Cornwall Community Hospital
Hôpital communautaire de Cornwall

QUALITY IMPROVEMENT PLAN (QIP) SCORECARD 2020/2021

Vision: Exceptional Care. Always.

Mission: Our health care team collaborates to provide exceptional patient centered care

Values: *I C A R E* *Integrity - Compassion - Accountability - Respect - Engagement*

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

PATIENT INSPIRED CARE					
Indicator	**Reference**	**Q1**	**Q2**	**Q3**	**Q4**
Patient Experience Survey: Information	QIP	R	Y	Y	Y
Repeat Emergency Visits for Mental Health	QIP	R	G	G	G

PARTNERING FOR PATIENT SAFETY AND QUALITY OUTCOMES					
Indicator	**Reference**	**Q1**	**Q2**	**Q3**	**Q4**
Discharge Summary Sent to Primary Care Within 48 Hours	QIP	G	Y	G	Y
Emergency Visits - Wait Time for Inpatient Bed (TIB)	QIP/OPT	G	Y	R	R
Inpatients Receiving Care in Unconventional Spaces/Day	QIP	G	G	G	G
Medication Reconciliation on Discharge Rate (ROP)	QIP/Accreditation	Y	Y	Y	Y

OPERATIONAL EXCELLENCE THROUGH INNOVATION					
Indicator	**Reference**	**Q1**	**Q2**	**Q3**	**Q4**

OUR TEAM OUR STRENGTH					
Indicator	**Reference**	**Q1**	**Q2**	**Q3**	**Q4**
Workplace Violence Prevention - Incidents	QIP	G	G	G	Y

Results:

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

Reference Definitions:

Accreditation - Accreditation Canada

OPT - (Annual) Operating Plan Target

QIP - Quality Improvement Plan

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Indicator: Patient Experience Survey - Information Inpatient

Strategic Direction: Patient Inspired Care

Definition: Percentage of Inpatient respondents who responded positively (positive response include "completely" and "quite a bit") (Top2Box) to "Did you receive enough information from hospital staff about what to do if you were worried about your condition or treatment after you left the hospital?" (Question #38).

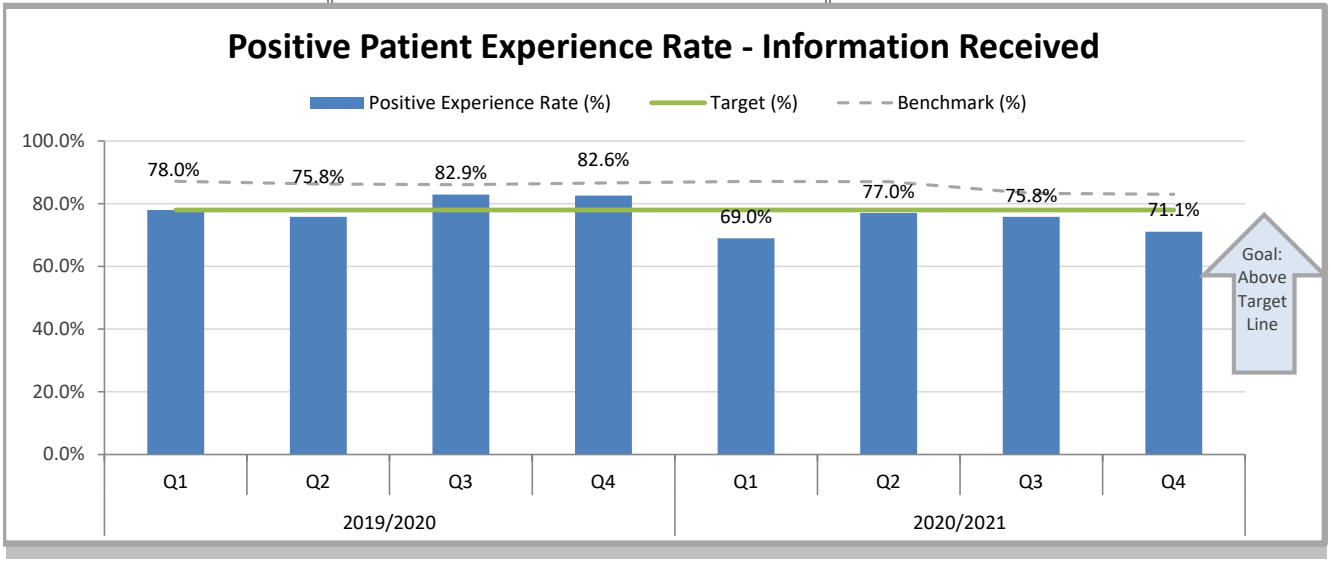
Significance: Taken from HQO, "Patient satisfaction is an important measure of Ontarians' experience with the health care system. Too often, the needs of institutions and healthcare providers come first in Ontario. A paradigm shift is needed, toward a patient-centered health system delivering care that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

Data Source: NRC (National Research Corporation)

Target Information: Set internally at 78%.

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

	2019/2020				2020/2021			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Positive Experience Rate (%)	78.0%	75.8%	82.9%	82.6%	69.0%	77.0%	75.8%	71.1%
Benchmark (%)	87.1%	86.3%	86.1%	86.6%	87.1%	87.0%	83.3%	83.0%
Target (%)	78.0%	78.0%	78.0%	78.0%	78.0%	78.0%	78.0%	78.0%



Performance Analysis:

Q1 Target not met. The biggest impact on Q1 were the low results for April at 55.6%; results for May at 73.1%, and June at 77.4% show an increase by 20% each month over April. Response rate for Q1 is also a bit low at 26.0% due to June being incomplete with closure date being mid September.

Q2 Results for Q2 just slightly below target at 77%, however, it is a significant increase from Q2. The biggest impact on Q2 were the low results for August at 66.7%; both July and September are above target at 81.1% and 82.8% respectively. Response rate for Q2 at 28.2%; however, September is incomplete with closure date being mid-December.

Q3 Target not met. The biggest impact on Q3 were the low results for November at 69.7%; results for October are at 77.8%, and December is currently above target at 80%. Response rate for Q3 is at 30.3%; however, December is incomplete with closure date being mid-March.

Q4 Target not met. Q4 includes results from January at 63.6% and February at 70.1%. March data is not included in Q4 due to analysis calculated over an 11 month period.

Plans for Improvement:

Q1 Continue to educate staff about the importance of PODS (patient oriented discharge summaries) usage and perform regular audits.

Q2 Improve distribution of "discharge folders" (previously circulated by volunteers pre-COVID) to inpatients to retain their PODs and all other education material provided while in hospital. This folder also includes a letter from Mrs. Despatie that links the value of the information received back to the survey satisfaction question.

Q3 Continue to provide the discharge folder for patients' to organize their patient education material. Continue to educate front line staff on the importance of sharing the PODS package with patients on discharge.

Q4 Continue as above.

Accountable: VP, Community Programs / Director, Quality and Risk

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Indicator: Repeat ED Mental Health Visits

Strategic Direction: Patient Inspired Care

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

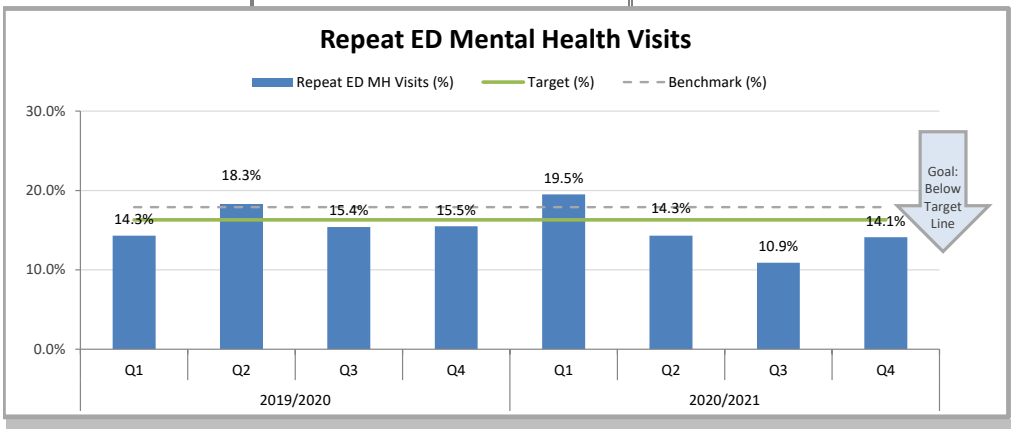
Significance: Repeat emergency visits among those with mental health conditions contribute to emergency visit volumes and wait times. Repeat emergency visits generally indicate premature discharge or a lack of coordination with post-discharge care. Given the chronic nature of the mental health conditions,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

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

Target Information: Target to align with 2018-2019 HSAA and MSAA

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

	2019/2020				2020/2021			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Repeat ED MH Visits (%)	14.3%	18.3%	15.4%	15.5%	19.5%	14.3%	10.9%	14.1%
Benchmark (%)	17.9%	17.9%	17.9%	17.9%	17.9%	17.9%	17.9%	17.9%
Target (%)	16.3%	16.3%	16.3%	16.3%	16.3%	16.3%	16.3%	16.3%



Performance Analysis:

Q1 Data for Q1 is reported on this quarter. All coding has been completed. Total visits to the ED was 267. Of these, 52 were repeat visits representing 19.5% and above our target of 16.3%. There was a slight reduction in overall visits which historically exceeds 300 visits per quarter. This is notable as community programs moved most of their services to virtual and there was concern we would see increased volumes to the ED. There were multiple clients with 3 or more repeat visits within this reporting period. Often, individuals are presenting with complex mental health and concurrent disorders and are involved with multiple services including community programs who require a number of service interactions before stabilizing.

Q2 Data for Q2 is reported on this quarter. All coding has been completed. Total visits to the ED was 328. Of these, 47 were repeat visits representing 14.3% and below our target of 16.3%. There were multiple clients with 3 or more repeat visits within this reporting period. Often, individuals are presenting with complex mental health and concurrent disorders and are involved with multiple services including community programs who require a number of service interactions before stabilizing. A number of clients left against medical advice and returned within the 30 days for ongoing symptoms.

Q3 Data for Q3 is reported on this quarter. All coding has been completed. Total visits to the ED for mental health was 339. Of these, 37 were repeat visits representing 10.9% and below our target of 16.3%. There were multiple clients with 3 or more repeat visits within this reporting period. As previously seen, often individuals are presenting with complex mental health and concurrent disorders and are involved with multiple services including community programs who require a number of service interactions before stabilizing.

Q4 Data for Q4 is reported on and all coding has been completed. Total visits to the ED for mental health was 291 – a reduction from last quarter. Of these, 41 were repeat visits representing 14.1% and below our target of 16.3%. YTD saw 1225 total visits of which 177 were repeat representing 14.4% and meeting our target. This is a slight reduction from the fiscal 19/20 repeat visit rate of 15.3%. Again this quarter, there were multiple clients with 3 or more repeat visits. As previously seen, often individuals are presenting with complex mental health and concurrent disorders and are involved with multiple services including community programs and require a number of service interactions before stabilizing

Plans for Improvement:

Q1 The automatic notification report to the Manager is in queue to be built into Cerner. This will allow us to more quickly identify and intervene with individuals who are repeatedly accessing the ED. Strengthening discharge planning and collaboration between community programs and IMHU will continue to be a focus as will increased collaborative case planning between ED, Community Programs and Inpatient Mental Health in the coming year. The one-year funding of one FTE RN to implement co-response with OPP is moving forward.

Q2 The automatic notification report to the Manager has been built in Cerner and became active November 2020. Repeat visits are now being monitored in real time and individuals are being contacted to offer support and information of services available. Strengthening discharge planning and collaboration between community programs and IMHU continues to be a focus as is increased collaborative case planning between ED, Community Programs and Inpatient Mental Health in the coming year. The Mental Health Crisis Team has received base funding to support mobile co-response with police. The funding will support 1 FTE which will be shared between OPP and CPS. One goal of the program is ED diversion.

Q3 Continue to monitor repeat visits in real time and follow-up where needed. Continued focus on discharge planning and collaboration between community programs and IMHU including collaborative case planning between ED, Community Programs and Inpatient Mental Health. New power form document has been launched in cerner to allow MHCT staff to document client status which ED staff now have immediate access to. Additionally, MHCT now receives automatic referral faxes from the ED when a consult is ordered.

Q4 Continue to monitor repeat visits in real time and follow-up where needed. Utilize power form in cerner consistently and continued focus on discharge planning and collaboration between community programs and IMHU including collaborative case planning between ED, Community Programs and Inpatient Mental Health.

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

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

Strategic Direction: Partnering for Patient Safety and Quality Outcomes

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

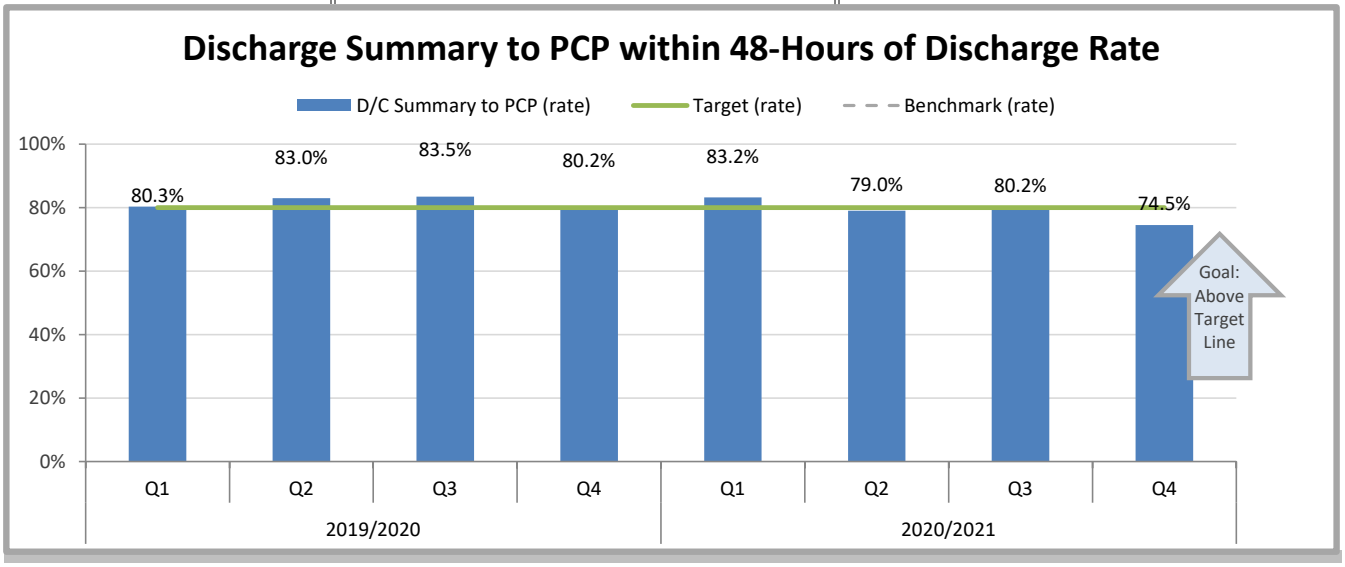
Significance: Health Quality Ontario (HQO) explains "Patients who have multiple conditions and complex needs may require care across different health care settings (e.g., hospitals, family physicians, etc.), which could potentially pose serious risks to their safety and quality of their care. Incomplete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

Data Source: Cerner - Discern Analytics, Electronic Health Record

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

Benchmark Information: N/A

	2019/2020				2020/2021			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
D/C Summary to PCP (rate)	80.3%	83.0%	83.5%	80.2%	83.2%	79.0%	80.2%	74.5%
Benchmark (rate)								
Target (rate)	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%



Performance Analysis:

Q1 Target met. This is a new QIP initiative for FY2021. There were 874 discharge summaries within 48 hours sent to primary care providers in Q1 out of the 1050 applicable discharge summaries. The rate for FY1920 was 81.7%

Q2 Q2 results are slightly below target. There were 286 discharge summaries not sent to PCP within the 48-hour target out of the 1359 applicable discharges. Compared to Q1, we saw a 30% increase in applicable discharges. Of the delinquent discharge summaries, there were six physicians contributing to 64% of the discharge summaries due to timing and beyond the 48-hour target.

Q3 Target met. There were 281 discharge summaries not sent to PCP within the 48-hour target out of the 1420 applicable discharges. While this quarter is green, it was a marginal improvement over last quarter.

Q4 Target not met. There were 324 discharge summaries not sent to PCP within the 48-hour target out of 1272 applicable discharges. It is worth acknowledging that this quarter reports the lowest performance since we began reporting on this indicator. A higher than usual numerator coupled with a lower than usual denominator has had a significant impact on performance in this area.

Plans for Improvement:

Q1 Continue monitoring; look for opportunities for additional automation of processes.

Q2 Further review of automation process to identify gap in performance. Ensure strategies are in place with physicians to close the gap and ensure the 48-hour target is met.

Q3 Continue monitoring. We anticipate that the increased awareness of clear, efficient, timely documentation to support the CCH Patient Portal will have a positive affect on this indicator.

Q4 This indicator is closely related to the "Incomplete Charts" indicator. As we continue to improve in our chart completion and work closely to support the individuals affecting these volumes we expect to see improvement in both areas.

Accountable: Chief Information and Operations Officer / Manager, Patient Flow

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

Strategic Direction: Partnering for Patient Safety and Quality Outcomes

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

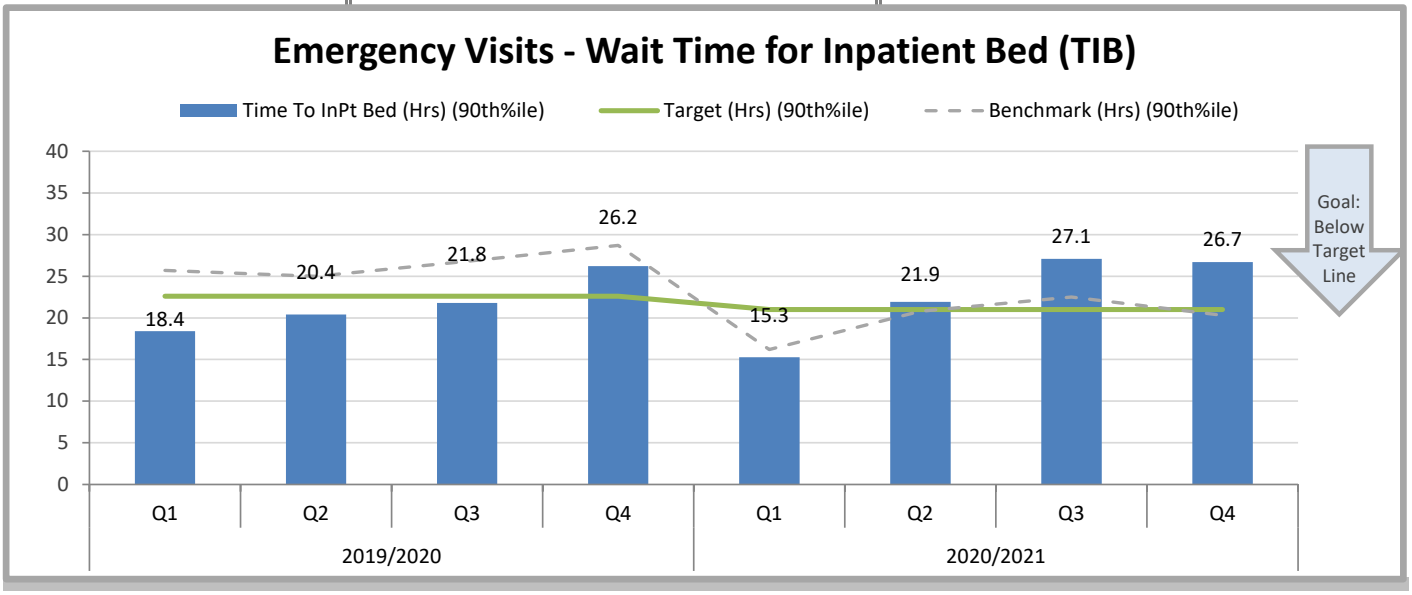
Significance: Time is crucial to the effectiveness and outcome of patient care, especially for emergency patients. In conjunction with other indicators, this can be used to monitor the inpatient bed turnover rate and the total length of time admitted patients spend in the ED in an effort to improve the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

Data Source: Anzer -NACRS

Target Information: Target set in accordance to QIP indicator. Established at 5% reduction of prior FY1920 (Q1-Q4) performance of 22.2.
*Formula is 22.2 * (1 - 5%) =21.0

Benchmark Information: Benchmark performance is based on ATC ER Fiscal Year Report 'High-Volume Community Hospital Group' results in Q1; effective FY2021-Q2, benchmark performance is based on ATC ER Fiscal Year Report 'Medium-Volume Community Hospital Group' results due to our emergency visits dropping to just under 50,000 visits in FY1920. Benchmark results are presented as a year-to-date value.

	2019/2020				2020/2021			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Time To InPt Bed (Hrs) (90th%ile)	18.4	20.4	21.8	26.2	15.3	21.9	27.1	26.7
Benchmark (Hrs) (90th%ile)	25.7	25.0	26.8	28.7	16.2	20.8	22.5	20.3
Target (Hrs) (90th%ile)	22.6	22.6	22.6	22.6	21.0	21.0	21.0	21.0



Performance Analysis:

Q1 Target met and continues to trend well below benchmark high-volume hospitals.

Q2 Q2 slightly below target.

Q3 Target not met.

Q4 Target not met.

Plans for Improvement:

Q1 Adopt a structured and phased approach to manage patient flow based on the number on patients requiring isolation and the total number of inpatients with immediate escalation within the phases by PFM and AHM. Ensure maximum efficiency of space utilization (utilize privates on all levels for new admissions requiring isolation).

Q2 Continued monitoring and strategies as above.

Q3 Continued monitoring and strategies as above.

Q4 Phased approach utilized to increase inpatient capacity based on total volume with goal of zero admissions in ED.

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

Return to Dashboard

Indicator: Inpatients Receiving Care in Unconventional Spaces per Day

Strategic Direction: Partnering for Patient Safety and Quality Outcomes

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

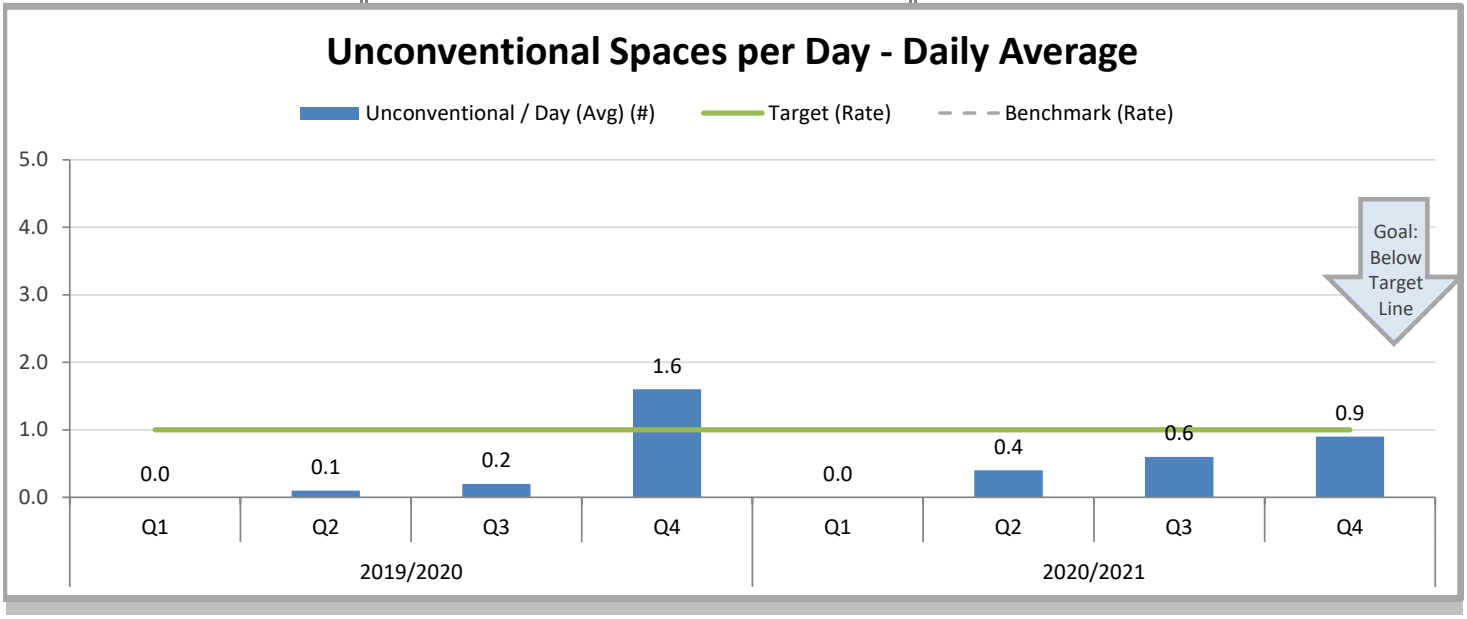
Significance: This indicator provides contextual information on the average number of patients who were admitted into hospitals receiving care in unconventional spaces during the third quarter, 2018/19. This may reflect seasonal surges. The indicator profiles the average number of beds over capacity in Ontario hospitals during this time. In conjunction with other indicators such as time to inpatient bed and the ALC rate, this indicator can be used to monitor a hospital's space capacity and contribute to a better understanding of the issue.

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

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

Benchmark Information: N/A

	2019/2020				2020/2021			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Unconventional / Day (Avg) (#)	0.0	0.1	0.2	1.6	0.0	0.4	0.6	0.9
Benchmark (Rate)								
Target (Rate)	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0



Performance Analysis:

Q1 Target met for overall bed census count.

Q2 Target met.

Q3 Target met.

Q4 Target met.

Plans for Improvement:

Q1 No plans for improvement at this time.

Q2 No plans for improvement at this time.

Q3 No plans for improvement at this time.

Q4 Continue with current process.

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

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

Strategic Direction: Partnering for Patient Safety and Quality Outcomes

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

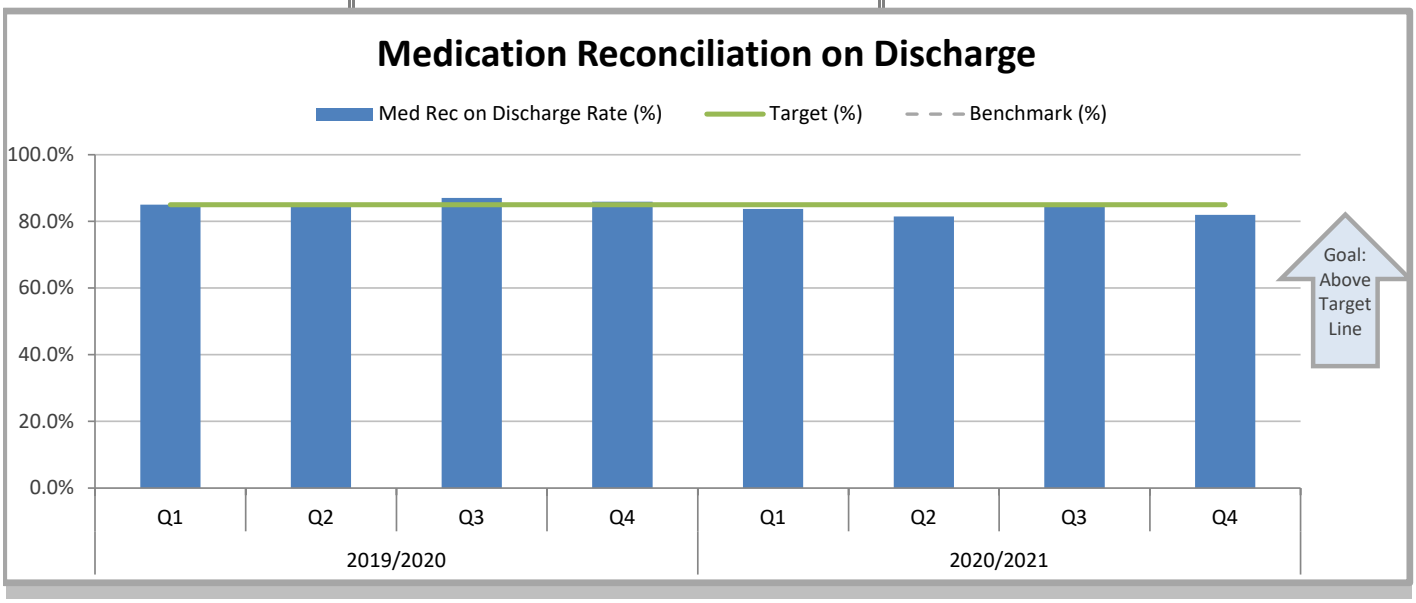
Significance: Medication reconciliation is a formal process in which healthcare providers work together with patients, families and care providers to ensure accurate and comprehensive medication information is communicated consistently across transitions of care. Medication reconciliation requires a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

Data Source: Cerner electronic health record

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

Benchmark Information: N/A

	2019/2020				2020/2021			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Med Rec on Discharge Rate (%)	85.0%	85.0%	87.0%	85.9%	83.7%	81.5%	84.7%	82.0%
Benchmark (%)								
Target (%)	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%



Performance Analysis:

Q1 Target not met, but just slightly. Breakdown by department shows CCU and Mental Health below target at 50% and 80%. All other departments are well within suggested target.

Q2 Target not met. Breakdown by department shows CCU and Mental Health below target at 47.6% and 74.5% respectively. Surgery slightly lower at 77.9%. All other departments are well within suggested target.

Q3 Target met.

Q4 Target not met. Below target are CCU at 34.3%, Cornwall ED at 62.2% and Mental Health at 74.7 for Q4.

Plans for Improvement:

Q1 Focus on CCU and work with intensivists and department to idenitfy barriers and opportunities for improvement; continue improvement in IPMH.

Q2 Ongoing review of department specific strategies.

Q3 Ongoing review of department specific strategies.

Q4 Continue as above.

Accountable: Chief Information and Operating Officer / Chief of Staff

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Indicator: Workplace Violence Prevention - Incidents Reported

Strategic Direction: Our Team Our Strength

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

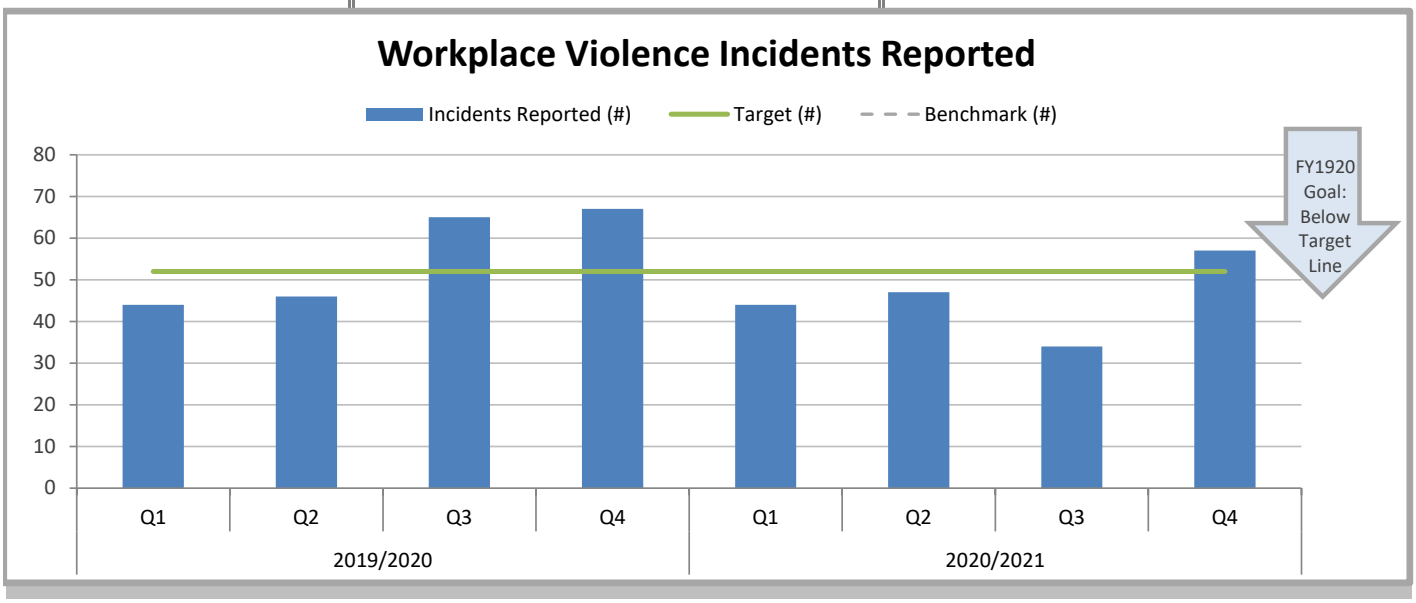
Significance: Workplace violence is defined by the Occupational Health and Safety Act as the exercise of physical force by a person against a worker, in a workplace, that causes or could cause physical injury to the worker. Violence in the workplace is an increasingly serious occupational hazard. Like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

Data Source: RL Solution -Incident Management System

Target Information: Target is set internally at 52 per quarter (total of 210 annually) in accordance to QIP indicator.

Benchmark Information: N/A

	2019/2020				2020/2021			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Incidents Reported (#)	44	46	65	67	44	47	34	57
Benchmark (#)								
Target (#)	52	52	52	52	52	52	52	52



Performance Analysis:

Q1 Target met.

Q2 Target met.

Q3 Target met. Unclear at this point if downtrend is due to lack of reporting of incidents.

Q4 Target not met.

Plans for Improvement:

Q1 Continue with encouraging reporting of incidents by staff and improvement strategies through the Joint Health and Safety Committee.

Q2 Continue with current strategy.

Q3 Continue with current strategy. Emphasize importance of reporting of incidents.

Q4 Continue with current strategy.

Accountable: Chief Privacy and Human Resources Officer / Manager Human Resources

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