2021 / 2022 Quality Improvement Plan (QIP) Indicators, Targets, and Initiatives Approved March 22 2022

Themes	Quality Dimension	QIP Indicators	F21/22 Target	YTD F20/21	Target Justification	Planned Improvement Initiative (Change Ideas)	Methods	Process Measures	Target for Process Measure
	EFFICIENT	Length of Stay (LOS) For Top 5 Most Responsible Diagnosis (MRDx)	**6.5 days**	6.9 Days (Sept 2020)	This indicator calculates the LOS for the top 5 MRDx. These are COPD, Pneumonia, CHF, Stroke, and Sepsis. It is an indicator of SAH's Objective of "Optimize Length of Stay." Exploration of data measures indicates a small number of patients with an extended length of stay skews results. By removing the 10% of patients with the longest stays, the distribution becomes close to normal and mean becomes a statistically appropriate measure. The FY2020/2021 presented unique challenges that created difficulty in achieving the target. Renewed efforts are underway; however, given the current climate, achieving the target is unlikely. The target of 6.5 days for 2021/2022 will be maintained.	1. Improve identification and opportunities to reduce conservable days.	Implementation and sustainment of Blaylock tool.	% of completed Blaylock Tool on 3B and 3C (band).	95%-100% completion of Blaylock Tool of patients on 3B and 3C.
							Monthly review of conservable days data at Governance to identify units/physician targets.	% of Estimated Length of Stay identified for patients on 3B and 3C (band).	95%-100% of patients on 3B and 3C have ELOS identified at daily rounds.
							Introduce Estimated Date of Discharge (EDD) on Acute Medicine to support clinical physician documentation at discharge.	EDD identified for all admitted patients within 24 hours of admission (band).	95%-100% of patients have a documented EDD on Acute Medicine.
						2. Standardize order set completion for top 5 MRDx.	Ensure best practices are being followed by researching evidence informed order sets.	% completion of order sets for each of the 5 MRDx (band).	95%-100% Completion of order sets for each of the 5 MRDx.
							Complete comparison of order sets to ensure they are aligned with the QBP (where applicable).	% orders sets for the 5 MRDx are aligned with QBP (where applicable) (band).	95%-100% of 5 MRDx order sets are aligned with QBP (where applicable).
							Annual review and physician education for order set completion.	% of order sets reviewed annually (band). % physician order set education completed and rolled out (band).	95%-100% of 5 MRDx order sets reviewed annually. 95%-100% roll out of order set education.
	TIMELY	ED Wait Time for Inpatient Bed (90th Percentile)	**21 hours**	23.4 hours (Oct 2020)	This indicator calculates the time from disposition (or decision to admit) to the time the patient leaves the Emergency Department for an inpatient bed.	1. Improve identification of opportunities to reduce conservable days in the Medical Program.	Implementation and sustainment of the Blaylock tool.	% of completed Blaylock Tool on 3B and 3C (band).	95%-100% completion of Blaylock Tool of patients on 3B and 3C.

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					It is a performance measure of SAH's indicators of ED LOS for Admitted Patients and Patient Experience, under the Objective of "Enhance Patient Experience".		Introduce EDD in Acute Medicine to support timely discharges and planning for the clinical team.	EDD identified for all admitted patients within 24 hours of admission (band).	95%-100% of patients have a documented EDD.
					General flow within the hospital was impacted by COVID 19 response. Due to the number of process and documentation changes plus changes in patient volumes, validity of the YTD result is questionable. The target of 21 hours for 2021 / 2022 will be maintained.	2. Identify opportunities to improve availability of acute beds on Medicine.	Explore opportunities for digital bed board that supports timely identification of barriers to patient movement.	TBD	TBD
		ED Admitted Patient Length of Stay (Median)	**10 hours**	9.1 hours median (Oct 2020)	Admitted patient length of stay in the Emergency Department (ED) is a closely monitored metric due to its impact on quality patient care and hospital operations. It is an indicator and performance metric for SAH's Objective of "Enhance Patient Experience." This target is calculated using the median. This better reflects the experience of patients. General flow within the hospital was impacted by COVID 19 response. Due to the number of process and documentation changes plus changes in patient volumes, validity of the YTD result is questionable. The target of 10 hours for 2021 / 2022 will be maintained.	1. Identify opportunities related to the admission process for ED patients to reduce LOS in the ED.	Review and evaluation of the EDMC model for admissions – explore opportunities to reduce batching of referrals to EDMC overnight.	% of batched EDMC overnight referrals.	↓ % of batched EDMC overnight referrals.
						2. Initiatives, Methods, Process Measures, and Target for Process Measure as described in QIP Indicator ED Wait Time for Inpatient Bed (90th Percentile)			

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THEME II: SERVICE EXCELLENCE	PATIENT-CENTRED	Patient Experience % Excellent	**64%**	65.1% (Oct 2020)	Patient experience is the primary measure of quality through the patient lens and is an indicator of the 2021/2022 SAH Objective "Enhance Patient Experience." In 2016 / 2017, we gathered baseline data from which to determine multi-year target progression to 2021 / 2022. The Board approved a patient experience target for 2021 / 2022 of 70% which would place Sault Area Hospital within the Top 25% of NRC hospitals as reported in 2016 / 2017. When setting the target for this year, consideration was given to the significant change the hospital is experiencing as a result of COVID 19 and how this is impacting results. The target of 64% will be maintained for 2021/2022.	1. Continued focus on the Emergency Department patient experience. The ED has a percent excellent score YTD July 2020 - 51.9% and FY 19/20 was 42.3%.	Focused communication efforts at Triage. The Triage Nurse will increase communication and check in with patients in the waiting area.	Increased communication between triage nurse and patients in the waiting area.	65% Excellent in communication dimension of patient experience.
							Review of entire triage process and action items used to develop future initiatives.	% of completion of triage review process.	95%-100% review completed.
						2. Optimization of the EMR has the following benefits for patients a. Improves information sharing b. Reduces length of stay	Socialize Goals of Care with patients, families, and staff.	% completed of Goals of Care pilot	95%-100% completion of Goals of Care pilot.
								Percentage of NRC Patient Experience survey respondents who answered 'Always' (Top Box) to the questions: How often did doctors, nurses, and other hospital staff seem informed and up-to-date about your hospital care.	58% 'Always' result on the question.

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THEME III: SAFE AND EFFECTIVE CARE	SAFE	Reported Incidents of Workplace Violence (overall)	**346**	308 (Dec 2020)	For organizations focusing on building a reporting culture, OHQ recommends setting a target to increase the number of reported incidents. In June 2020, SAH implemented a new incident reporting system and the way the data for this metric is tracked and collected, changed. The new system makes it simpler to report incidents and the target of 288 for 2020/2021 was surpassed in December 2020. The new target is a 20% increase over the previous target.	1. Continue with a focused education campaign on the definition of workplace violence and the importance of incident reporting, highlighting how/where workplace violence incidents are to be reported in our new incident reporting system.	Create workplace violence specific education module for the LMS that provides workers with education related to workplace violence and the importance of reporting. This is a multi-year project with completion expected in 2021/2022.	% completion of the LMS Module.	50% completion of the LMS module.
							Include articles in *Vital Links*, *Doc Talks*, and information to share at huddles (i.e. health and safety news flash)	Number of communications disseminated, huddles attended, and delivery of management session.	Minimum of 3 communications disseminated.
						2. We will develop, pilot and launch the SAH Respectful Workplace Program to replace our current harassment and discrimination policy.	The program will focus on informal resolution and will include tools and guidance regarding how to report and address bullying in the workplace.	% of program rolled out.	Program will be 100% rolled out.

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						3. Consistently review and enhance our Workplace Violence Prevention Program and begin implementation of recommendations from employee consultation.	The following Recommendations from the employee consultation will be considered: • Ongoing review of the code white protocol and subsequent education for staff • Enhance comfort and skills of frontline staff to manage violent situations when they happen, including the delivery of non-violent crisis intervention and de-escalation training • Increased security presence and training for security personnel focussed on de-escalation • Increased access to panic alarms Review of areas of hospital that may be less secure than others, particularly after hours and weekends • Implementation of Senior Leadership Team (SLT) follow-up calls with workers who experience a health care or lost time incident after an assault or incident of violence • Add questioning regarding psychological safety to monthly safety inspections	Number of completed program improvements.	3 completed program improvements.

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		Medication Reconciliation at Discharge	**82%**	85.1% (Oct 2020)	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 and the target of 70% was quickly reached. It has been consistently above 80% since June 2020. It is likely that there is an impact as a result of COVID 19; therefore, a reserved target of 82% has been set.	1. Provide ongoing physician and staff education/support to outline: • Processes related to electronic completion of medication reconciliation and Best Possible Medication History (BPMH) in Meditech Expanse • Proper steps to obtaining an accurate Best Possible Medication History Clearly defining the expectations for completion and target measures	Roll out BPMH and Medication Reconciliation learning modules with nursing staff and new nursing hires. • Ensure expectations pertaining to BPMH and Medication Reconciliation in the updated policy are known to all stakeholders.	% of staff completion of updated educational materials in LMS.	78% completion of updated educational materials.
						2. Provide ongoing physician and staff education/support to outline: • Processes related to electronic completion of medication reconciliation and Best Possible Medication History (BPMH) in Meditech Expanse • Proper steps to obtaining an accurate Best Possible Medication History • Clearly defining the expectations for completion and target measures • Leverage HIS and Analytics Improvements. The previous auditing process was a random sampling of a handful of charts in various	Identify prescribers and areas that are experiencing challenges with medication reconciliation, investigate to determine root, and provide additional targeted education and support as required.	Improved rate of BPMH in targeted areas with BPMH below 82%.	> Baseline % of targeted areas identified with BPMH confirmed rate and/or discharge med rec below 82%.
							Routinely monitor/audit compliance with completion rates and assess to identify opportunities for improvement at the department and provider levels.	Measure rates of % BPMH confirmed. Review % of discharge medication reconciliations completed by provider and unit.	80% or higher BPMH confirmed in all areas. 82% or higher medication reconciliation at discharge completed.

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						inpatient areas. With Expanse data and an updated Analytics algorithm, there is accurate organization-wide data of all admissions.			
						3. Assess quality of BPMH and discharge medication reconciliation for the following indicators: • Med rec completed within 24 hours • Is it confirmed with 2 sources? • Are any errors identified in medication incidents submitted in iReports? 4. Are errors identified by community pharmacies?	Leverage data against results obtained from regional partners / other hospital's BPMH completion and discharge medication reconciliation rates for comparison to help determine an appropriate baseline completion rate. Ensure our metrics for quality meet or exceed standards set by regional ONE steering committee	% BPMH Comparison Baseline	>/= % of Comparators
						5. Assess quality of BPMH and discharge medication reconciliation for the following indicators: • Med rec completed within 24 hours • Is it confirmed with 2 sources? • Are any errors identified in medication incidents submitted in iReports? • Are errors identified by community pharmacies?	Monitor quality indicators such as BPMH confirmation within 24 hours of admission, utilizing 2 sources for verification, and rates of physicians ordering from unconfirmed Home Medication Lists.	% BPMH confirmed within 24 hours.	70% or higher BPMH confirmed within 24 hours.

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						6. Assess quality of BPMH and discharge medication reconciliation for the following indicators: • Med rec completed within 24 hours • Is it confirmed with 2 sources? • Are any errors identified in medication incidents submitted in iReports? • Are errors identified by community pharmacies?	Monitor quality indicators such as BPMH confirmation within 24 hours of admission, utilizing 2 sources for verification, and rates of physicians ordering from unconfirmed Home Medication Lists. Review all medication incidents submitted pertaining to medication reconciliation and BPMH.	% of BPMH confirmed using more than 1 source.	70% or higher BPMH confirmed using more than 1 source.
								% of prescriber orders from unconfirmed BPMH.	Less than 25% of prescriber orders continued from an unconfirmed BPMH.
								% of medication incidents reviewed.	100% medication incidents reviewed.
						Improve transitions from the ED visits to other services within the continuum of care and to home.	Survey community pharmacies, physicians, and NPS to ensure Home Medication Summary is accurate.	Decrease in volume of identified concerns.	↓ # of identified concerns.
	EFFECTIVE	Mental Health & Addictions (MH&A) Revisit Rate	**32%**	35.4% (Oct, 2020)	This indicator measures the percent of unscheduled repeat Emergency Department (ED) visits following an ED visit for mental health and substance abuse conditions. It is a performance measure of the SAH Objective "Optimize Length of Stay." A visit is counted as a repeat visit to the ED if it is either a mental health or substance abuse condition and occurs within 30 days of an index visit for same. It was determined that the previous target of <20 was determined using a different	Improve transitions from the ED visits to other services within the continuum of care and to home.	Utilize the Addiction Medicine Consult Team, (AMCT), Crisis Services (CS), and/or Peer Navigators (PN) to facilitate improved transitions from ED.	% individuals presenting to the ED related to Substance Use Disorders (SUD) who received support from or are followed AMCT, CS, or PN.	75% of those presenting to the ED will be supported or followed-up by AMCT, CS, or PN.

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					definition than the data that was reported. This, coupled with limited community supports, has resulted in a revised target.				
					This indicator measures the percent of unscheduled repeat Emergency Department (ED) visits following an ED visit for mental health and substance abuse conditions. It is a performance measure of the SAH Objective "Optimize Length of Stay." A visit is counted as a repeat visit to the ED if it is either a mental health or substance abuse condition and occurs within 30 days of an index visit for same. It was determined that the previous target of <20 was determined using a different definition than the data that was reported. This, coupled with limited community supports, has resulted in a revised target.	Improve transitions from the ED visits to other services within the continuum of care and to home.	Utilize the Addiction Medicine Consult Team, (AMCT), Crisis Services (CS), and/or Peer Navigators (PN) to facilitate improved transitions from ED. Utilize the MH&A Quality Committee to review and approve pathways for transitions in care for those presenting to ED with MH&A-related presentations.	% of Crisis, Addictions, and Outpatient Mental Health staff who receive training in concurrent disorders and program-wide cross training	85 % of Crisis, Addictions, and Outpatient Mental Health staff will receive training in concurrent disorders and program-wide cross training re: services and pathways
								# Monthly MH&Q Quality Committee meetings.	10 Monthly MH&Q Committee Meetings
							Utilize the MH&A Quality Committee to review and approve pathways for transitions in care for those presenting to ED with MH&A-related presentations.	# Monthly MH&Q Quality Committee meetings.	10 Monthly MH&Q Committee Meetings

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."

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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"								