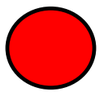
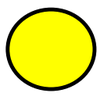
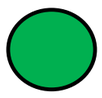
CKHA Quality Improvement Plan (QIP) Scorecard

2017-18

Quality dimension	Performance Indicator	2017-18 Performance Goals	Current Value	Page
Safety	**Medication Reconciliation completed on Discharge**	**100.0%**	**29.6%**	QIP Page 3
Safety	**Medication Reconciliation completed on Admission**	**100.0%**	**72.8%**	QIP Page 4
Patient-centred	**Patient experience "How you would rate your care?" ED Source NRC**	**>58.8%**	**51.7%**	QIP Page 5
Patient-centred	**Patient experience "How would you rate this hospital?" MED/SURG Source NRC**	**>55%**	**53.0%**	QIP Page 6
Effective	**QBP Readmission Rate, all cause to CKHA for Congested Heart Failure, Chronic Obstructive Pulmonary Disease, Pneumonia**	**<10.3%**	**11.4%**	QIP Page 7
Effective	**Patient received enough information on discharge**	**>55%**	**51.1%**	QIP Page 8
Timely	**Emergency Department Physician Initial Assessment (hours)**	**<3.5 hrs**	**4.3 hrs**	QIP Page 9

Glossary of Terms

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	**Medication Reconciliation on Discharge**
Quality dimension	**Safety**
Timeframe	**FY 2017-18**
Data Source	**Manual Count Numerators and STAR Registration Denominators**

Performance Management Summary

Definition:

Medication reconciliation at discharge: Total number of discharged patients for whom a Best Possible Medication Discharge Plan was created as a proportion the total number of patients discharged.

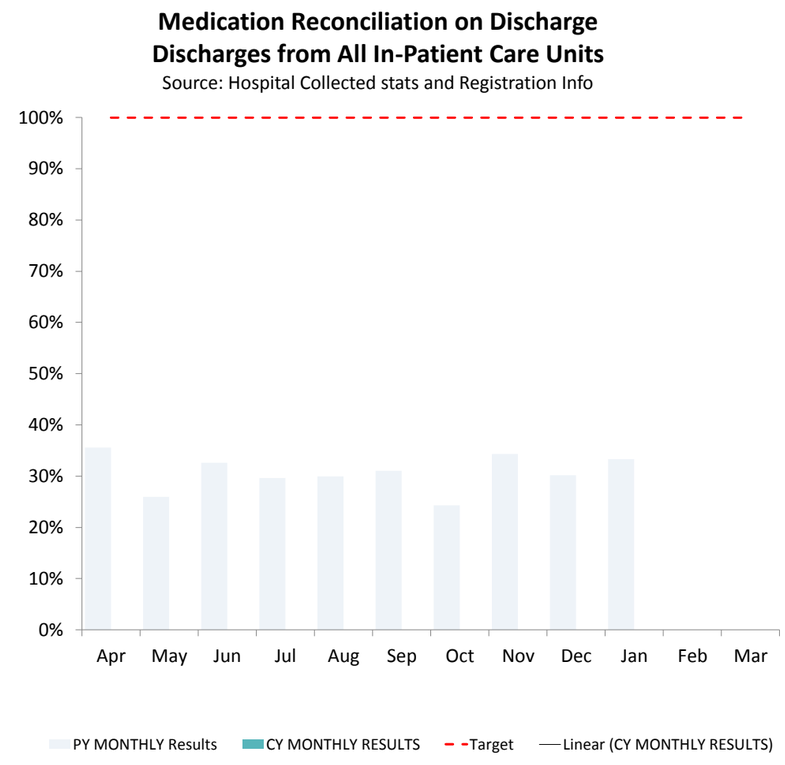
Significance:

Medication Reconciliation can prevent harmful medication errors or adverse drug events when used effectively it can intercept these errors before they lead to an adverse event. Because this practice is so important to the safety of our patients we are striving for a completion target of 100%. Our change ideas associated within this indicator are designed to support our team to get from where we are to 100%. Misses and errors will be viewed as a collaborative learning opportunity rather than a failure.

Performance Goal:

The target is set to 100%.

Current YTD Value	Previous YTD Value	Target	Indicator Status
29.6%	30.7%	> 100.0%	Opportunities for improvement



Analysis

Change

Planned Improvement initiatives (Change Ideas)	Methods	Process measures	Target for process measure	Comments
•Develop process for delivery of Medication Reconciliation on discharge for Inpatient Surgery, Intensive care, Progressive care, Psychiatry and Women and Children's Health.	•Using LEAN methodology conduct a process mapping session with all key stakeholders including patients and families. Deliverables include the development of a process, implementation plan and auditing method	•Completion of processing mapping session, completion of implementation plan and development of auditing process.	•100 % completion of mapping session, implementation plan and auditing method by May 30th, 2017	

Indicator	**Medication Reconciliation on Admission**
Quality dimension	**Safety**
Timeframe	**FY 2017-18**
Data Source	**Manual Count Numerators and STAR Registration Denominators**

Performance Management Summary

Definition:

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

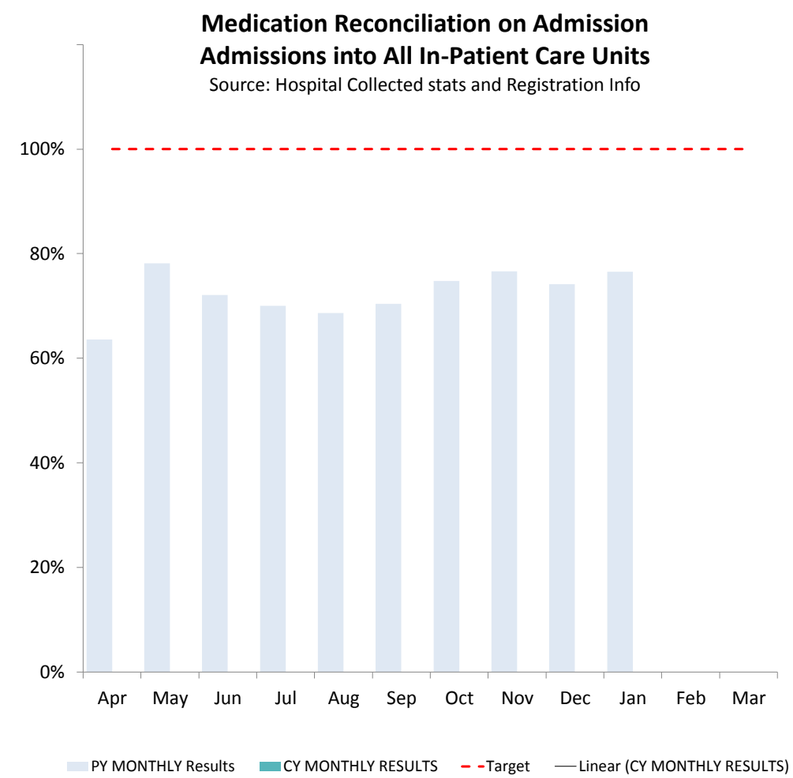
Significance:

Medication Reconciliation can prevent harmful medication errors or adverse drug events when used effectively it can intercept these errors before they lead to an adverse event. Because this practice is so important to the safety of our patients we are striving for a completion target of 100%. Our change ideas associated within this indicator are designed to support our team to get from where we are to 100%. Misses and errors will be viewed as a collaborative learning opportunity rather than a failure.

Performance Goal:

The target is set to 100%

Current YTD Value	Previous YTD Value	Target	Indicator Status
72.8%	**71.8%**	**> 100.0%**	**Opportunities for improvement**



Analysis

Change

Planned Improvement initiatives (Change Ideas)	Methods	Process measures	Target for process measure	Comments
•Develop process for collection of Best Possible Medication History for patients admitted to Women and Children's Health. Identify process and resources required.	•Using LEAN methodology conduct a process mapping session with all key stakeholders including patients and families. Deliverables include the development of a process, implementation plan and auditing method	•Completion of processing mapping session, completion of implementation plan and development of auditing process.	•100 % completion of mapping session, implementation plan and auditing method by September 30th, 2017	

Indicator In-Patient Acute Rate Your Care
Quality dimension Patient-centred
Timeframe YTD 2017/18
Data Source NRC using NRC using CPES Standardized Surveys

Performance Management Summary

Definition:

From NRC Canada results from the Canadian Experience Patient Survey (CPES): "Using any number from 0 to 10, where 0 is the worst hospital possible and 10 is the best hospital possible, what number would you use to rate this hospital during your stay?" - For Inpatient Med/Surg (add together % of those who responded with score of 9 or 10)

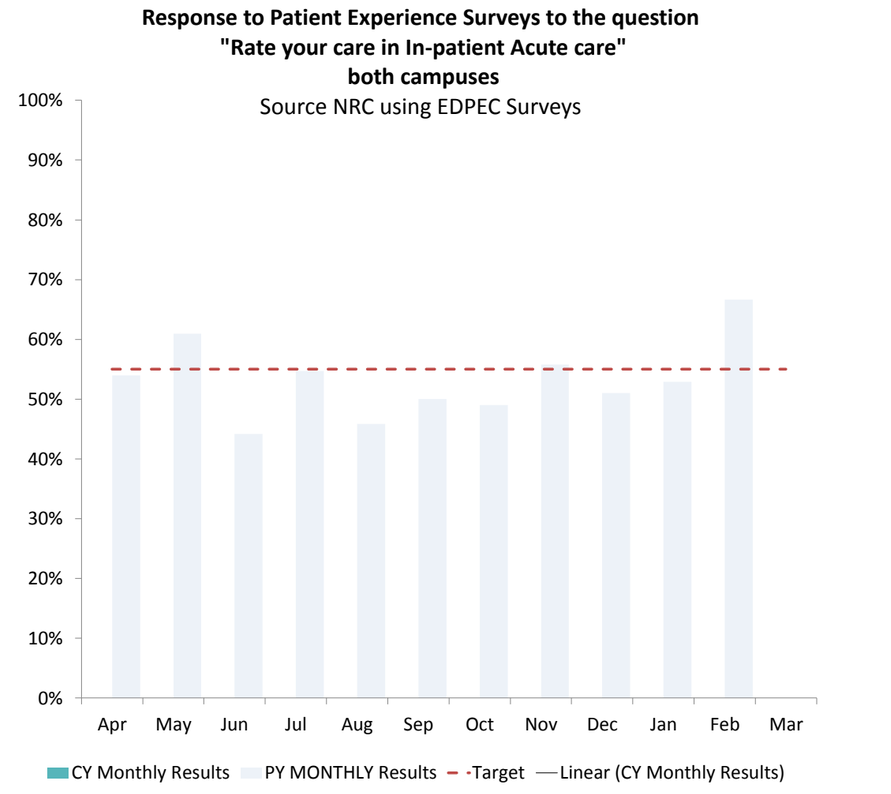
Significance

Measuring patient experience and satisfaction with the care they have received is an important indicator for measuring the quality in health care. Patient satisfaction affects clinical outcomes. It affects the timely, efficient, and patient-centered delivery of quality health care. Patient satisfaction is a very effective indicator to measure the success of hospitals and the staff who deliver care. This indicator is the voice of our patients and provides us with rich information on what we are doing well and what we need to improve on.

Performance Goal:

The survey to measure the patient experience changed April 1, 2016.to the Canadian Institute of Health Information (CIHI) Canadian Patient Experience Survey - Inpatient Care (CPES). The question although similar affect the survey's data comparability. We have been provided with 3 quarters of data related to new survey. We have based target justification on Q1 results which showed best performance in all three quarters.

Current YTD Value	Previous YTD Value	Target	Indicator Status
53.0 %	%	< 55.0 %	Opportunities for improvement



Analysis

Change

Planned Improvement initiatives (Change Ideas)	Methods	Process measures	Target for process measure	Comments
• Patients will be asked daily what their goals are and this will be communicated on the navigator board • Patient feedback (i.e. CPES results)is communicated to all staff on a quarterly basis • Managers of Surgery and Medicine will perform Patient Rounding based on Studor methodology	• Random audits weekly by department manager to identify if goals are recorded on white board. Monitor scores on CPES questions #2, #30 and #31 for improvement. These questions all relate to communication and information sharing • Unit based Quality and Performance Boards will be updated quarterly and results shared in daily staff huddles • Managers will submit monthly report to Program Directors regarding Rounding statistics. They will identify percentage of rounding completed compared to number required. (80 pt.'s/month)	• % CPES questions #2,#30, #31 that are answered "usually " and "always" % navigator boards with goals identified • # of times Unit Based Quality and Performance Boards are updated quarterly with CPES results • Number of patient rounds completed by clinical manager	• By September 2017, 100% of navigator boards audited will have patient identified goals recorded on them • Results will be posted 100% quarterly beginning April 1, 2017 • 100% of patients received manager rounding based on 80 patients/month	•80 patients per month is based on 4 patients per day

Indicator	**ED Rate Your Care**
Quality dimension	**Patient-centred**
Timeframe	**YTD 2017/18**
Data Source	**NRC using EDPEC Standardized Surveys**

Performance Management Summary

Definition:

From NRC Canada results from Emergency Department Patient Experience of Care (EDPEC) "Using any number from 0 to 10, where 0 is the worst care possible and 10 is the best care possible, what number would you use to rate your care during this emergency department visit?" - ED at Chatham and Sydenham Campus (add together % of those who responded 9 or 10)

Significance

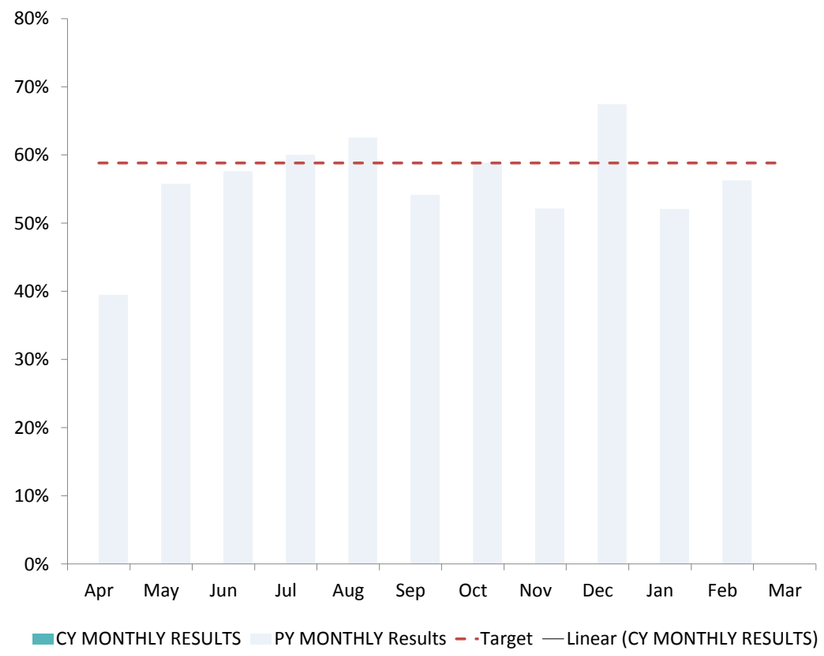
Measuring patient experience and satisfaction with the care they have received is an important indicator for measuring the quality in health care. Patient satisfaction affects clinical outcomes. It affects the timely, efficient, and patient-centered delivery of quality health care. Patient satisfaction is a very effective indicator to measure the success of hospitals and the staff who deliver care. This indicator is the voice of our patients and provides us with rich information on what we are doing well and what we need to improve on.

Performance Goal:

The survey to measure the patient experience changed April 1, 2016 to the Canadian Institute of Health Information (CIHI) Canadian Patient Experience Survey. Emergency Department (EDPES). The questions although similar affect the survey's data comparability. The results from Q1 show performance above average. We have reviewed preliminary data from the following 2 quarters related to new survey. Results from Q2 and Q3 show increases beyond Q1.

Current YTD Value	Previous YTD Value	Target	Indicator Status
51.7 %	%	< 58.8 %	Opportunities for improvement

Response to Patient Experience Surveys to the question
"Rate your care in ED"
both campuses
Source NRC using EDPEC Surveys



Analysis

Change

Planned Improvement initiatives (Change Ideas)	Methods	Process measures	Target for process measure	Comments
•Establish and maintain a program for the Emergency Department team for clear communication and patient education. •Conduct nurse leader rounding on patients in the ED following a standard process with established expectations of nurse leader.	• Facilitate learning that assures competency of the ED team in patient education, communication and cultural appreciation by providing staff training • Establish nurse leader expectations and standards for rounding as well as tracking requirements	•% of ED team (including Registration staff, Nurses and Physicians) who attend education sessions •% of required patients seen by nurse leader	•100% attendance at education sessions. •100% of required patients seen by nurse leader	

Indicator 30 Day Readmission Rate for QBP CHF, COPD, and Pneumonia patients
Quality dimension Effective Collaboration
Timeframe YTD FY 2017-18
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 failure (CHF), Chronic Obstructive Pulmonary Disease (COPD) or Pneumonia, 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, COPD or Pneumonia (QBP). Rates are expressed per 100 total of CHF, COPD and Pneumonia QBP patients.

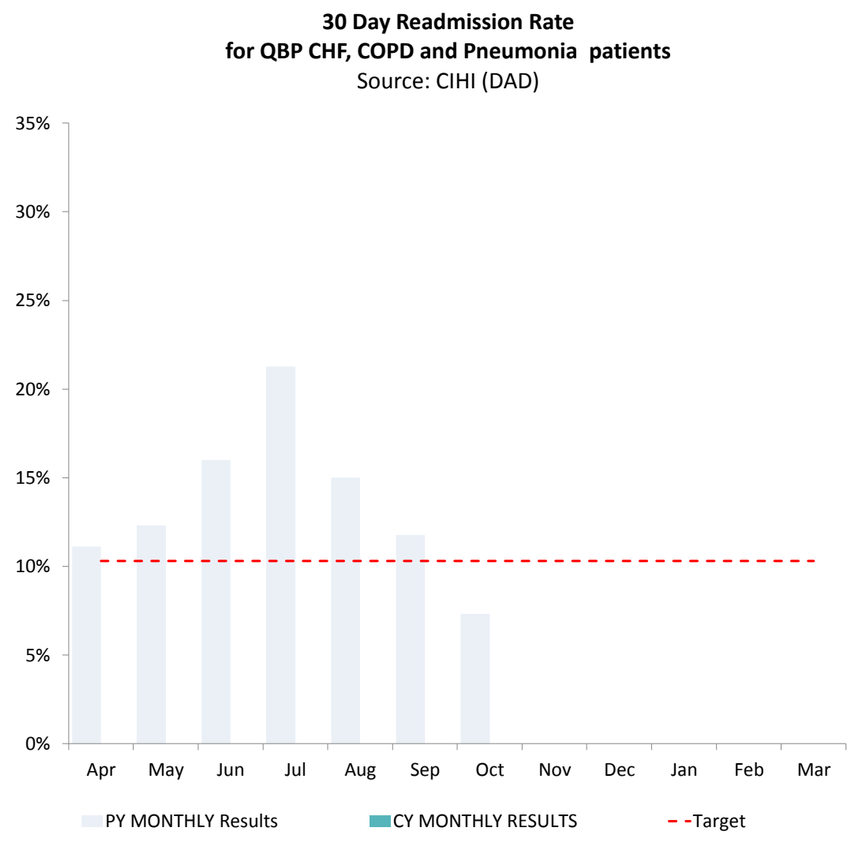
Significance:

CHF, COPD and Pneumonia patients have a high rate of readmissions in Ontario. More than 1 in 5 CHF patients in Ontario are re-admitted to an acute care institution within 30 days of their initial hospital admission. Health Quality Ontario (HQO) encouraged using indicators for QBP cohorts (CHF, COPD and Stroke) for 2016-17 QIP. The Cohort is small in volume for just one QBP here at CKHA; by combining the three QBPs the indicator better trends the quality of care given to these patients and reflects our effort to integrate with our community partners. All these QBP cohorts returning to CKHA within 30 days, were below Provincial rates for readmissions, however, the rate for these three combined was on the rise. We hope to reverse that trend.

Performance Goal:

CKHA chose to address these three conditions together as we have put significant focus on strategies to prevent readmissions for these QBPs. Our goal is to reduce by 10%

Current YTD Value	Previous YTD Value	Target	Indicator Status
11.95%	10.80%	< 10.30%	Opportunities for improvement



Analysis

Change

Planned Improvement initiatives (Change Ideas)	Methods	Process measures	Target for process measure	Comments
•Develop profile of readmitted patients to explore and identify existence of common themes resulting in readmission •Implement the use of a validated tool to assess patient risk of readmission •Increase collaboration between CCAC and CKHA when patients discharged to ensure patients are being referred to CCAC	•Chart reviews of all 30 day readmissions for COPD, CHF, Pneumonia cohorts •Identify tool to be implemented, develop an implementation plan including education •Increase communication between CCAC coordinators and Inpatient Units regarding patients admitted with CHF, COPD, Pneumonia as well as education regarding referral process.	•% of readmitted patient charts reviewed •2017/18 Q2- tool identified 2017/18 Q3- Implementation plan completed 2017/18 Q4- Implementation •Develop a process that will validate referrals are being received by CCAC	•100% of readmitted patient charts will be audited •September 2017- Validated tool to assess patient risk of readmission will be chosen November 2017- Implementation Plan Complete February 2018- All admitted patients that meet criteria will be assessed for risk of readmission using validated tool •Increase % of patients admitted with CHF and COPD referred to CCAC on discharge	

Indicator Patient Survey Response to "Did you receive enough information about your condition or treatment after you left the hospital?
Quality dimension Effective
Timeframe YTD FY 2017-18
Data Source NRC Standardized Inpatient Care (CPES) Surveys

Performance Management Summary

Definition:

NRC Survey results in response to this question "Did you receive enough information from hospital staff about what to do if you were worried about your condition or treatment after you left the hospital?" surveys sent to all patients from inpatient acute.

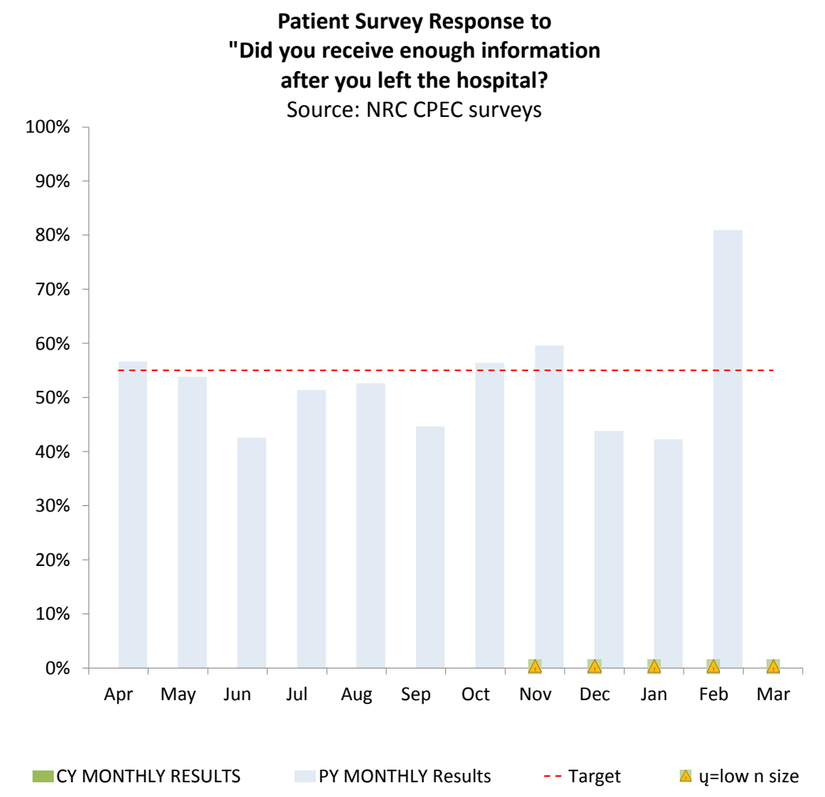
Significance:

The more a patient knows about the management of his/her own condition, the better the outcome during their post hospital recovery. When patient/family and caregivers have the same goal and plan as the healthcare provider, they're less likely to relapse and need rehospitalization. This is accomplished through patient/family education, discharge instructions, appropriate support in the home and follow-up with physicians, both primary care and specialists, when necessary.

Performance Goal:

Benchmark not yet available from NRC as this is a new survey. The results from Q1 2016-17 were 51.1%

Current YTD Value	Previous YTD Value	Target	Indicator Status
51.1%		55.0%	Opportunities for improvement



Analysis

Change

Planned Improvement initiatives (Change Ideas)	Methods	Process measures	Target for process measure	Comments
•Implementation of patient orientated discharge summaries (PODS) in partnership with University Health Network Open Lab on CKHA's inpatient rehabilitation unit. This initiative will result in the development of discharge plans and discharge procedures in collaboration with patients and families' •Implement clinician to clinician information transfer close to time of discharge i.e. Hospital MRP to Primary Care Provider	•Manually collect data on the number of patients discharged from the inpatient Rehabilitation unit who have PODS documentation on their chart at time of discharge. •Conduct focus groups with clinicians to develop a process to facilitate information transfer at time of discharge	•% of patients discharged from inpatient Rehabilitation unit who have PODS documentation on their chart at time of discharge. •% of clinicians who participate in stakeholder focus groups % of clinicians who implement process	•50% of patients discharged from inpatient Rehab will have documentation of PODS on discharge by September 2017 and 80% by December 2017. •One Family Health Team implements clinician to clinician information transfer process	•PODS development will commence in May 2017 with a goal to have implemented in inpatient Rehabilitation in year 1. •In year 2, we plan to spread PODS to inpatient Medicine and Surgery

Indicator ED Physician Initial Assessment
Quality dimension Timely Access
Timeframe YTD 2017/18
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 physician 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

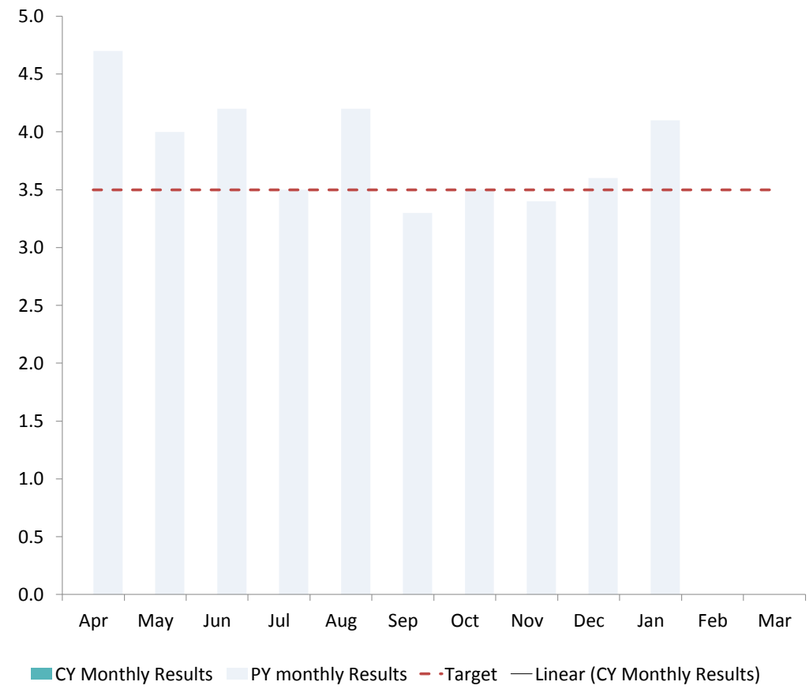
PIA is one of the most important Emergency Department (ED) wait time metrics--it represents safe patient care (by ensuring our patients are assessed by a Physician in a timely manner) and is also highly linked to patient satisfaction within the ED. Furthermore, by reducing the time to PIA we should be 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:

Ontario Benchmark is 3.0. CKHA will attempt to achieve this over next 48 months

Current YTD Value	Previous YTD Value	Target	Indicator Status
3.8 hrs	4.3 hrs	< 3.5 hrs	Opportunities for improvement

Provider Initial Assessment Time
(P4R indicator, ALL visits PGH only)
Source: iPort Level 1 NACRS



Analysis

Change

Planned Improvement initiatives (Change Ideas)	Methods	Process measures	Target for process measure	Comments
•Analyze all ED visits to identify trends in visit volumes and visit times and adjust Provider hours to match these trends •Reduce ED processes where work and tasks completed are not value added and increase patient length of stay in the ED	•Engage key stakeholders to analyze data and develop schedules Interdisciplinary Work Group (Physicians, Nurses, Patient Flow, Leadership, Lab, D.I) will identify areas for improvement using LEAN methodology	•Provider staffing levels will match peak visit volume •Number of projects implemented per quarter that result in measureable improvement in at least one P4R indicator	•Scheduling changes will be complete and implemented by September 2017 •1 project per quarter	