CKHA Quality Improvement Plan (QIP) Scorecard

Cumulative Quarter Results 2016-17

Collapse Rows and Columns

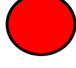
Q1	Q2	PY YTD

results where available

Refresh Scorecard

Success Factor	Performance Indicator	2016-17 Performance Goals	YTD Q1	YTD Q2	PY YTD	Trend	Page	Graphic Trend
Timely	**Emergency Department Physician Initial Assessment**	<4.0 hrs.	4.3	4.0	4.5	↑	3	
PIA --drill down	*Emergency Department Physician Initial Assessment*							
Effective	**30 Day Readmission Rate for QBP CHF patients**	<13.8%	16.4%	19.1%	17.0%	↓	4	
30 D QBP CHF--drill down	*30 Day Readmission Rate for QBP CHF patients*							
Effective	**High Users Cumulative LOS as a proportion of All LOS in acute care**	CB	11.3%	10.6%	10.9%	↑	5	
High User Cumulative LOS--drill down	*High Users Cumulative LOS as a proportion of All LOS in acute care*							
Safety	**Medication Reconciliation done on Discharge**	>76.5%	88.8%	91.2%	70.3%	↑	6	
Med Rec on Discharge--drill down	*Medication Reconciliation done on Discharge*							
Safety	**Medication Reconciliation done on Admissions and Transfers**	>84%	85.6%	86.9%	78.9%	↑	7	
Med Rec on Adm/Trn--drill down	*Medication Reconciliation done on Admissions and Transfers*							
Safety	**Delirium Screening performed for Elderly Patients within 24 hours of Admission**	>70%	76.0%	81.8%	n/a	↑	8	
Delirium--drill down	*Delirium Screening performed for Elderly Patients within 24 hours of Admission*							
Safety	***Clostridium difficile* Infection rate (per 1000 patient days)**	<.26	0.12	0.23	0.26	↑	9	
C-diff--drilldown	*Clostridium difficile* Infection rate (per 1000 patient days)							

Glossary of Terms

Term		Definition
Current Value		The Current Value is the curent fiscal year-to-date value calculated for the indicator. Most indicators are measured quarterly and the reporting period is communicated on the top right corner of the summary sheet (Page 1). For those indicators that are measured monthly, the reporting month will appear on the indicator detail page.
Performance Goal		Performance Goal--This is the goal for each indicator as outlined in the CKHA Strategic Plan/QIP
Current Status		Red indicates that the performance indicator has not met the performance goal for the current reporting period, and has not improved over the prior reporting period
		Yellow indicates that the currrent performance has not met the performance goal but has improved over the prior period
		Green indicates that the performance indicator has met or exceeded or is not statistically different than the performance goal for the current reporting period.
Performance Trend		Performance has improved over the previous reporting period.
		Performance has decreased over the previous reporting period.
		Performance has not changed over the previous reporting period.

Indicator	**ED Physician Initial Assessment**
Success Factor	**Patient Centered Care**
Timeframe	**YTD November 2016/17**
Data Source	**CCO Level 1 NACRS**

Performance Management Summary

Definition:

Time to Physician Initial Assessment (PIA)--Defined as the time from registration date/time or triage date/time (whichever is earlier and valid) to the physcian initial assessment date/time; ED Wait times: 90th percentile ED time to Provider Initial Assessment (PIA) time for all ED patients is measured monthly through Access to Care--Cancer Care Ontario.

Significance:

PIA is one of the most important Emergency Department (ED) wait time metrics--it represents safe patient care (by ensuring our patients are assessed by a Physician in a timely manner) and is also highly linked to patient satisfaction within the ED. Furthermore, by reducing the time to PIA we should be able to reduce all other wait time indicators at the same time, so the level of impact on the overall ED wait times is quite significant.

Performance Goal:

The target is set to 4.0 hours with plan to reach Provincial benchmark (3.0 hrs) in two year.

Current YTD Value	Previous YTD Value	Target	Indicator Status
3.9 hrs	**4.5 hrs**	**< 4.0 hrs**	**Opportunities for improvement**

Provider Initial Assessment Time

(P4R indicator, ALL visits PGH only)
Source: iPort Level 1 NACRS

6.0
5.0
4.0
3.0
2.0
1.0
0.0
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar
PY monthly Results
CY Monthly Results
Target
Linear (CY Monthly Results)

Analysis

The gap between the Provincial benchmark is large we are setting a goal to reach established benchmark in two years. PIA 2015/16 was 4.3 hours Established benchmark is 3.0hrs

Action Plan

Action	Lead	Date Initiated	Current Status
1)Development and Implementation of a "Rapid Assessment Zone " (RAZ) in the Emergency Department 2)Establish a culture of empowerment, knowledge based decision making, teaching and learning regarding the provincial indicators of Provider Initial Assessment (PIA) and ED length of stay (ED LOS)	Lisa High	Apr-16	Ongoing

QIP QPSC MLAA and Program 2016_17 scorecards with filter--30D Readmit CHF QBP

Indicator	**30 Day Readmission Rate for QBP CHF patients**
Success Factor	**Cultivate Collaboration**
Timeframe	**2016-17 September**
Data Source	**Discharge Abstract Database (DAD), CIHI**

Performance Management Summary

Definition:

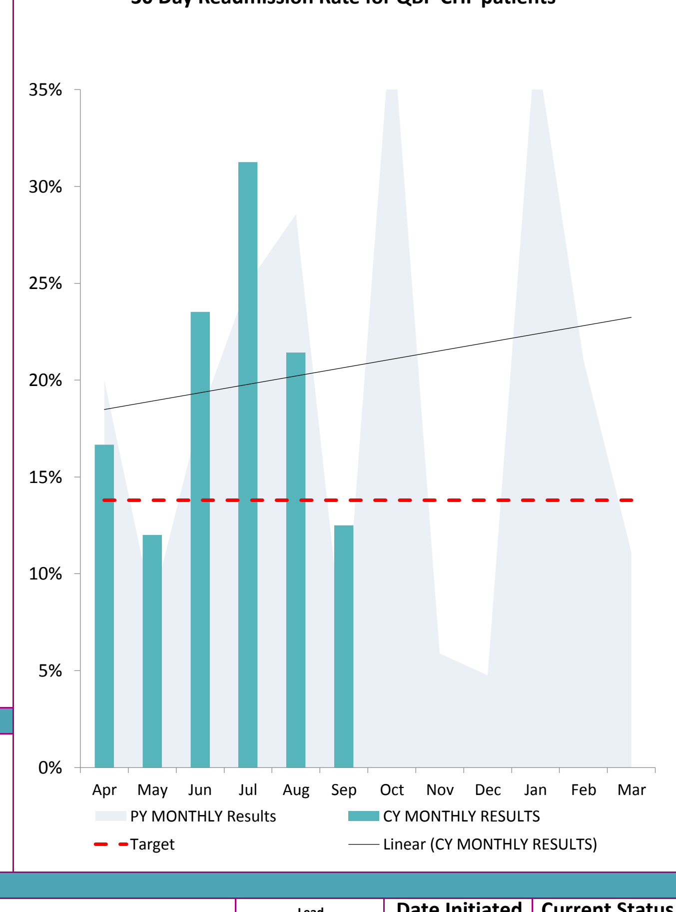
30 day all-cause readmission to CKHA rate for patients with congestive heart failure (CHF), Quality based procedure (QBP) cohort

Significance:

Performance Goal:

The target is set at 13.8%

Current YTD Value	Previous YTD Value	Target	Indicator Status
19.1%	**17.0%**	**< 13.8%**	**Opportunities for improvement**



Analysis

Performance last two years 15.4% and 15.9% respectively, 10% reduction-consistent with our LHIN partners working on integrated plan.

Action Plan

Action	Lead	Date Initiated	Current Status
1)Work on process to facilitate notification of Primary Care Providers via e-notification when patient discharged from hospital Chatham -Kent Quality Integration Committee has been formed. Member representation includes, Hospital, LTC, PCP, FHT, CHC, CCAC. This team will work with Transform (IT provider) to create e-notification 2)Formation of a team that's membership is cross sectorial to reduce 30 day readmission rates. Known as "Chatham-Kent Quality Integration Project" Team will meet monthly, facilitated by Erie St.Clair LHIN Health System Manager. Each sector represented has QIP change initiatives associated with			

QIP QPSC MLAA and Program 2016_17 scorecards with filter--High Users Acute Care

Indicator	**Cumulative LOS for High Users as a percentage of all LOS in acute care during the same period**
Success Factor	**Patient Centered Care**
Timeframe	**2016-17 September**
Data Source	**STAR Registration**

Performance Management Summary

Definition:

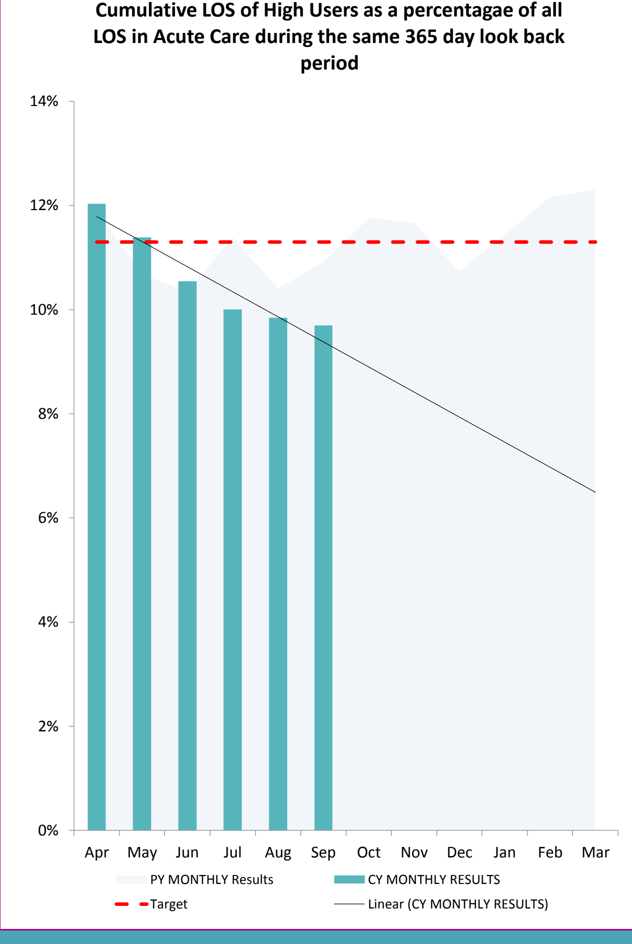
"High users" are defined as patients who have 3 or more admissions within the 365 day look back period and greater than 30 day cumulative LOS, Cumulative LOS of the High User group admitted to CKHA (acute inpatient) within 365 day look back period for any cause is expressed as a % of all LOS to acute care in the same look back period.

Significance:

Performance Goal:

Collecting Baseline

Current YTD Value	Previous YTD Value	Target	Indicator Status
10.6 %	**10.9** %	**CB** %	Collecting Baseline



Analysis

By identifying the patients in the active High User group, individual strategies will be developed and employed to reduce admissions amongst this group. Target is to reduce readmission rate by 10%, however this is a new indicator and we are still collecting baseline. Crude estimate for January 2016- Dec 2016 is. 10.7%.

Action Plan

Action	Lead	Date Initiated	Current Status
1)When a client who is identified as a "high user" is admitted to hospital the CKHA discharge planner and the client's community case manager will meet with client while in hospital 2)Patients defined as "high user" admitted to CKHA will have their community case manager meet with them while in hospital or within three business days of discharge 3)Patients defined as "high users" will have an individualized action plan implemented or action plan revision while in hospital or within seven business days of discharge			

QIP QPSC MLAA and Program 2016_17 scorecards with filter--Med Rec Discharge

Indicator	**Medication Reconciliation on Discharge**
Success Factor	**Patient-Centered Care**
Timeframe	**2016-17 November**
Data Source	**Manual Count Numerators and STAR Registration Denominators (Adm, Trn and Dis)**

Performance Management Summary

Definition:

Total number of adult acute care discharges with medications reconciled as a proportion of the total number of adult acute care discharges (Measured on Medicine and Rehabilitation units only)

% Med Recs done on

●Medicine ● Rehab ● Stroke / patient discharged from those units

Significance:

ROP and Safety CSPI standard

Performance Goal:

The target is set to 76.5%

Current YTD Value	Previous YTD Value	Target	Indicator Status
92.5%	71.2%	> 76.5 %	Have exceeded target

Analysis

Medication Reconciliation on Discharge

Discharges from Medicine, Stroke and Rehabiliation Units

100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%

Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar

PY MONTHLY Results
CY MONTHLY RESULTS
Target
Linear (CY MONTHLY RESULTS)

Action Plan

Action	Lead	Date Initiated	Current Status
1)Realignment of Pharmacy resources to meet demand for Med Rec at discharge Pharmacy Technician participation in daily "bullet" rounds to identify 24 hour discharge/transfer potential. Analysis of admission/transfers occurring that are not receiving med rec currently to inform realignment/reassignment of resources 3)Enhance method of collecting statistics for Medication Reconciliation	Nancy Kay		Ongoing

QIP QPSC MLAA and Program 2016_17 scorecards with filter--Med Rec Admission_Transfer

Indicator	**Medication Reconciliation on Admission and Transfers**
Success Factor	**Patient-Centered Care**
Timeframe	**2016-17 November**
Data Source	**Manual Count Numerators and STAR Registration Denominators (Adm, Trn and Dis)**

Performance Management Summary

Definition:

The total number of adult care admissions and transfers with medications reconciled on the following units; Medicine, Mental Health, ICU/PCU, Surgery as a proportion of the total number of adult care admissions and transfers to those units.

% Med Recs done on ●Medicine ●Psych ●ICU ●PCU ●Surgery

/patients admitted or transferred to those units

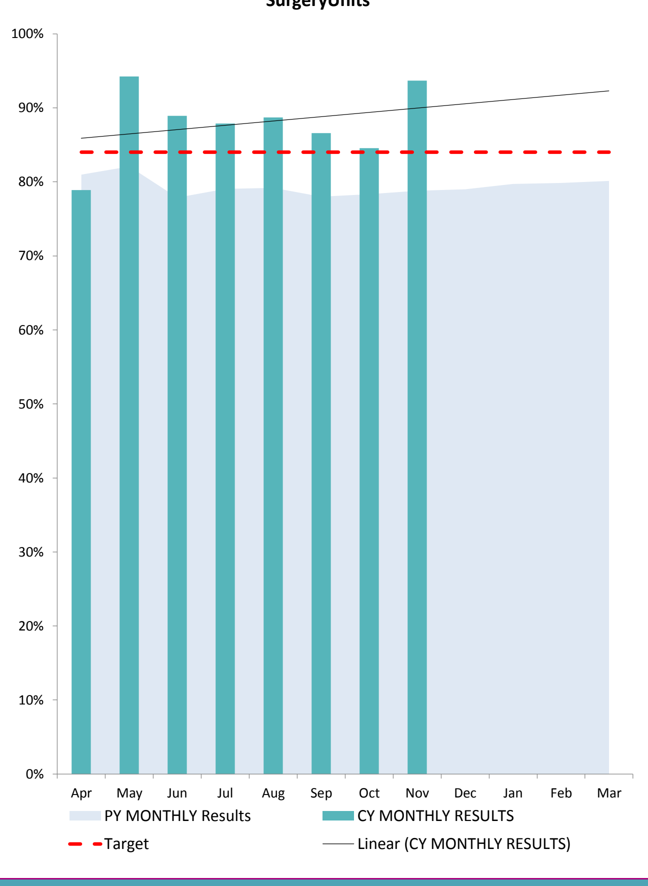
Significance:

Increase the percentage of patients receiving Medication Reconciliation in designated units by 5%

Performance Goal:

The target is set to 84%

Current YTD Value	Previous YTD Value	Target	Indicator Status
87.9%	**78.8%**	**> 84.0 %**	Have exceeded target



Analysis

Action Plan

Action	Lead	Date Initiated	Current Status
1)Realignment of Pharmacy resources to meet demand for Med Rec at admission Pharmacy Technician participation in daily "bullet" rounds to identify 24 hour discharge/transfer potential. Analysis of admission/transfers occurring that are not receiving med rec currently to inform realignment/reassignment of resources	Nancy Kay		Ongoing

QIP QPSC MLAA and Program 2016_17 scorecards with filter--Delirium ICU Medicine

Indicator	**Elderly Patients screened for Delirium using Confusion Assessment Measure (CAM) done within 24 hours of Admission**
Success Factor	**Patient-Centered Care--Care of the Elderly**
Timeframe	**2016-17 October**
Data Source	**CAM Assessment Report from Care Manager and STAR Registration**

Performance Management Summary

Definition:

Percentage of patients (65 and older) receiving delirium screening daily using a validated tool upon admission to hospital. (Includes Medicine, ICU only)

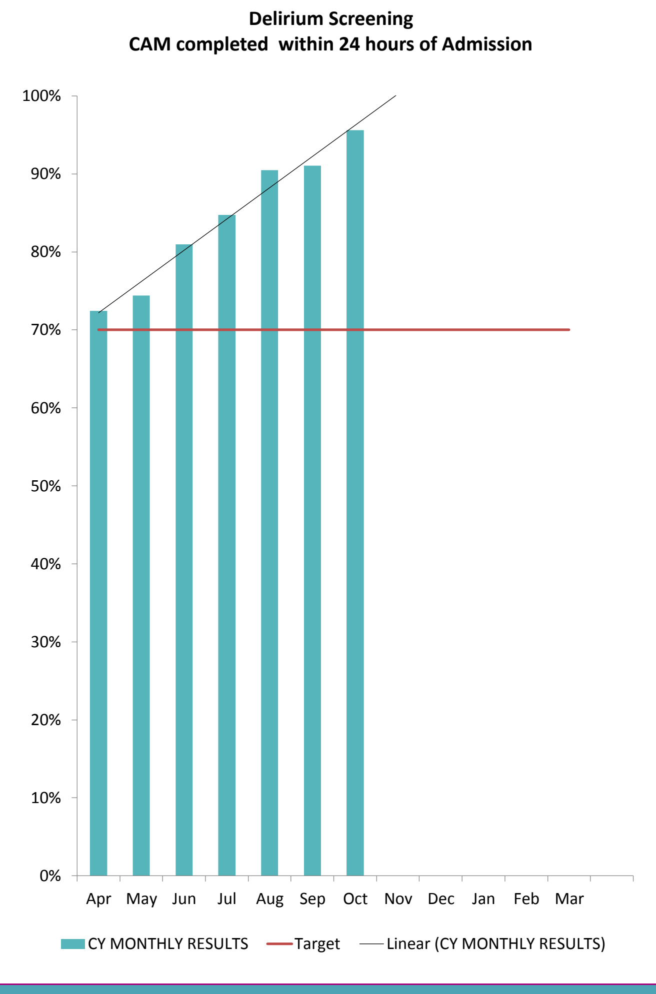
Significance:

Reduce rates and duration of delirium episodes in admitted patients over 65 years of age

Performance Goal:

The target is set at 70% of patients 65 and over, will have CAM assessments completed within 24 hours of admission

Current YTD Value	Previous YTD Value	Target	Indicator Status
77.4 %	new indicator	> 70.0%	**Have exceeded target**



Analysis

Action Plan

Action	Lead	Date Initiated	Current Status
1)Patients 65 and older admitted to ICU and Medicine will receive delirium screening using a validated tool within the first 24 hours admission and daily 2)Development of an electronic tool to audit completion of validated delirium screening tool at admission and daily for all patients on Medicine and ICU	Lisa Northcott	Apr-16	Ongoing

QIP QPSC MLAA and Program 2016_17 scorecards with filter--C.Diff Corporate

CHATHAM-KENT Health Alliance

Indicator	Clostridium difficile Infection rate (per 1000 patient days)
Success Factor	Patient-Centered Care
Timeframe	2016-17 November
Data Source	Self Reporting Initiative (SRI) MoHLTC

Performance Management Summary

Definition:

CDI rate per 1,000 patient days: Number of patients newly diagnosed with hospital-acquired CDI during the reporting period, divided by the number of patient days in the reporting period, multiplied by 1,000.

Significance:

Performance Goal:

Goal is to improve by 3.7 % over last years performance

Current YTD Value	Previous YTD Value	Target	Indicator Status
2.08 per 1000 PD	0.26 per 1000 PD	< 0.26 per 1000 PD	Opportunities for improvement

Clostridium difficile Infection rate
(per 1000 patient days)
Corporate Rate and # of Cases per month
SRI Infection Control

Analysis

Antibiotic Stewartship

Action Plan

Action	Lead	Date Initiated	Current Status
1)Implement the use of the Nocospray cleaning system (sporicidal)on all C-difficile patient rooms and equipment upon discharge or transfer 2)Physician "champion" will review all C-difficile cases in depth with IPAC team to determine possible contributing factors and will consult with patient's MRP and Pharmacist regarding antibiotic use if applicable			Ongoing