fiscal 2018-2019 **Q1**

1st quarter ended June 30, 2018

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

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

Strategic Direction 3

Improve the experience of our people through a focus on work-life quality

Outcome: Out people are inspired and proud to be part of the KHSC community

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

KHSC Quality Improvement Plan (QIP) Performance Report

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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Q1 FY2019 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	% of patients that respond 'definitely yes' to the question, "Would you recommend this hospital to your friends and family?" (ED) (KHSC QIP)	Y	Y	Y	Y	Y
		% of patients that respond in the 'top box' to the question, "Would you recommend this hospital to your friends and family?" (inpatient) (KHSC QIP)	Y	Y	Y	G	G
		% of patients that respond in the 'top box' to the question, "Would you recommend this hospital to your friends and family?" (UCC) (KHSC QIP)	R	Y	R	Y	Y
		Percent of patients requiring palliative care that are discharged from hospital with the discharge status of "Home with Support" (KHSC QIP)	G	Y	G	G	Y
		Medication reconciliation at discharge (KHSC QIP)	N/A	N/A	N/A	N/A	G
		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? (KHSC QIP) (LQ2F)	Y	Y	Y	Y	G
Improve the experience of our people through a focus on work-life quality	Our people are inspired and proud to be part of the KHSC community	# of workplace violence incidents reported by workers within a 12-month period (KHSC QIP)	N/A	N/A	N/A	N/A	G
Enable clinical innovation in complex-acute and specialty care	KHSC is positioned as a leading centre for complex-acute & specialty care	# days from clinic appointment until dictated clinic letter has been verified [Result verification date - Clinic appt. date] (KHSC QIP)	Y	Y	Y	Y	N/A
		Readmission QBP (COPD) (KHSC QIP)	R	R	Y	Y	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	Readmission: Mental Health and Addiction (KHSC QIP)	N/A	N/A	N/A	N/A	N/A

	SPR F19		QIP F19		SAA F19	
	Q1 %	Q1 #	Q1 %	Q1 #	Q1 %	Q1 #
R	0%	0	0%	0	33%	23
G Y	100%	14	70%	7	59%	41
N/A	0%	0	30%	3	7%	5
		14		10		69

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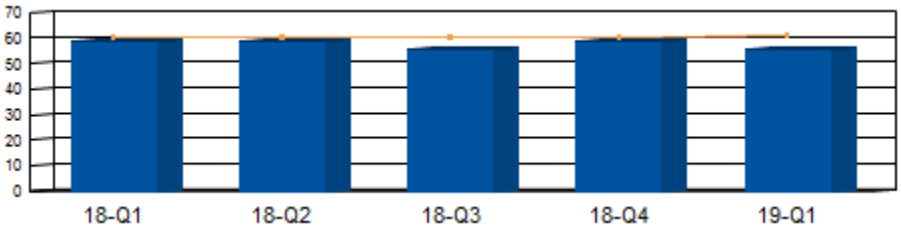
Q1 FY2019 Quality Improvement Plan Report

Improve the patient experience through a focus on compassion and excellence

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

Indicator: % of patients that respond 'definitely yes' to the question, "Would you recommend this hospital to your friends and family?" (ED) (KHSC QIP)



	Actual	Target
18-Q1	59.2	**60**
18-Q2	59.0	**60**
18-Q3	55.6	**60**
18-Q4	58.9	**60**
19-Q1	55.9	**61**

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

The staffs in the Emergency Department strive to provide exemplary care. Patient experience survey results are reviewed with staff including physicians and patient experiences advisors with our Patient Relations and Quality Advisor at the programs departmentally meetings: they are reviewed for opportunities for improvement noted by trends and to understand which dimensions of patient experience correspond most closely with high levels of patient.

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 Q4 results will be reported in Q1.We knowing from previous surveys a major patient satisfier in the ED is reduced wait times we continue to work on these and look for any trends in surveys to gear new efforts to.

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 look for opportunities identified by our patient from there feedback to improve the experience in the emergency department, at present we are at risk to meet the target, we have noticed a decline in the definitely yes both this last quarter and with the new surveys that takes only the top choice definitely yes and not "definitely yes" and "probably yes". This new survey is one source of information regarding patient experience at KGH. The challenge is how we move people from 'probably' to 'definitely'. The perception may be that 'definitely' does not allow room for improvement. We continue to work on improving access and flow through the emergency department as wait times are associated with satisfaction. We have been working to increase access for all patients by improving the flow to in-patient beds therefore improving access to space with-in the ED for patients to be seen. This includes use of additional chairs when beds were not needed for certain patients. We have added 3 additional chairs to one section by converting underused space, for patients to wait once minor testing is done. We are working on signage for the waiting areas as well, patient feedback has requested been that clearer signage.

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).

ED patient care team will work with Patient Relations and Patient Experience Advisors to review patient experience data and patient relations data to identify improvement opportunities and gauge improvement.

Target: Target 18/19: 61% Perf. Corridor: Red <51% , Yellow 51% - 60%, Green >=61%

Prior Targets:
- Target 17/18: 60% Perf. Corridor: Red <54% , Yellow 54%-59%, Green >=60%
- 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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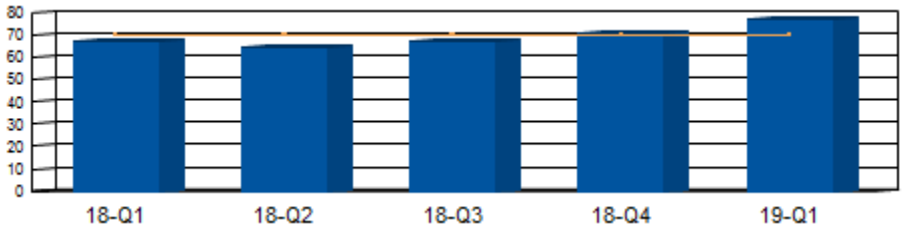
Q1 FY2019 Quality Improvement Plan Report

Improve the patient experience through a focus on compassion and excellence

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

Indicator: % of patients that respond in the 'top box' to the question, "Would you recommend this hospital to your friends and family?" (inpatient) (KHSC QIP)



	Actual	Target
18-Q1	67.6	**70**
18-Q2	64.1	**70**
18-Q3	67.2	**70**
18-Q4	70.7	**70**
19-Q1	77.2	**70**

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

Patients and families will recommend the hospital to friends and family if they are satisfied with the care they receive. Feedback is provided through patient surveys and feedback to the Patient Relations Program.

The majority of comments on patient surveys are related to the environment (cleanliness) and to the food that is serviced to inpatients.

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

Each quarter, the patient care programs review the inpatient survey results and comments as well as the Patient Relations feedback related to cleanliness and food. We find opportunities for improvement within those two areas and involve other departments and services as needed.

We also continue to report on the patient- and family-centred care standards by performing regular audits of the standards. Standards include: hourly rounding, identification badges worn at chest level, updated patient white boards, introductions with each patient interaction and patient led feedback forums.

Results are reported to all stakeholders on a regular basis. Each program makes one improvement per quarter and ensures the standards meet or exceed the set 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?

We met the target this quarter. We will continue to review survey results and commentary at program council meetings, staff meetings and with the Patient and Family Advisory Council. We will also ensure the patient care areas perform 20 audits of the patient- and family-centred care standards monthly and each patient care program performs 2 patient led feedback forums each year.

Definition: DATA: Pam Pero COMMENTS: Cynthia Phillips, Reg Hart EVP: Mike McDonald, Silvie Crawford REPORT: QUALITY IMPROVEMENT PLAN (QIP)

Percentage of respondents who responded positively to the following question: Would you recommend this hospital to friends and family?

1. The majority of comments on patient surveys are related to the environment (cleanliness) and to the food that is serviced to inpatients. Each quarter, review the Medicine inpatient survey results and comments as well as the Patient Relations feedback related to cleanliness and food. Find opportunities for improvement within those two areas. Involve other departments and services as needed.
2. Continue to report on the PFCC standards by performing regular audits of the standards. Standards include: hourly rounding, identification badges worn at chest level, updated patient white boards, introductions with each patient interaction and patient led feedback forums.

Target: Target 18/19: 70% Perf. Corridor: Red <60%, Yellow 60% - 69%, Green >=70%

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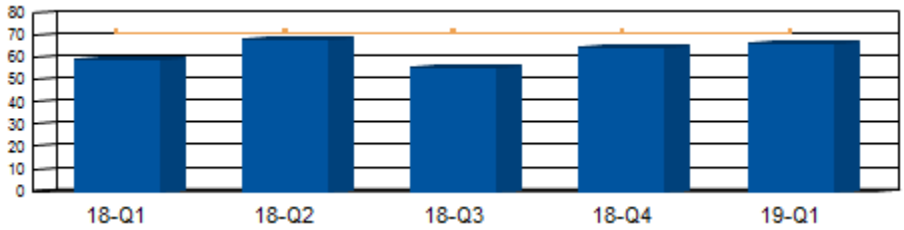
Indicator: % of patients that respond in the 'top box' to the question, "Would you recommend this hospital to your friends and family?" (UCC) (KHSC QIP)



	Actual	Target
18-Q1	59.2	**71**
18-Q2	68.5	**71**
18-Q3	55.6	**71**
18-Q4	64.2	**71**
19-Q1	66.7	**71**

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

We continued to modify the triage area, initial modifications completed with staff, patient experience adviser where implemented and feedback initial from patients was that the area needed modification, privacy screens were added.

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 Q1 results are being reported in the Q2 scorecard. This indicates 66.7 % of patients felt that they would pick 10 on a scale of 0 to 10 (0 being the worst hospital/facility and 10 being the best) when asked would you recommend this hospital/facility.

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 are working with our Patient Relations and Quality Advisor as well as patient experience advisors, to identify issues and trends to work on improving the experience. It was noted that communication could be improved with signage of what to expect in the Urgent care center during a visit, and we are working with the Emergency Department on signage to help with this.

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

ED patient care team will work with Patient Relations and Patient Experience Advisors to review patient experience data and patient relations data to identify improvement opportunities and gauge improvement.

Target: Target 18/19: 71% Perf. Corridor: Red <61%, Yellow 61% - 70%, Green >=71%

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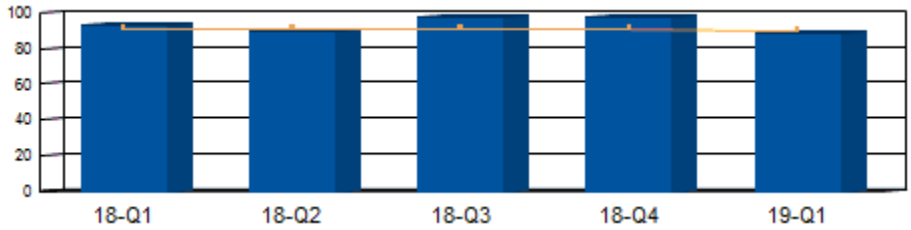
Indicator: Percent of patients requiring palliative care that are discharged from hospital with the discharge status of "Home with Support" (KHSC QIP)



	Actual	Target
18-Q1	93.5	**91**
18-Q2	90.0	**91**
18-Q3	97.0	**91**
18-Q4	97.0	**91**
19-Q1	89.0	**90**

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

KHSC continues to monitor this indicator as part of the strategic initiative to expand access to Palliative Medicine and palliative care approaches. A quality improvement project is underway through IDEAS with involvement from leaders within KHSC, the South East LHIN's Home and Community Care, and Primary Care. The overall aim is to improve and ensure timely continued palliative care services from hospital to home. Progress this quarter includes: examination of current discharge planning processes for handover of information between hospital and LHIN H&CC; identifying patients in common, and conducting a small chart audit to identify specific opportunities for improvement.

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

89% of patients diagnosed or receiving inpatient palliative service were discharged home with support. This is 1% below the target, yet represents an 8% decrease from Q4 last year. One possibility to explain the findings could be that more individuals are being appropriately diagnosed as requiring palliative care, and that this means there is a greater volume of individuals for which performance is being evaluated. It could be that the result is a more accurate indication of performance, however, further investigation will be undertaken to validate accuracy and reliability of data capture for this indicator. Given the importance of this initiative to help avoid readmission and avoidable 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: Decision Support - Alex Ungar COMMENTS: Lori Van Manen EVP: Brenda Carter REPORT: QUALITY IMPROVEMENT PLAN (QIP)

Patients with advanced life-limiting illnesses and who receive palliative care often require new/enhanced home supports to ensure a safe discharge and continuity of care. Our objectives are:

1. to determine the percentage (%) of admitted patients determined as requiring palliative (discharge diagnosis) care that return to their own homes with home supports;
2. to review cases (charts) of patients that did not receive home support at the time of discharge;
3. to distinguish the accuracy of completing the discharge disposition— i.e., understanding "home" to mean private community residence and not a location where there is managed care; and
4. to inform the development of a discharge pathway and standards for this high risk population, in collaboration with the South East LHIN Home and Community Care and other stakeholders.

Target: Target 18/19: 90% Perf. Corridor: Red <= <80% , Yellow 80%-89% , Green >=90%

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

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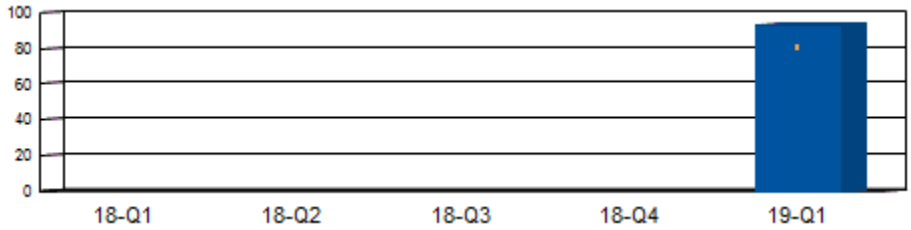
Indicator: Medication reconciliation at discharge (KHSC QIP)



	Actual	Target
18-Q1		
18-Q2		
18-Q3		
18-Q4		
19-Q1	93	**80**

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

In Fiscal 2018 19 quarter 1, the upgraded, in house built, software system for prescriber completion of the electronic discharge (e discharge) summary prior to patient discharge from the Hospital was implemented. The new system including improved medication reconciliation on discharge process resulted in 93% prescriber compliance with 66% of the patients having a best possible medication history (BPMH) or home medication history completed or verified by Pharmacy staff.

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

During the period April to June 2018, 93% of all patients admitted to KHSC (at both KGH and HDH sites) received, on discharge from the Hospital, detailed medication information and instructions on the medicines they should continue to take at home as well as a list of home medications that were stopped or changed as a result of the Hospital stay and also a list of the new medications that were started (with a prescription for their community pharmacy). 66% of the patient home medication lists were gathered or verified on admission with the patient and/or family by Pharmacy staff for patient safety.

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 are on track to meet the target by year end with goal to increase the percentage of patient's BPMH completed or verified by Pharmacy staff from 66% to 80% with either an increase in staffing or the implementation of the BDM Axis software system.

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

Total number of discharged patients for whom a Best Possible Medication Discharge Plan (BPMDP) was created as a proportion of the total number of patients discharged.

1. Increase compliance rate by 5% quarterly by increasing the number of Pharmacy technicians certified in Medication Reconciliation. The total number of discharged patients for whom a Best Possible Medication Discharge Plan (BPMDP) was created as a proportion of the total number of patients discharged increases to 65% in F19 Q1, 70% in F19 Q2, 75% in F19 Q3 and to 80% in F19 Q4.
2. Continuously review and improve the pharmacy procedures for conducting medication reconciliation including optimizing support and resources for staff.
3. Evaluate the extension of the pharmacy software system for home medication documentation that would provide transferable data and auditing capabilities.

Target: Target 18/19: 80% Perf. Corridor: Red <70% Yellow 70%-79% Green >=80%

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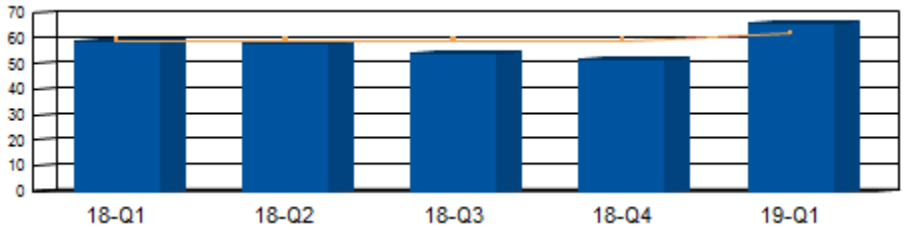
Indicator: Did you receive enough information from hospital staff about what to do if you were worried about your condition or treatment after you left the hospital? (KHSC QIP) (LQ2F)



	Actual	Target
18-Q1	58.5	**59**
18-Q2	58.3	**59**
18-Q3	54.0	**59**
18-Q4	51.6	**59**
19-Q1	65.8	**62**

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 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 began with an initial focus in several areas. Staff and physicians in the Renal Program received 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 called My Discharge Plan (MDP). The MDP 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 patient oriented discharge summary. A registered nurse is dedicated to this project and a steering committee with representation from care providers, Information Management and patient experience advisors worked on the development of the discharge process and summary. The MDP was incorporated into the discharge summary that the medical team completes and gives to the patient before discharge.

This year, we have secured funding from the SE LHIN to support the work on strengthening transitions from hospital to home. We will build on our work and add post-discharge follow-up telephone calls. Registered nurses will call patients discharged from the Internal Medicine Program within 72 hours of discharge to answer questions, clarify information and provide necessary follow up.

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 Q1 shows that we are meeting the set target. The Q1 result means that 65.8% of patients who completed the survey said they 'completely' received enough information.

The first patient received MDP in Q1 to meet our goal that all internal medicine patients be discharged with MDP. This represents an annual discharge volume of approximately 4,900 patients. In the first quarter of this fiscal year 1,086 care providers received health literacy, teach-back and MDP education. The clinical flowsheet has been redesigned to include a section on discharge care provided.

We now have a web enabled plain language dictionary that describes medical and medically related terms in everyday language. The dictionary is available on the KHSC website for easy access. This project will align with the patient oriented discharge summary 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 MDP 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?

Yes, we are on track to meet our goal. This quarter we successfully implemented MDP in the internal medicine populations of patients. This fiscal year we will spread the discharge summary across the organization.

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Definition: DATA: Pam Pero (CPES-IC) COMMENTS: Cynthia Phillips, Reg Hart EVP: Mike McDonald, Silvie Crawford REPORT: QUALITY IMPROVEMENT PLAN (QIP), LQ2F INDICATOR

1. Implement a patient oriented discharge summary called My Discharge Plan (MDP) on specified patient populations.
2. Include a focus on the use of plain language and the 'teach-back' method, recommended health literacy best practices shown to enhance provider and patient communication.
3. Submit a Pay 4 Results proposal for a redesigned discharge process that includes the combined use of evidence-based health literacy strategies, My Discharge Plan and post discharge phone calls to be completed within 24 to 48 hours following discharge of Internal Medicine patients.

Target: Target 18/19: 62% Perf. Corridor: Red <52% , Yellow 52% - 61% , Green >=62%

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

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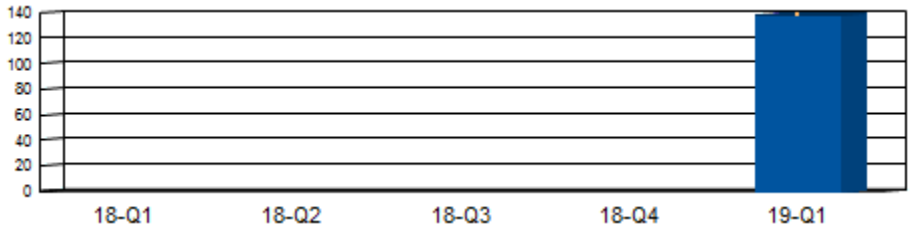
Q1 FY2019 Quality Improvement Plan Report

Improve the experience of our people through a focus on work-life quality

Our people are inspired and proud to be part of the KHSC community

Indicator: # of workplace violence incidents reported by workers within a 12-month period (KHSC QIP)



	Actual	Target
18-Q1		
18-Q2		
18-Q3		
18-Q4		
19-Q1	138	**138**

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

Action items initiated or completed in Q1 from the QIP violence prevention work plan included the following: 1) the organization's Workplace Violence Prevention Program was reviewed using the PSHSA toolkit, 2) the organization's security program as it relates to workplace violence prevention and management was assessed using the PSHSA toolkit, 3) a scorecard specific to workplace violence containing comprehensive data was developed, 4) an environmental health & safety checklist in the Mental Health Program was implemented to ensure potential issues with the physical environment are promptly identified and resolved, and 5) a new model for regular crisis debriefing/stress management for staff in the Mental Health Program to support psychological health & safety in the workplace was implemented. In focusing our attention on a number of violence prevention program improvements, the goal is to improve staff awareness and importance of reporting.

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 attached to the mandatory workplace violence indicator on the QIP is to increase the reported incidents of violence by 10% this fiscal. We did achieve the target in Q1 but there was a corresponding increase in incident severity with 17 of the 138 incidents reported resulting in injuries to staff that required them to seek health care or lose time from work.

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

Items to be initiated in Q2 include finalizing the assessment of the NVCI training Program and putting forward recommendation for improvement/change, exploring the feasibility of real-time incident analysis for incidents of violence, and initiating a revision to the existing patient Risk Reduction/Care plan. Development and implementation of an action plan in Q2 that addresses opportunities for improvement identified in the violence program and security assessment will further assist in violence prevention. Additionally, we are awaiting the results of the external risk assessments that were completed in the Mental Health & Emergency Programs in late June 2018.

Definition:

DATA: Joanna Noonan COMMENTS: Joanna Noonan EVP: Sandra Carlton REPORT: QUALITY IMPROVEMENT PLAN (QIP)

1. Conduct a review of the organization's Workplace Violence Prevention Program and develop an action plan to address gaps/areas for improvement.
2. Assess the organization's security program in relation to the prevention and management of workplace violence and develop an action plan to address gaps/areas for improvement.
3. Reassess our existing staff training program across both sites and prepare a proposal for a revised training program for approval.
4. Develop a scorecard that is specific to workplace violence that includes comprehensive data that is collected quarterly and reported to stakeholder groups including the JHSCs and the Violence Working Group.
5. Explore the feasibility of real-time incident analysis for incidents of violence.
6. Implement an environmental health & safety checklist in the Mental Health Program to ensure potential issues with the physical environment are promptly identified and resolved; evaluate its use for possible reapplication to other high risk units.
7. Implement a new model for regular crisis debriefing/stress management for staff in the Mental Health Program to support psychological health & safety in the workplace.
8. Renew training with all clinical staff who use voceras to reaffirm understanding of the procedures to be followed to activate the double tap feature to summon immediate assistance
9. Revise the existing patient Risk Reduction/Care plan.
10. Integrate the individual KGH and HDH site violence prevention policies that are specific to patient violence and develop new supporting materials (e.g. public posters, Violence Prevention Guide for Patients, Families, and Visitors, etc.) so that content and messaging is standardized across KHSC.

Target: Target 18/19: Increase the number of reported incidents by 10% (> 550 incidents) (Quarterly targets: Q1 – Q3: 137/quarter; Q4: 139) Perf. Corridor: Red <495 (<123 (Q1-3)) , Yellow 495-549 (123-136 (Q1-3)), Green >=550 (>=137 (Q1-3))

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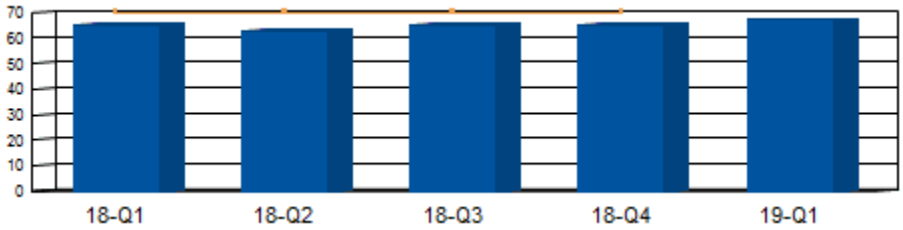
Q1 FY2019 Quality Improvement Plan Report

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 appt. date] (KHSC QIP)

N/A



	Actual	Target
18-Q1	65.0	**70**
18-Q2	63.0	**70**
18-Q3	65.0	**70**
18-Q4	65.0	**70**
19-Q1	67.1	

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

The current year is being used to understand baseline data for this metric, which will guide goal-setting in the future.

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

See above

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: Chris Gillies EVP: Mike Fitzpatrick REPORT: QUALITY IMPROVEMENT PLAN (QIP)

days from clinic appointment until dictated clinic letter has been verified; Includes only clinic letters that are dictated using the central hospital dictation system; Excludes letters that are dictated by physician offices and not transcribed into the Patient Care System (PCS)[Result verification date - clinic appt. date]

1. Clearly communicate the rationale and expectations for this indicator to all KHSC physicians and demonstrate a hospital-wide commitment to review, understand, discuss, and improve performance.
2. Gain endorsement from the Medical Advisory Committee (MAC) to develop a policy to guide when a dictated clinic letter is expected.

Target: Target 18/19: TBD Perf. Corridors: Red TBD, Yellow TBD, Green TBD

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

Kingston Health Sciences Centre

Centre des sciences de la santé de Kingston

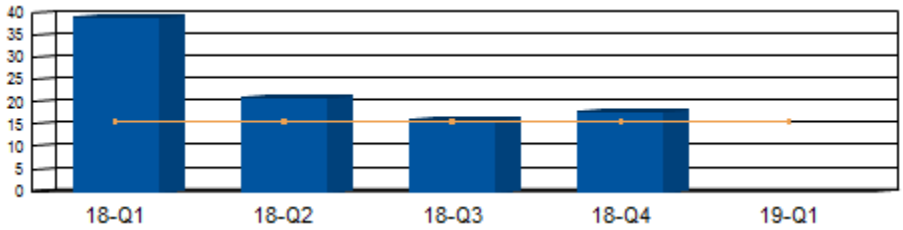
Q1 FY2019 Quality Improvement Plan Report

Enable clinical innovation in complex-acute and specialty care

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

Indicator: Readmission QBP (COPD) (KHSC QIP)

N/A



	Actual	Target
18-Q1	39	**15.5**
18-Q2	21	**15.5**
18-Q3	16	**15.5**
18-Q4	18	**15.5**
19-Q1		**15.5**

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

Data not yet available for this quarter. The work is in the planning phase and the COPD navigator should be in place in Q2. The navigator will identify patients, complete a COPD action plan for the patients outlining actions to manage symptoms. There will also be a discharge information sign off sheet to ensure all education and supports are in place upon discharge. This approach will improve care and build patient confidence to manage their symptoms. We expect significant improvements in the transition to home including improved outcomes relevant to the patient and family; for example, less breathlessness, more stamina, recognition and management of COPD and use of medications. The navigator will be available to provide guidance and support for all aspects of COPD management.

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

Data not yet available for this quarter. The work is in the planning phase and the COPD navigator should be in place in Q2. The navigator will identify patients, complete a COPD action plan for the patients outlining actions to manage symptoms. There will also be a discharge information sign off sheet to ensure all education and supports are in place upon discharge. This approach will improve care and build patient confidence to manage their symptoms. We expect significant improvements in the transition to home including improved outcomes relevant to the patient and family; for example, less breathlessness, more stamina, recognition and management of COPD and use of medications. The navigator will be available to provide guidance and support for all aspects of COPD management.

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 work to meet the set target this fiscal year. The navigator will follow up with patients and ensure a plan is in place to manage symptoms and decrease re-visits to the hospital.

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

1. KHSC will continue to ensure Health Links referrals are made as indicated by the referral criteria. Health Links is an initiative focused on patients with multiple chronic conditions and on seniors to connect them with resources across SE LHIN that can provide them with support in the community. KHSC role is to refer patients who meet criteria. KHSC refers patients admitted to Medicine and Mental Health units and patients in Renal Program. Health Links goal is to provide better care to high users of health care, reduce costs, decrease ED visits and hospital admissions.
2. The Health Care Tomorrow pathway for admitted COPD patients across SE LHIN is a regional pathway to ensure consistent care is provided across the region. The goal is to improve care for the COPD patients, ensure these patients have community supports upon discharge in order to avoid visits to the ED and avoid hospital admission. The pathway consists of a standardized order set that reflects COPD QBP. The COPD care navigator will perform follow up post-discharge phone calls and education as needed, and adopt e INSPIRED program. The INSPIRED program includes self-management support education, action plans, telephone help line, home visits & advance care planning where needed.

Target: Target 18/19: 15.5% Perf. Corridors: Red >10% of the expected Rate, Yellow Within 10% of the expected Rate, Green <= Expected Rate

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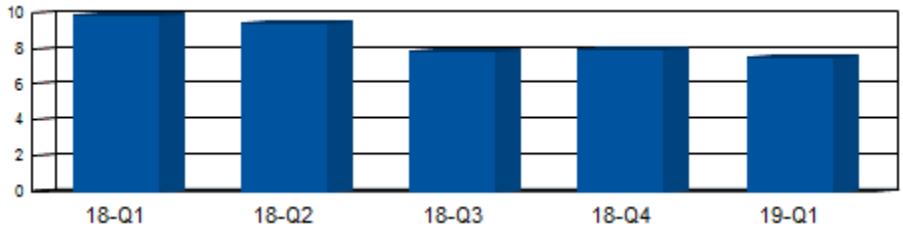
Q1 FY2019 Quality Improvement Plan Report

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: Readmission: Mental Health and Addiction (KHSC QIP)

N/A



	Actual	Target
18-Q1	9.9	
18-Q2	9.4	
18-Q3	7.8	
18-Q4	7.9	
19-Q1	7.5	

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

This is a new indicator and baseline year for data collection. We are working with decision-support to understand trends with re-admission rates according to diagnostic categories that will help inform tactics moving forward.

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 believe data analysis will identifying high risk patients that require assertive community treatment teams (ACTT) to be effectively supported in the community. Current performance reflects early work with community partners in AMHS-KFLA and PCC ACTT to ensure referrals are in place prior to discharge.

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

Baseline data, target to be established.

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

Three improvement initiatives will be undertaken to strengthen discharge supports and community partnerships for successful transfers of care and/or reintegration into community following acute care admission (for optimal patient outcomes), reducing avoidable re-admission t hospital within a 30 day period.

1. Establish baseline data for this indicator. Conduct analysis of current re-admissions by patient unique identifier and diagnostic category. It is important to identify trends of high risk patient groups contributing to re-admission rates in order to target specific interventions.
2. Assess patient flow between acute care, specialized chronic care and community providers; identify gaps in service for high risk patients develop strategy/action plan.
3. Assess current inpatient discharge planning process for high risk patients, identify opportunities to strengthen process.

Target: Target 18/19: TBD Perf. Corridors: Red TBD, Yellow TBD, Green TBD

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Q1 FY2019 Quality Improvement Plan Report

Status:

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