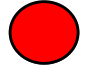
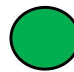
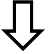
CHATHAM-KENT
Health Alliance

CKHA Quality Improvement Plan (QIP) Scorecard

2016-17

Success Factor	Performance Indicator	unit	2016-17 Performance Goals	YTD Q1	YTD Q2	YTD Q3	YTD Q4	most recent YTD	PY YTD	Trend
				Cumulative Quarter Results (results where available)						
Timely	Emergency Department Physician Initial Assessment	90th % tile hours	<4.0 hrs.	4.3	4.0	3.8		3.8	4.3	
Effective	30 Day Readmission Rate for QBP CHF patients	percent	<13.8%	16.7%	19.1%	17.6%		18.4%	18.8%	
Effective	High Users Cumulative LOS as a proportion of All LOS in acute care	percent	CB	10.6%	9.7%	8.1%	10.0%	10.0%	12.36%	
Safety	Medication Reconciliation done on Discharge	percent	>76.5%	89.5%	93.2%	92.8%	94.3%	94.3%	75.4%	
Safety	Medication Reconciliation done on Admissions and Transfers	percent	>84%	87.3%	87.5%	88.2%	88.8%	88.8%	79.3%	
Safety	Delirium Screening performed for Elderly Patients within 24 hours of Admission	percent	>70%	81.9%	85.6%	82.6%	83.8%	83.81%	n/a	
Safety	*Clostridium difficile* Infection rate	rate per 1000PD	<.26	0.18	0.27	0.28	0.24	0.24	0.27	

Glossary of Terms

Term		Definition
Current Value		The Current Value is the curent fiscal year-to-date value calculated for the indicator. Most indicators are measured quarterly and the reporting period is communicated on the top right corner of the summary sheet (Page 1). For those indicators that are measured monthly, the reporting month will appear on the indicator detail page.
Performance Goal		Performance Goal--This is the goal for each indicator as outlined in the CKHA Strategic Plan/QIP
Current Status		Red indicates that the performance indicator has not met the performance goal for the current reporting period, and has not improved over the prior reporting period
		Yellow indicates that the currrent performance has not met the performance goal but has improved over the prior period
		Green indicates that the performance indicator has met or exceeded or is not statistically different than the performance goal for the current reporting period.
Performance Trend		Performance has improved over the previous reporting period.
		Performance has decreased over the previous reporting period.
		Performance has not changed over the previous reporting period.

Indicator	**ED Physician Initial Assessment**
Success Factor	**Timely Access**
Timeframe	**2016-17 Feburary**
Data Source	**CCO Level 1 NACRS**

Performance Management Summary

Definition:

Time to Physician Initial Assessment (PIA)--Defined as the time from registration date/time or triage date/time (whichever is earlier and valid) to the physcian initial assessment date/time; ED Wait times: 90th percentile ED time to Provider Initial Assessment (PIA) time for all ED patients is measured monthly through Access to Care--Cancer Care Ontario.

Significance

PIA is one of the most important Emergency Department (ED) wait time metrics--it represents safe patient care (by ensuring our patients are assessed by a Physician in a timely manner) and is also highly linked to patient satisfaction within the ED. Furthermore, by reducing the time to PIA we should be able to reduce all other wait time indicators at the same time, so the level of impact on the overall ED wait times is quite significant.

Performance Goal:

The target is set to 4.0 hours with plan to reach Provincial benchmark (3.0 hrs) in two year.

Current YTD Value	Previous YTD Value	Target	Indicator Status
3.8 hrs	4.3 hrs	< 4.0 hrs	Have exceeded target

Provider Initial Assessment Time

(P4R indicator, ALL visits PGH only)
Source: iPort Level 1 NACRS

Analysis

The gap between the Provincial benchmark is large we are setting a goal to reach established benchmark in two years. PIA 2015/16 was 4.3 hours Established benchmark is 3.0hrs

High User Cumulative LOS--drill down

Action	Lead	Date Initiated	Current Status
1)Development and Implementation of a "Rapid Assessment Zone " (RAZ) in the Emergency Department 2)Establish a culture of empowerment, knowledge based decision making, teaching and learning regarding the provincial indicators of Provider Initial Assessment (PIA) and ED length of stay (ED LOS)	Eleanor Groh	Apr-16	Ongoing

Indicator	**30 Day Readmission Rate for QBP CHF patients**
Success Factor	**Effective Collaboration**
Timeframe	**2016-17 February**
Data Source	**Discharge Abstract Database (DAD), CIHI**

Performance Management Summary

Definition:

The rate of patients returning to hospital with their index admission being diagnosis of congestive heart failture (CHF) and qualifying as a Quality Based Procedure (QBP) cohort, within 30 days for all-cause as a proportion of all patients admitted that month for CHF (QBP). Rates are expressed per 100 CHF QBP patients.

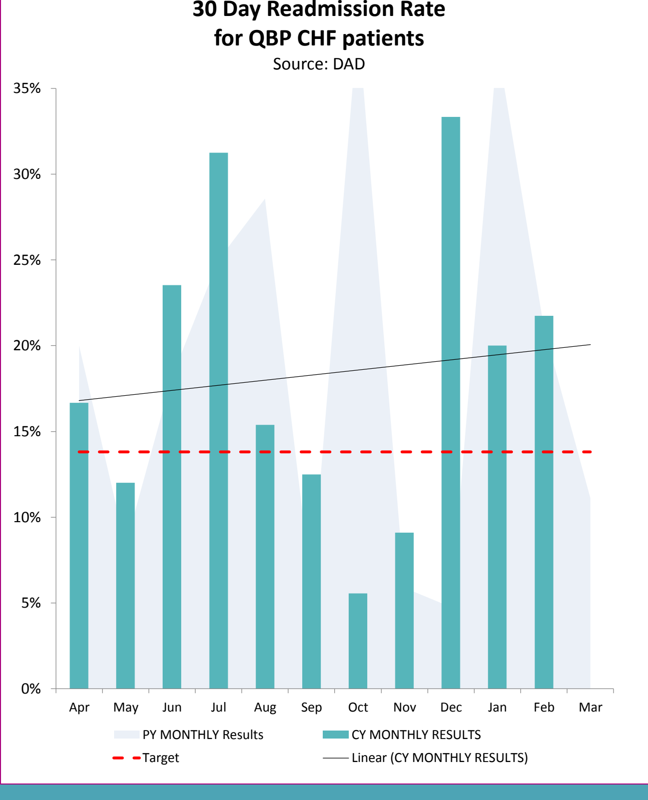
Significance:

CHF patients have the highest rate of readmissions in Ontario(Health Quality Ontario & Ministry of Health and Long-Term Care, 2013). More than 1 in 5 CHF patients in Ontario are re-admitted to an acute care institution within 30 days of their inital hospital admission. Health Quality Ontario (HQO) introduced indicators for QBP cohorts (CHF, COPD and Stroke) for 2016-17 QIP. CHF was chosen as an indicator that best reflects intergration with our comunity partners. All the QBP cohorts returning to CKHA within 30 days, were below target for readmissions rates, however, the rate for CHF was on the rise.

Performance Goal:

The target is set at 13.8%

Current YTD Value	Previous YTD Value	Target	Indicator Status
15.4%	**18.5%**	**< 13.8%**	**Opportunities for improvement**



Analysis

Performance last two years 15.4% and 15.9% respectively, 10% reduction-consistent with our LHIN partners working on integrated plan.

Action Plan

Action	Lead	Date Initiated	Current Status
1)Work on process to facilitate notification of Primary Care Providers via e-notification when patient discharged from hospital Chatham -Kent Quality Integration Committee has been formed. Member representation includes, Hospital, LTC, PCP, FHT, CHC, CCAC. This team will work with Transform (IT provider) to create e-notification 2)Formation of a team that's membership is cross sectorial to reduce 30 day readmission rates. Known as "Chatham-Kent Quality Integration Project" Team will meet monthly, facilitated by Erie St.Clair LHIN Health System Manager. Each sector represented has QIP change initiatives associated with reducing readmission rates 3) Review if all charts of patients readmitted in Quarter 2 to identify any potential improvement opportunities. Roll-out of CHF Care Path/Action Plan to ICU and Emergency Departments	Lisa Northcott	Apr-16	Ongoing

Indicator	**Cumulative LOS for High Users as a percentage of all LOS in acute care during the same period**
Success Factor	**Effective**
Timeframe	**2016-17 Mar**
Data Source	**STAR Registration**

Performance Management Summary

Definition:

"High users" are defined as patients who have 3 or more admissions within the 365 day look back period and greater than 30 day cumulative LOS, Cumulative LOS of the High User group admitted to CKHA (acute inpatient) within 365 day look back period for any cause is expressed as a % of all LOS to acute care in the same look back period.

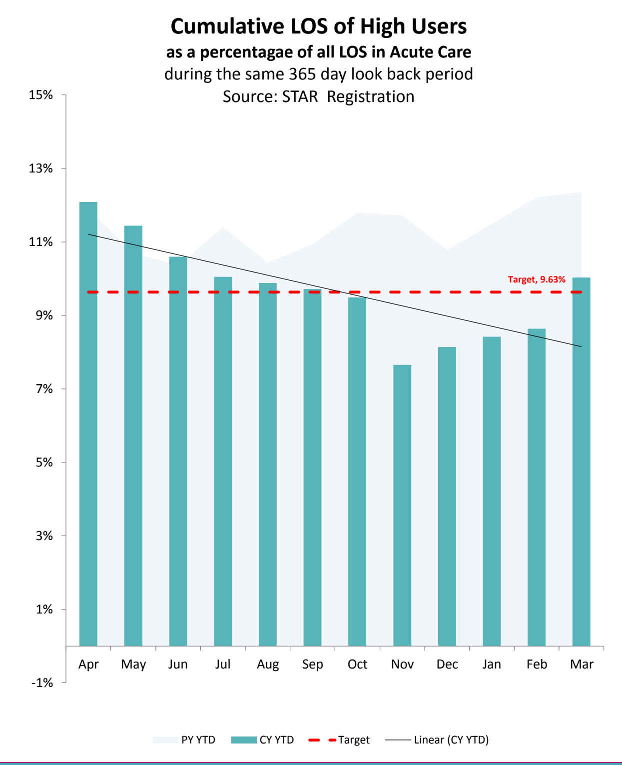
Significance:

Research has demonstrated that a small proportion of the population uses a large percentage of health care resources; This indicator is a measure of health system performance as it relates to appropriateness and efficiency of care among all inpatients (regardless of clinical condition) receiving care in acute hospitals.

Performance Goal:

Collecting Baseline

Current YTD Value	Previous YTD Value	Target	Indicator Status
10.0%	**12.4%**	**CB** %	Collecting Baseline



Analysis

By identifying the patients in the active High User group, individual strategies will be developed and employed to reduce admissions amongst this group. Target is to reduce readmission rate by 10%, however this is a new indicator and we are still collecting baseline. Crude estimate for January 2016- Dec 2016 is. 10.7%.

Action Plan

Action	Lead	Date Initiated	Current Status
1)When a client who is identified as a "high user" is admitted to hospital the CKHA discharge planner and the client's community case manager will meet with client while in hospital 2)Patients defined as "high user" admitted to CKHA will have their community case manager meet with them while in hospital or within three business days of discharge 3)Patients defined as "high users" will have an individualized action plan implemented or action plan revision while in hospital or within seven business days of discharge		Apr-16	Ongoing

Indicator	**Medication Reconciliation on Discharge**
Success Factor	**Safety**
Timeframe	**2016-17 Mar**
Data Source	**Manual Count Numerators and STAR Registration Denominators (Adm, Trn and Dis)**

Performance Management Summary

Definition:

Total number of adult acute care discharges with medications reconciled as a proportion of the total number of adult acute care discharges (Measured on Medicine and Rehabilitation units only)

% Med Recs done on

●Medicine ● Rehab ● Stroke / patient discharged from those units

Significance:

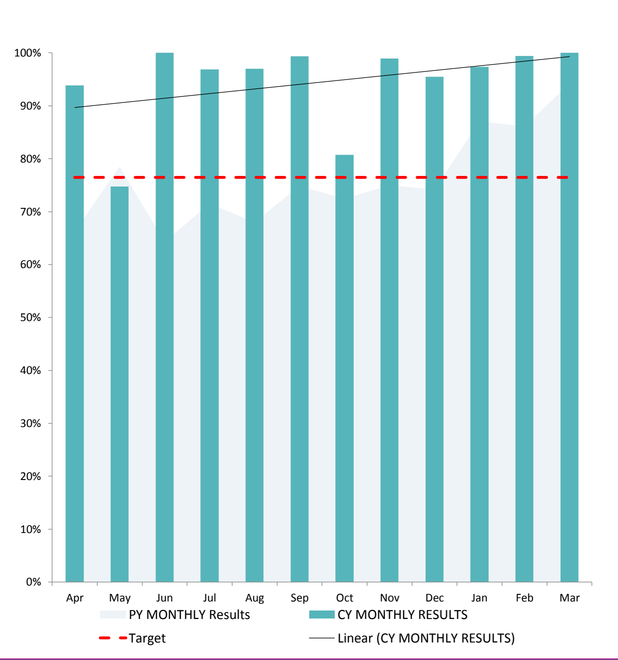
By identifying and resolving medication discrepancies, the likelihood of adverse events occurring within health care organizations across the continuum of care will be reduced. Mediciation Reconciliation is performed at three touch points in a patient's journey through CKHA. On admission, with transfers within the hospital and at discharge. Accredication ROP and Safety CSPI standards guide the implementation of the protocol

Performance Goal:

The target is set to 76.5%

Current YTD Value	Previous YTD Value	Target	Indicator Status
94.3%	75.4%	> 76.5%	Have exceeded target

Analysis



Action Plan

Action	Lead	Date Initiated	Current Status
1)Realignment of Pharmacy resources to meet demand for Med Rec at discharge Pharmacy Technician participation in daily "bullet" rounds to identify 24 hour discharge/transfer potential. Analysis of admission/transfers occurring that are not receiving med rec currently to inform realignment/reassignment of resources 3)Enhance method of collecting statistics for Medication Reconciliation	Nancy Kay		Ongoing

Indicator Medication Reconciliation on Admission and Transfers
Success Factor Safety
Timeframe 2016-17 Mar
Data Source Manual Count Numerators and STAR Registration Denominators (Adm, Trn and Dis)

Performance Management Summary

Definition:

The total number of adult care admissions and transfers with medications reconciled on the following units; Medicine, Mental Health, ICU/PCU, Surgery as a proportion of the total number of adult care admissions and transfers to those units.
% Med Recs done on ●Medicine ●Psych ●ICU ●PCU ●Surgery
/patients admitted or transferred to those units

Significance:

By identifying and resolving medication discrepancies, the likelihood of adverse events occurring within health care organizations across the continuum of care will be reduced. Mediciation Reconciliation is performed at three touch points in a patient's journey through CKHA. On admission, with transfers within the hospital and at discharge. Accredication ROP and Safety CSPI standards guide the implementation of the protocolIncrease the percentage of patients receiving Medication Reconciliation in designated units by 5%

Performance Goal:

The target is set to 84%

Current YTD Value	Previous YTD Value	Target	Indicator Status
88.8%	79.3%	> 84.0%	Have exceeded target

Medication Reconciliation on Admission and Transfers

Admission/Transfers into Medicine, Psych, ICU, Pcu SurgeryUnits

100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar
PY MONTHLY Results
CY MONTHLY RESULTS
Target
Linear (CY MONTHLY RESULTS)

Analysis

Action Plan

Action	Lead	Date Initiated	Current Status
1)Realignment of Pharmacy resources to meet demand for Med Rec at admission Pharmacy Technician participation in daily "bullet" rounds to identify 24 hour discharge/transfer potential. Analysis of admission/transfers occurring that are not receiving med rec currently to inform realignment/reassignment of resources	Nancy Kay	Apr-15	Ongoing

Indicator	**Elderly Patients screened for Delirium using Confusion Assessment Method (CAM) done within 24 hours of Admission**
Success Factor	**Patient-Centered Care--Care of the Elderly**
Timeframe	**2016-17 Mar**
Data Source	**CAM Assessment Report from Care Manager and STAR Registration**

Performance Management Summary

Definition:

Delirium is a temporary disturbance in consciousness with changes in cognition. Daily assessments Confusion Assessment Method (CAM assessments) monitor these disturbances. The indicator is the percentage of patients (65 and older) receiving delirium screening daily using a validated tool upon admission to hospital. (Includes Medicine, ICU only)

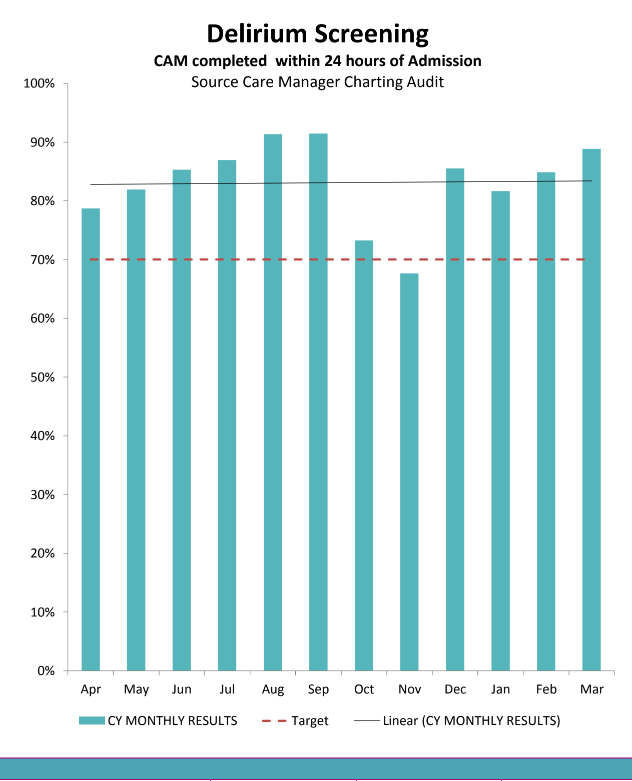
Significance:

Reduce rates and duration of delirium episodes in admitted patients over 65 years of age. Delirium can be reduced by implementing strategies such as identifying and treating its underlying causes, assessing sedation every day, displaying calendars and clocks, and encouraging visitors. Develop a standardized protocol for preventing or managing delirium, including identifying and treating underlying causes; implement non-drug strategies such as early mobility; implement environmental strategies such as visible daylight; reassess sedation daily.

Performance Goal:

The target is set at 70% of patients 65 and over, will have CAM assessments completed within 24 hours of admission

Current YTD Value	Previous YTD Value	Target	Indicator Status
83.8%	new indicator	**> 70.0%**	**Have exceeded target**



Analysis

Action Plan

Action	Lead	Date Initiated	Current Status
1)Patients 65 and older admitted to ICU and Medicine will receive delirium screening using a validated tool within the first 24 hours admission and daily 2)Development of an electronic tool to audit completion of validated delirium screening tool at admission and daily for all patients on Medicine and ICU	Lisa Northcott	Apr-16	Ongoing

Indicator	**Clostridium difficile Infection rate (per 1000 patient days)**
Success Factor	**Safety**
Timeframe	**2016-17 Mar**
Data Source	**Self Reporting Initiative (SRI) MoHLTC**

Performance Management Summary

Definition:

CDI rate per 1,000 patient days: Number of patients newly diagnosed with hospital-acquired CDI during the reporting period, divided by the number of patient days in the reporting period, multiplied by 1,000.

Significance:

Clostridium difficile (C.difficile) is a bacterium that causes mild to severe diarrhea and intestinal conditions like pseudomembrancus colitis (inflammation on the colon) C.difficile is the most frequent casue of infectioius diarrhea in hospitals and long-term care facilities in Canada. For healthy people, C. difficile does not pose a health risk. The elderly and those with other illnesses or who are taking antibiotics, are at greater risk of infection. Most cases of C.difficile occur in patients who are taking certain anitiotics in high doses or over a prolonged period of time. C. difficile bacteria and their spores are found in feces. People can get infected if they touch surfaces contaminated with feces, and then touch their mouth. Healthcare workers can spread the bactiera to their patients if their hands are contaminated.

Performance Goal:

Goal was set at .26 per 1000 PD. This is an improvement of 3.7% over last years performance. Previous years performance was .27 and Provinical Benchmark (2015-16) was .27 per 1000 PD.

Current YTD Value	Previous YTD Value	Target	Indicator Status
0.23 Rate per 1000 PD	**0.25** Rate per 1000 PD	< **0.26** Rate per 1000 PD	**Have exceeded target**

Clostridium difficile Infection rate
(per 1000 patient days)
Corporate Rate and # of Cases per month
SRI Infection Control

Analysis

Other areas to watch are participation in an Antibiotic Stewardship Program, Hand Hygiene, and Environmental Cleaning

Action Plan

Action	Lead	Date Initiated	Current Status
		2008 SRI began	Ongoing