Let's Make Healthy Change Happen.

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

Cornwall Community Hospital
Hôpital communautaire de Cornwall

2020-03-05

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 Health Quality Ontario (if required) in the format described herein.

Overview

Cornwall Community Hospital is dedicated to the delivery of exceptional care and to continually enhancing the quality and safety of care in an environment that reduces risk for patients and staff. 2020 marks the final year of our five-year strategic planning cycle. The plan's vision of "Exceptional Care. Always." includes a strong focus on ensuring the organization's sustainability in light of ongoing fiscal challenges in acute care. We are committed to and accountable for providing care and services to our patients and families that reflect our four strategic pillars namely:

1. Partnering for patient safety and quality outcomes: We will partner with experts and our peers.
2. Patient inspired care: We will ensure the delivery of patient inspired care.
3. Our team, our strength: We will continue to develop and promote our team.
4. Operational excellence through innovation: We will reinforce our commitment to solid operational and financial performance

The 2020-21 Quality Improvement Plan will continue to build on some of the initiatives from the previous year's plan to further enhance the quality and safety of care delivered; focusing on transitions of care by ensuring timely, meaningful discharge information, and reducing likelihood of hallway medicine by improving access to inpatient beds. Our focus was and continues to be to improve wait times in the Emergency Department. Indirectly, the improvements chosen are intended to improve the patient, family and caregivers' experience along their continuum of care.

Cornwall Community Hospital serves a community that has some unique challenges. According to Cancer Care Ontario's report titled Cancer Risk Factors Atlas of Ontario (2017), there is a higher propensity for someone residing in Cornwall to have cancer for the following reasons: (1) the consumption of alcohol by males exceed cancer prevention recommendations (2) females in parts of Cornwall consume less vegetables and fruit and lastly (3) females have increased sedentary behavior and also have higher incidences of smoking.

The community that is served by Cornwall Community Hospital has a population of approximately 110,000 and includes the Akwesasne First Nations Community. Cornwall is among the 20% most deprived areas in Ontario; 47% of the population has post-secondary education and 14.5% are living below the low-income cut-off. Within the Champlain Local Health Integration Network, the Cornwall area is noted to have the highest rate of Chronic Obstructive Pulmonary Disease (COPD), the second highest stroke rate and a very high diabetes rate especially amongst the Indigenous population. Cornwall's population has a higher percentage of seniors residing in the area; 23.2% of the population is 65 years and older compared to the province at 16.7%. According to the 2016 Statistics Canada report, 41.7% of the residents of Cornwall speak both English and French.

Cornwall Community Hospital has a partial designation under the French Language Services Act; as such services provided to our community are provided in both official languages. There has also been a significant commitment to establishing a culturally competent health care environment for the Akwesasne First Nations Community. Last year, approximately 15% of the staff participated in indigenous cultural awareness training and we are actively working to increase that percentage this fiscal year. This has become part of our mandatory training expectations and all new staff receive this during their onboarding period.

Over the past year, many of the dedicated physicians retired and it continues to be a challenge to recruit some medical specialists most notably psychiatrists. This challenge is not unique to Cornwall as there is a significant shortage of psychiatrists across Ontario. It should also be noted that access to primary care in the community is challenging; Cornwall is identified by the Ministry of Health as being an "area of high physician need". This impacts access to care, for example there are times when establishing safe discharge plans for patients becomes

challenging because a majority of patients are unlikely to have access to their primary care physicians within seven (7) days of discharge (as is suggested for many patients with specific chronic illnesses).

Our selection of key performance indicators has been informed by these environmental factors. In order to support the 2020-2021 Quality Improvement Plan, Cornwall Community Hospital will strive to further improve the capacity of the organization's quality agenda by focusing on the indicators below. These are priority (P) or mandatory (M) indicators as defined by Health Quality Ontario.

1. Number of inpatients receiving care in unconventional spaces (P)
2. Time to inpatient bed (M)
3. Patient experience regarding information received at discharge (P)
4. Discharge summaries sent from the hospital to primary care provider within 48 hours of discharge (P)
5. Number of violence incidents (M)
6. Medication reconciliation at discharge (P)
7. Repeat emergency visits for mental health (P)

Describe your organization's greatest QI achievement from the past year

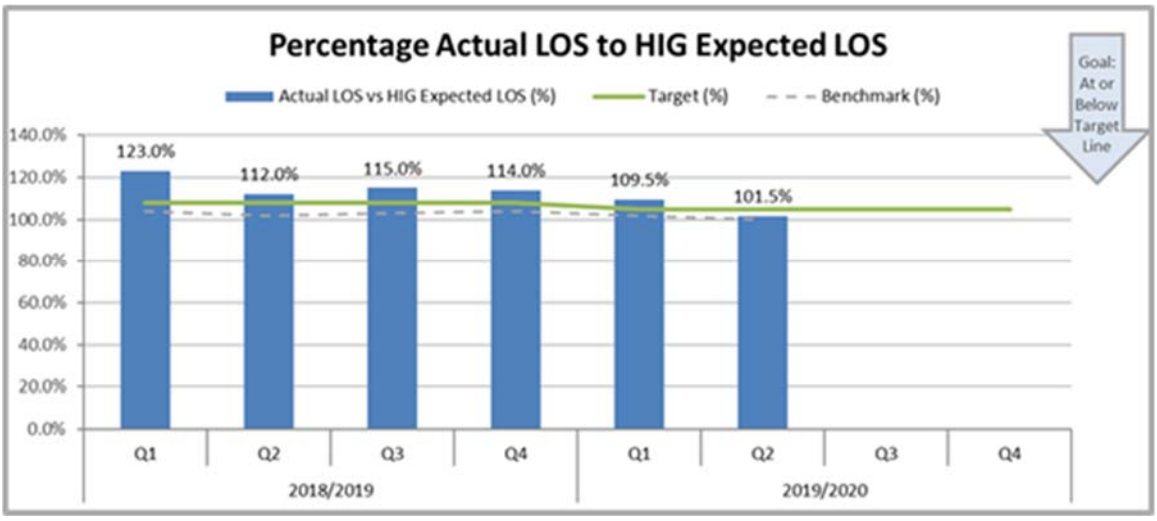
Over the past year, the focus for Cornwall Community Hospital remains improving the patient experience by focusing on the following major corporate initiatives:

1. Reduce length of stay for inpatients

   An innovative approach was used to assist in reducing inpatient length of stay including process improvements, resource adjustments and the use of business analytics.

   The four pillars of the project are:

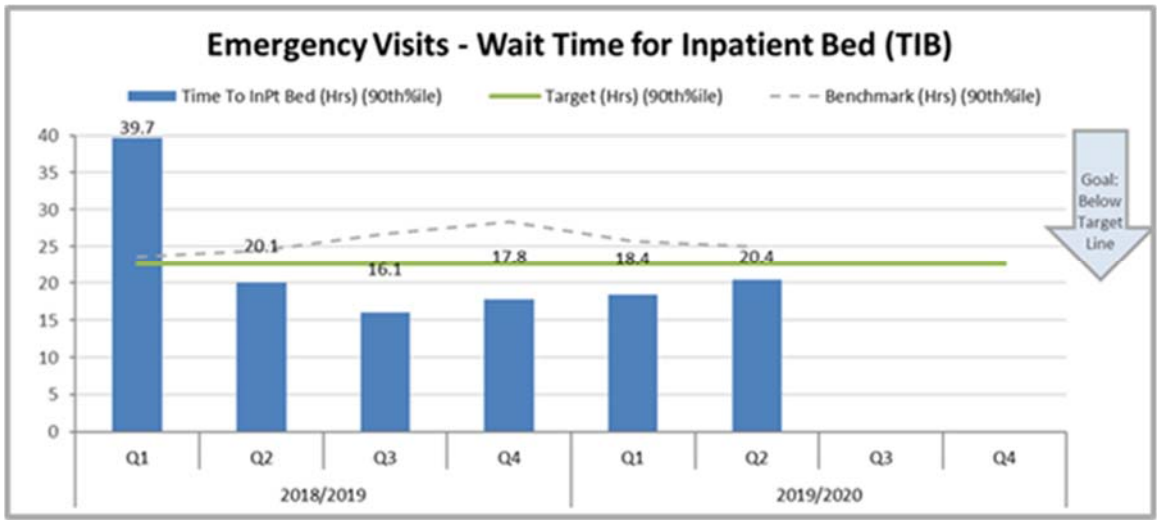
   - Analytics, understanding the problem - we looked at 2 years of length of stay data and compared with our peers. The team considered input from a variety of stakeholders to determine where the issues were, what the targets should be and how to achieve them. The issue was broken into smaller parts and by service (hospitalist, surgeon, intensivists, etc.).
   - Optimization of Abstracting and Coding - using coding software, 3terra, charts are further reviewed for missed opportunities. Weight and expected length of stay (ELOS) recovery targets were set at 3% (achieved for 2018). We improved coding turnaround time to 32-35 days (target 21 days) from 60-0 days, coder education, and outlier case analysis.
   - Optimization of physician documentation - implemented standardized structured discharge templates to facilitate better data capture for coding. This included providing physician education.
   - Application of Knowledge - using predicative modeling, we applied what was learned to our orthopedic surgical cases. We reviewed the assumed precursors for length of stay (LOS); anesthetist involved, time of day of a case, length of time in recovery, physiotherapy availability and learned that early mobilization was the strongest predictor for shortened length of stay. As a result, we adjusted our physiotherapy hours, optimized our orthopedic PowerPlans (order sets) to enhance early mobilization and provided education to physicians and nurses to improve understanding.



2. Improve emergency room length of stay for admitted patients

   Ensuring that patient flow is done as quickly as possible, minimizing the time that an inpatient bed is empty between patients has been a priority. Improving turnaround time from leaving the Emergency Room to transfer to inpatient bed has been achieved using a variety of process improvements:

   - Housekeeping hours of coverage aligned with peak discharge periods to ensure that beds are cleaned as soon as patient has vacated bed.
   - Identify barriers that delay transfers out of the Emergency Room once bed is available.
   - Discharge phones installed on medicine and surgery units to facilitate timely notification by patient and/or family member.
   - Improving discharge planning so that it starts earlier and the expected date of discharge is documented and communicated to the healthcare team, patients and family.
   - Increased discharge planning staff and hours of coverage to include Geriatric Emergency Management (GEM) nurse in the Emergency Room.
   - Discharge Planners assigned to geographic locations to optimize continuity of care and communication with patients, family and healthcare team.
   - Ensure case conferences are held for patients that are complex and include families.
   - Re-education of staff and physicians on home first philosophy to include external partners and resources.
   - Estimated date of discharge embedded in the electronic health record (EHR) on admission and communicated with patients and families on the bedside boards.
   - Creation of the new position of Transition Nurse on medicine. The role was created to help facilitate timely discharges and improve client flow.



3. Achieve success with our Accreditation survey

    - Participated in our 4-year Accreditation survey September 23-25, 2019 and October 16, 2019, we were Accredited with Exemplary Standing under the Qmentum accreditation program.

4. Establish a collaborative, cross-sector approach to Infant Mental Health for the region.

    - Infant Mental Health - where high risk mothers are identified and supportive therapy is initiated with the mom being at the center of the planning process.
    - Neonatal Abstinence Syndrome Program - to ensure wrap-around services for women experiencing Opioid Use Disorder, who are pregnant or recently delivered.

5. Lead the development of an integrated care model, with multiple stakeholders, through the implementation of a Youth Wellness Hub (operating at two newly renovated sites) in our region.

    - Youth Wellness Hub, where integrated services are provided for youth 12 – 25 years to provide coordination of follow-up and responsive services preventing repeated Emergency Room visits. Partners in this project included Emergency Medical Services (EMS), Hospital, Long-Term Care (LTC), and Primary Care.

6. Develop the plan for the creation/implementation of a patient portal.

    - Completed a user needs assessment, a readiness assessment and a privacy impact analysis in preparation for the implementation of a patient portal 2020-2021.
    - A technical implementation plan has been developed and a steering committee established, including membership from the Patient and Caregiver Experience Advisory Council, to provide oversight.
    - Currently finalizing the broader implementation plan

Collaboration and integration

Cornwall Community Hospital (CCH) is adding “Repeat Emergency visits for mental health” to this year’s list of Quality Improvement Plan (QIP) indicators. CCH has a broad spectrum of Addiction and Mental Health services (ranging from Child and Youth Mental Health to Adult Mental Health, including Crisis Services for both of this sector; the Adult Mental Health Service includes counselling/therapy as well as specialty teams - Assertive Community Treatment (ACT) Team, First Episode Psychosis, and Geriatric Services. CCH’s Addiction Services, includes counselling/psychotherapy, Withdrawal Management, and Residential Services.

CCH’s community-based Addiction and Mental Health Services, and other community-based sectors (municipal social and housing services, police, Canadian Mental Health Association, developmental services, flexible assertive community treatment, etc.) will collaborate to address repeat Emergency Department visits. We will be working with our Emergency Department and acute Inpatient Mental Health Unit (IMHU) to improve communication, and implement a discharge planning process.

CCH is the lead organization for The Cornwall and Area Ontario Health Team (OHT), which has been designated by the Ministry as “in development”. Our proposed population and geographic service area for the Cornwall and Area OHT at maturity covers the counties of Stormont and Glengarry, the city of Cornwall and Akwesasne. The total population is 89,831 (2016 Canada census - note that this does not include Akwesasne, which was not enumerated) and covers 2,286 square kilometres. This is primarily a rural area with small towns and villages, the small urban centre of the City of Cornwall, as well as Akwesasne, the second most populous First Nation community in Canada. Cornwall and area is also home to a significant number of off-reserve Indigenous people, some of our most vulnerable population in terms of the social determinants of health. Twenty-seven percent (27%) of the population is Francophone. The high rates of chronic diseases, lifestyle-related conditions, marginalization, poverty, lower education and literacy levels and material deprivation across our area are important factors in planning our OHT. We have one of the highest rates per capita of patients/clients with high needs in Champlain. We have the highest rate of patients/clients not attached to a primary care provider in Champlain. The Ministry provided data that strongly supported our boundaries and partner membership.

Our OHT is in its infancy. At this stage, we are ensuring that we develop a shared vision, and that we address important issues related to building trust and relationship, as we believe this is foundational to our future success. Our OHT Steering Committee has many partners who have a long history of working collaboratively on numerous cross-sector initiatives. In addition to those already mentioned, we worked on the cross-sector projects; Situation Table (to address situations of acutely elevated risk by triaging to services immediately thereby pre-empting further decompensation); Health Links; Community Safety and Wellbeing Plan; Community Mental Health Plan for Children and Youth; and bundled care funding across clinical pathways.

Over the next year, as we head towards full submission, we will be focusing on two goals: 1) increase engagement of primary care; and 2) explore digital health solutions that will work for our OHT. We are challenged with recruitment of family care providers to our community. It is hoped that, by joining forces, our collaborative will create an innovative recruitment approach. As primary care is the foundation of the OHT model, we need to address this challenge as a priority. We will work with our partners to increase access to virtual care. CCH is investing in expansion of Ontario Telemedicine Network (OTN) and Zoom technologies. We will be developing a “Digital Health Improvement Plan” to create a path forward.

Communicating health information accurately and timely plays an important role in the provision of quality care. Giving patients access to their own health information has been demonstrated as an effective means of improving communication and increasing satisfaction amongst providers and patients/caregivers alike. This coming year

CCH is implementing a patient portal to bring us towards our goal of better information sharing amongst our attributed OHT population.

Fostering a positive client and caregiver experience is a priority. Our OHT partners are open to sharing data about patient/caregiver experiences, and agree to explore the implementation of a common tool. Also, as an OHT, we recognize the importance to satisfaction that meaningfully engaging patients/caregivers in the development of our transformed system plays. Members of our OHT have successfully utilized co-design methodologies and we plan to use this experience in our development process.

In our self-assessment, we defined our priority population as those 45 years of age and older who were experiencing at least one chronic disease with an overlay of one of the following: addiction/mental illness, palliative, end-of-life, or dementia and complicating social factors (e.g., inadequate housing or transportation, isolation, financial needs, etc.). We will be further refining this target population in the coming year, as more data becomes available. With this further refinement, we may need to adjust our partners.

Patient/client/resident partnering and relations

One of Cornwall Community Hospital's strategic goals is to improve the delivery of patient inspired care. We strive to identify patient needs as this is the core of our business; measuring and improving quality; and improving transitions into and out of hospital. Throughout the year, Cornwall Community Hospital provides quarterly progress reports on the Quality Improvement Plan indicators to the Quality and Performance Monitoring Committee of the Board and the Board of Directors. The 2020-2021 Quality Improvement Plan was developed with feedback from Patient and Caregiver Experience Advisors, the Quality and Performance Monitoring Committee, the Medical Advisory Committee and the Board of Directors.

The focus has and continues to be to respond to patients and families when there is a real or perceived gap in care, coordination or communication. Our Patient Experience Specialist ensures that the voice of the patient is heard and influences planning and decision-making on issues that affect patient care, ensuring the needs and expectations of patients and their families are addressed. For a number of years now, there has been a very active Mental Health Family Advisory Council that focuses on the needs of families both in the Community Mental Health Programs as well the Inpatient Mental Health unit.

The Hospital has expanded its Patient Experience Program and regrouped advisors to form the Patient and Caregiver Experience Advisory Council. Just this year, they have provided feedback on patient education, the hospital complaint and disclosure process, and visiting hours. They participated and provided feedback on wayfinding and they are members on numerous committees (e.g. Ethics, Falls, Accessibility, Quality and Performance Monitoring Committee of the Board).

Patient and family input is collected through a variety of mechanisms including impromptu online surveys, solicited inpatient and outpatient surveys, the electronic patient incident reporting process, the Patient Experience Specialist, our physician and front-line staff's day-to-day interactions. The Canadian Institute for Health Information (CIHI) patient satisfaction survey data has been carefully analyzed to identify areas where our patients are telling us we can do better. The top three and bottom three survey performers are shared each quarter with department managers and with the Quality and Performance Monitoring Committee so they can celebrate good results and work to improve the others. Survey results continue to support the need for the hospital to remain focused on the information provided at the time of discharge. In response, the Hospital has enhanced the patient handbook to make it more user-friendly for our patient population.

Workplace Violence Prevention

Workplace violence incidents in health care have highlighted the need for increased diligence in this area and a focus group, which included members of Senior Administration, was introduced in January 2015. This group has been meeting monthly to advance this important agenda. The hospital has a zero-tolerance policy to violence (or the threat of violence) against staff or physicians.

This focus group was transformed into the Workplace Violence Prevention Committee with increased staff participation, and is chaired by the Chief Executive Officer. Violence in the workplace is a standing item for both the Joint Health and Safety Committee (JHSC) as well as for the Senior Administration Team.

We recently completed the Public Services Health and Safety Association Risk Assessment Tool using all four (4) targeted assessments:

- Individual Client Risk Assessment
- Flagging for Acting Out Behaviour (AOB)
- Security Gap Analysis
- Personal Safety Response System

Sub-groups of the Workplace Violence Prevention Committee have been created to develop action plans related to the findings from each tool.

In the meantime, we continue to monitor individual incidents of violence that arise; assess risk and regularly review to ensure that initiatives/improvements are implemented. The goal of keeping staff, physicians and patients safe is paramount. At all times, staff and physicians are encouraged to report concerns and offer suggestions to mitigate the potential for violence. Following one of our recent quality reviews, we had an external team come on site to assess our safety plans and the environment and provide recommendations for improvement. Feedback is routinely provided to the team to ensure closing the loop.

Virtual care

Expanding virtual care services and enabling other virtual care tools such as remote monitoring and secure messaging is a high priority for CCH. In 2018/2019, 1593 virtual visits were performed at CCH, mostly for endocrinology, hematology and mental health services.

Virtual medicine for remote monitoring and online consultations is becoming mainstream amongst healthcare professionals. Considering the high demand, and rapidly gaining popularity amongst healthcare providers and patients alike, CCH has identified establishing a comprehensive virtual care program as an operational goal for 2020-2021. Leveraging a variety of virtual care technologies, the program will bring dedicated resources and expertise to a number of services, including oncology, cardiology, and primary care; specialties that CCH patients and the community require access to. The program also aims at increasing the use of technology to allow for remote monitoring and follow up with unique patient populations, such as Chronic Obstructive Pulmonary Disease (COPD) and Congested Heart Failure (CHF) patients.

Additionally, CCH has identified implementing a comprehensive patient portal as an operating goal for 2020-2021; the portal will allow patients virtual access for their health care information, education material and scheduled appointments. Patients will also be able to receive notifications and reminders for appointments.

Executive Compensation

Cornwall Community Hospital performance-based compensation plan for the Chief Executive Officer and the individuals reporting directly to this role are linked to achieving targets in the Quality Improvement Plan as per the *Excellent Care for All Act* (ECFAA) requirements.

The achievement of the annual targets for the Quality Improvement Plan indicators outlined below account for a total of 2% of the overall compensation for the chief executive officer and the executives below. Payments will be determined by assigning comparable weights to each indicator, and the use of a sliding scale for the percentage of target achieved.

- President and Chief Executive Officer
- Vice-President, Patient Services and Chief Nursing Officer
- Vice-President, Community Programs
- Chief Financial Officer
- Chief Information Officer
- Chief Privacy and Human Resources Officer
- Chief of Staff

Contact Information

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Sign-off

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

Debora M. Daigle Board Chair	Michael Pescod Quality and Performance Monitoring Committee Chair	Jeanette Despatie Chief Executive Officer

2020/21 Quality Improvement Plan
"Improvement Targets and Initiatives"

Cornwall Community Hospital 840 McConnell Avenue, Cornwall , ON, K6H5S5

M = Mandatory (all cells must be completed) P = Priority (complete ONLY the comments cell if you are not working on this indicator) C = custom (add any other indicators you are working on)

AIM		Measure									Change				
Issue	Quality dimension	Measure/Indicator	Type	Unit / Population	Source / Period	Organization Id	Current performance	Target	Target justification	External Collaborators	Planned improvement initiatives (Change Ideas)	Methods	Process measures	Target for process measure	Comments
Theme I: Timely and Efficient Transitions	**Efficient**	Unconventional spaces	P	Count / All inpatients	Daily BCS / TBD	967*	0.2	1.00	Baseline target and performance achieved for FY1920. Keep same target as prior year at a daily average of one within period.		1)Continue to work with the Chiefs and medical teams to align Length of Stay (LOS) with Expected Length of Stay (ELOS) targets established from our HIG peer group.	Provide Chiefs and Department Managers Length of Stay (LOS) reports.	Length of Stay = Expected Length of Stay (ELOS) unless variance supported by documentation.	Overall Total = 105.0% (Corporate Scorecard) Medicine = 117.0% Surgery = 92% Ortho = 82% Hospitalist = 115.0%	Length of Stay (LOS) that exceed target should be tracked when gaps in the system. (In order to protect patient privacy "X" is used when there are any indicators with numerator less than 5 and denominator less than 30
											2)Adopt underlying principle that ER should have zero patients admitted	Data to be tracked and reported to the Length of Stay Working Group by Decision Support team	Track Daily Access Reporting Tool (DART)	That on average, 100% of patients will be admitted to a conventional bed.	
											3)Encourage chiefs to transfer patients to rural hospitals that have capacity.	Number of patients repatriated from ER to HGMH or WDMH.	Track occupancy of other hospitals utilizing the LHIN Daily Flow Report.	That when occupancy is greater than 90%, patients will be transferred to a rural hospital.	
											4)Level out the number of surgical cases over 5-day elective booking period.	Number of cases by day of the week.	Track the number of OR cancellations related to shortage of surgical beds.	That by July 1, 2020 0 (zero) cases cancelled.	
	Timely	Percentage of patients discharged from hospital for which discharge summaries are delivered to primary care provider within 48 hours of patient's discharge from hospital.	P	% / Discharged patients	Hospital collected data / Most recent 3 month period	967*	68.48	80.00	New indicator for FY2021. Collecting baseline. Target set at 80.0%.		1)Improve utilization of structured documentation discharge templates to ensure timely exchange of information to primary care at discharge.	a) Continue to provide "elbow support" to physicians during onboarding to set up personal requests in templates and ensure strong understanding of technology/processes. b) Track the percentage of discharge summaries using structured templates.	a) Number of new providers receiving elbow support/ total number of new providers onboarded. b) Number of patients with a structured discharge note/total number of discharges	By March 2021 80%	
											2)Evaluate the turn-around time for completion of discharge notes	Track the turn-around time from discharge to distribution of the discharge summary to measure the percent received in 48 hrs	Number of discharge summaries "distributed" in 48 hrs/ total number of discharge summaries	By the end of Q2 80%	
											3)Assess the quality of documentation received by primary care - are they receiving what they need for continuity of care	Seek feedback from the community primary care providers on the new templates and their usefulness and/or gaps	Analysis of a feedback tool distributed to primary care providers and review of workflows as indicated.	By Jan 2021 greater than 80% satisfaction.	

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		The time interval between the Disposition Date/Time (as determined by the main service provider) and the Date/Time Patient Left Emergency Department (ED) for admission to an inpatient bed or operating room.	**MANDATORY**	**Hours / All patients**	**CIHI NACRS, CCO / Oct 2019– Dec 2019**	**967***	**21.35**	**21.00**	**Target established at 7% reduction of FY1920 target of 22.6.**		**1)Early discharge planning is embraced as part of organizational culture and philosophy of care.**	**Continue with the corporate project of monitoring Time to Inpatient Bed (TIB) with a goal of meeting or exceeding target.**	**Track the metrics for Time to Inpatient bed using the Daily Access Reporting Tool (DART).**	**That by Q 1, 2 - TIB will be less than or equal to 21.0**	**Target justification is aggressive as performance excellent in q1-3; typically more challenging in q4 (*Formula is 23.8 * (1 - 5%) =22.6)**
											2)Continue recruitment of hospitalists to better manage workloads.	Hospitalist working group to monitor volume of patients per physician.	Track the number of patients per hospitalist related to number of discharges	By July 1, 2020, hospitalist case load not to exceed 27 patients (Monday - Friday)	
											3)Realign hospital services to ER activity.	Daily review of DART - TIB.	Track the number of times that target for TIB is not met.	By the end of Q2, TIB less than or equal to 21.0	
Theme II: Service Excellence	**Patient-centred**	Patient Experience: Percentage of respondents who responded “completely” and "quite a bit" to the following 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? Inpatient (**Top 2 Box)	C	Percentage/Top 2 Box- Completely and Quite a Bit / All inpatients	NRC Picker / Most recent 12 months	967*	73.3	78.00	Continue to maintain or exceed last FY1920 performance. No change in target from FY1920 to FY2021, continued focus to exceed target of 78%.		1)Audit the number of patients receiving a Patient Oriented Discharge Summaries (PODS).	Audit the use of PODS through the electronic health record.	Number of patients receiving a POD on discharge/number of discharges	By July 1, 2020 75% of patients on the Medicine unit will receive PODS information on discharge. By July 1,2020 75% of discharges(home) from CCU have received a PODs. By July 1, 2020 75% of admitted patients discharged from ED have received a PODs	
											2)Continue to educate staff and physicians about Healthwise.	Audit the use of HealthWise educational material given to patients	Number of patients receiving educational material from Healthwise/ Total number of discharges	By July 1, 2020, 40% of patients on Medicine unit will have received Healthwise information.	
											3)Implement the Patient Discharge folder to assist patient retaining the educational material provided during their course of stay. The folder includes a letter from our CEO related to the potential to receive a survey after they leave the hospital asking about the information they received to assist in caring for themselves at home.	Audit the number of admitted patients receiving the newly created "Discharge folder"- to be distributed by a volunteer on Day 1 of admission	Number of patients receiving a discharge folder/ total number of admissions	By the end of Q1 total number of admitted patients receiving a Discharge folder 50%, Q3 75%	
Theme III: Safe and Effective Care	**Effective**	Medication reconciliation at discharge: Total number of discharged patients for whom a Best Possible Medication Discharge Plan was	P	Rate per total number of discharged patients / Discharged patients	Hospital collected data / Oct 2019– Dec 2019 (Q3 2019/20)	967*	86.4	85.00	Continue to maintain or exceed last FY1920 performance. Continue with same target of 85% as prior		1)Optimize information shared with community partners obtained via medication reconciliation at discharge to promote patient safety.	Track the number of fax referrals that were made from CCH to community pharmacies and primary care practitioners.	Number of (e-referrals or faxes) made to primary care practitioners.	85% of patients will have medication reconciliation completed on discharge by July 2020.	

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		created as a proportion the total number of patients discharged.							fiscal year.		2)Leverage technology to improve medication information from hospital to primary care practitioners at the time of patient discharge.	Audits through the electronic health record.	Number of patients with medication reconciliation completed at discharge/number of discharges	85% of patients will have medication reconciliation completed at discharge. 90% of CCU patients discharged home from the unit will have med reconciliation completed at discharge.	
											3)Embed in Patient Handbook and hospital website "Five Questions to Ask About Your Medications?" (I.S.M.P.)	Empower patients to better understand their medication prescriptions at discharge	Track patients response to "did you receive enough information at discharge?"	78% of patient respondents to NRC Patient Satisfaction Survey indicates positive results.	
											4)Promote awareness of polypharmacy when preparing discharge prescriptions (Senior Friendly Initiative) at Medical Grand Rounds.	Track number of patients discharged that are greater than or equal to 65 year of age that have medication reconciliation	Number of patients that are greater than or equal to 65 year of age that have medication reconciliation completed at discharge/total number of patients discharged that are greater than or equal to 65 year of age	85% of seniors will have medication reconciliation completed on discharge.	
		Percent of unscheduled repeat emergency visits following an emergency visit for a mental health condition.	P	% / ED patients	CIHI NACRS / April - June 2019	967*	17.78	16.30	Target established through HSAA agreement. Current performance of 17.78% for Apr-June.2019 is auto-populated by QIP-HQO using return visits from all other facilities. CCH results for Apr-June.2019 using only return visits to CCH shows current performance of 13.3% for Apr-June.2019.		1)Initiate process that facilitates coordinated care for Repeat ED patients	Generate a real-time report through our electronic health record for repeat ED patients.	A health link Coordinated Care Plan developed for repeat ED patients	70% of repeat ED patients have a coordinated care plan	
											2)Enhance the capacity of the MH Crisis Team (MHCT) to service patients under 16 years of age.	Work with CHEO to complete training for youth appropriate approaches for suicide risk assessment.	Increase the rate of youth served by the team.	A 20% increase in the total number of youth served over total number of clients served by the MHCT.	
											3)Increase rapid access to Adult MH Services by implementing a brief services model of care.	Implement a model of care for brief services	Increase the rate of patients seen less for 3 or fewer sessions.	A 25% increase in the number of adults served through a brief model over the total number of adults who are served by Adult MH.	
	Safe	**Number of workplace violence incidents reported by hospital workers (as defined by OHSA) within a 12 month period.**	**MANDATORY**	**Count / Worker**	**Local data collection / Jan - Dec 2019**	**967***	**223**	**210.00**	**Continue to maintain or exceed last FY1920 performance. Target established at 6% reduction of Jan-Dec2019 performance of 223.**		**1)Continue on and report on progress made utilizing the various tool kits to promote safety; risk assessments, individual chart risk assessment, flagging security and personal safety response systems. Optimize information that has transferred from police to ER department Health IM (policy software purchased by police) to establish safety plans for staff.**	**Tracking through the Police Liaison Committee the number of patients brought to ER by Cornwall Police Services wherein Health IM has been utilized.**	**The number of times a patient in ER is restrained (as reported through the electronic incident reporting system).**	**To decrease the number of reported incidents of violence by 10% by March 31, 2021.**	

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Issue	Quality dimension	Measure/Indicator	Type	Unit / Population	Source / Period	Organization Id	Current performance	Target	Target justification	External Collaborators	Planned improvement initiatives (Change Ideas)	Methods	Process measures	Target for process measure	Comments
											2)Support staff to navigate the judicial system when charges are laid against a patient or external perpetrator.	Number of incidents that result in personal injury or damage to hospital property.	Track number of assaults or threats that result in charges being laid.	Track through the Police Liaison Committee.	
											3)Continue to evaluate the efficacy of training programs delivered by the hospital.	Obtain feedback from staff through our work life pulse survey and during quality reviews	Track compliance of mandatory Nonviolent Crisis Intervention Awareness (NVCI)Training through the Learning Management System (LMS).	By January 2021 90% of all staff will be trained in NVCI Awareness.	
											4)Begin adoption of voluntary standard CSA Z1003, Psychological Health and Safety in the workplace.	Voluntary standard CSA Z1003 Psychological Health and Safety in the Workplace audit tool.	Completion of voluntary standard CSA Z1003, Psychological Health and Safety in the Workplace audit tool to identify gaps.	By March 2021 audit tool will be completed with recommendations.	