fiscal 2017-2018 **Q2**

2nd quarter ended September 30, 2017

KHSC this quarter

QIP **Performance** Report

Hôpital Hotel Dieu Hospital

Hôpital Général de Kingston General Hospital

Kingston Health Sciences Centre

Centre des sciences de la santé de Kingston

KHSC Quality Improvement Plan (QIP) Performance Report Fiscal 2017-18

Strategic Direction 1

Improve the patient experience through a focus on compassion and excellence

Outcome: KHSC is a top performer on the essentials of quality, safety & service

KHSC Quality Improvement Plan (QIP) Performance Report Fiscal 2017-18

Strategic Direction 3

Enable clinical innovation in complex-acute and specialty care

Outcome: KHSC is positioned as a leading centre for complex-acute & specialty care

Strategic Direction 4

Create seamless transitions in care for patients across our regional health-care system

Outcome: KHSC is fully engaged with our community partners to support patients with complex-acute and chronic conditions

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Q2 FY2018 Quality Improvement Plan Report

Strategic Direction	2019 Outcome	Indicator	18-Q1	18-Q2	18-Q3	18-Q4	19-Q1
Improve the patient experience through a focus on compassion and excellence	KHSC is a top performer on the essentials of quality, safety, & service	"Would you recommend this ED to your friends and family?" (KGH QIP)	Y	N/A	N/A	N/A	N/A
		Percent of patients that respond "definitely yes" or "probably yes" to the question, "Would you recommend this Emergency Dept to your friends and family?" (HDH QIP)	G	N/A	N/A	N/A	N/A
		Percent of patients that rate their care during this emergency room visit as 7 or higher (on 10-point scale) (HDH QIP)	R	N/A	N/A	N/A	N/A
		90th Percentile ED Wait Time - All Admitted Patients (hrs.) - (KGH QIP)	G	G	N/A	N/A	N/A
		Medication Reconciliation at Admission (KGH QIP)	Y	Y	N/A	N/A	N/A
		# of eligible clients receiving formal med rec upon admission to mental health clinics/by total # of eligible clients admitted for the quarter (HDH QIP)	G	G	N/A	N/A	N/A
		# of eligible clients receiving formal med rec upon admission to EPACU for total joint arthroplasty/by total # of eligible clients admitted for the quarter (HDH QIP)	Y	Y	N/A	N/A	N/A
		# of eligible clients receiving formal med rec upon admission for bariatric surgery/by total # of eligible clients admitted for the quarter (HDH QIP)	G	G	N/A	N/A	N/A
		# of eligible patients receiving Best Possible Medication Discharge Plan (BPMDP) at disch from EPACU for total Joint Arthroplasty/by total # of eligible patients discharged for the quarter(HDH-QIP)	G	G	N/A	N/A	N/A
		Reduce percent of patients with facility acquired pressure injury (KGH QIP)	G	G	N/A	N/A	N/A
		Percent ALC Days (KGH QIP)(KGH SAA)	Y	R	N/A	N/A	N/A
		Percent of palliative care patients discharged from hospital with the discharge status "Home with Support". (KGH QIP)	G	Y	N/A	N/A	N/A
		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? (KGH QIP)	Y	N/A	N/A	N/A	N/A

			18-Q1	18-Q2	18-Q3	18-Q4	19-Q1
		Percent of patients who wanted information that respond "very confident" that they have the information they need and/or know who to contact after they leave their appointment (HDH QIP)	G	G	N/A	N/A	N/A
		Percent of patients in adult ambulatory clinics that rate the quality of care and services received as 'excellent' or 'very good'. (HDH QIP)	G	G	N/A	N/A	N/A
		90% UCC Length of Stay (LOS-hrs) for complex patients (CTAS 1,2,3) (HDH QIP/SAA)	G	G	N/A	N/A	N/A
Enable clinical innovation in complex-acute and specialty care	KHSC is positioned as a leading center for complex-acute & specialty care	[(# of regular clinics held + # of special clinics held) / (# regular clinics assigned)] x 100 (HDH QIP)	G	G	N/A	N/A	N/A
		# days from clinic appointment until dictated clinic letter has been verified [Result verification date - Clinic appointment date] (HDH QIP)	Y	Y	N/A	N/A	N/A
Create seamless transitions in care for patients across our regional health-care system	KHSC is fully engaged with our community partners to support patients with complex-acute and chronic conditions	Risk-Adjusted 30-Day All-Cause Readmission Rate for Patients with COPD (QBP cohort) (KGH QIP)	G	G	N/A	N/A	N/A
		Patient Journey Process maps as developed by each organization (presented to HCT COPD Clinical Steering Team) Best Practice and QBP Guidelines. (HDH QIP)	G	G	N/A	N/A	N/A

	SPR			QIP			SAA		
	F18			F18			F18		
	Q1 %	Q2 %	Q2 #	Q1 %	Q2 %	Q2 #	Q1 %	Q2 %	Q2 #
R	0%	0%	0	5%	10%	2	30%	28%	15
G Y	100%	100%	15	95%	90%	18	67%	70%	38
N/A	0%	0%	0	0%	0%	0	4%	2%	1
			15			20			54

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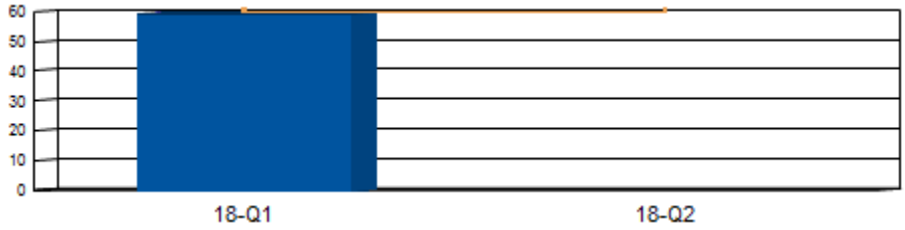
Q2 FY2018 Quality Improvement Plan Report

Improve the patient experience through a focus on compassion and excellence

KHSC is a top performer on the essentials of quality, safety, & service

Indicator: "Would you recommend this ED to your friends and family?" (KGH QIP)



	Actual	Target
18-Q1	59.2	**60**
18-Q2		**60**

Describe the tactics that were implemented in this quarter to address the achievement of the target:

Staff and physicians in the Emergency Department strive to provide exemplary care. Patient experience results are reviewed with staff and physicians to highlight strengths and opportunities for improvement and to understand which dimensions of patient experience correspond most closely with high levels of patient satisfaction.

Explain the current performance of the target. Where possible, translate statistics and numbers into plain language, focusing on the impact to patients and staff:

Patient experience survey results from the Emergency Department Patient Experience of Care (EDPEC) survey are always somewhat delayed; thus, the Q2 results will be reported in Q3.

Are we on track to meet the target by year end? If not, what new tactics are planned to ensure the target is met?

Yes. A major patient satisfier in the ED is reduced wait times. As such, we are continuing successful projects like ATU (which reduces boarding time for admitted patients while drastically improving bed access in the ED) and the expansion of the use of Section F. Patient surveys done in Section F earlier this year show a 92% satisfaction rate measured across quality of care and accessibility.

Definition: DATA: Pam Pero COMMENTS: Carol McIntosh EVP: Mike McDonald REPORT: QUALITY IMPROVEMENT PLAN (QIP)

"Would you recommend this ED to your friends and family?" add the number of respondents who responded "Yes, definitely" (for NRC Canada) or "Definitely yes" (for HCAHPS) and divide by number of respondents who registered any response to this question (do not include non-respondents).

Target: Target 17/18: 60% Perf. Corridor: Red <54% , Yellow 54%-59%, Green >=60%

Previous fiscal year - Target 16/17: 69.3% Perf. Corridor: > 10% quarterly teach. Target, Yellow Within 10% of quart. Teach. Target, Green At or above the teach avg. /quarter

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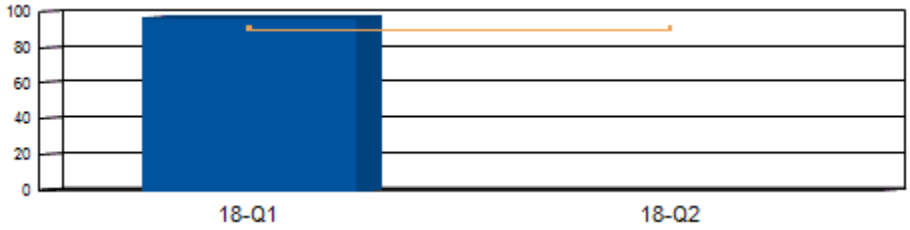
Indicator: Percent of patients that respond "definitely yes" or "probably yes" to the question, "Would you recommend this Emergency Dept to your friends and family?" (HDH QIP)



	Actual	Target
18-Q1	96	**90**
18-Q2		**90**

Describe the tactics that were implemented in this quarter to address the achievement of the target:

Staff and physicians in the Urgent Care Centre at the HDH site strive to provide exemplary care. Patient experience results are reviewed with staff and physicians to highlight strengths and opportunities for improvement and to understand which dimensions of patient experience correspond most closely with high levels of patient satisfaction.

Explain the current performance of the target. Where possible, translate statistics and numbers into plain language, focusing on the impact to patients and staff:

The target for Q1 has been achieved. Patient experience survey results from the Emergency Department Patient Experience of Care (EDPEC) survey are always somewhat delayed; thus, the Q1 results are being reported in the Q2 scorecard.

Are we on track to meet the target by year end? If not, what new tactics are planned to ensure the target is met?

Yes.

Definition: DATA: Ontario Emergency Department Patient Experience of care Survey (OEDPEC) - Janine Schweitzer COMMENTS: Carol McIntosh EVP: Mike McDonald REPORT: QUALITY IMPROVEMENT PLAN (QIP)

Patient satisfaction with UCC has been high. The goal is to maintain positive performance. Target based on Apr - Jun 2016 Performance.Target based on Apr - Jun 2016 performance. New survey and new rating scale. Target may be adjusted by UCC leaders once survey has been longer. Renovate triage area and implement new volunteer position. Performance is review quarterly.

Target: Target 17/18: 90% Perf. Corridor: Red <80% , Yellow 80%-89% , Green >=90%.

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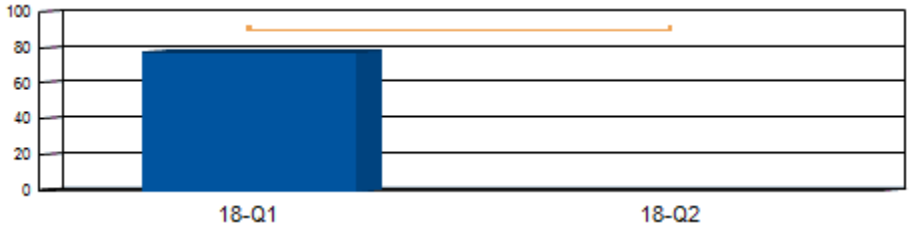
Indicator: Percent of patients that rate their care during this emergency room visit as 7 or higher (on 10-point scale) (HDH QIP)



	Actual	Target
18-Q1	77	90
18-Q2		90

Describe the tactics that were implemented in this quarter to address the achievement of the target:

Staff and physicians in the Urgent Care Centre at the HDH site strive to provide exemplary care. Patient experience results are reviewed with staff and physicians to highlight strengths and opportunities for improvement and to understand which dimensions of patient experience correspond most closely with high levels of patient satisfaction.

Explain the current performance of the target. Where possible, translate statistics and numbers into plain language, focusing on the impact to patients and staff:

The target for Q1 has not been achieved. Patient experience survey results from the Emergency Department Patient Experience of Care (EDPEC) survey are always somewhat delayed; thus, the Q1 results are being reported in the Q2 scorecard. Results will be reviewed what specific dimensions of care correlate most closely with positive care experiences. HDH recently completed a redesign of its triage area to address patient feedback that triage area was a source of confusion and an area of congestion. Staff and patient experience advisors were consulted in the re-design to improve the entrance and natural flow of patients entering the Urgent Care Centre. Volunteers were introduced in the waiting room to assist in flow and with way finding. With the re-design an additional triage nurse can easily assist when high volumes of patients arrive. Prior to re-design the area used for additional triage was inside the unit.

Are we on track to meet the target by year end? If not, what new tactics are planned to ensure the target is met?

Yes. The target for Q1 has not been achieved. Results will be reviewed what specific dimensions of care correlate most closely with positive care experiences. Patient experience survey results from the Emergency Department Patient Experience of Care (EDPEC) survey are always somewhat delayed; thus, the Q1 results are being reported in the Q2 scorecard. Previous Hotel Dieu Hospital (HDH) Q4 result was 86% of patients rated their care during this UCC (categorized as an emergency room) visit as 7 or higher out of 10. HDH recently completed a redesign of its triage area to address patient feedback that triage area was a source of confusion and an area of congestion. Staff and patient experience advisors were consulted in the re-design to improve the entrance and natural flow of patients entering the Urgent Care Centre. Volunteers were introduced in the waiting room to assist in flow and with way finding. With the re-design an additional triage nurse can easily assist when high volumes of patients arrive. Prior to re-design the area used for additional triage was inside the unit.

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Target: Target 17/18: 90% Perf. Corridor: Red <80% , Yellow 80%-89% , Green >=90%.

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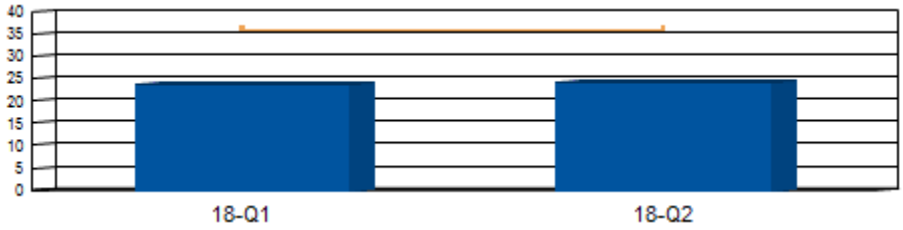
Indicator: 90th Percentile ED Wait Time - All Admitted Patients (hrs.) - (KGH QIP)



	Actual	Target
18-Q1	24	**36**
18-Q2	24	**36**

Describe the tactics that were implemented in this quarter to address the achievement of the target:

Increased bed spaces in the Medicine program, the Home First Specialist role, the Medical/Surgical Assessment and Procedure clinic and the advent of the Admission Transfer Unit have contributed to the sharp improvement of this indicator.

Explain the current performance of the target. Where possible, translate statistics and numbers into plain language, focusing on the impact to patients and staff:

Continued utilization and optimization of bed use (particularly in the Medicine program) has benefitted this indicator. The 9 new beds in the Admissions Transfer Unit, coupled with 11 beds converted to Medicine from Pediatrics, has provided more capacity for newly admitted patients to depart the Emergency department earlier in their stay. In addition, continued success of the Home First specialist and the complex discharge team in the Emergency Department have augmented the improvement by expediting plans for patients in complex social/housing situations who traditionally would require very long admissions not necessarily for medical reasons (up to two years in some cases). Finally, the Medical/Surgical Assessment and Procedure clinic helps with admission avoidance, giving some patients the option for urgent treatment in lieu of an admission or quick follow-up post-discharge to avoid readmission.

Are we on track to meet the target by year end? If not, what new tactics are planned to ensure the target is met?

The performance of this indicator is the best we have seen in recent years, but we will be maintaining vigilance into the coming winter/influenza season. Extra funded bed spaces, recently secured from the Ministry of Health and Long Term Care) are being planned in order to assist in the annual surge - typically late December until mid to late March.

Definition: DATA: Decision Support - Alex Ungar COMMENTS: Carol McIntosh EVP: Mike McDonald REPORT: QUALITY IMPROVEMENT PLAN (QIP)

This indicator measures the amount of time 9 out of 10 patients (90th percentile) spend in an ED being diagnosed, receiving treatment and waiting for admission to a hospital bed. Most patients spend less time, while 1 out of 10 patients will spend more time. The time being measured is defined as when a patient registers until the time when the patient is admitted to an inpatient hospital bed. For this indicator, 9 out of 10 patients (for all admitted patients at all levels of complexity) will spend no more than 31 hours within the ER from the time they arrive and register to the time they leave the ED.

Target: Target 17/18: 36 Perf. Corridor: Red >39 , Yellow 37 - 39 , Green <=36.

Previous fiscal year - Target 16/17: 29 Hours Perf. Corridor: Red >33 Yellow 30 - 33 Green <30

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Indicator: Medication Reconciliation at Admission (KGH QIP)

	Actual	Target
18-Q1	93	**96**
18-Q2	93	**96**

Describe the tactics that were implemented in this quarter to address the achievement of the target:

Medication reconciliation reduces medication discrepancies at interface of care and prevents patient harm. Medication reconciliation on admission requires the documentation of the complete home medication list or Best Possible Medication History (BPMH) on the admission orders. Standardized admission order sets support the process by prompting the prescribers to document the BPMH on the admission orders.
Admission order sets including the medication reconciliation process are now available in an electronic format via EntryPoint for all prescribers to access online.
This quarter, the Chief of Staff sent a letter to all Department Heads of Services below target in F18 Q1 requesting a reminder be sent to all prescribers to comply with hospital policy. The services were Cardiology, General Surgery, Pediatric General Surgery and Pediatric Medicine, Neurosurgery, Orthopedics and Urology.

Explain the current performance of the target. Where possible, translate statistics and numbers into plain language, focusing on the impact to patients and staff:

The percentage of patients who received medication reconciliation at the time of admission to the Hospital (KGH site only) remains constant this quarter with a rate of completion of 93% for all admitted patients in Fiscal 18 Q2, in comparison to a corrected F18 Q1 compliance rate of 93%.

Are we on track to meet the target by year end? If not, what new tactics are planned to ensure the target is met?

Target of >= 96% is a stretch target for this fiscal year.
The F18 Q1 intervention through the Chief od Staff office had a positive impact overall (Cardiology: Q1: 88%/Q2:87%, General Surgery Q1: 94%/Q2:96%,Pediatric General Surgery: Q1: 91%/Q2:93%, Neurosurgery: Q1: 91%/Q2:87%, Orthopedics: Q1: 88%/ Q2:90%, Pediatric Medicine: Q1: 89%/Q2:90%, Urology: Q1: 72%/Q2:79%.
Compliance will continue to be monitored in F18 Q3. Based on the results of the intervention in F18 Q2, consideration will be given to enforcing the KHSC policy requiring prescribers to use admission order sets including the medication reconciliation process for all patients admitted to the hospital.

Definition: DATA: Decision Support - David Barber COMMENTS: Veronique Briggs EVP: Troy Jones REPORT: QUALITY IMPROVEMENT PLAN (QIP)

The total number of patients with medications reconciled as a proportion of the total number of patients admitted to the hospital.

Target: Target 17/18: 96% Perf. Corridor: Red < 86% , Yellow 86%-95% , Green >=96%

Previous fiscal year - Target 16/17: 96% Perf. Corridor: Red <= 80% Yellow 80%-89% Green >=90%

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Indicator: # of eligible clients receiving formal med rec upon admission to mental health clinics/by total # of eligible clients admitted for the quarter (HDH QIP)

	Actual	Target
18-Q1	99.0	**90**
18-Q2	99.6	**90**

Describe the tactics that were implemented in this quarter to address the achievement of the target:

Medication reconciliation is fully implemented in the ambulatory mental health clinics at HDH site, with quality and compliance audits conducted regularly. The best possible medication history (BPMH) is completed by intake nurses in both adult and child mental health programs. This is part of the initial telephone intake and screening process, the med rec is completed by psychiatry or NP at the first visit.

Explain the current performance of the target. Where possible, translate statistics and numbers into plain language, focusing on the impact to patients and staff:

The medication reconciliation process has been embedded into the clinical flow, with some programs using an electronic system. Prescribers find it helpful to have the most up to date complete medication history available and appreciate improved medication safety for patients, contributing to continued high rate of compliance.

Are we on track to meet the target by year end? If not, what new tactics are planned to ensure the target is met?

We continue to perform well and achieve targets.

Definition: DATA: Decision Support - David Barber COMMENTS: Michelle Mathews EVP: Mike McDonald REPORT: QUALITY IMPROVEMENT PLAN (QIP)

The number of eligible clients receiving formal med rec upon admission to mental health clinics divided by total the number of eligible clients admitted for the quarter (HDH QIP).

Target: Target 17/18: 90% Perf. Corridor: Red <80% , Yellow 80%-89% , Green >=90%.

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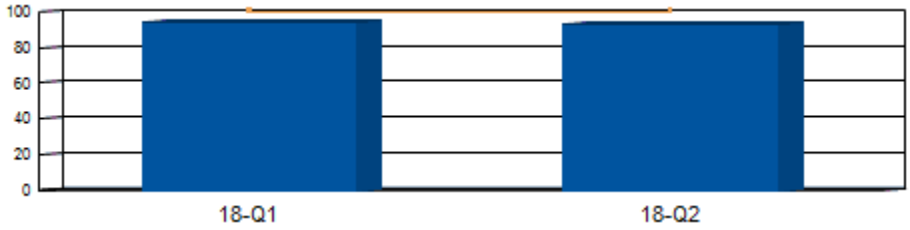
Indicator: # of eligible clients receiving formal med rec upon admission to EPACU for total joint arthroplasty/by total # of eligible clients admitted for the quarter (HDH QIP)



	Actual	Target
18-Q1	93.8	**100**
18-Q2	92.9	**100**

Describe the tactics that were implemented in this quarter to address the achievement of the target:

The arthroplasty team in collaboration with the pharmacy department are reviewing medication reconciliation practices and continue to make progress in achieving this target.

Explain the current performance of the target. Where possible, translate statistics and numbers into plain language, focusing on the impact to patients and staff:

All total joint arthroplasty patients receive a complete medication reconciliation summary at the time of discharge.
This summary includes all previously noted medications as well as any new medications prescribed.

Are we on track to meet the target by year end? If not, what new tactics are planned to ensure the target is met?

We will continue to work in collaboration with the Orthopedic and Pharmacy teams in order to achieve the target of 100% by the fourth quarter.

Definition: DATA: Decision Support - David Barber COMMENTS: Laurie Thomas EVP: Silvie Crawford REPORT: QUALITY IMPROVEMENT PLAN (QIP)

The number of eligible clients receiving formal med rec upon admission to EPACU for total joint arthroplasty divided by total the number of eligible clients admitted for the quarter (HDH QIP).

Target: Target 17/18: 100% Perf. Corridor: Red <90% , Yellow 90%-99% , Green >=100%.

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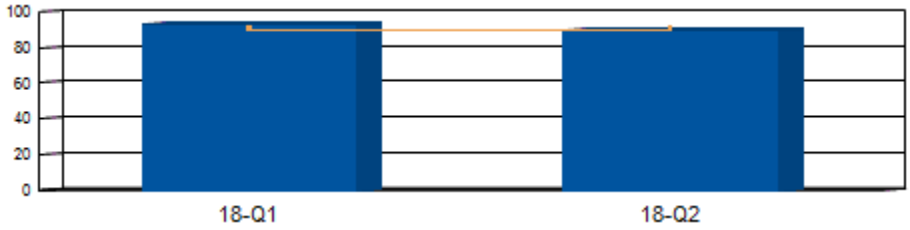
Indicator: # of eligible clients receiving formal med rec upon admission for bariatric surgery/by total # of eligible clients admitted for the quarter (HDH QIP)



	Actual	Target
18-Q1	92.6	**90**
18-Q2	90.2	**90**

Describe the tactics that were implemented in this quarter to address the achievement of the target:

The bariatric team continues to make strides in the area of medication reconciliation for all patients.

Explain the current performance of the target. Where possible, translate statistics and numbers into plain language, focusing on the impact to patients and staff:

The pharmacy department is presently working on new initiatives that will assist in medication reconciliation improvements for all surgical patients, which includes the bariatric patient population.

Are we on track to meet the target by year end? If not, what new tactics are planned to ensure the target is met?

This target remains on track and we will continue to improve over the next quarter.

Definition: DATA: Decision Support - David Barber COMMENTS: Laurie Thomas EVP: Silvie Crawford REPORT: QUALITY IMPROVEMENT PLAN (QIP)

The number of eligible clients receiving formal med rec upon admission for bariatric surgery divided by total the number of eligible clients admitted for the quarter (HDH QIP).

Map current process for obtaining med history, BPMH; Assess processes and resources necessary to complete BPMH; Provide training, implement tools and support staff to achieve target. Target will be achieved by Sept. 30, 2017.

Target: Target 17/18: 90% Perf. Corridor: Red <80% , Yellow 80%-89% , Green >=90%.

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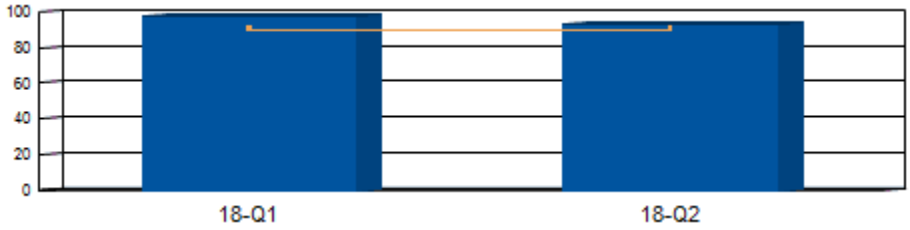
Indicator: # of eligible patients receiving Best Possible Medication Discharge Plan (BPMDP) at discharge from EPACU for total Joint Arthroplasty/by total # of eligible patients discharged for the quarter (HDH QIP)



	Actual	Target
18-Q1	97.87	**90**
18-Q2	93.02	**90**

Describe the tactics that were implemented in this quarter to address the achievement of the target:

The SPA program in collaboartion with the Pharmacy department continue to work together in the interest of safe medication reconcilation.

Explain the current performance of the target. Where possible, translate statistics and numbers into plain language, focusing on the impact to patients and staff:

Best practices in medication reconcilation are being implemented at all points of care for the arthroplasty population to ensure safe, quality care.

Are we on track to meet the target by year end? If not, what new tactics are planned to ensure the target is met?

We continue to achieve this target.

Definition: DATA: Decision Support - David Barber COMMENTS: Laurie Thomas EVP: Silvie Crawford REPORT: QUALITY IMPROVEMENT PLAN (QIP)

The number of eligible patients receiving Best Possible Medication Discharge Plan (BPMDP) at discharge divided by total the number of eligible patients discharged for the quarter (HDH QIP).

Target: Target 17/18: 90% Perf. Corridor: Red <80% , Yellow 80%-89% , Green >=90%.

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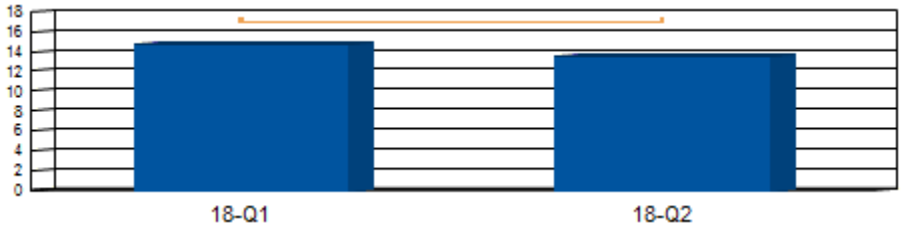
Indicator: Reduce percent of patients with facility acquired pressure injury (KGH QIP)



	Actual	Target
18-Q1	14.8	**17**
18-Q2	13.5	**17**

Describe the tactics that were implemented in this quarter to address the achievement of the target:

This quarter we have expanded our prevalence study to include those patients who stay in overnight at the HDH site. Work is being done to ensure we have continued support of wound and skin care champions on each unit as staff turnover. Continued audit and feedback of risk assessment for pressure injury demonstrates high adherence to completion of risk assessment and skin assessment.

Explain the current performance of the target. Where possible, translate statistics and numbers into plain language, focusing on the impact to patients and staff:

We are showing a steady improvement on the rate of facility acquired pressure injury. A corporate rate of 13.5% is within target and benchmark of other organizations. This means that we are showing a steady decrease in the number of our patients who are developing pressure injuries while being cared for in our organization.

Are we on track to meet the target by year end? If not, what new tactics are planned to ensure the target is met?

Continued vigilance on prevention of facility acquired pressure injury is required to maintain progress and good performance. We are on track to meet this target.

Definition: DATA: Leanne Wakelin COMMENTS: Leanne Wakelin EVP: Silvie Crawford QUALITY IMPROVEMENT PLAN (QIP)

Mini continuous-improvement cycles focused at particular inpatient units as indicated by the compliance data collected. Other continuous improvement techniques and tools, audit and feedback will be critical. Specifically, each unit in cooperation with professional practice and nursing unit leadership will conduct a prescribed number of monthly audits with respect to incidence of pressure injuries and compliance with documentation and communication protocols.

Completion of required admission documentation (i.e. risk assessments, strategies documented on kardex). Gap analysis of how closely the planned strategies match the assessment, and how consistently they are implemented and documented.

Target: Target 17/18: 17% Perf. Corridor: Red >19%, Yellow 18%-19%, Green <=17%.

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Q2 FY2018 Quality Improvement Plan Report

Improve the patient experience through a focus on compassion and excellence

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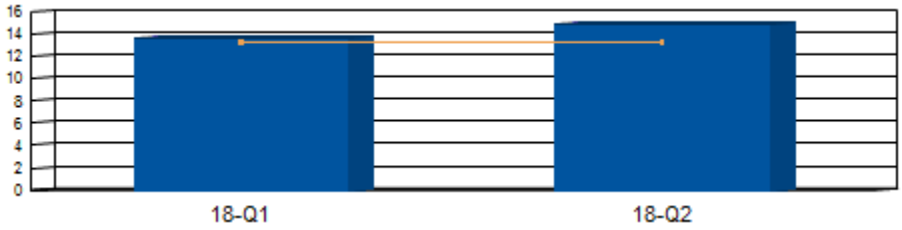
Indicator: Percent ALC Days (KGH QIP)(KGH SAA)



	Actual	Target
18-Q1	13.7	**13.2**
18-Q2	14.8	**13.2**

Describe the tactics that were implemented in this quarter to address the achievement of the target:

In Q2, there was ongoing focus on the patient flow initiatives in the Emergency Department and the inpatient units. Our work is aligned to the SE LHIN patient flow action plan to ensure consistent practices exist across the region.

All patient care programs are utilizing the ALC escalation guideline (implemented in F17 Q3). This procedure requires manager, SE LHIN Home & Community Care manager and director level approval prior to designating a patient as ALC for long term care to ensure all other discharge destinations have been explored and are not viable options to discharge.

The SE LHIN approved a Pay for Results proposal for a refresh of the Home First philosophy to end of fiscal year 2018. A specialist is focused to work with each patient care area to ensure all opportunities for discharge home are explored rather than designating patients as ALC for long term care (LTC). This work requires support from our internal and external stakeholders and education regarding this philosophy was delivered at the end of the quarter to incoming residents at their orientation session. The education session was the same one that all care providers received last fiscal year to ensure consistent messaging to our patients, their families and the primary care teams.

In the Emergency Department, the specialist leads a team including the social worker, nurse practitioner, physiotherapist and nurses at daily morning rounds to plan complex discharges back to the community to prevent admissions for patients at risk of being designated ALC-LTC.

Explain the current performance of the target. Where possible, translate statistics and numbers into plain language, focusing on the impact to patients and staff:

On average, in Q2 there were 62 patients waiting for beds at other destinations.

There is much movement within our ALC patients. We started Q2 with 64 patients designated as ALC waiting for different destinations. Thirty of these patients (47%) were waiting for beds at a LTC home. We ended Q2 with 64 patients designated as ALC with 30 patients (47%) waiting for LTC. During the quarter, we discharged 179 ALC patients and 14 of these patients went to LTC.

This clarifies the assumption that it is the same ALC patients waiting at KHSC for beds at other facilities.

In Q2, nine long stay ALC patients with length of stays between 106 and 943 days were discharged. This caused the spike in ALC days since ALC days in this indicator are based on hospital discharge information.

Are we on track to meet the target by year end? If not, what new tactics are planned to ensure the target is met?

At this time, we are on track to meet our target. This success if based on the provision of SE LHIN funding for the Home First specialist to assist with ensuring patients are returning to the community rather than waiting at KHSC for their next destination.

The organization has submitted a proposal to the SE LHIN for a transitional unit for patients designated as ALC for destinations other than LTC. These patients would benefit from an off site location with restorative therapy services while complex discharge planning is ongoing. KHSC has received funding to support and is in the process of implementing this strategy.

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Definition: DATA: Decision Support - Lana Cassidy COMMENTS: Cynthia Phillips EVP: Silvie Crawford REPORT: QUALITY IMPROVEMENT PLAN (QIP) SAA INDICATOR

When a patient occupies a hospital bed and does not require the intensity of resources/services provided in the acute care setting, the patient must be designated alternate level of care (ALC) by the physician or his/her delegate. The ALC wait period starts at the time of designation and ends at the time of discharge/transfer to a discharge destination, or when the patient's needs or condition changes and the designation of ALC no longer applies.

Total number of ALC inpatient days contributed by ALC patients within the specific reporting period (open, discharged and discontinued cases), divided by the total number of patient days for open, discharged and discontinued cases (Bed Census Summary) in the same period.

Target: Target 17/18: 13.2% Perf. Corridor: Red >14.6% Yellow 13.3%-14.6% Green <=13.2%

Previous fiscal year - Target 16/17: 13.2% Perf. Corridor: Red >13% Yellow >10%-13% Green <=10%

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Improve the patient experience through a focus on compassion and excellence

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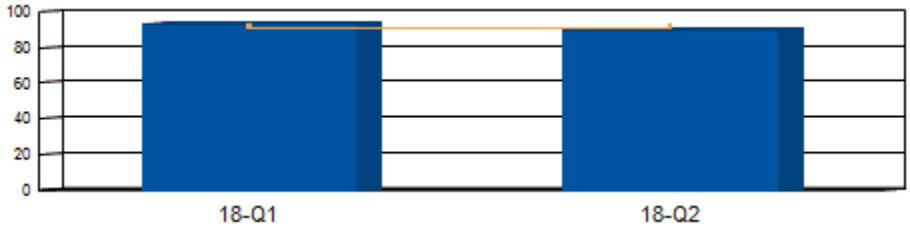
Indicator: Percent of palliative care patients discharged from hospital with the discharge status "Home with Support". (KGH QIP)



	Actual	Target
18-Q1	93.5	**91**
18-Q2	90.0	**91**

Describe the tactics that were implemented in this quarter to address the achievement of the target:

A Palliative Care Redesign Team is in place to develop and implement pathways to expand access to Palliative Medicine and palliative care approaches for specific life-limiting illnesses (CHF, CKD, COPD, Metastatic Cancer (breast, colon, pancreas and lung). KHSC continues to monitor this indicator as part of the strategic initiative to expand access to Palliative Medicine and palliative care approaches.

Leaders are working with SE LHIN Home and Community Care and Primary Care to determine length of response time to receive services and ways to ensure and enhance a discharge pathway for this patient population. With a standard approach to identifying and coordinating care planning including discharge, we can maximize efforts to discharge palliative care patients home with support.

Explain the current performance of the target. Where possible, translate statistics and numbers into plain language, focusing on the impact to patients and staff:

90% of patients diagnosed or receiving inpatient palliative service were discharged home with support. This represents a 3.5% decrease from Q1.

Even though this is a slight decrease from Q1, further investigation will be undertaken to validate accuracy and reliability of data capture for this indicator. Given the importance of individuals with a palliative diagnosis being discharged home with support to help avoid re-hospitalization and unnecessary ED visits, action will be taken to maintain target performance in this area.

Are we on track to meet the target by year end? If not, what new tactics are planned to ensure the target is met?

Yes

Definition: DATA: Christine Knott COMMENTS: Brenda Carter EVP: Brenda Carter REPORT: QUALITY IMPROVEMENT PLAN (QIP)

This year, we are aiming to create a comprehensive, well-coordinated set of care pathways for patients, families and care providers. Based on consultation with stakeholders we developed a plan and performance management framework for enhancing palliative care at KGH. We are working with stakeholders in the oncology, renal, respirology and cardiology programs to map out draft palliative care pathways for their patient populations. We are developing draft pathways for the four areas. Together with clinical leaders we are reviewing the pathways to determine next steps and action items with a view to creating an implementation plan.

In addition to meeting all project milestones, a measurement plan for the performance of palliative care pathway will be developed and act as a template for measuring the performance of other pathways. The measurement plan will include the voice of the patient. Referral time to palliative care will also be measured and monitored.

Target: Target 17/18: 91 Perf. Corridor: Red <= <82% , Yellow 82%-90% , Green >=91.

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Improve the patient experience through a focus on compassion and excellence

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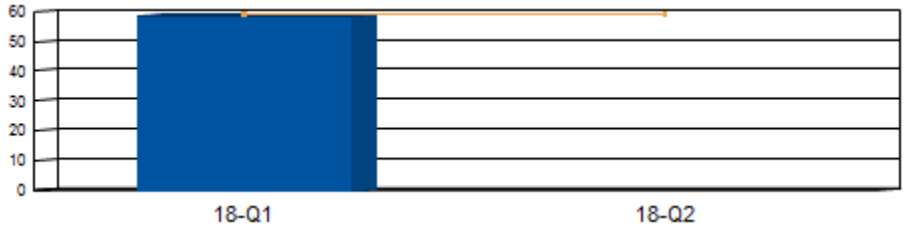
Indicator: Did you receive enough information from hospital staff about what to do if you were worried about your condition or treatment after you left the hospital? (KGH QIP)



	Actual	Target
18-Q1	58.4	**59**
18-Q2		**59**

Describe the tactics that were implemented in this quarter to address the achievement of the target:

This indicator is related to one question on the patient survey asking if the patient received enough information about what to do if she or he had any concerns related to condition or treatment after leaving the hospital. The question relates to receiving the information in an easy to understand format.

A health literacy environmental scan completed last fiscal year identified areas across the organization where there are opportunities to reduce health literacy burden for patients and families. The scan led to several key recommendations to improve communication with patients and families.

One evidence-based health literacy strategy is the teach-back system. This year we are aiming to implement the teach-back system, which provides members of the care team with the tools to reduce health literacy barriers through patient-centered communication. Implementation of teach-back will begin with an initial focus in several areas. Staff and physicians in the Renal Program will receive education related to teach- back methodology to enable the use of this strategy with patients with chronic kidney disease. A teach-back education plan aimed to augment our existing falls prevention program is under development.

Another component of KHSC's health literacy strategy is the Patient Oriented Discharge Summary (PODS). The PODS is an easy to read, understandable, and usable discharge summary for patients, their families and their care providers. It focuses on using the teach-back method when providing important discharge information to patients and families. KHSC was selected as one of two SE LHIN sites to implement the PODS. A registered nurse is dedicated to this project and funding was provided by the Registered Nurses Association of Ontario/Associated Medical Services fellowship grant and the Adopting Research to Improve Care (ARTIC) Program.

A steering committee and working group with representation from all health disciplines as well as patient experience advisors have been working on the development of the discharge process and summary and involving Information Management for their technical expertise. The PODS will be incorporated into the discharge summary that the medical team completes and gives to the patient before discharge.

Explain the current performance of the target. Where possible, translate statistics and numbers into plain language, focusing on the impact to patients and staff:

The data for Q2 is not yet available. Data is usually one quarter behind the reporting schedule. The Q1 result of 58.4% means that 58% or 174 patients who completed the survey said they 'completely' received enough information. There were 298 responses to the survey and 23.8% (n=71) answered 'quite a bit', 13.8% (n=41) answered 'partly' and 4% (n=12) answered 'not at all'.

The first patient will receive PODS in Q3.This year, a minimum of 1,225 patients will be discharged with a PODS. This is one quarter of the yearly discharge amount for medicine patients. Our goal is that all internal medicine patients will be discharged with PODS. This represents an annual discharge volume of approximately 4,900 patients.

We are also working on a web-enabled plain language dictionary that describes medical and medically related terms in everyday language. This project will align with the PODS project and the organization's focus on health literacy.

There is clear evidence in the literature that lack of patient involvement in care decisions and not receiving written discharge instructions are associated with unplanned readmissions. It is expected that the PODS will provide patients, families and care providers with the information they need to manage their health care needs and minimize unplanned visits to the Emergency Department and admissions to the hospital.

Are we on track to meet the target by year end? If not, what new tactics are planned to ensure the target is met?

Our goal is to successfully implement PODS in a sustainable way in the internal medicine populations of patients this fiscal year then to spread the discharge summary across the organization.

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Improve the patient experience through a focus on compassion and excellence

KHSC is a top performer on the essentials of quality, safety, & service

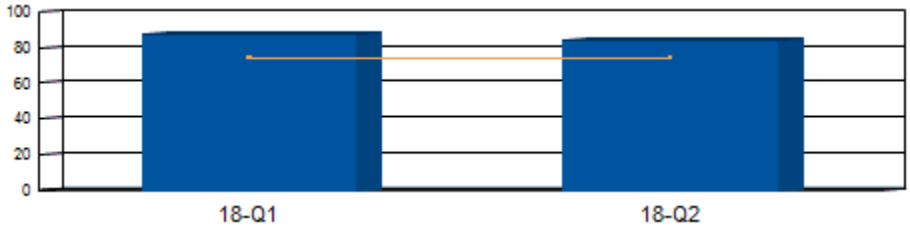
Definition: DATA: Astrid Strong(Q1), Pam Pero COMMENTS: Cynthia Phillips EVP: Mike McDonald REPORT: QUALITY IMPROVEMENT PLAN (QIP)

This year we are aiming to implement the 'teach-back' system, which provides members of the care team with the tools to improve health literacy through patient-centered communication. We will introduce the topic of health literacy in the CKD program and discuss how to introduce the concept in the pre-dialysis clinic. In addition, KGH has been accepted as a partner site with University Health Network to implement an ARTIC-funded Patient-Oriented Discharge Summary (PODS) starting with the medicine program. This is a innovative discharge communication tool that meets the health literacy needs of patients and their families and includes our teach-back method as a component.

As per ARTIC project plan deliverables. The ARTIC project will start April 1st 2017. KGH is just receiving materials for the Project Coordinators and are in the pre-planning phase of this work.

Target: Target 17/18: 59% Perf. Corridor: Red <53% , Yellow 53%-58% , Green >=59.

Indicator: Percent of patients who wanted information that respond "very confident" that they have the information they need and/or know who to contact after they leave their appointment (HDH QIP)



	Actual	Target
18-Q1	87	**74**
18-Q2	84	**74**

Describe the tactics that were implemented in this quarter to address the achievement of the target:

The Hotel Dieu Hospital (HDH) site administers at least one ambulatory care point of care patient experience survey; surveys are rotated between different clinics. Survey results are reviewed and shared with staff to identify unit- specific initiatives that may be undertaken to improve patient experience. In Q2 surveys were conducted in adult clinics on JM4 & JM5. Results were positive. No specific improvement opportunities were identified.

Explain the current performance of the target. Where possible, translate statistics and numbers into plain language, focusing on the impact to patients and staff:

Current performance exceeds target. It is important from the perspective of patient safety that patients and families know what to do after they leave their clinic appointments and who to contact if questions arise after they leave the clinic.

Are we on track to meet the target by year end? If not, what new tactics are planned to ensure the target is met?

Yes

Definition: DATA: Jennifer Sawyer COMMENTS: Carol McIntosh EVP: Mike McDonald REPORT: QUALITY IMPROVEMENT PLAN (QIP)

Performance reviewed by mangers, physicians, and leaders quarterly to identify strengths and improvement opportunities. Patients' response to this question has traditionally been positive; goal is to maintain positive performance, understand improvement opportunities.

Target: Target 17/18: 74% Perf. Corridor: Red <64% , Yellow 64%-73% , Green >=74%.

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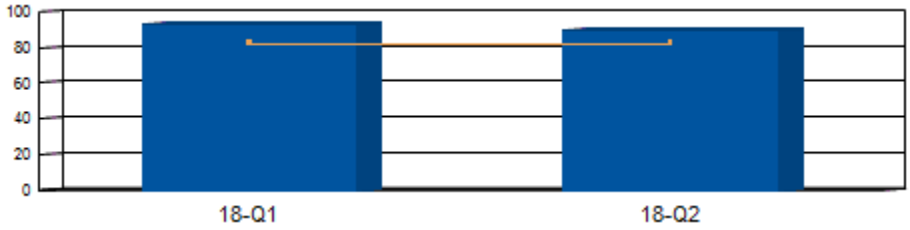
Indicator: Percent of patients in adult ambulatory clinics that rate the quality of care and services received as 'excellent' or 'very good'. (HDH QIP)



	Actual	Target
18-Q1	93	**82**
18-Q2	90	**82**

Describe the tactics that were implemented in this quarter to address the achievement of the target:

The Hotel Dieu Hospital (HDH) site administers at least one ambulatory care point of care patient experience survey; surveys are rotated between different clinics. Survey results are reviewed and shared with staff to identify unit- specific initiatives that may be undertaken to improve patient experience. In Q2 surveys were conducted in adult clinics on JM4 & JM5. Results were positive. No specific improvement opportunities were identified.

Explain the current performance of the target. Where possible, translate statistics and numbers into plain language, focusing on the impact to patients and staff:

Current performance exceeds target.

Are we on track to meet the target by year end? If not, what new tactics are planned to ensure the target is met?

Yes.

Definition: DATA: Jennifer Sawyer COMMENTS: Carol McIntosh EVP: Mike McDonald REPORT: QUALITY IMPROVEMENT PLAN (QIP)

Maintain aggregate ratings of 'excellent' and ' very good' on point-of-care survey in adult clinics. Performance is reviewed quarterly to identify strengths and improvement opportunities.

Target: Target 17/18: 82% Perf. Corridor: Red <72% , Yellow 72%-81% , Green >=82%.

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Improve the patient experience through a focus on compassion and excellence

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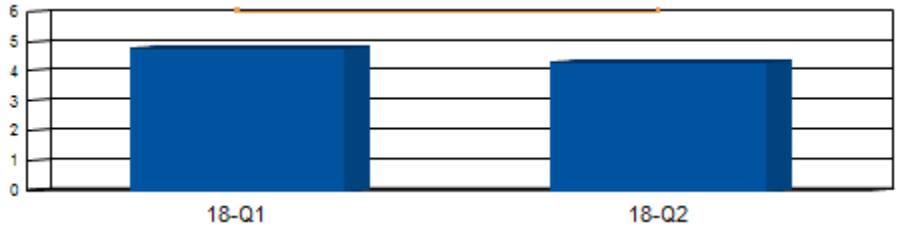
Indicator: 90% UCC Length of Stay (LOS-hrs) for complex patients (CTAS 1,2,3) (HDH QIP/SAA)



	Actual	Target
18-Q1	4.8	**6**
18-Q2	4.3	**6**

Describe the tactics that were implemented in this quarter to address the achievement of the target:

Multiply measures that were done in Q1, are now resulting in decrease times this quarter. These included triage redesign and an emphasis on training staff on medical directives. Medical directives allow a nurse to start specific care within parameters such as ordering Tylenol for a patient with fever or ordering x-rays on a suspected broken ankle or taking blood work with-in specific parameters even before seeing the physician.
The Rapid Access clinic for patients with chronic disease prevented prolonged stays in the urgent care to watch and monitor when there were concerns related ability to see family physician in the next few days. The clinics allowed for 24 to 48 hour referral to a nurse practitioner for follow-up. An ear, nose and throat scope was acquired to provide the ability to perform procedures that previously required a transfer to acute care by ambulance. This allows urgent care to provide the service immediately and requires transfer to acute care only when admission or consult is required. This has been used more and more over the quarter. Transfers to the emergency department have been occurring in a more timely manner related to internal flow improvement at the emergency department and therefor decreasing the urgent cares LOS for complex patients.

Explain the current performance of the target. Where possible, translate statistics and numbers into plain language, focusing on the impact to patients and staff:

We will need to prepare for the flu season and historical peaks in visits; we are working with partners to look at community strategies not just site or unit specific ones. We have had staffing issues in the Rapid Access Clinic and have had challenges fill vacant Nurse Practitioner position. We are continuing on medical directive training.

Are we on track to meet the target by year end? If not, what new tactics are planned to ensure the target is met?

Definition: DATA: Decision Support - David Barber COMMENTS: Carol McIntosh EVP: Mike McDonald REPORT: QUALITY IMPROVEMENT PLAN (QIP) SAA INDICATOR

Maintain current performance.

Target: Target 17/18: 6 Perf. Corridor: Red <8 , Yellow >6-8 , Green <=6.

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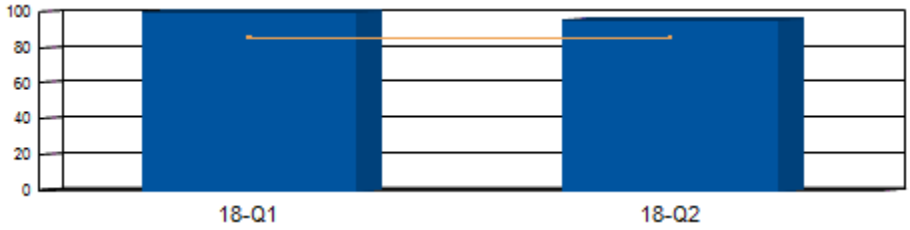
Enable clinical innovation in complex-acute and specialty care

KHSC is positioned as a leading centre for complex-acute & specialty care

Indicator: [(# of regular clinics held + # of special clinics held) / (# regular clinics assigned)] x 100 (HDH QIP)



	Actual	Target
18-Q1	99.8	**85**
18-Q2	94.8	**85**

Describe the tactics that were implemented in this quarter to address the achievement of the target:

Careful recycling of clinic resources within groups until one month before the clinic date, followed by availability of clinic resources outside that group, has worked well to date.

Explain the current performance of the target. Where possible, translate statistics and numbers into plain language, focusing on the impact to patients and staff:

This performance is excellent in an environment where there is significant unpredictability - for example, the need to cancel clinics because of opportunity to use additional operating room time, planned cancellations for attending on clinical teaching units and ICU, etc.

Are we on track to meet the target by year end? If not, what new tactics are planned to ensure the target is met?

Yes.

Definition: DATA: Decision Support - David Barber COMMENTS: Mike Fitzpatrick EVP: Mike Fitzpatrick REPORT: QUALITY IMPROVEMENT PLAN (QIP)

Maintain 2016-17 target to accommodate possible variations in physician resources. Clinic utilization is multi-faceted. Goal is to understand reasons for variation. Ensure efficient clinic utilization.

Target: Target 17/18: 85% Perf. Corridor: Red <75% , Yellow 75%-84% , Green >=85%.

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Enable clinical innovation in complex-acute and specialty care

KHSC is positioned as a leading centre for complex-acute & specialty care

Indicator: # days from clinic appointment until dictated clinic letter has been verified [Result verification date - Clinic appointment date] (HDH QIP)

	Actual	Target
18-Q1	68	**70**
18-Q2	64	**70**

Describe the tactics that were implemented in this quarter to address the achievement of the target:

Data on this target has been discussed at the Ambulatory Care Committee and has also been communicated to department heads.

Explain the current performance of the target. Where possible, translate statistics and numbers into plain language, focusing on the impact to patients and staff:

Current performance is below target. Communication with referring physicians is an important aspect of high quality ambulatory clinical care. The fall in performance during Q2 is not surprising, however, because of delays caused by vacation.

Are we on track to meet the target by year end? If not, what new tactics are planned to ensure the target is met?

The Director of Medical Affairs will meet with those physician groups whose performance on this indicator is most deficient, to request attention to clinic letter sign-off in a timely fashion.

Definition: DATA: Decision Support - David Barber COMMENTS: Mike Fitzpatrick EVP: Mike Fitzpatrick REPORT: QUALITY IMPROVEMENT PLAN (QIP)

Increase data quality auditing to identify long queues out outstanding clinic letters of 14 days or more; Oversight by Medical Admin; Leadership by department heads, division chairs to review and understand performance relative to target; continue to implement improvements. % of dictated clinic letters that are verified within target each quarter.

Target: Target 17/18: > 70% of dictated letters signed off by 2 wks post clinic Perf. Corridor: Red <60%, Yellow 60%-69%, Green >=70%.

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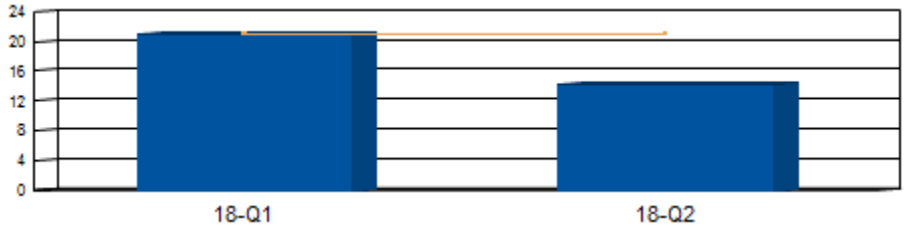
Create seamless transitions in care for patients across our regional health-care system

KHSC is fully engaged with our community partners to support patients with complex-acute and chronic conditions

Indicator: Risk-Adjusted 30-Day All-Cause Readmission Rate for Patients with COPD (QBP cohort) (KGH QIP)



	Actual	Target
18-Q1	21.0	**21**
18-Q2	14.3	**21**

Describe the tactics that were implemented in this quarter to address the achievement of the target:

This indicator relates to work of the Health Care Tomorrow team.

The team is working on a regional map of the patient care processes related to patients presenting with chronic obstructive pulmonary disease (COPD).

A plan comprised of phases of work will be implemented across the SE LHIN.

Explain the current performance of the target. Where possible, translate statistics and numbers into plain language, focusing on the impact to patients and staff:

The initial phase of work was to establish a working group to oversee analysis and provide advice on process.

The COPD hospital care pathway has been mapped out at each site in the SE LHIN. We are working on bridging the links between the hospital and the community initiatives.

Are we on track to meet the target by year end? If not, what new tactics are planned to ensure the target is met?

Yes, we are on track to meet the target set for this fiscal year.

Definition: DATA: Decision Support - Alex Ungar COMMENTS: Silvie Crawford EVP: Mike Fitzpatrick REPORT: QUALITY IMPROVEMENT PLAN (QIP)

A plan comprised of phases of work will be developed and implemented across the SE LHIN. The initial phase of work will be to establish a working group to oversee analysis and provide advice on process. Subsequent phases of work will focus on building a retrospective care continuum at the patient level. This will include visits across acute care sites and other venues of care. The purpose of which is to better understand the current state of regional COPD care. The final phase of work will be to develop system level recommendations aimed at optimizing COPD care in the SE LHIN.

Note: Due to the 3 quarter delay in results we have created a non-risk-adjusted proxy readmission rate for those quarters whose results are yet to be realized.

Target: Target 17/18: 21 Perf. Corridor: Red >10% of the expected Rate Yellow Within 10% of the expected Rate Green <= Expected Rate

Previous fiscal year - Target 16/17: 17.08 Perf. Corridor: Red >10% of the expected Rate Yellow Within 10% of the expected Rate Green <= Expected Rate

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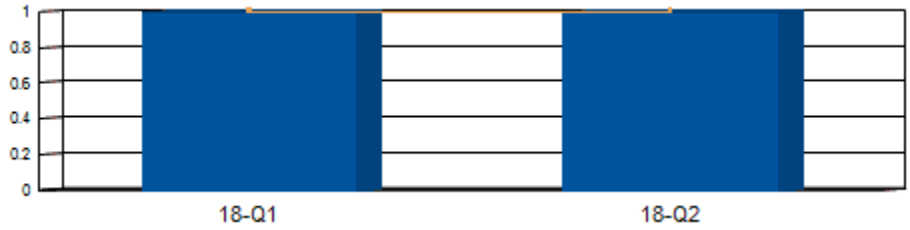
Q2 FY2018 Quality Improvement Plan Report

Create seamless transitions in care for patients across our regional health-care system

KHSC is fully engaged with our community partners to support patients with complex-acute and chronic conditions

Indicator: Patient Journey Process maps as developed by each organization (presented to HCT COPD Clinical Steering Team) Best Practice and QBP Guidelines. (HDH QIP)



	Actual	Target
18-Q1	1	**1**
18-Q2	1	**1**

Describe the tactics that were implemented in this quarter to address the achievement of the target:

The 2016-17 target was partly met. A regional working group was formed and current-state analysis conducted. Work continues in 2017-18. The goal is to develop regional COPD care plan for patients in SE LHIN to improve consistency of care, reduce need for hospital admission, urgent/emergent care. The original plan developed in 2016-17 has been modified to include implementation of the INSPIRED COPD program, thus involving community care providers. The long-tem goal is to reduce readmission rates for patients with COPD in the SE LHIN (INSPIRED is a LHIN-wide evidence based care project focused on care in the community)

Explain the current performance of the target. Where possible, translate statistics and numbers into plain language, focusing on the impact to patients and staff:

The patient journey map will be implemented for patients admitted with COPD exacerbations before the end of fiscal 2018, at KHSC.

Are we on track to meet the target by year end? If not, what new tactics are planned to ensure the target is met?

There is significant ongoing work towards building community supports for the transitions of care of patients with COPD in the SELHIN. The hospital program is poised to launch but now liaising with the community primary care network with a view to providing synchronized transitions of care. The order set for patients admitted to KHSC with AECOPD has been completed.

Definition: DATA: Mike Fitzpatrick COMMENTS: Mike Fitzpatrick EVP: Mike Fitzpatrick REPORT: QUALITY IMPROVEMENT PLAN (QIP)

Develop regional COPD care plan for patients in SE LHIN to improve consistency of care, reduce need for hospital admission, urgent/emergent care. The original plan developed in 2016-17 has been modified to include implementation of the INSPIRED COPD program, thus involving community care providers.

Target: Target 17/18: See change plan Perf. Corridor: Red No = 0, Yellow In progress = BLANK with Yellow Status, Green Yes = 1.

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Q2 FY2018 Quality Improvement Plan Report

Status:

N/A	Currently Not Available
	Green-Meet Acceptable Performance Target
	Red-Performance is outside acceptable target range and requires improvement
	Yellow-Monitoring Required, performance approaching target