QUALITY IMPROVEMENT PLAN (QIP) SCORECARD 2022/2023

Vision: Exceptional Care. Always.

Mission: Our Team collaborates to provide exceptional patient-centered care

Values: *ICARE* *Integrity* - *Compassion* - *Accountability* - *Respect* - *Engagement*

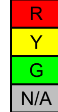
Instructions: Clicking on the indicator takes the user to additional supporting details.

RECOVERY					
Indicator	**Reference**	**Q1**	**Q2**	**Q3**	**Q4**
Emergency Visits - Wait Time for Inpatient Bed (TIB)	QIP/OPT	R	R	R	Y
Inpatients Receiving Care in Unconventional Spaces/Day	QIP	G	G	G	G
Repeat ED Mental Health Visits	QIP/HSAA/MSAA	G	G	Y	N/A

INTEGRATION					
Indicator	**Reference**	**Q1**	**Q2**	**Q3**	**Q4**
Discharge Summary Sent to Primary Care Within 48 Hours	QIP	Y	G	G	R
Medication Reconciliation on Discharge Rate (ROP)	QIP/Accreditation	G	G	G	G

PEOPLE					
Indicator	**Reference**	**Q1**	**Q2**	**Q3**	**Q4**
Patient Experience Survey: Information	QIP	N/A	N/A	N/A	N/A
Workplace Violence Prevention - Incidents	QIP	G	R	R	Y

Results:



Metric underperforming target	R
Metric within 10% of target	Y
Metric equal to or outperforming target	G
Data not available	N/A

Overall Indicator Performance:	Q1	Q2	Q3	Q4
% Indicators equal to or outperforming targets:	64%	73%	64%	40%
% Indicators within 10% of targets:	27%	0%	9%	30%
% Indicators underperforming targets:	9%	27%	27%	30%

Reference Definitions:

Accreditation - Accreditation Canada

Board - Board Directed

HSAA - Hospital Services Accountability Agreement

MoHLTC - Public Reporting Requirement; Ministry directive

MSAA - Multi-Sector Service Accountability Agreement

OPT - (Annual) Operating Plan Target

Senior Friendly - Senior Friendly Initiative (HSAA)

QIP - Quality Improvement Plan

Indicator: Emergency Visits - Wait Time for Inpatient Bed (TIB)

Strategic Direction: RECOVERY

Definition: This is a mandatory QIP indicator. The indicator is measured in hours using the 90th percentile, which represents the time interval between the Disposition Date/Time Patient Left the Emergency Room Department for admission to an Inpatient bed or Operating Room.

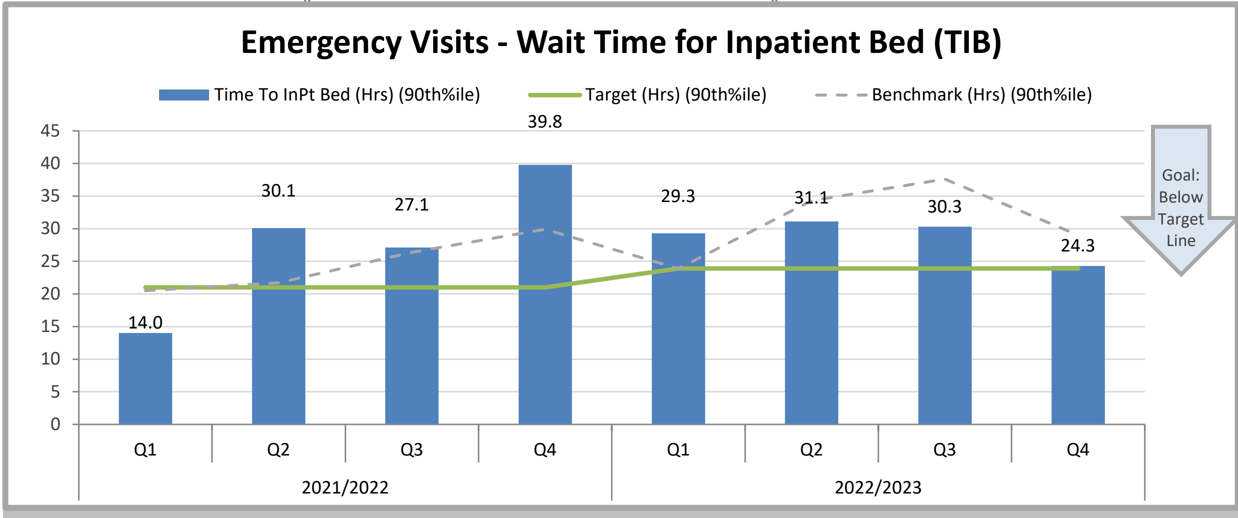
Significance: Time is crucial to the effectiveness and outcome of patient care, especially for emergency patients. In conjunction with other indicators, this can be used to monitor the inpatient bed turnover rate and the total length of time admitted patients spend in the ED in an effort to improve the efficiency and, ultimately, the outcome of patient care. The 90th percentile of this indicator represents the maximum length of time that 90% of patients in the ED wait for an inpatient bed or an operating room in the ED.

Data Source: Anzer -NACRS

Target Information: Target set in accordance to QIP indicator. Based on quarterly ATC ER Fiscal Year Report 'Medium-Volume Community Hospital Group' results.

Benchmark Information: Benchmark set in accordance to QIP indicator. Based on quarterly ATC ER Fiscal Year Report 'Medium-Volume Community Hospital Group' results.

	2021/2022				2022/2023			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Time To InPt Bed (Hrs) (90th%ile)	14.0	30.1	27.1	39.8	29.3	31.1	30.3	24.3
Benchmark (Hrs) (90th%ile)	20.5	21.7	26.4	29.9	23.9	34.3	37.6	29.0
Target (Hrs) (90th%ile)	21.0	21.0	21.0	21.0	23.9	23.9	23.9	23.9



Performance Analysis:

Q1 Target not met but trending downward when comparing to Q4 of last fiscal year.
Q2 Target not met this quarter but trending below benchmark hospitals.
Q3 Target not met this quarter, but continue to trend below our benchmark Medium-Volume Community Hospitals.
Q4 Results slightly above target this quarter but continue to trend downwards and below our benchmark Medium-Volume Community Hospitals.

Plans for Improvement:

Q1 In Q1 CCH continued to maintain surge capacity beds to maintain additional inpatient beds. We were unable to occupy inpatient hall way beds on the inpatient units related to Infection Control restrictions. There were multiple COVID-19 outbreaks that impacted the Inpatient flow out of the Emergency Department (ED). We maintained our ED Flow Nurse position which facilitates flow within and out of the ED. Work was done with Decision Support to clarify our use of ED ISO, directly improving our time to inpatient bed.

Q2 In Q2 CCH continued to maintain surge capacity beds to maintain additional inpatient beds through most of this time period. We were still unable to occupy inpatient hall way beds on the inpatient units related to Infection Control restrictions. There were multiple COVID-19 outbreaks that impacted the Inpatient flow out of the Emergency Department (ED). We maintained our ED Flow Nurse position and expanded our Flow Nurse coverage, which facilitates flow within and out of the ED. We have experienced a high number of patients awaiting a bed on our Inpatient Mental Health Unit, attributing to the increase in Time to Inpatient Bed. Similar trends have been experienced across the Province.

Q3 In Q3 CCH continued to maintain surge capacity beds to maintain additional inpatient beds, including both in the Auditorium and beds in the hall way on inpatient units. There were multiple COVID-19 outbreaks that impacted the Inpatient flow out of the Emergency Department (ED). We maintained our ED Flow Nurse position and continued our expanded our Flow Nurse coverage, which facilitates flow within and out of the ED. Similar trends have been experienced across the Province.

Q4 In Q4 CCH continued to maintain surge capacity beds to maintain additional inpatient beds through most of this time period. We were able to utilize hallway beds on the Inpatient Units when seeing increased inpatient volumes. There were multiple COVID-19 outbreaks that impacted the Inpatient flow out of the Emergency Department (ED). We maintained our ED Flow Nurse position and expanded our Flow Nurse coverage, which facilitates flow within and out of the ED. We have experienced a high number of patients awaiting a bed on our Inpatient Mental Health Unit, attributing to the increase in Time to Inpatient Bed. Similar trends have been experienced across the Province. We optimized the use of our apple indicator through this time period. We have had regular discussions with our Patient Flow team to for awareness and improvement of this indicator.

Accountable: Chief of Information and Operating Officer / Manager, Emergency Department

Indicator: Inpatients Receiving Care in Unconventional Spaces per Day

Strategic Direction: RECOVERY

Definition: This indicator measures the average number of inpatients admitted to bed/stretcher, etc. that is placed in an unconventional space to receive care at 12am. (Excludes patients admitted and discharged within same day). An unconventional space is an area in a hospital, which has been enabled to place beds to provide care to inpatients. Unconventional spaces refer specifically to the placement of a bed in any place spacious enough, i.e. an office, hallways, including hallways in the emergency department or inpatient unit, or auditorium that does not meet the required fire and safety standards. Patients placed in beds in unconventional spaces do not have access to nurse call-bell, washrooms, suction, oxygen, etc.

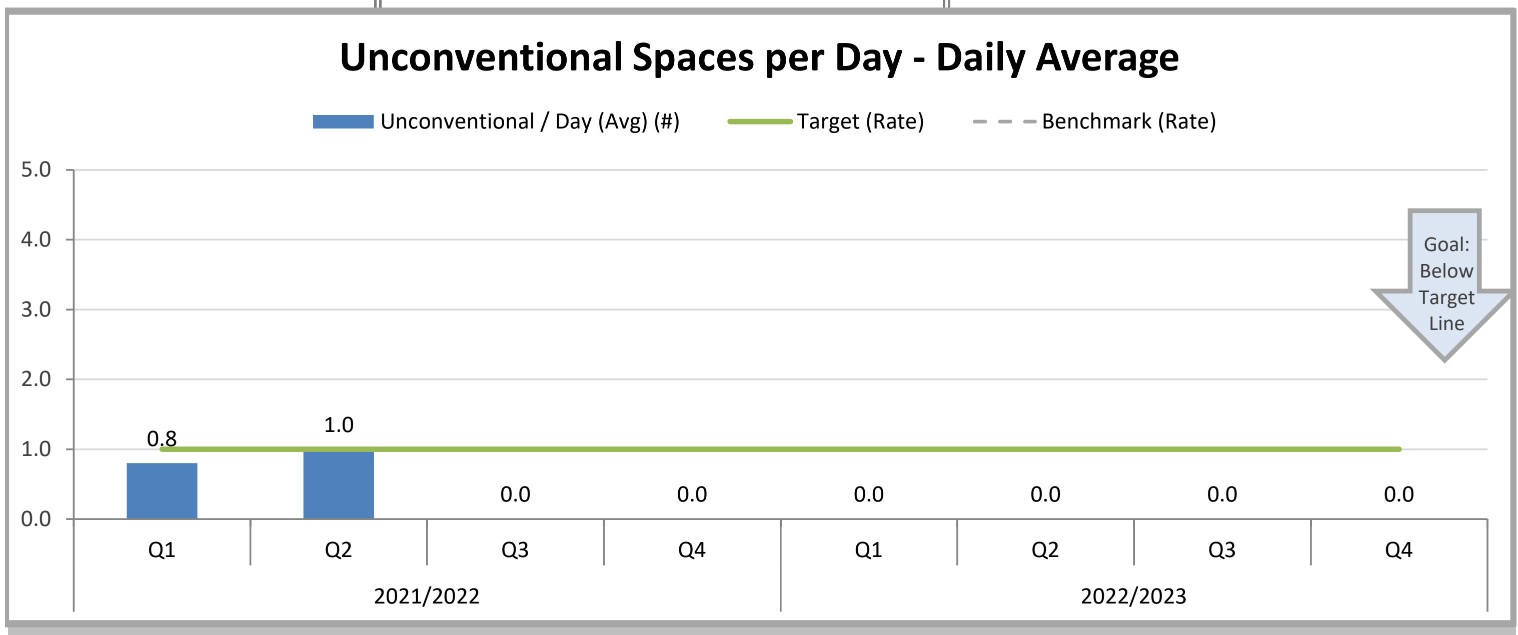
Significance: This indicator provides contextual information on the average number of patients who were admitted into hospitals receiving care in unconventional spaces. This may reflect seasonal surges. The indicator profiles the average number of beds over capacity in Ontario hospitals during this time. In conjunction with other indicators such as time to inpatient bed and the ALC rate, this indicator can be used to monitor a hospital's space capacity and contribute to a better understanding of the issue.

Data Source: Cerner - Discern Analytics (Daily Census Report)

Target Information: Target set internally; in accordance to QIP indicator

Benchmark Information: N/A

	2021/2022				2022/2023			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Unconventional / Day (Avg) (#)	0.8	1.0	0.0	0.0	0.0	0.0	0.0	0.0
Benchmark (Rate)								
Target (Rate)	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0



Performance Analysis:

Q1 Target met.
Q2 Target met.
Q3 Target met.
Q4 Target met.

Plans for Improvement:

Q1 Continue with current process.
Q2 Continue with current process.
Q3 Continue with current process.
Q4 Continue with current process.

Accountable: Chief Information and Operating Officer / Manager, Patient Flow and Bed Management

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Indicator: Repeat ED Mental Health Visits

Strategic Direction: RECOVERY

Definition: The percentage of repeat emergency visits (for a mental health or substance abuse condition) following an emergency visit for a mental health condition. The repeat visit must be within 30 days of the 'index' visit (first visit). This is based on the Most Responsible Diagnosis (mental health codes - ICD-10) and includes only CCH cases.

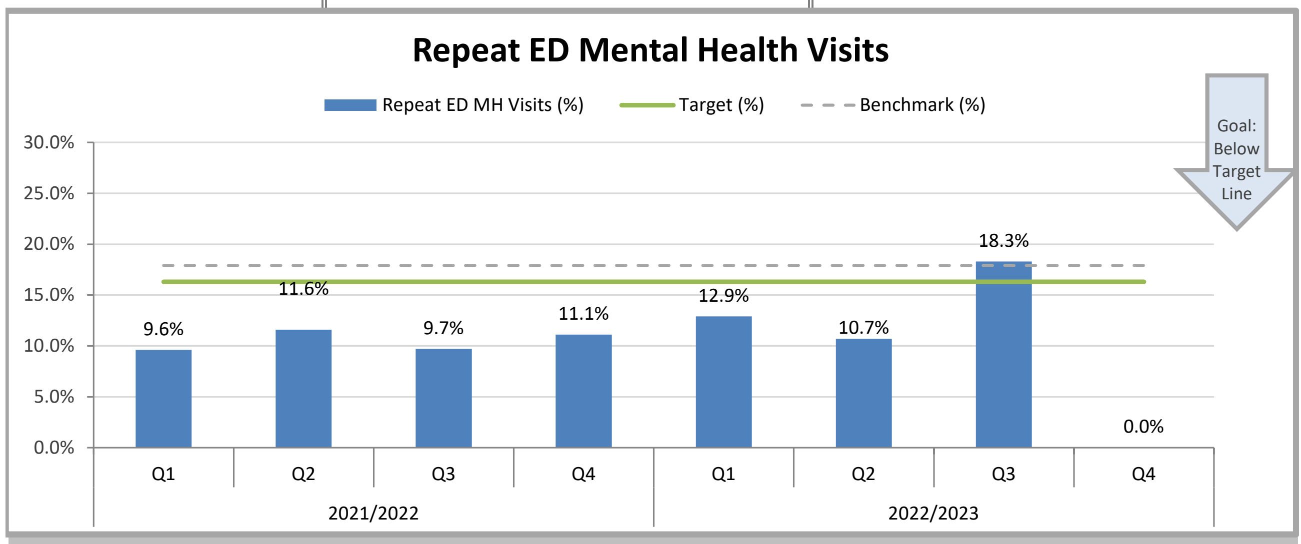
Significance: Repeat emergency visits among those with mental health conditions contribute to emergency visit volumes and wait times. Repeat emergency visits generally indicate premature discharge or a lack of coordination with post-discharge care. Given the chronic nature of the mental health conditions, access to effective community services should reduce the number of repeat unscheduled emergency visits. This indicator attempts to indirectly measure the availability and quality of community services for patients with mental health conditions. Investments in community mental health services such as crisis response and outreach, assertive community treatment teams, and intensive case management are intended to provide supports to allow individuals with mental illness to live in the community (CMHA, 2009; Every door is the right door, 2009). This indicator also supports the future development and improvement of data collected that could be used to directly measure the quality and availability of community mental health especially relating to wait times.

Data Source: Anzer -NACRS (National Ambulatory Care Reporting System)

Target Information: Target to align with HSAA and MSAA

Benchmark Information: Based on Champlain LHIN 2017/18 Q2 - Appendix A results as reported in Champlain LHIN Measuring Performance Second Quarterly Report 2017-18 January 2018

	2021/2022				2022/2023			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Repeat ED MH Visits (%)	9.6%	11.6%	9.7%	11.1%	12.9%	10.7%	18.3%	N/A
Benchmark (%)	17.9%	17.9%	17.9%	17.9%	17.9%	17.9%	17.9%	17.9%
Target (%)	16.3%	16.3%	16.3%	16.3%	16.3%	16.3%	16.3%	16.3%



Performance Analysis:

Q1 Data for Q1 is reported on and all coding has been completed. Total visits to the ED for mental health was 294. Of these, 38 were repeat visits representing 12.9% and below our target of 16.3%.

Q2 Data for Q2 is reported on and all coding has been completed. Total visits to the ED for mental health was 270. Of these, 29 were repeat visits

Q3 Data for Q3 is reported on. Total visits to the ED for mental health was 311. Of these, 57 were repeat visits representing 18.3% and slightly above our target of 16.3%.

Q4 Results unavailable due to system failure (Anzer).

Plans for Improvement:

Q1 We continue to work closely with police services in our co-response services which helps divert visits from the ED. The Safe Bed program is well underway and supports ED diversion as well. Will continue to monitor repeat visits in real time and follow-up where needed. Ongoing focus on discharge planning/collaboration between community programs and IMHU including collaborative case planning between ED, Community Programs and IMHU.

Q2 As with last quarter, we continue to work/collaborate closely with our Police partners in both co-response and Safe Bed programs which helps divert visits from the ED. As well, will continue to monitor repeat visits in real time and follow-up where needed. Continued focus on discharge planning/collaboration between community programs and IMHU including collaborative case planning between ED, Community Programs and IMHU.

Q3 We continue to work/collaborate closely with our Police partners in both co-response and Safe Bed programs to help divert visits from the ED as well as monitoring repeat visits real time and follow-up where needed. Continued focus on discharge planning/collaboration between community programs and IMHU including collaborative case planning between ED, Community Programs and IMHU.

Q4 N/A

Accountable: VP, Community Programs / Director, Community Addiction and Mental Health Services

Indicator: Discharge Summary Sent from Hospital to Primary Care Provider Within 48 Hours of Discharge

Strategic Direction: INTEGRATION

Definition: This indicator measures the percentage of patients discharged from hospital for which discharge summaries are delivered to their primary care provider (PCP) within 48 hours of patient's discharge from hospital.

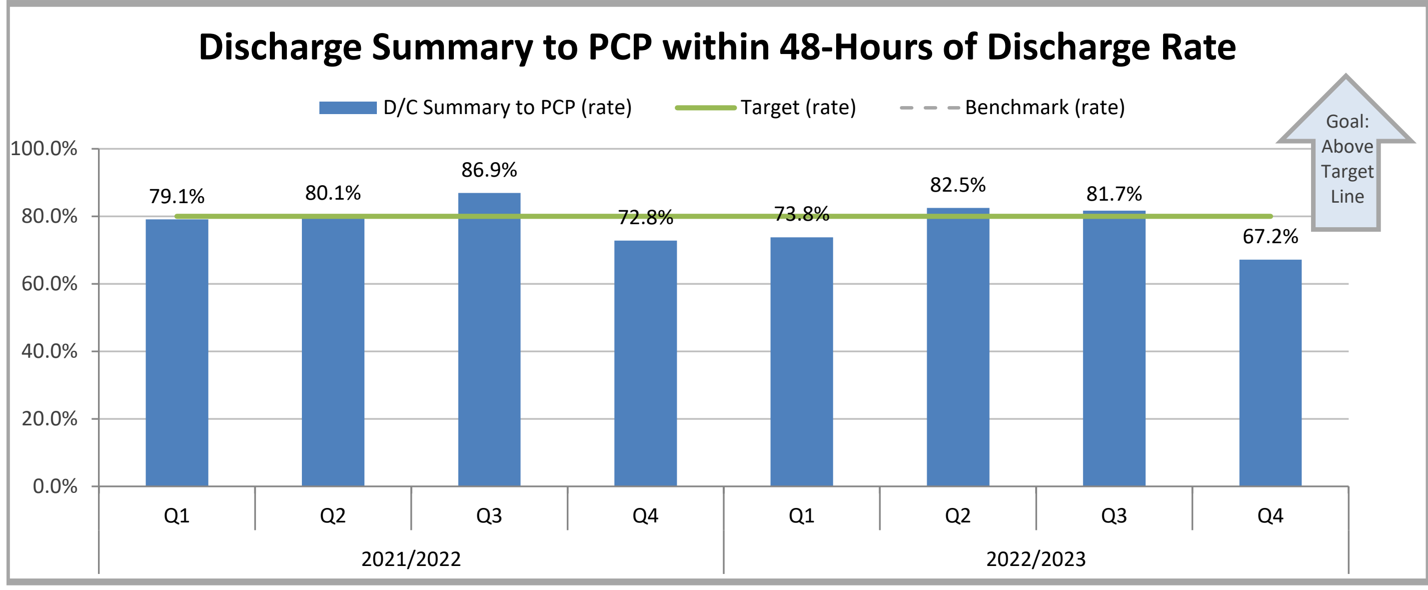
Significance: Health Quality Ontario (HQO) explains "Patients who have multiple conditions and complex needs may require care across different health care settings (e.g., hospitals, family physicians, etc.), which could potentially pose serious risks to their safety and quality of their care. Incomplete or inaccurate transfer of information, lack of comprehensive follow-up care, and/or medication errors at the time of transition could be very dangerous and cause serious, preventable harm to patients. Furthermore, the impact of these risks may be intensified by patients and families who feel unprepared for self-management, and are unsure of how to access appropriate health care providers for follow-up."

Data Source: Cerner - Discern Analytics, Electronic Health Record

Target Information: Target is set internally at 80.0% in accordance to QIP indicator

Benchmark Information: N/A

	2021/2022				2022/2023			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
D/C Summary to PCP (rate)	79.1%	80.1%	86.9%	72.8%	73.8%	82.5%	81.7%	67.2%
Benchmark (rate)								
Target (rate)	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%



Performance Analysis:

Q1 Results slightly below target. There were a total of 1348 applicable discharges with 996 completed within 48 hours for Q1.

Q2 There was an 11% increase in performance between Q1 and Q2.

Q3 Target met. There were a total of 1332 applicable discharges with 1088 completed within 48 hours for Q3.

Q4 Results have fallen below target for this quarter, with 932 of 1386 applicable discharges completed within 48 hours. The results for January, February and March are 76.9%, 69.2% and 56.7% respectively indicating a strong trend in performance decline.

Plans for Improvement:

Q1 Performance remains below target. Several new discharge support processes (i.e. post-discharge follow up clinic, enhanced discharge planning) will be implemented over Q2 and Q3. We anticipate these to have very favourable impacts on this indicator and look forward to being able to provide our external partners with timely access to the information they need.

Q2 As anticipated, the discharge support processes implemented in Q2 appear to have had a positive impact on this indicator. Plan to continue implementation and optimization of these new processes.

Q3 Continue to monitor the implemented discharge support processes.

Q4 Current compliance workflow is a highly manual process for reminding physicians to complete their outstanding summaries; reminders are already present in their worklist in Millennium, the compliance reminders are a 'nag' process. HIS will investigate methods to incentivise or assist in the completion of summaries to improve adherence.

Accountable: Chief Information and Operating Officer / Manager, Health Information Services

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Indicator: Accreditation Canada Required Organizational Practice (ROP) - Medication Reconciliation on Discharge Rate

Strategic Direction: INTEGRATION

Definition: This is a priority indicator; medication reconciliation at care transition has been recognized as best practice, and is an Accreditation Required Organization Practice. Total number of discharged patients with completed Medication Reconciliation divided by the total # of discharged patients. (Excludes - Interfacility Transfers, Deaths, ED Hold, PACU, Obstetrical and Newborn patients).

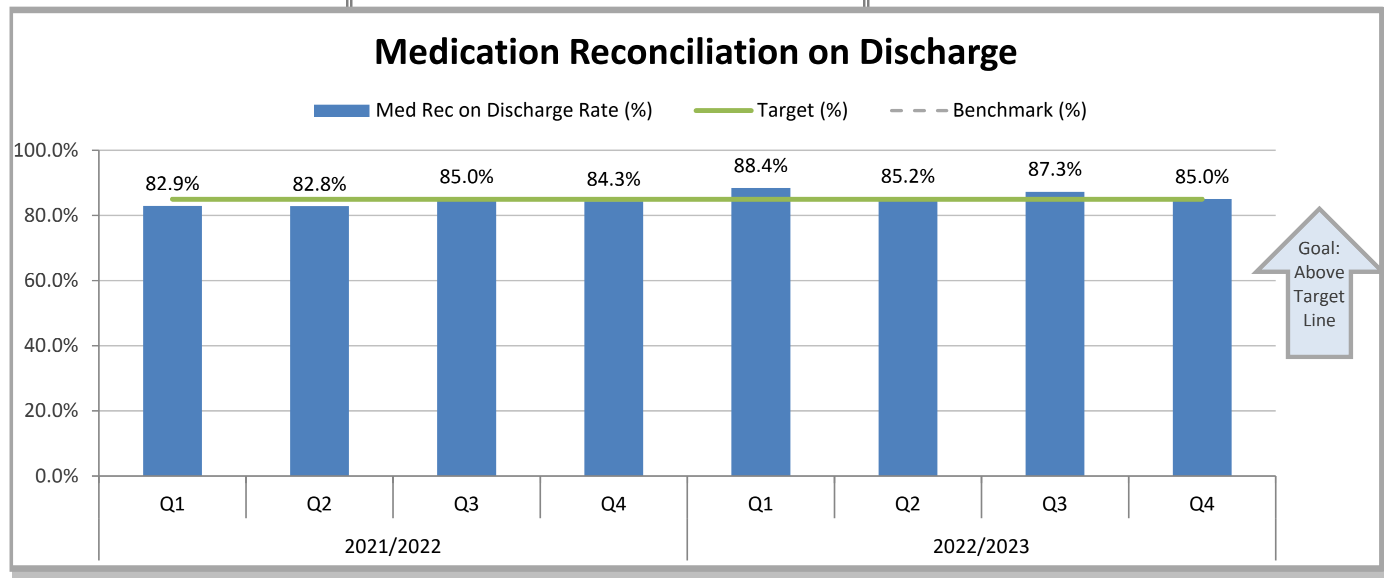
Significance: Medication reconciliation is a formal process in which healthcare providers work together with patients, families and care providers to ensure accurate and comprehensive medication information is communicated consistently across transitions of care. Medication reconciliation requires a systematic and comprehensive review of all the medications a patient is taking to ensure that medications being added, changed or discontinued are carefully evaluated. It is a component of medication management and will inform and enable prescribers to make the most appropriate prescribing decisions for the patient (Safer Healthcare Now! Medication Reconciliation in Acute Care Toolkit, Sept 2011).

Data Source: Cerner electronic health record

Target Information: Set internally at 85% in accordance to QIP indicator

Benchmark Information: N/A

	2021/2022				2022/2023			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Med Rec on Discharge Rate (%)	82.9%	82.8%	85.0%	84.3%	88.4%	85.2%	87.3%	85.0%
Benchmark (%)								
Target (%)	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%



Performance Analysis:

Q1 Above target at 88.4% for this quarter.

Q2 Target met. L6S improved substantially, sitting below target at 78% in Q1 and now up to 93% in Q2.

Q3 The overall target met this quarter at 87.3%.

Q4 The overall target was met this quarter.

Plans for Improvement:

Q1 Target met. There were a total of 940 medication reconciliations on discharge completed out of the 1063 total discharges.

Q2 L2 Med, L2 Surg and L4 Psych are below target. Discussed with the unit managers who will bring this forward to the physicians at their next meeting, to highlight the importance. Level 4 Psych expects some improvements now that they have more consistent inpatient physician coverage. The Unit Manager reached out to psychiatrists to better understand what caused the decline and to plan how it will be addressed. It was discussed that discharges <24hrs from admission are to be excluded from the audit. Education to be provided to psychiatry team on the importance of discharge med recs being completed.

Q3 Meeting target overall this quarter. L4 MH is sitting at 72.7%; continue to work with the department to ensure compliance with Med Rec on discharge. From discussion, it seems the Med Rec on discharge that are not being completed are those leaving AMA or who are not on any meds. These two instances still require a Med Rec on discharge. Working with Decision Support to obtain more details on the three departments below target (L4 MH, Level 2 Surg and Level 6 S) to audit the types of discharges.

Q4 We were successful at improving the target for L4P (Q3 = 72.7%, Q4 = 85.4%). This is a great improvement. Outstanding units sitting below target are L6S (83.7%) and L2S (77%). Discussed L2S's and L6S results with the Managers and this will be added as a point of discussion to review with the physicians at their next meeting, identify any gaps and discuss the importance of this being completed for all discharges.

Accountable: Chief Information and Operating Officer / Chief of Staff

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Indicator: Patient Experience Survey - Information Inpatient

Strategic Direction: PEOPLE

Definition: Percentage of Inpatient respondents who responded positively (positive response include "completely" and "quite a bit") (Top2Box) to "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?" (Question #38).

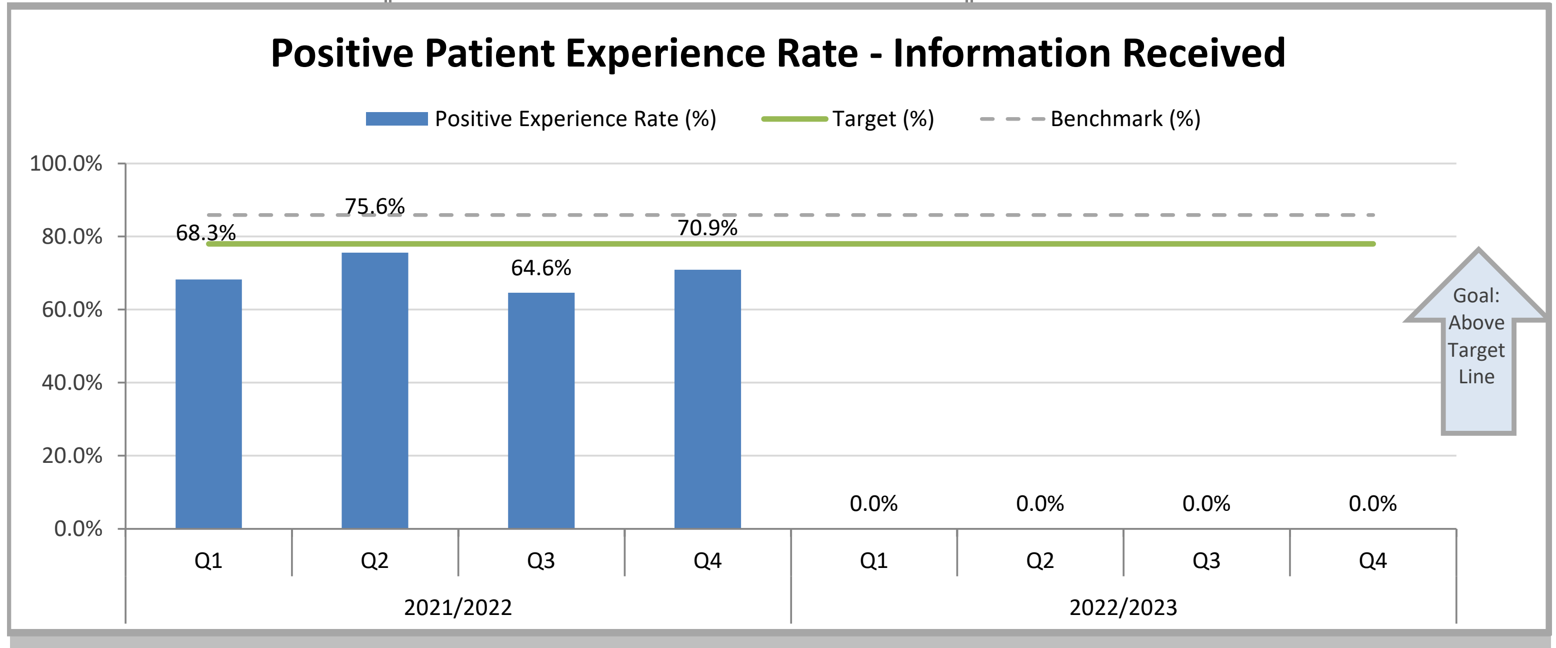
Significance: Taken from HQO, "Patient satisfaction is an important measure of Ontarians' experience with the health care system. Too often, the needs of institutions and healthcare providers come first in Ontario. A paradigm shift is needed, toward a patient-centered health system delivering care that is sensitive to patients' concerns and comfort, and that actively involves patients and family members in shared decision-making about their care."

Data Source: NRC (National Research Corporation)

Target Information: Set internally at 78%

Benchmark Information: Benchmark performance is based on NRC - Champlain LHIN average quarterly performance

	2021/2022				2022/2023			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Positive Experience Rate (%)	68.3%	75.6%	64.6%	70.9%	N/A	N/A	N/A	N/A
Benchmark (%)	85.9%	85.9%	85.9%	85.9%	85.9%	85.9%	85.9%	85.9%
Target (%)	78.0%	78.0%	78.0%	78.0%	78.0%	78.0%	78.0%	78.0%



Performance Analysis:

Q1 No data due to OHA survey transition to new vendor.
Q2 No data due to OHA survey transition to new vendor.
Q3 No data due to OHA survey transition to new vendor.
Q4 No data due to OHA survey transition to new vendor.

Plans for Improvement:

Q1 CCH currently in the process of signing a new contract with new vendor.
Q2 CCH currently in the process of signing a new contract with new vendor.
Q3 CCH currently in the process of signing a new contract with new vendor.
Q4 CCH currently in the process of signing a new contract with new vendor.

Accountable: VP, Patient Services and Chief Nursing Officer / Director, Quality and Risk

Indicator: Workplace Violence Prevention - Incidents Reported

Strategic Direction: PEOPLE

Definition: This is a mandatory QIP indicator. The number of workplace violence incidents reported by hospital workers (as defined by OHSA) within a 12-month period. Directive of Improvement is focused on building our reporting culture to increase the number of reported incidents. Awareness created in FY2018-19. As of 2019-20 the focus is to have less incidents.

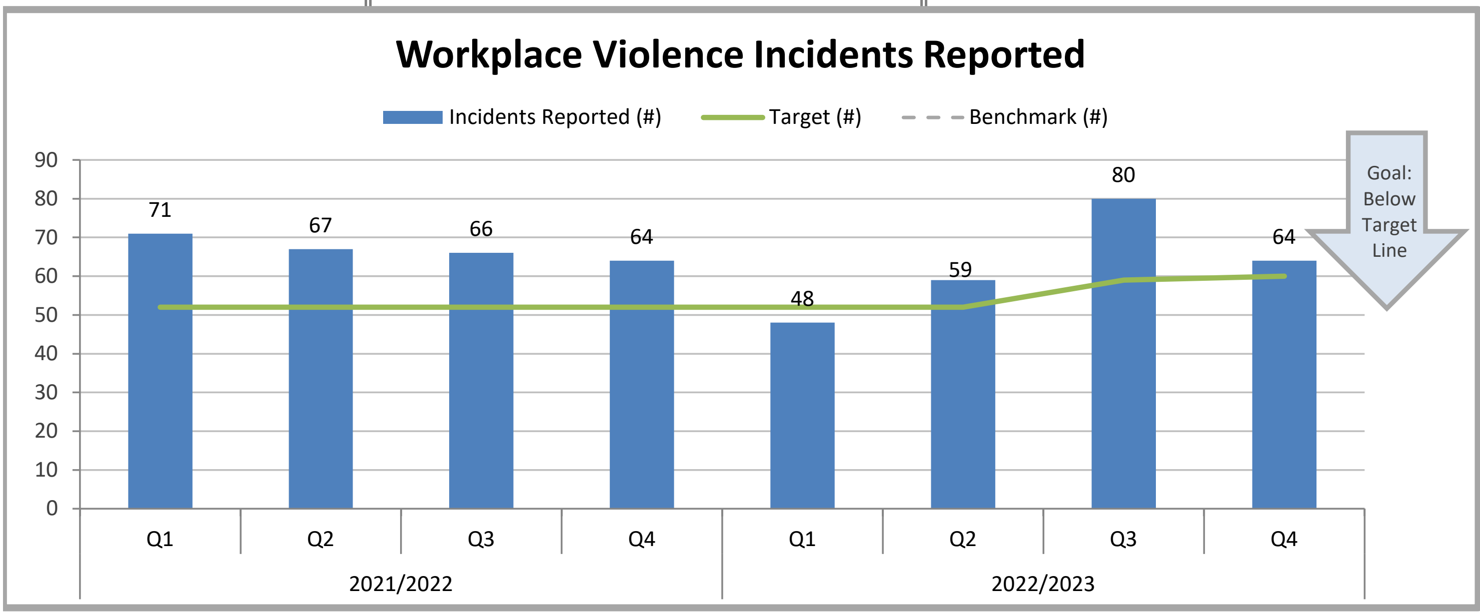
Significance: Workplace violence is defined by the Occupational Health and Safety Act as the exercise of physical force by a person against a worker, in a workplace, that causes or could cause physical injury to the worker. Violence in the workplace is an increasingly serious occupational hazard. Like other injuries, injuries from violence are preventable. Reporting all incidents is done for the purpose of identifying priorities for intervention to reduce hazards.

Data Source: RL Solution -Incident Management System

Target Information: Target is set internally at 223 annually in accordance to QIP indicator.

Benchmark Information: N/A

	2021/2022				2022/2023			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Incidents Reported (#)	71	67	66	64	48	59	80	64
Benchmark (#)								
Target (#)	52	52	52	52	52	52	59	60



Performance Analysis:

Q1 Target met.
Q2 Results slightly above target for this quarter.
Q3 Results are above target for this quarter. There was 43 incidents for Emergency Department this quarter, which accounts for 54% of the total.

Q4 Target not met this quarter with a total of 64 incident reported, however the incidents have decreased compared to Q3.

Plans for Improvement:

Q1 A sub-committee has been created as part of the JHSC to put together action plans to take a more detailed approach to eventually decrease this number.
Q2 Sub-committee held it's first meeting in October. Continue with current strategy and monitor outcomes.
Q3 In Q3 the sub-committee conducted an education session in the ED to assist staff to identify and evaluate factors which may lead to workplace violence. This lead to an increased number of reported near misses. The committee will continue to evaluate and make recommendations for violence prevention.
Q4 The committee will continue to evaluate and make further recommendations for violence prevention.

Accountable: Chief Human Resources Officer / Manager, Human Resources

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