	939*			Holland Bloorview does not have an Emergency Department therefore will not be reporting on this measure						
	Reduce wait times for families awaiting Autism Services	80th percentile - longest wait measured in days	Days / paediatric	Hospital collected data / 2013/14	939*	134	151	Our target has been reduced to 151 days from 182 days last fiscal year. While our performance is better than our posted target, the organization will be receiving another paediatric services from North York General Hospital with an estimated additional 150 clients per year, and the service will need to be incorporated into our current model. Wait times currently from the clinic are in excess of our performance and may play a factor. Our measure continues to be aligned with National Work being conducted in Children's Rehabilitation on wait times for Autism and Cerebral Palsy, and we continue to focus on access for our families.	Improve	1. Redesign of the model of service delivery of North York General's clinic to align and be standardized to the current design (e.g. work load levelling) 2. Centralization of referrals across all sites to standardize process 3. Cross linkage of initiatives - Appointment Services redesign with centralized referral flow 4. Implementation of visual management system of performance to monitor demand, capacity, utilization within Appointment Services 5. Implementation of a new 'referral' process to community practitioners (18 month initiative) to reduce the number of clients waiting for service secondary to 'defects' within the referral form.	1. Data will be collected centrally through Decision Support, with data to be validated through our Data Governance Structure 2. Data will be collated and pushed to operations managers and reviewed weekly for accuracy and impact. 3. Overall metrics of Appointment Services will be reviewed weekly for issues within process	1. Incorporation of North York General Clinic in April 2014 2. 80% compliance of new 'referral process' by external stakeholders (when implemented) 3. Increase in referrals processed annually within Autism (percentage to be determined when redesign of Appointment Services is complete) 4. Quarterly reporting of wait times within Programs & Services Performance Reporting Structure 5. 80th percentile - longest wait in days (151 days) across all Autism services	1. 80% compliant to outlined milestones in critical path for all change ideas	
Effectiveness	**Improve organizational financial health**	Total Margin (consolidated): % 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.	% / N/a	OHRS, MOH / Q3 2013/14	939*	1.62	0.5	Fiscal Stewardship continues to be a key priority for every organization and active monitoring and oversight is pivotal. Over the next five years, the fiscal environment will continue to pose challenges for all organizations with a zero base budget increase. The target is based on the historical performance, projected performance and trending. We have continued to focus on business optimization and strategies to ensure fiscal stewardship.	Maintain	1. Monthly/Quarterly Performance Reporting 2. Business Optimization Strategy 3. Implementation of Long Term Deficit Strategy at Senior Management Team	1. Data is collected through decision support with validated operational definitions and validation through Data Governance Strategy. The information is reported organizationally through a full day event quarterly with full Senior Management Team involvement. 2. Business Optimization Strategy is a fulsome approach of leadership in the generation of ideas and coding	1. % of indicators linked to 'fiscal stewardship' 2. % of strategies/goals implemented as part of plan for fiscal 2014/15 3. % of strategies/goals implemented as part of plan for fiscal 2014/15	Inclusion of key performance indicators linked to 'fiscal stewardship' within quarterly performance reporting	The Business Optimization and Long Term Deficit Strategy continues to evolve in development and process/outcome measures will be developed when complete

AIM		Measure								Change				
	Reduce unnecessary deaths in hospitals	HSMR: Number of observed deaths/number of expected deaths x 100.	Ratio (No unit) / All patients	DAD, CIHI / 2012/13	939*			This measure does not apply to Holland Bloorview as the facility is a paediatric rehabilitation facility, where there are no 'expected' deaths.						
Integrated	**Reduce unnecessary time spent in acute care**	Percentage ALC days: Total number of acute inpatient days designated as ALC, divided by the total number of acute inpatient days.	% / All acute patients	Ministry of Health Portal / Q3 2012/13 – Q2 2013/14	939*			Holland Bloorview is a paediatric rehabilitation hospital and the measure currently does not apply						
	Reduce unnecessary hospital readmission	Readmission to any facility within 30 days for selected CMGs for any cause: The rate of non-elective readmissions to any facility within 30 days of discharge following an admission for select CMGs.	% / All acute patients	DAD, CIHI / Q2 2012/13-Q1 2013/14	939*			Holland Bloorview is a paediatric rehabilitation hospital which would not have a readmission rate therefore the measure does not apply						
	Ensure community integration post inpatient discharge	Percentage of clients contacted post inpatient discharge within 3 business days to assess if clients have been appropriately integrated back into the community	% / Discharge families	Hospital collected data / 2014/15	939*	CB	80	The target is anchored in what the organization has deemed the change in service delivery model, implementation of a new discharge process/pathway will be able to feasibility achieve within the first year. The process will be fully implemented at the end of Q2 fiscal year 2014/15 with auditing occurring in Q3. The measure will have approximately 3 months of data to report on in the analysis for 2014/15 QIP, however the sample size will be sufficiently large to validate the measure.	Improve	1. Development of the Discharge Tool for Families to ensure community integration 2. Development of Discharge Process/Pathway for warm handovers into the community 3. Implementation of a 3 business day phone call to families to ensure re-integration home 4. Implementation of family satisfaction survey of discharge process for future quality improvement initiatives 5. Training of key staff as part of core competencies (nursing)	All information will be collected through manual auditing process. Discharge data will arise from our Decision Support team, and a cross reference to 'calls made' and time stamps to ascertain target is achieved.	1. Completion of tool development for discharge 2. Completion of discharge pathway for all inpatients (excludes sleep study/respite clients) 3. % of families contacted within three business days 4. % of families satisfied with discharge process 5. % of staff trained in discharge process	1. 100% completion of tool by Q2 fiscal 2014/15 2. 100% completion of discharge pathway by Q1 fiscal 2014/15 3. 80% of all families contacted within 3 business days post discharge 4. To be determined the target as baseline data is being collected 5. 100% of all staff trained in discharge process as part of core competency	This is an 18 month initiative and will be implemented in phases with the calls to families occurring by Q3 fiscal year 2014/15
	Ensuring 'authentic' partnerships with our families	Percentage of families that would rate their partnership at Holland Bloorview as 'authentic'	% / Family Leaders	In-house survey / 2013/14	939*	88	90	Authentic partnerships with our families is core to our values, and fully aligned with our Strategic Plan, Accreditation Canada and local strategy to augment our Client and Family Integrated Care portfolio. This indicator will be entering into its third year, with the goal of testing the survey for validity.	Maintain	1. Partner with Bloorview Research Institute to explore validating the tool for 'engagement' 2. Focus group interviews to identify areas for change in augmenting engagement, respect and authenticity 3. Exploration of more rigorous statistical analysis between Client Relations data and survey responses	1. Psychometric properties of the tool will be in partnership with the Bloorview Research Institute 2. Data will be collected using an internal tool and will be provided to the 100 Family Leaders for completion semi-annually. The data is annualized and common themes identified for the purpose of structuring the questions for the interviews. 3. Correlational and regression analysis will be conducted in partnership with our Decision Support area,	1. % of Family Leaders who rate their experience at Holland Bloorview as an 'authentic partnership' 2. Face validity of the tool 3. relationship between complaints/compliments and authenticity	1. 90% of Family Leaders rating their partnership as authentic 2. 100% completion of research proposal completed by March 2015 3. Completion of correlational analysis by March 2015	

AIM		Measure								Change				
											with information from our complaints/compliments process and the tool analyzed.			
Patient-centered	**Improve patient satisfaction**	From NRC Picker: "Would you recommend this hospital (inpatient care) to your friends and family?" (add together % of those who responded "Definitely Yes" or "Yes, definitely").	% / All patients	NRC Picker / Oct 2012-Sept 2013	939*			We will not be including the measure in the 2014/15 QIP as the organization has consistently performed above 95% and given we are the only standalone rehabilitation facility, the indicator will become a 'watch' indicator organizationally. Other measures will address client satisfaction.						
		From NRC Picker: "Overall, how would you rate the care and services you received at the hospital (inpatient care)?" (add together % of those who responded "Excellent, Very Good and Good").	% / All patients	NRC Picker / Oct 2012-Sept 2013	939*	68	70	The measure has evolved to ensure the organization is challenged in providing a positive health care experience for our clients and their families. We have historically performed well above 95% and more recently with a two-fold increase in sampling (over 800 completed surveys). The original measure captured excellent and very good responses. The organization has committed to focusing on solely 'excellent' responses. Over the past three years responses have ranged from 65% to 69% using the 'excellent' category alone. We are embarking upon a new strategy again this upcoming year and the focus will be on identifying 'what' makes an experience excellent rather than very good. As this is the first year embarking upon this stratification of data, and our shift in methodology and strategy, our target is set at 70% with a goal of exceeding the target. Our measure continues to be aligned with our larger quality strategy, as well, our Client and Family Integrated Care Plan.	Improve	1. Redesign of methodology to ensure more voices are captured through the use of email and website feedback 2. Focus group interviews with our Family Leaders and FAC to better understand 'what' makes the care experience 'excellent' 3. Pulse Checks with our inpatient units to ensure all families receive surveys upon discharge	1. Data will be collected through a Modified Dillman approach to surveys and we will utilize - mail out, email, drop box and manual distribution at inpatient discharge 2. Focused interviews and group interviews with Family Leaders using semi-structured questions. Data will be analyzed for thematic information and concepts 3. Advanced statistical analysis will be employed to understand if correlations exist with some of the items within the survey to 'overall care experience'	% increase in survey response rate % increase in 'excellent' responses R-square of item to overall care experience	10% increase in responses from 2013/14 70% responding 'excellent' care to the care experience question % of surveys that were collected via email	This measure is advancing how we historically have viewed patient satisfaction with understanding 'what' makes the experience excellent and pushing the organization to shifting from good and very good. This year will be a year of exploration and using mixed methods (quantitative and qualitative) to better define process improvement initiatives.
		From NRC Picker: Would you recommend this ED to your friends and family?" (add together % of those who responded "Definitely Yes" or "Yes, definitely")	% / ED patients	NRC Picker / 2013	939*			The organization does not have an Emergency Department and the patient satisfaction scores will be that of inpatient and ambulatory care services. We also, as mentioned above, will not be reporting on the measure.						

AIM		Measure								Change				
		From NRC Picker: "Overall, how would you rate the care and services you received at the ED?" (add together % of those who responded "Excellent, Very Good and Good").	% / ED patients	NRC Picker / 2013	939*			The organization does not have an Emergency Department and the patient satisfaction scores will be that of inpatient and ambulatory care services.						
		Percentage of 'straight forward complaints' resolved within 10 business days	% / All patients	Hospital collected data / Fiscal year 2014/15	939*	CB	70	This is an evolving measure from last year's measure which evaluated our ability to commence the issue resolution process by measuring the % of complaints whereby the issue resolution process was initiated within two business days. The measure is fully aligned with our Client and Family Integrated Care Strategy and will focus on ensuring that the voice of client is addressed in a timely and meaningful way.	Improve	1. Develop categorization of complaints with a 'predefined' conceptual framework 2. Partner with families in defining the conceptual framework of 'straight forward', 'moderate' and 'complex' complaints 3. Partner with Programs & Services to provide consultation in complaint resolution	1. Review historical data collected over the past 3 years (qualitative data) to assist in developing a categorization of 'types' of complaints and time to resolution. 2. Use existing committee structures to gather qualitative information to assist in defining the categories	1. % of 'straight forward complaints' resolved within 10 business days 2. Development of categories of complaints	70% of 'straight forward complaints resolved within 10 business days	
Safety	**Increase proportion of patients receiving medication reconciliation upon admission**	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.	% / All patients	Hospital collected data / Most recent quarter available (e.g. Q2 2013/14, Q3 2013/14 etc)	939*	97.9	100	This is the second year in a row where the target has been set to the theoretical maximum of 100%. The organization has consistently performed within the pre-established corridors set at 5% and 10% to account for natural variation within any given process. Our goal continues to be reaching the theoretical maximum.	Maintain	1. Visual management of monthly auditing process 2. Monthly huddles around performance 3. Ongoing medication management discussion at the Medical Advisory Committee 4. Implementation of medication management questions within the 'Tell Us' patient satisfaction survey to link activity to knowledge translation	1. Visual management - Quality Board in clinical areas 2. Safety, Management huddles 3. Standing agenda item on MAC 4. Inclusion of questions in Tell Us What You Think Survey	1. Posting of medication reconciliation on Quality Boards 2. Monthly Huddle executed across clinical areas 3. Medication Reconciliation identified as a standing item on the agenda 4. Responses from families around medication management	1. 80% of time medication reconciliation data present on Quality Boards 2. 80% of time huddles occurring monthly 3. Quarterly discussion of medication management performance	
	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. 2013, consistent with publicly reportable patient safety data.	Rate per 1,000 patient days / All patients	Publicly Reported, MOH / 2013	939*		0.1	We continue to use the median of the provincial benchmark as our target. Our performance has not shifted significantly over the past few years in spite of improved hand hygiene performance, family education on nosocomial infections and improve vaccination rates of our employees. Organizationally we have very few cases on an annual basis and the target is anchored in historical performance.	Maintain	1. Implementation of antimicrobial steward ship 2. Quarterly 'trigger tool' analysis to include potential c-difficile triggers	1. The Required Organizational Practice standard of Accreditation Canada will be implemented and review of the c-difficile rate using process control charts will be analyzed 2. Quarterly reports of our trigger tools will be reviewed for identification of possible linkages between c-difficile and current practice	% completion of antimicrobial standard	100% implementation	
		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	% / Health providers in the entire facility	Publicly Reported, MOH / 2013	939*	93	95	Our hand hygiene over the past few years has continuously improved, with the organization conducting well over 1,500 audits annually. With the implementation of a new electronic platform, and the expectation of sample sizing	Maintain	1. Performance Reporting within Programs & Services to share results 2. Evaluation of 'electronic auditing tool' to allow for 'real time' information and one on one mentoring at point of audit 3. Targeted Discipline Education - leveraging existing practice councils to shift 'standards of practice'	1. Information is collected using the electronic hand hygiene tool where information is collated and stored in real time, and enables broader utility for analysis and implementation	% of compliance of hand hygiene practices across ALL 4 moments of care. The measure is reported individually across each moment.	95% compliance of hand hygiene practices across ALL 4 moments of care	The measure the organization is collecting is across all 4 moments of care.

AIM		Measure								Change					
		contact multiplied by 100 - consistent with publicly reportable patient safety data.						doubling, and the implementation of more auditors we anticipate that will remain the same or marginally reduce. We continue to focus on reducing nosocomial spread and innovation of ideas to improve hand hygiene, however our performance has remained stable over the past 12 months.		4. Leverage the Family Advisory Committee and Family Leaders in a new Hand Hygiene Initiative on 'community and family' awareness 5. Just Clean Your Hands Campaign (outpatient campaign) - a joint venture where both clinicians and families wash their hands together to demonstrate technique, and entrench hand hygiene practices within the community 6. Just Clean Your Hands (inpatient campaign) - refreshed education with families every 60 days to understand the importance of hand hygiene and nosocomial spread	results. 2. Discussion of hand hygiene at Professional Advisory Committee will be tracked through agenda's and minutes 3. Success of the 'Just Clean Your Hands Campaign' will be achieved through auditing practices and satisfaction from families. 4. Auditing of our EHR for evidence of education to families			
		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 - consistent with publicly reportable patient safety data.	Rate per 1,000 ventilator days / ICU patients	Publicly Reported, MOH / 2013	939*			The measure is not appropriate for Holland Bloorview							
		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 - consistent with publicly reportable patient safety data.	Rate per 1,000 central line days / ICU patients	Publicly Reported, MOH / 2013	939*			This measure is not appropriate for Holland Bloorview							
		Percentage of 'eligible staff and volunteers' receiving influenza vaccine annually	% / Eligible Staff and Volunteers	Occupational Health and Safety / 2014/15	939*	60	80	The target was selected based on two years of data surrounding influenza vaccination of our staff and volunteers. This initiative is anchored in system wide initiatives to reduce the spread of nosocomial infection, and the target is quite ambitious for the organization. While we achieved one year of 80%, historically the influenza vaccination rate has been anywhere between 30-50%.	Improve	1. Implementation of staff on an annual basis signing an 'Influenza Vaccination Form' which identifies the reason for not receiving the vaccination 2. Implementation of vaccination as a condition of service or volunteering at Holland Bloorview (if eligible) 3. Improved vaccination with availability across shifts, days and weekends	Data will be collected annually during influenza vaccination season. There will be a period of activity during the early fall to implement the initiatives in collaboration with all leadership. Information will be collected, collated, analyzed and reported by our Occupational Health and Safety Partners, as well as our Human Resources partners.	1. % of staff/volunteers completing the 'Influenza Vaccination Form' 2. % of new staff/volunteers hired as a condition of employment/volunteerism 3. Improved access to influenza vaccine is provided across shifts	100% of staff/volunteers will complete the forms 1. 80% of all eligible staff/volunteers will receive influenza vaccination 2. Collection of Baseline data for 'new' hired staff to determine future target 3. Increase the number of days and times the vaccine is available to shifts - TBD as baseline information to be collected	This measure is a new measure, aligned with the Toronto Academic Health Sciences Network (TAHSN) CEO initiative to improve the rate of vaccination of all employees with the aim of reducing nosocomial spread within hospital settings. This initiative will

AIM		Measure								Change				
														be a phased approach at Holland Bloorview with the measure evolving over time as new information becomes available.
	Reduce incidence of new pressure ulcers	Percent of complex continuing care (CCC) residents with a new pressure ulcer in the last three months (stage 2 or higher).	% / Complex continuing care residents	CCRS, CIHI (eReports) / Q2, 2013/14	939*	0		Our measure is within the paediatric lens and will be reported in a different indicator						
	Avoid Patient falls	Percent of complex continuing care (CCC) residents who fell in the last 30 days.	% / Complex continuing care residents	CCRS, CIHI (eReports) / Q2 2013/14	939*	0		Our measure is within the paediatric lens and will be reported in a different indicator						
	Reduce rates of deaths and complications associated with surgical care	Rate of 5-day in-hospital mortality following major surgery: The rate of in-hospital deaths due to all causes occurring within five days of major surgery.	Rate per 1,000 major surgical cases / All patients with major surgery	CIHI eReporting Tool / 2012/13	939*			This measure is not appropriate for Holland Bloorview						
		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 - consistent with publicly reportable patient safety data.	% / All surgical procedures	Publicly Reported, MOH / 2013	939*			This measure is not appropriate for Holland Bloorview						
	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 divided by all cases with a full admission assessment.	% / Mental health/addiction patients	OMHRS, CIHI / Q4 2010/12 - Q3 2012/13	939*			This measure is not appropriate for Holland Bloorview						
	Increase proportion of patients receiving medication reconciliation at an outpatient clinic visit	Percent complete Medication Reconciliation on outpatient clinic visits	% / outpatient clinics	Hospital collected data / 2014/15	939*	98	100	We have moved and aligned our outpatient medication reconciliation target with our inpatient target - with the key message that irrespective of where you receive service targets should be similar to ensure safety. Our shift is anchored in historical data, and recognized is there will be a performance corridor outlined to address natural variation within process. Our decision to continue to focus on ambulatory care is	Improve	Please see change ideas listed under medication reconciliation within the inpatient setting. The initiatives are similar and span across the continuum of care from inpatients to outpatients.				

AIM		Measure								Change				
								anchored in the review conducted two years ago, as well aligned with Accreditation Canada.						
	Increase proportion of patients receiving medication reconciliation upon transfers and discharges	Percentage of complete medication reconciliation at transfers and discharge	% / Inpatients	Hospital collected data / 2014/15	939*	52	80	This measure has been evolved to include all points of transition requiring medication reconciliation. Our performance upon admission historically has ranged from 97 to 100 percent, and the evolution of the measure is to ensure that irrespective of where the client is within the health system, that medication reconciliation will occur. This measure is fully aligned with the Institute of Safe Medication Practices, Canadian Patient Safety Institute, Accreditation Canada and our strategic safety plan.	Improve	1. Visual management of performance using 'performance boards' on inpatients 2. Quarterly huddling at the performance boards with the Safety Committee 3. Standing agenda item of medication management discussion at the Medical Advisory Committee 4. Standing agenda item on the Nursing Advisory Committee 5. Individual mentoring and follow up with staff through auditing process 6. Implementation of medication management questions on the patient satisfaction survey to explore task and knowledge translation (this will be an 18 month initiative)	The information will be 'pulled' from the Electronic Health Record monthly with analysis and follow up with individual service areas and practitioners. Collated information will be posted quarterly to staff in the visual management structure for usage of managers. Information from our patient satisfaction survey will be analyzed to better understand if our reconciliation elements within our processes of care are understood by our clients and families to ensuring medication safety.	1. % implementation of visual management board 2. % of quarterly huddles discussing medication reconciliation across all points of care 3. Agenda item on both Medical Advisory Committee and Nursing Advisory Committee 4. % response of understanding medication safety	100% implementation of visual management board by Q2 fiscal year 2014/15 100% implementatin of 'huddles' by Q3 fiscal year 2014/15 Full implementation of 'agenda item' on each respective committee	Our goal is to embed the measure into practice with as part of the larger safety vision and plan. Full partnership with our Collaborative Practice service will be pivotal to success.
	Increase the proportion of staff asking for two client identifiers for all care	Percentage of staff compliant with 2 client identifiers for all care	% / All patients	Hospital collected data / 2014/15	939*	CB	90	As part of our Accreditation journey which concluded October 2013 with an evaluation of 100%, the Quality Strategy is to continue to build upon practices and sustain them to ensure embedding into clinical care. While we have 5 months of data through auditing, the journey this year will to further our understanding and strive for a 90% performance.	Improve	1. Branding Campaign of 'Ask Me, Match Me' across the organization 2. Ongoing education within risk rounds, business meetings and safety meetings surrounding the campaign and importance 3. Targeted strategy with the Professional Advisory Committee and Collaborative Practice Leads to ensure all staff see the strategy within their own practice	Information will be collected manually through auditing, and evaluated monthly and quarterly.	1. % of staff compliant with campaign for two identifiers 2. Implementation of revised 'Ask Me, Match Me' 3. % of Practice Council agenda items linked to safety and client identifiers 4. Ensure the family voice is firmly embedded in the revised 'Ask Me, Match Me' Campaign	1. 90% of staff auditing using two client identifiers prior to provision of care 2. 100% implementation of campaign by Q2 fiscal year 2014/15 3. Percentage being scoped with firm target to be set in 2014/15 4. Involving families and children in the campaign re-launch	Rehabilitation is very different than acute care where clients may be with their health care providers for a prolonged period of time resulting in the questioning of 'why' identification is required every time. The campaign will be anchored in ensuring the right care is provided to the right person - rather than two client identifiers alone to be relevant within this setting.

AIM		Measure								Change				
	Reduce the number of falls in children identified as 'high risk'	Percent of inpatients with a completed Falls Risk Assessment who sustain an accidental fall	% / all inpatients	Hospital collected data / 2014-15	939*	55	40	This measure has evolved from ensuring that all our clients received a 'falls risk assessment' when admitted to our inpatient unit. The target is anchored in historical data which identified that over 50% of our kids identified as high risk continued to fall. This measure is aligned with the Provincial Rehabilitation Council as an appropriate measure for rehabilitation.	Improve	1. Implementation of our new 'falls strategy' for high risk clients 2. Levering the Professional Advisory Committee to assess the interdisciplinary role for falls prevention 3. Review of the current paediatric falls assessment tool for specificity and sensitivity	Data will be collected through our QMRM incident reporting system, Electronic Health Record and manual auditing. The information will be collated and analyzed	% of 'high risk' clients with identified strategy in the 'care plan' % of children identified as 'high' risk falling	80% of 'high risk' children with an identified care plan <40% of children identified as high risk who go on to sustain a fall	This measure continues to be complex as part of paediatric development is falling, as well, during the rehabilitation process this may be part of the care plan. The goal is to identify those who are at high risk and experience an unanticipated, unexpected, unusual fall.
	Reduce the number of pressure ulcers children acquire during their inpatient stay	% of inpatients (complex continuing care, rehabilitation and respite clients) with newly acquired pressure ulcers in the last three months (stage 2 or higher) while at Holland Bloorview	% / all inpatients (excluding sleep study)	Hospital collected data / 2014/15	939*	0.74	1.5	The target is anchored in the provincial benchmark provided by HQO. While the benchmark suggests 1.6%, the organization has maintained its target. The population is quite diverse than adult Complex Continuing Care, and skin breakdown is infrequent within this population.	Maintain	1. Inclusion of 'core competency' during annual re-certification addressing wound prevention and management 2. Auditing of compliance to the 'Braeden Scale' for measuring would risk 3. Review 'high' risk clients and those who go on to develop a pressure ulcer - exploring relationship	1. Ensuring the core competency for nursing includes wound management and assessment - collaboratively work with the Collaborative Practice Leads 2. Data will be pulled from the Electronic Health Record for completion of the assessment tool 3. Manual review of QMRM (incidents) and assessment of wounds will occur to better understand those assessed at high risk if they go on to develop a wound.	% of 'high risk' clients going on to develop wounds % compliance of nursing staff completing training % compliance of Braeden Scale tools completed	1. Still to be determined as this is a new exploratory idea 2. 95% of all nursing staff completing core competency 3. 95% of all nursing staff completing the Braeden tool	