fiscal 2018-2019 **Q3**

3rd quarter ended December 31, 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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Q3 FY2019 Quality Improvement Plan Report

Strategic Direction	2019 Outcome	Indicator	18-Q3	18-Q4	19-Q1	19-Q2	19-Q3
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	G	N/A
		% 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	G	Y	Y	N/A
		% 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	Y	Y	N/A
		Percent of patients requiring palliative care that are discharged from hospital with the discharge status of "Home with Support" (KHSC QIP)	G	G	G	G	G
		Medication reconciliation at discharge (KHSC QIP)	N/A	N/A	G	G	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	N/A
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	G	Y	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	N/A	N/A	N/A
		Readmission QBP (COPD) (KHSC QIP)	Y	Y	G	R	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				QIP				SAA			
	F19				F19				F19			
	Q1 %	Q2 %	Q3 %	Q3 #	Q1 %	Q2 %	Q3 %	Q3 #	Q1 %	Q2 %	Q3 %	Q3 #
R	0%	14%	14%	2	0%	0%	12%	1	35%	26%	26%	18
G Y	100%	86%	86%	12	100%	100%	88%	7	61%	70%	70%	48
N/A	0%	0%	0%	0	0%	0%	0%	0	4%	4%	4%	3
				14				8				69

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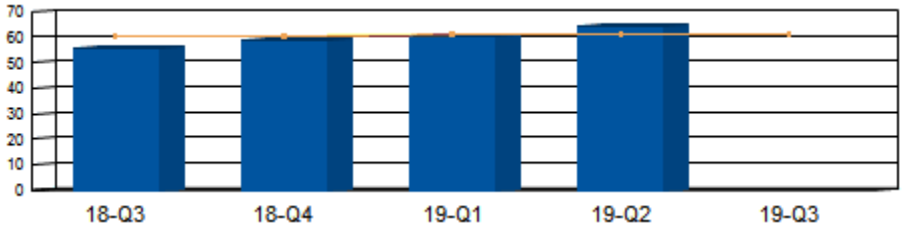
Q3 FY2019 Quality Improvement Plan Report

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-Q3	55.6	**60**
18-Q4	58.9	**60**
19-Q1	60.4	**61**
19-Q2	64.7	**61**
19-Q3		**61**

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

Our patient experience survey results are reviewed with staff , patient experiences advisors and our Patient Relations and Quality Advisor at our quarterly departmentally meetings: there we looked at opportunities for improvement noted. We work on improving Length of stay and communication as we know they have high correlations with 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. The reported results from Q 1 & 2 indicate improvements from 58.9 %to 60.4 % and now 64.7 %. We have been working on internal flow through the ED with increased use of chair space, for those that do not need a bed to seen by a Health Care Professional. The Nurse Practitioner has been seeing patients in our fast track areas during the day and in Dec our first designated NP for fast track started and all 3 fast tracks NP's are in place as of Jan. 14. We continue to work on hospital wide over capacity and surge plans, as increased wait times in ED negatively correlate with satisfaction. .

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, although volumes and hospital capacity increased this quarter with capacity over 100 % during the latter part of Dec. This result in increased length of stay for admitted patients in the emergency department. This decreased available bed space and increased wait times, increased wait times generally will decrease satisfaction. The first of 3 Nurse Practitioner hired to cover the early afternoon and evening hours assigned to see low acuity patients that arrive during this time started and by mid-January except all 3 to be in place. These NP's see those that do not need a bed and have low acuity issues in the designated section F space created in the waiting area.

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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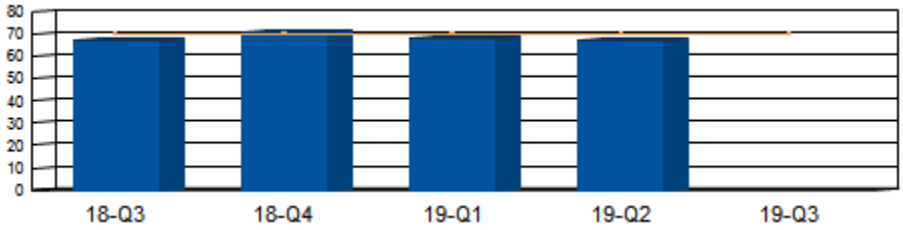
Q3 FY2019 Quality Improvement Plan Report

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-Q3	67.2	**70**
18-Q4	70.7	**70**
19-Q1	68.5	**70**
19-Q2	67.3	**70**
19-Q3		**70**

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

Patients and families will recommend KHSC to friends and family based on satisfaction in a variety of different domains "the C's" related to their inpatient experience including: Cleanliness, Cuisine (Food), Care, Comfort (pain control), Communication, Care Coordination, Calm Environment (Quiet) and Compassion. Valuable patient and family feedback in these domains is gathered directly through patient surveys, the Patient Relations Program, and Patient and Family Feedback Forums which are held by twice per year by each clinical program. This feedback stimulates initiatives, broadly divided into "clinical" and "non-clinical" categories.

The major ongoing clinical initiatives addressing this indicator are:
• "My Discharge Plan" - a patient-oriented discharge summary for patients in all programs except for Mental Health which uses clear and easy to understand language and helps patients prepare for self-care after discharge
• Training for staff in health literacy techniques such as using plain language and using the "Teach Back" method in order to improve effectiveness of patient and family education
• Post-discharge follow-up phone calls within 48-72 hours for all patients discharged from General Internal Medicine units
• Bedside handovers in Critical Care units in order to engage patients and families in their care
• Monitoring and adjusting noise levels via noise monitoring devices embedded in care areas
• Care Navigator/NP roles for specific patient populations and/or affiliated with specific programs who work with physicians and the interprofessional team to assist with care planning and coordination, patient and family education, discharge planning, follow-up care and communication with the patient's Primary Care provider

With respect to non-clinical initiatives addressing this indicator it is important to note that the majority of comments on patient surveys are related to the environment (cleanliness) and to the food that is provided to inpatients. Each quarter, the patient care programs review the inpatient survey results and comments and Patient Relations feedback related to cleanliness and food in order to identify opportunities for improvement and involve other departments and services as needed.

In addition, each program continues to monitor adherence to the patient and family-centred care standards by performing regular audits of the standards which 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.

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 result reflects Q2 data due to a delay in the data availability. The Q2 result is slightly lower than the Q1 result but due to insufficient data points may not necessarily indicate a trend. More data is required. It is also important to note that many of the tactics described above were not fully implemented in Q2.

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

Unknown. More data points are required to understand the impact of the interventions above on the patient experience and what changes need to be made to attain the target result.

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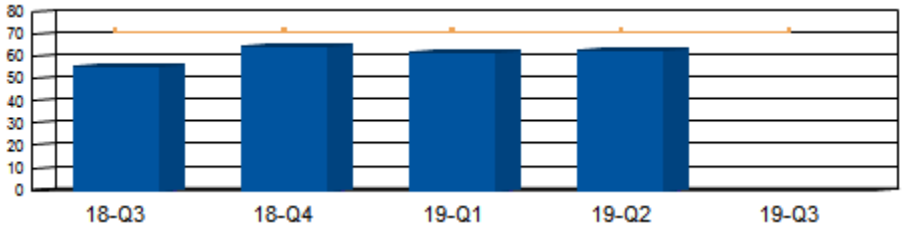
Indicator: % of patients that respond in the 'top box' to the question, "Would you recommend this hospital to your friends and family?" (UCC) (KHSC QIP)



	Actual	Target
18-Q3	55.6	71
18-Q4	64.2	71
19-Q1	61.6	71
19-Q2	63.1	71
19-Q3		71

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

We modified the triage area, and added additional privacy measures, after further feedback from staff and patient experience adviser we have added new privacy screens, noise buffers and continue to look for ways to improve. As volumes increase we have increased the use of two triage nurses when possible, to ensure less time spent at the triage waiting area. Staffs have been highlighting patient feedback related to satisfaction and privacy in staff meetings and looking for opportunities to improve the experience.

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 are being reported in the Q3 scorecard. This indicates 63.1 % 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. This is a improvement from last reported results.

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 in danger of not meeting the 71% target in Q 3 &4, as Q3 & Q4 are traditionally higher volumes and we are looking at ways to improve flow in the Urgent Care during the winter flu and cold season to ensure wait times do not increase. In Jan. our Nurse Practitioner's expanded her role to assist with the flow of lower acuity patients in the am during high arrival times while continuing her chronic disease clinic activity in the afternoon. This has expanded the role from 3 days a week to 5 days a week. .

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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Q3 FY2019 Quality Improvement Plan Report

Improve the patient experience through a focus on compassion and excellence

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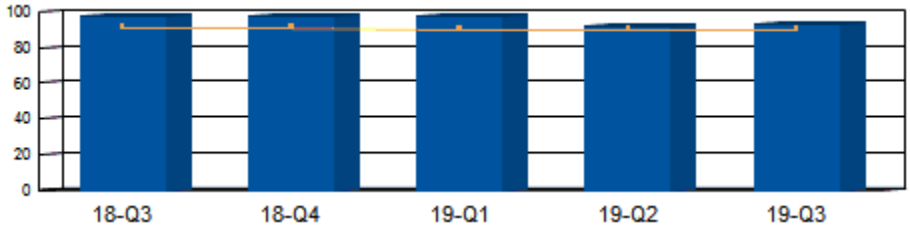
Indicator: Percent of patients requiring palliative care that are discharged from hospital with the discharge status of "Home with Support" (KHSC QIP)



	Actual	Target
18-Q3	97	**91**
18-Q4	97	**91**
19-Q1	97	**90**
19-Q2	92	**90**
19-Q3	93	**90**

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

The working group is working with IT to establish the automated process using a validated tool to identify patients requiring a palliative approach to care; this will ensure a robust denominator that reflects the true extent of the target population. In preparation for the next phase, stakeholder outreach has been conducted with senior leadership for medicine, inclusive of representation from the discharge planning team. The working group has agreed to scope the next tests of change to one area in the hospital. Presentations of findings from the quality improvement project through IDEAS were shared within KHSC and with external stakeholders. KHSC continues to monitor this indicator as part of the strategic initiative to expand access to Palliative Medicine and a palliative approach to care.

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

Result is stable and slightly improved over last quarter. This is reflective of continued efforts to maintain awareness and promote early identification of patients requiring palliative care and ensuring their continued support at home post discharge. There have been no major changes to process for this past quarter.

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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Q3 FY2019 Quality Improvement Plan Report

Improve the patient experience through a focus on compassion and excellence

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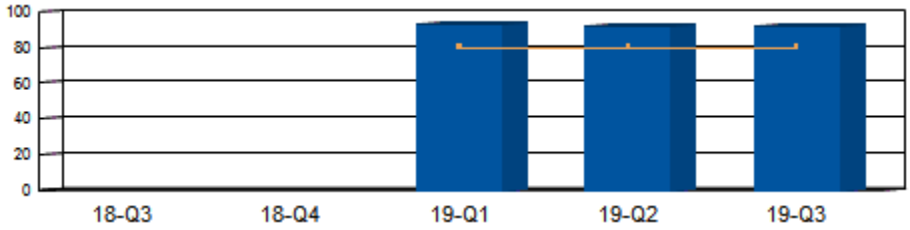
Indicator: Medication reconciliation at discharge (KHSC QIP)



	Actual	Target
18-Q3		
18-Q4		
19-Q1	93	80
19-Q2	92	80
19-Q3	92	80

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

In Fiscal 2018-19 quarter 3, the KHSC medication reconciliation on discharge process was completed by prescribers for 92% of patients admitted to the Hospital (F19 Q2 was also 92%) with 54% of the patients having a best possible medication history (BPMH) or home medication history completed or verified by Pharmacy staff (F19 Q2 was 62%, a drop related to Pharmacy staffing challenges this past quarter).

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 October to December 2018, 92% 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). 54% 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 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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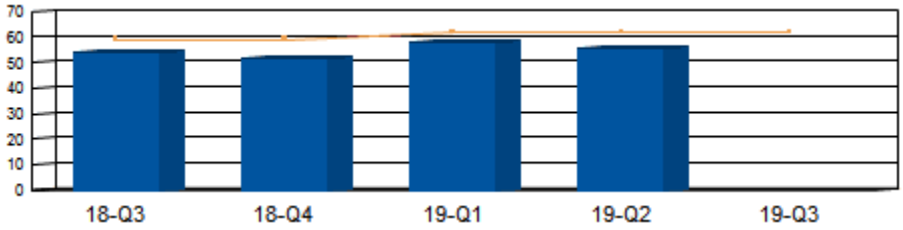
Indicator: Did you receive enough information from hospital staff about what to do if you were worried about your condition or treatment after you left the hospital? (KHSC QIP) (LQ2F)



	Actual	Target
18-Q3	54.0	**59**
18-Q4	51.6	**59**
19-Q1	57.9	**62**
19-Q2	55.7	**62**
19-Q3		**62**

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

The primary tactics to address this indicator are:
- teach back methodology provided to nurses on inpatient units in order to improve effectiveness of discharge teaching and address gaps in health literacy
- My Discharge Plan - a patient-oriented discharge summary with a highlighted section instructing patients on action steps should symptoms or complications occur, including when to seek medical assistance
- Post-Discharge calls within 72 hours for all patients discharged from inpatient medicine units conducted by Health Literacy Nurses. Via this call the Nurse can ascertain whether the patient requires further medical assistance, education in self-management, and can coordinate community supports to address the patient's issue as required which may prevent an unnecessary hospital admission.

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 result reflects Q2 performance due to a delay in accessing data. The result of 55.7 is slightly lower than the Q1 result and is well below our target of 62; however is slightly higher than the F17/18 mean of 55.6. It is important to note that the majority of the tactics described above did not reach full implementation or spread by Q2 and are still undergoing continuous improvements to improve reach and efficiency. There are insufficient data points to determine whether the current result represents a trend - more data is required.

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

Unknown. The tactics described above once fully implemented and spread should begin to improve this indicator in the next fiscal. Taking into consideration the reporting delay of one quarter, improvements may not be realized until Q2 or Q3.

Definition: DATA: Pam Pero (CPES-IC) COMMENTS: Mike McDonald, 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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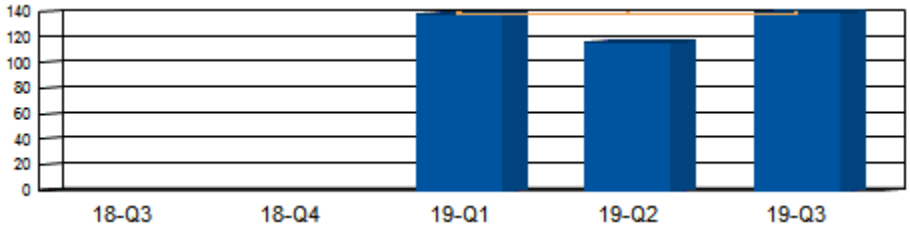
Q3 FY2019 Quality Improvement Plan Report

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-Q3		
18-Q4		
19-Q1	138	**138**
19-Q2	116	**138**
19-Q3	140	**138**

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

Of the 140 incidents of physical violence/physical reported in Q3, 38 staff (27%) indicated they had sustained an injury and of these, 8 (6%) sought first aid or above. The violence prevention initiatives attached to the QIP are on track for completion by end of Q4.

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

One of the main areas of focus in Q3 was the customization of the Stay Safe training program for the Jan 21 & 23 pilot, and compilation of a risk assessment/action plan for the Mental Health Program with incorporation of the recommendations from the external risk assessment results. A working group with union and JHSC representation will oversee the priority setting of controls/recommendations on the action plan in Q4.

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 may not meet our target for a 10% increase in incident reporting; we believe we have plateaued earlier this year however in light of the increased visibility of violence programming in the hospital, we may see an increase in reporting in Q4 which would bring us on target. With regard to the injury rate (requiring first aid treatment or higher), we are on track to meet the target of <7% annually.

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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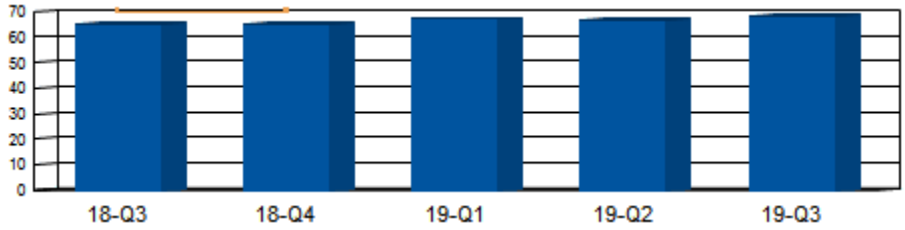
Q3 FY2019 Quality Improvement Plan Report

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)



	Actual	Target
18-Q3	65.0	**70**
18-Q4	65.0	**70**
19-Q1	67.1	
19-Q2	67.0	
19-Q3	68.0	

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

In the past there has been some discrepancy with this metric as not all clinics have a dictated letter and not all letters are generated at KHSC. This metric is still being examined to determine baseline for future 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:

Still validating baseline as described 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?

Once baseline is verified there may be a need to take the information back to the Ambulatory Care Committee and department heads for further conversation.

Definition: DATA: Decision Support - David Barber COMMENTS: Christine Wilkinson 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

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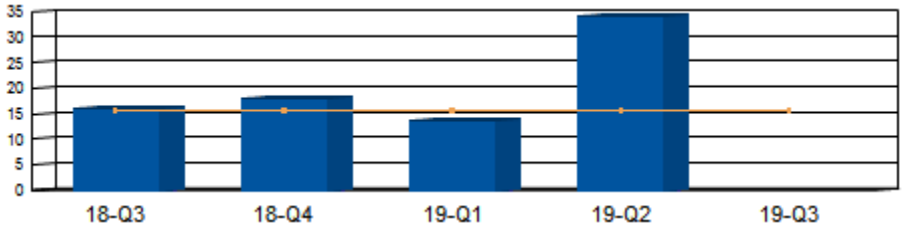
Q3 FY2019 Quality Improvement Plan Report

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)



	Actual	Target
18-Q3	16.0	**15.5**
18-Q4	18.0	**15.5**
19-Q1	13.6	**15.5**
19-Q2	34.2	**15.5**
19-Q3		**15.5**

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

The tactical work plan to address this QBP is described in the COPD QBP (COPD Nurse Navigator for optimization, self-management education, intensive smoking cessation intervention, care coordination/discharge planning, staff education and capacity building, standardized order sets)

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 result reflects Q2 performance as data availability for this indicator demonstrates a delay. For Q2 the result is red, which means the actual result exceeds the target. This result precedes the implementation of all of the tactics described 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?

By Q4 we may begin to see some impact of the comprehensive COPD interventions that were initiated in Q3 but due to the delay of data reporting by one quarter as described above it is likely that we may not see impact until Q2 of the next fiscal and beyond.

Definition: DATA: Decision Support - Alex Ungar COMMENTS: Deanna Abbott-McNeil 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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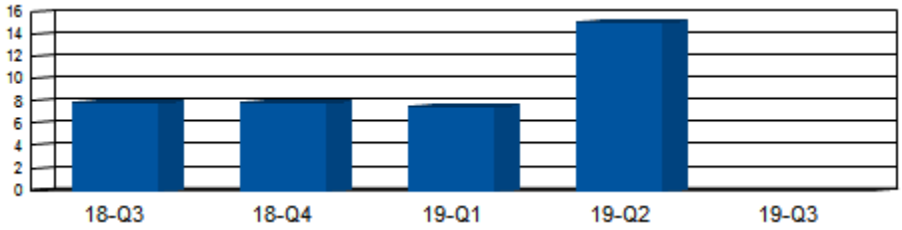
Q3 FY2019 Quality Improvement Plan Report

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)



	Actual	Target
18-Q3	7.8	
18-Q4	7.9	
19-Q1	7.5	
19-Q2	15.0	
19-Q3		

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

Data not yet available

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

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: 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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Q3 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