2022 / 2023 Quality Improvement Plan (QIP) Indicators, Targets, and Initiatives March 2022

Themes	Quality Dimension	QIP Indicators	F22/23 Target	YTD F21/22	Target Justification	Planned Improvement Initiative (Change Ideas)	Methods	Process Measures	Target for Process Measure
THEME I: TIMELY AND EFFICIENT TRANSITIONS	EFFICIENT	Length of Stay (LOS) For COPD (SAH Custom)	**5.7 days**	6.3 days	This indicator calculates the Length of Stay in days for patients having MRDx of Chronic Obstructive Pulmonary Disease (COPD). As of Oct 2021, the average LOS was 6.3 days and the average expected LOS was 5.7 days. Historically SAH trends 1 day over the expected LOS. This target aligns with benchmarking data.	Improve identification of and opportunities to reduce conservable days	Improve use of indwelling catheters	% of indwelling catheter orders	95-100% of indwelling catheters have associated order
		Length of Stay (LOS) for CHF (SAH Custom)	**6.8 days**	6.8 days	This indicator calculates the Length of Stay in days for patients having MRDx of Congestive Heart Failure (CHF) As of Oct 2021, the average LOS was 6.8 days and the average expected LOS was 6.9. Target aligns with benchmarking data.		Improve early mobilization. Monitor and track patient mobilization in the first 24 hours of their admission	% of patients monitored for mobilization in the first 24 hours	95-100% of patients are monitored for mobilization in the first 24 hours
							Ensure timely consults. Reduce time from when a consult is ordered to the time of actual consult	% of patients who have a reduction in consultation time	50% of patients experience reduction in consultation time

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	TIMELY	ED Wait Time for Inpatient Bed (90th Percentile)	**21.0 hours**	18 hours	This indicator calculates the time from disposition (or decision to admit) to the time the patient leaves the Emergency Department for an inpatient bed. 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". 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 should likely remain the same due to recent fluctuations and pandemic impacts.	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.	Will be determined during the initial stages of the project	% of project completed	75% of project completed by year end
		Ambulance Offload Times	**40 minutes**	53 minutes	Measures the time in minutes from Arrival of Ambulance to Transfer of Care (TOC) for the 90th percentile A stretch target of 40 minutes is recommended as we prioritize work with our partners to reduce offload times.	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.	Will be determined during initial stages of project	% of project completed in the ED	75% of project completed by year end

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		ED Wait Time for High Acuity Patients (HSAA)	**10.0 hours**	11.5 hours	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.	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.	Will be determined during initial stages of project	% of project completed in the ED	75% of project completed by year end
		ED Wait Time for Low Acuity Patients (HSAA)	**5.0 hours**	5.5 hours	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 II: SERVICE EXCELLENCE	PATIENT-CENTRED	Patient Experience % Excellent	**64%**	62.5%	Patient experience is the primary measure of quality through the patient lens. There will be a new survey vendor for 2022/23. As of January 24, 2022, details are still pending from OHA. When setting the target for this year consideration is given for this significant change and the continued pandemic impact on results. The target of 64% shall remain with the caveat that this will be revisited should the vendor change indicate such.	Continued focus on the Emergency Department patient experience. The ED has a percent excellent score YTD July 2021 -49.0% and FY 20/21 was 54.7%.	Patient flow and the physical layout of the ED are under review to determine if a different model of care is warranted.	Increased overall Emergency Department patient experience percent positive responses.	54.7% Excellent in Emergency Department patient experience responses.
						Develop a standardized approach for Patient Experience Surveys.	A new vendor presents an opportunity to revise SAH's approach to the process and develop tools to support leaders.	% completion of revised process/tools.	95-100% of the revised process/tools rolled out.
THEME III: SAFE AND EFFECTIVE CARE	SAFE	Reported Incidents of Workplace Violence (overall)	**34 per month** **Annual forecast 408**	36 per month	For organizations focusing on building a reporting culture, OHQ recommends setting a target to increase the number of reported incidents. For 2022/2023 SAH will continue this approach with additional proactive work specific to reducing workplace violence. Once a reporting culture has been established, the future WPV Indicator will focus on a decrease in the number of reported incidents. The new target is just over a 20% increase of the previous target. It will be measured on a monthly average as opposed to a yearly sum, to better monitor reporting. Previous yearly target was 336. New target is 408 or 102 per Quarter	Consistently review and enhance our response and proactive work specific to workplace violence.	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 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 Continue the ongoing analysis of incidents at JHSC. Consider recommendations for improvement.	Number of completed improvements.	3 completed improvements.

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		Medication Reconciliation at Discharge	**82%**	Dec 2021 was 76.1%	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 achieved. It has been consistently above 80% since June 2020. In recent months it has declined likely due to COVID impacting patient flow, discharge planning, physician/midwife workflow and re-training capacity. A target of 80% or higher is recommended to align with other hospitals in the shared Health Information System (HIS). Recommendation is to maintain the 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 and Best Possible Medication History (BPMH) in Meditech Expanse	Share BPMH and Medication Reconciliation 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.
						Formal periodic survey of practitioners and patients to assess opportunities.	Utilize survey results to identify areas that are experiencing challenges; investigate to determine root cause, and provide additional targeted education and support as required.	Improved rate of BPMH in targeted areas Measure rates of % BPMH confirmed.	> Baseline % of targeted areas identified with BPMH confirmed rate and/or discharge med rec below 82%.
						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.

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	EFFECTIVE	Mental Health & Substance Use (MH&A) Related ED visit Rate (SAH Custom)	**55/1000**	55/1000 FY20/21 61/1000	The previous indicator was related to repeat visits to the Emergency Department within 30 days. Until services in the community are enhanced, there are limitations to moving this target. It has been removed as a QIP Indicator but will continue to be monitored by the MH&A program. In its place is the indicator which will measure the rate of unscheduled Emergency Department (ED) visits whose most responsible diagnosis is a mental health or substance abuse conditions per 1000 ED visits. 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.	Develop new and improve existing pathways to SAH and community partner outpatient and community-based services along the continuum of care.	Pilot and implement Remote Care Monitoring	ED Revisit Rate for M&A related visits	2% decrease
							Develop and Implement 'Parents Like Us' Navigation	Crisis Line call diversion	2% decrease
							Progress the MH&A Project Phase 1 & 2 (WMS project Community-based MH&A campus)	Withdrawal Management & Safe Beds utilization	Baseline year for new service location and service capacity
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"