Appendix C 2023 / 2024 Quality Improvement Plan (QIP) Indicators, Targets, and Initiatives Worksheet February 2023

Themes	Quality Dimension	QIP Indicators	F23/24 Target	YTD F22/23	Target Justification	Planned Improvement Initiative (Change Ideas)	Methods	Process Measures	Target for Process Measure
THEME I: TIMELY AND EFFICIENT TRANSITIONS	EFFICIENT	Alternate Level of Care	**24.0%**	25.5% (Nov)	The number of patient beds occupied by patients who have been, as determined by a physician, designated as requiring an alternative level of care (ALC) divided by the total number of occupied patient beds within the reporting period multiplied by 100. Stretch of 5% of the Nov Target.	Early identification of discharge planning barriers in collaboration with care team, patients, and families. Streamline ALC process and communication with internal/external stakeholders.	Enhanced interdisciplinary rounds with key focus on discharge barriers. Early engagement of community partners. Ensure accurate discharge plan is documented on all patients with Estimated Date of Discharge (CRUM) Shorten the ALC process to minimize delays to an accurate ALC designation	% of documented ALC Plans Number of days to discharge disposition.	80% ALC patients have documented ALC plans. The formal discharge disposition will be determined in 3 days.
	TIMELY	Time to Inpatient Bed (90th Percentile)	**23.5 hours**	27.1 hours Nov	This indicator calculates the time from disposition (or decision to admit) to the time the patient leaves the Emergency Department for an inpatient bed. 23.5 hours, while higher than the 22/23 target is still a 14% improvement from the YTD Nov results. This is a significant increase.	Collaboration with Analytics to determine system inefficiencies and bottle necks in patient flow. This data will be used to drive change projects which will improve time to bed.	Updated reports with new and relevant information will be developed. They will be used to determine trends and identify areas with potential for improvement with most significant impact.	% of reports revised.	100% of reports revised.
						Anticipate patient movement in advance; develop and implement a system to capture anticipated discharge dates and times that can be shared amongst the care team, patient, and family. This information will be used to determine anticipated bed availability in advance.	Rework of the current red, yellow, green system to better communicate anticipated discharge date. Use the information to predict movement of patients in advance and plan for overflow as needed.	Stoplight system upgraded.	100% of stoplight system upgraded.
						Focused communication and follow up by hospital supervisors and unit leadership 24/7 for any delays in transfers out of the ED.	Tracking of delays for the purpose of identification of barriers to timely transitions.	Reduction in delayed transfers.	Overall decrease in time to bed by 10%.

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		Ambulance Offload Times	**80 minutes**	90.0 minutes Nov	Measures the time in minutes from Arrival of Ambulance to Transfer of Care (TOC) for the 90th percentile This target represents a 10% improvement from current performance.	SAH will plan for a continued dedicated ambulance offload nurse for 2023/24. The ED Triage Reconstruction Project. The ED Flow improvement project is a collaborative approach with stakeholders (both internal and external). The project will review all aspects of flow in the ED, the physical layout and use of space and the care models. The result will be improved wait times, ambulance offload times.	Ambulance offload time reporting Will be determined during initial stages of project. The triage reconstruction project is a portion of the overall ED Flow improvement project. The goal will be to complete the Triage portion of the overall project in this fiscal year.	% of improved ambulance offload time % of project completed in the ED % of project completed in the ED	Improved Ambulance offload time by 10%. To be determined once the Triage project scope has been determined. 25% of ED Flow Improvement project completed by year end
		ED Length of Stay for High Acuity Patients (HSAA)	**13.3**	14.8 hours Nov	This is a Hospital Service Accountability Agreement (HSAA) indicator. It measures the length of stay for the 90th percentile of high acuity patients experienced in the Emergency Department from time of triage/registration until discharged from ED or decision is made to admit.				
		ED Length of Stay for Low Acuity Patients (HSAA)	**6.2 hours**	6.9 hours Nov	This is a Hospital Service Accountability Agreement (HSAA) indicator. It measures the length of stay for the 90th percentile of low acuity patients experienced in the Emergency Department from time of triage/registration until discharged from ED or decision is made to admit.				

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THEME III: SAFE AND EFFECTIVE CARE	**SAFE**	Reported Incidents of Employee Workplace Violence (VPW) (overall)	**201 Incidents**	159 Employee WPV Incidents Dec 212 is the expected year end result	Workplace violence is a priority indicator recommended by OHQ. SAH has been focusing on building a reporting culture for the last several years and we are confident that a reporting culture has been established specific to WPV. SAH will now transition to decreasing Employee incidents of Workplace Violence of all severity – no treatment, first aid, health care and lost time. This is our first year and the target is to decrease our overall Employee incidents of WPV by 5% from the expected F22/23 year end rate.	Consistently review and enhance our response and proactive work specific to workplace violence.	Continued education, checking and reinforcement of existing programs and practices aimed at reducing and/or preventing injury from workplace violence. Support the leadership of our high priority areas in developing department specific action plans to reduce Employee Incidents of workplace violence. The top 3-5 departments will be identified using F22/23 data.	Action plans in place for each identified high priority department. Education and reinforcement completed for 3 existing priority programs and practices.	100% of identified department action plans in place. 100% of planned education and reinforcement for 3 existing programs and practices completed.
		Medication Reconciliation at Discharge	**85%**	84.9% Dec	OHQ does not provide a recommended target; however, suggests an increase as the direction of improvement. Significant attention was focused on this indicator in 2020/2021, 2021/2022, and 2022/23. It has been consistently above 80% since June 2020. The 2022/2023 target was 82%. The new target of 85% is a 3% increase from last year's target.	Target low compliance areas and engage and re-train stakeholders. Provide ongoing physician and staff education/support to outline processes related to electronic completion of discharge medication reconciliation in Meditech Expanse	Share learning modules with all SAH practitioners with a special focus on practitioners such as locums, Obstetricians, CAP Psychiatrist, Pediatricians, Family Medicine Physicians (pods) and Midwives. Clearly outline process for completion of discharge medication reconciliation with departments and physician leaders	Higher % of providers in low compliance areas who have completed discharge medication reconciliation in Expanse and reviewed educational materials/received support.	Improvement in # of discharge medication reconciliation completed in low compliance areas. ↑ number of reviews of educational materials or retraining sessions for areas with low compliance.
						Use results of survey of practitioners, staff, and patients to implement/mobilize resources targeted to support admission BPMH. Prepare outpatient clinics (pre-admit is already using) coming	Using survey results and QA metrics provide additional targeted education and support as required.	Improved rate of BPMH in targeted areas Measure rates of % BPMH confirmed on admission. Reduction in incidents submitted related to	3% improvement of BPMH in targeted areas. > Baseline % of admission BPMH confirmed. Less than 322 BPMH related incidents.

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						online in Phase 2 of Meditech to perform electronic BPMH.		incorrect meds ordered on admission.	
						Continue to collect QI data for: • Med rec completed within 24 hours • Is it confirmed with 2 sources? • Are any errors identified in medication incidents submitted in iReports or from community pharmacies?	Leverage data against results obtained from regional partners / other hospital's BPMH completion and discharge medication reconciliation rates for comparison. Monitor quality indicators. Review all medication incidents. Actively engage with clinical informatics regarding process improvements.	% BPMH Comparison Baseline % BPMH confirmed within 24 hours. % of BPMH confirmed with patient/family as source. Number of medication errors reported where prescriber ordered from unconfirmed BPMH. % of medication incidents reviewed with provider/leader.	>/= % of Comparators 80% or higher BPMH confirmed within 24 hours. 60% or higher BPMH confirmed using more than 1 source. ↓ # BPMH errors following physician/midwife training. 100% medication incidents reviewed by leader/physician and pharmacy committees.
	EFFECTIVE	Mental Health & Substance Use (MH&A) Related ED visit Rate	**52/1000**	54.2/1000 Sept	This indicator measures the rate of unscheduled Emergency Department (ED) visits whose most responsible diagnosis is a mental health or substance abuse conditions per 1000 ED visits. The target for 2022/2023 was 55 days per 1000 visits. 52/1000 is a 4% improvement over the Sept YTD result.	Develop and implement a model of MH&A care and a care environment that is evidence informed, purposefully promotes safety and embraces diversity, equity and inclusivity.	Specialty Clinic revitalization	% of Specialty Clinic operational Establish a baseline for the volumes of 'no show'	100% of clinic operational. 100% of Baseline established
							Urgent Psychiatric Care Clinic	% improvement in the ED 30-Day revisit rate	4% improvement in the ED 30-Day revisit rate.

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					Analysis of the historical target found that accurate measurement should occur in the form of a rate out of 1000 (IC/ES) as opposed to a percentage of total visits. 23/24 target considers historical performance, benchmarks and peer comparisons, organizational commitment and resource allocation.				
							Progress the MH&A Project Phase 1 & 2 (WMS project Community-based MH&A campus)	Withdrawal Management & Safe Beds utilization	Baseline year –Q3 anticipating 80-85% occupancy.
Equitable									

LEGEND	
Planned Improvement Initiatives (Change Ideas)	Specific and practical changes that focus on improving specific aspects of a system, process or behaviour. Change ideas can be tested and measured so that results can be monitored. For example, "Institute a pain management protocol for patients with moderate to severe pain."
Methods	This column identifies the step-by-step methods the organization will use to track progress on its change ideas, and includes details such as how, and by whom (e.g. department) data on the change ideas will be collected, analyzed, reviewed and reported.
Process Measures	The measure that evaluates whether the change idea being tested is working as planned. Processes must be measurable as rates, percentages, and / or numbers over specific timeframes. For example, "Number of fall risk assessments reviewed per month by the quality team, "Number of patients / clients / families surveyed per month.", or "Number of staff that demonstrate uptake of education documented per quarter."
Targets for Process Measure	This is the organization's target for process measure (goal). The target / goal should be SMART – specific, measurable (numerical if possible), achievable, realistic, and time sensitive. E.g. "60% of complex patients will have documentation of a shared care plan at discharge by June 30, 2017 and 70% by December 31, 2017"